

# Centers for Medicare & Medicaid Services

## Medicaid 101: Overview of the Program

### Home and Community Based Services Conference

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# Title XIX of the Social Security Act

- Established in 1965 as a companion program to Medicare
- “Grants to States for Medical Assistance Programs” ---- Medicaid
- Federal/State entitlement partnership program – to individuals & States
- Emphasized dependent children and their mothers, older adults, & individuals with disabilities

# The Beginning of Medicaid

- Initially mostly covered primary/acute health care services
- LTC limited to Skilled Nursing Facility (SNF) services – e.g. nursing homes
- Institutional bias - eventual addition of community-based services---home health, personal care, home and community-based services (HCBS) in the 1980s

# Medicaid in Brief

- States determine their own unique programs
- Each State develops and operates a State plan outlining the nature and scope of services; the State Plan and any amendments must be approved by CMS
- Medicaid mandates some services, States elect optional coverage
- States choose eligibility groups, services, payment levels, providers

# The Single State Medicaid Agency

- Is responsible for the State's Medicaid program
- Assures accountability between the State and federal government
- May not delegate certain functions to another State agency, e.g. policy making or standard setting.
- May enter into a cooperative agreement with other state agencies to carry out specific functions or administrative tasks

# Key State Plan Requirements

- States must follow the rules in the Act, the Code of Federal Regulations (generally 42 CFR), the State Medicaid Manual, and policies issued by CMS
- States must specify the services to be covered and the “amount, duration, and scope” of each covered service
- States may not place limits on services or deny/reduce coverage due to a particular illness or condition
- Services must be *medically necessary*
- Third party liability rules require Medicaid to be the “payer of last resort”

# Additional State Plan Requirements

- Generally, services must be available Statewide
- Freedom of choice of providers
- Enrolled all willing and qualified providers
- Provider qualifications
- Payment for services (4.19-B pages)
- Reimbursement methodologies must include methods/procedures to assure payments are consistent with economy, efficiency, and quality of care principles

# Why Change the State Plan?

- Mandated legislative changes (State/federal)
- Change in eligibility group or resource standards or covered service(s)
- Change/addition of managed care services
- Implementation of optional services
- Change in payment methodology



# Medicaid Benefits in the Regular State Plan

## MANDATORY

- Physician services
- Laboratory & x-ray
- Inpatient hospital
- Outpatient hospital
- EPSDT
- Family planning
- Rural and federally-qualified health centers
- Nurse-midwife services
- NF services for adults
- Home health

## OPTIONAL

- Dental services
- Therapies – PT/OT/Speech/Audiology
- Prosthetic devices, glasses
- Case management
- Clinic services
- Personal care, self-directed personal care
- Hospice
- ICF/IID
- PRTF for <21
- Rehabilitative services

# EPSDT

- Early and Periodic Screening, Diagnostic and Treatment Services
- EPSDT is a preventive and comprehensive health service for Medicaid individuals under the age of 21
- Health care must be made available for treatment or other measures to correct or improve illnesses or conditions discovered by the screening service. All Medicaid 1905 (a) coverable, medically necessary, services must be provided even if the service is not available under the State plan to other Medicaid eligibles.
- The State Medicaid agency determines medical necessity.

# Medicaid Administrative Activities

- Must be found necessary by the Secretary for the proper and efficient administration of the State plan
- Must conform to Office of Management and Budget (OMB) Circular A-87
- Must be reasonable and necessary for the operation of the governmental unit or the performance of the federal award
- Are matched at a 50% FFP rate

# Medicaid Eligibility

- Individuals must be in a “group” covered by the State’s Medicaid program
- Some groups are mandatory, others are optional
- Almost all groups include people who are:
  - aged, blind, or disabled
  - under 21
  - pregnant
  - parent/caretaker of a child
  - Childless adults - 2014

# Home & Community-Based Services

Available through the State plan - 1905 (a) and other State plan authorities:

- Personal Care
- Home Health (nursing, medical supplies & equipment, appliances for home use, optional PT/OT/Speech/Audiology)
- Rehabilitative Services
- Targeted Case Management
- Community First Choice- 1915 (k)
- Self-directed Personal Care – 1915 (j)
- State plan HCBS- 1915 (i)

# Participant Direction of Services

- Available through the State plan [Sections 1915(i) (j), and 1915(k)]
- Available in 1915(c) waivers
- Permits beneficiaries to exercise decision-making authority over some/all waiver/State plan services and accept the responsibility for taking a direct role in managing them
- May allow for recruiting/hiring/firing staff
- Employer Authority and Budget Authority
- Supports – Information/Assistance and Financial Management Services

# Benchmark Benefit Packages – Section 1937 of the Act

- Permit States to provide alternative benefit coverage to specified groups
- Benchmark, now Alternative Benefit Plans (ABPs)
- Provision of Essential Health Benefits (EHB)
- States cannot require some groups to enroll (people with disabilities, special needs, children in foster care or adoption assistance, other groups)
- Coverage vehicle for newly eligibles in 2014
- CMS has been providing intensive technical assistance for states that are expanding their Medicaid programs.
- Separate session on ABPs and Marketplace

# §1937 Alternate Benchmark Plans

- States must submit a State Plan Amendment to CMS
- Key features
  - ABP8 may be used to link or authorize managed care
  - State can require most beneficiaries to get services from health plans (or primary care case manager)
  - State can allow health plans to provide different benefits to enrollees
- No 'cost' test
- Approval is infinite, so long as CMS approves managed care contracts and payment rates
- There are three states that use 1937 authority for their managed care program: Idaho, Kentucky (new adults only), & New Hampshire (new adults only)



# How can a State implement managed care?

- The 'default' delivery system in Medicaid is fee-for-service (FFS)
  - The State contracts directly with health care providers and pays them (typically) a fee for every covered service they provide to Medicaid beneficiaries
- To run a delivery system other than FFS, the State must get approval from CMS

# How can a State implement managed care?

- States can decide how to structure their managed care program by deciding:
  - Who will enroll (eligibility groups)
  - What services will be provided (scope of benefits)
  - Where will it operate (geographic reach)
  - Who will provide the services (type of provider)
- CMS provides technical assistance and directs States to the Federal authority that will accommodate their program design

# Managed Care Authorities

The Social Security Act (which authorizes the Medicaid program) provides four different ways under which states may operate managed care programs (numbers below reference sections of the SSA):

- 1915(a) - Voluntary Program
- 1932(a) - State Plan Amendment
- 1937 – Alternate Benchmark Plans
- 1915(b) - Managed Care Waiver
- 1115(a) - Research & Demonstration Waiver

# §1915(a) Voluntary Program

- Managed care enrollment is voluntary – beneficiaries must have option to receive services FFS
- State must contract with any qualified, willing provider
- Self-implementing upon approval of managed care contract by CMS
- No ‘cost’ test
- Approval is infinite, so long as CMS approves managed care contracts and payment rates

# §1915(a) Voluntary Program

- Less than 15 1915(a) programs in country
- Over half enroll elderly and/or disabled beneficiaries and may include HCBS services
  - DC
  - MA
  - MN
  - PA
  - WI

# §1932(a) State Plan Amendment

- States must submit a State Plan Amendment to CMS
- Key features
  - State can require most beneficiaries to get services from health plans (or primary care case manager)
  - State can operate managed care only in certain areas
  - State can limit the number of health plans it contracts with
  - State can allow health plans to provide different benefits to enrollees
- Certain populations are excluded from mandatory enrollment
  - Dual eligibles, AI/AN, and special needs children
- No 'cost' test
- Approval is infinite, so long as CMS approves managed care contracts and payment rates

# §1932(a) State Plan Amendment

- 20 States operate managed care through this authority
- They are split between small regional programs and large statewide programs
- States with statewide programs include:

| Colorado   | DC             |
|------------|----------------|
| Georgia    | Louisiana      |
| Maine      | Mississippi    |
| Nevada     | North Carolina |
| Ohio       | South Carolina |
| Washington | Wisconsin      |

# §1915(b) Managed Care Waiver

- States must submit a waiver application to CMS
- Key features
  - State can require all Medicaid beneficiaries to get services from health plans (or primary care case managers)
  - State can operate managed care only in certain areas
  - State can limit the number of health plans it contracts with
  - State can allow health plans to provide different benefits to enrollees
- State must show that waiver is “cost effective” over the waiver period
- Waiver approval is generally for two years at a time; state must apply to ‘renew’ within 90 days of expiration date
- CMS also has to approve managed care contracts and payment rates



# §1915(b) Managed Care Waiver

- About 14 States operate managed care through this authority
- Less than half provide limited benefits (primarily mental health) and the others are large statewide programs
- States with statewide programs include:

| Alabama       | Kentucky     |
|---------------|--------------|
| Michigan      | Missouri     |
| Nebraska      | Pennsylvania |
| Utah          | Virginia     |
| West Virginia |              |

# §1115 Research & Demonstration Waivers

- Must assist in promoting the objectives of the Medicaid or CHIP statute, as determined by the Secretary
- Provides waivers from statutory and regulatory requirements not available under SPAs or 1915(b) waivers
- Allows States to receive Federal match for activities not otherwise considered medical assistance
- In wide use since mid-1990s, esp. to expand coverage to childless adults

# §1115 Research & Demonstration Projects

- States must submit a demonstration application to CMS
- State must show that demonstration is “budget neutral” over the demonstration period
- Demonstration approval is generally for five years at initial approval and for three years at a time thereafter
- CMS also has to approve managed care contracts and payment rates

# §1115 Research & Demonstration Projects

- Less than 20 States operate managed care through this authority
- Virtually all are large statewide programs; 10 also include HCBS services(\*)

|               |                |           |
|---------------|----------------|-----------|
| Arizona*      | California*    | Delaware* |
| Florida       | Hawaii*        | Indiana   |
| Maryland      | Massachusetts* | Minnesota |
| New Mexico*   | New York*      | Oregon    |
| Rhode Island* | Tennessee*     | Texas*    |

# Concurrent Authorities

- States may also operate their managed care programs alongside other Federal authorities that provide benefits not available under the State plan
- For example, a state that wants to deliver home and community-based services through a managed care delivery system. (i.e. ‘managed long-term services and supports’) can operate any of the managed care authorities ‘concurrently’ with a 1915(c) waiver.

# Concurrent Authorities

- CMS has approved the following types of concurrent waivers:
  - 1915(b)/(c) waivers;
  - 1915(b)/(c)/(i) waivers;
  - 1915(b)/(i) waivers;
  - 1915(b)/(k) waivers;
  - 1932(a)/(c) waivers;
  - 1115(a)/1915(b); and,
  - 1115(a)/1915(c) waivers
- 17 States operate MLTSS programs using concurrent authorities

# Questions?

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