



Medicaid 101: Overview of the Program

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Medicaid Program Background

- Implementing legislation
 - *Title XIX of the Social Security Act*
- Section 1902(a)(10)(A) of the Social Security Act (the Act) provides “for making medical assistance available...”
- Partnership between Federal and State governments
- State administered program
- Policies & programs vary from state to state

The Beginning of Medicaid

- Emphasized dependent children and their mothers, older adults, & individuals with disabilities
- 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, optional services, payment levels, providers

State Administered/Federal Oversight

- Section 1902(a)(5) of the Act provides for the designation or establishment of a Single State Agency responsible for the administration of the State Plan.
- State Medicaid Agencies:
 - Establish eligibility standards
 - Determine the services available and their amount, duration and scope
 - Determine the delivery system for services
 - Set payment rates for services; and
 - Administer the day-to-day operations

Medicaid Eligibility

- Individuals must be in a “group” covered by the state’s Medicaid program
- Some groups are mandatory, others are optional
- Examples:
 - Aged, Blind, or Disabled
 - Under 21
 - Pregnant women
 - Parent/Caretaker of a child
 - Childless Adults - 2014

State/Federal Partnership & the Medicaid State Plan

- The Medicaid State Plan
 - is a comprehensive written statement
 - describes the nature & scope of the Medicaid program; and
 - contains assurances that the program will be operated per the requirements of Title XIX of the Social Security Act and other official issuances
- Developed and amended collaboratively with CMS

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 deny/reduce coverage due to a particular illness or condition
- Services must be medically necessary

Key State Plan Requirements: Sufficiency

- “Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose.” 42 CFR 440.230(b)
- Amount, duration, and scope:
 - How much
 - How long
 - To what extent
- Adequate to achieve purpose of service
- Cannot be reduced based on diagnosis, type of illness, or condition of beneficiary

Key State Plan Requirements: Statewideness

- Section 1902(a)(1) and 42 CFR 431.50: “. . .The plan will be in operation statewide through a system of local offices, under equitable standards for assistance and administration that are mandatory throughout the state. . .”
- Statewideness - Available throughout state to extent feasible, reasonable, and practical

Key State Plan Requirements: Comparability

- Section 1902(a)(10)(B) and 42 CFR 440.240
 - With certain exceptions, services available to any categorically needy recipient are not less in amount, duration, and scope than those services available to a medically needy recipient; services are equal for any individual within an eligibility group.
 - Same amount, duration, and scope within categorically needy and medically needy groups
 - Exceptions: targeted case management; services provided only to children under EPSDT; IMD for persons 65 years and older; inpatient psychiatric services for persons under 21; services to pregnant women

Key State Plan Requirements: Freedom of Choice

- Section 1902(a)(23) of the Act provides that “any individual eligible for medical assistance... may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required... who undertakes to provide him such services.”
 - Beneficiaries must have a choice of qualified providers
 - And any willing and qualified provider must be allowed to participate in Medicaid program

Additional State Plan Requirements

- Provider qualifications-42 CFR 431.51 (c) -Provider qualifications established by the state are reasonably related to the Medicaid service(s) furnished
- 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

State Plan Amendments

- Submission of a State Plan Amendment (SPA) is necessary to make any changes in coverage or reimbursement for services.
- Why change the state plan?
 - Mandated legislative changes (state/federal)
 - Change in eligibility group or resource standards
 - Change/addition of managed care services
 - Implementation of optional services or other changes to covered benefits
 - Change in payment methodology

Medicaid Benefits in the Regular State Plan

- **MANDATORY**

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment services
- Nursing Facility services
- Home Health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center services
- Laboratory and X-ray services
- Family Planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco Cessation counseling for pregnant women

- **OPTIONAL**

- Prescription Drugs
- Rehabilitative services
- Clinic services
- Therapies – PT/OT/Speech/Audiology
- Respiratory care services
- Other diagnostic, screening, and preventive services
- Podiatry services
- Optometry services
- Dental services & Dentures
- Prosthetics
- Eyeglasses
- Other Licensed Practitioner services
- Private Duty Nursing services
- Personal Care services
- Hospice
- Case Management & Targeted Case Management
- TB-related services
- State Plan HCBS - 1915(i)
- Community First Choice Option - 1915(k)

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 ameliorate 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 eligible individuals
- The State Medicaid Agency determines medical necessity

Home & Community-Based Services

- There are multiple HCBS available through the State Plan - 1905(a) and other State Plan authorities:
 - Personal Care Services
 - Home Health (mandatory: skilled nursing, home health aide, medical supplies, equipment and appliances; optional: PT/OT/Speech/Audiology)
 - Rehabilitative Services
 - State plan HCBS- 1915(i)
 - Self-directed Personal Care – 1915(j)
 - Community First Choice Option- 1915(k)

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 State Plan or waiver 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 options
- Supports: Information/Assistance and Financial Management Services

Benchmark Benefit Packages

Section 1937 of the Act

- Benchmark, now Alternative Benefit Plans (ABPs)
- Provision of Essential Health Benefits (EHB)
- Permits states to provide alternative benefit coverage to specified groups
- 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 eligible individuals since 2014
- CMS has been providing intensive technical assistance for states that are expanding their Medicaid programs

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 Medicaid authority that will accommodate their program design

Managed Care Authorities

- The Social Security Act provides six 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
 - 1115(A) – Duals Demonstrations (Medicare/Medicaid)

§1915(a) Voluntary Program

- Managed care enrollment is voluntary – beneficiaries must have option to receive services via 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

§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

§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

§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, especially to expand coverage to childless adults prior to ACA

§1115 Research & Demonstration Waivers

- 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

Concurrent Authorities

- States may also operate their managed care programs alongside other Federal authorities
- 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

Questions?

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