



# MEDICAID 101: EVERYTHING YOU WANTED TO KNOW ABOUT MEDICAID

...but were afraid to ask

August 26, 2019

# Welcome!



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- Welcome to the 2019 National Home and Community-Based Services Conference!
- This year, we will welcome over 1,500 Aging and Disability professionals from Federal & State Governments, nonprofits, providers, IT companies, advocacy organizations, consumer groups, and research entities
- NASUAD will also be announcing our new name during tomorrow's plenary!
- ...and don't forget the Tuesday night dance party celebrating our 55<sup>th</sup> Anniversary!

# Overview of the Day

- Given the breadth and depth of many of the conference sessions, prior year participants felt that a session on core Medicaid concepts would be helpful at the beginning
- We began the 101 intensive 5 years ago:
  - ▣ Feedback from prior participants indicates that it's useful for individuals new to the aging & disability field, for those working in non-Medicaid programs, and for those who want a refresher on issues
- This day is about you, the attendees:
  - ▣ We have a great cadre of experts who have led a number of different state programs
  - ▣ Ask questions and use the opportunity to learn from some of the best Medicaid minds the country has to offer!

# Today's Agenda



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- Medicaid Administration and Operations
- Medicaid Eligibility
- Services and Utilization Management
- Break:
  - ▣ Head to the Grand Ballroom for Lunch & Opening Plenary with Lance Robertson, ACL Administrator & Assistant Secretary for Aging
- Payments, Financing, and Program Integrity
- Long-term Services and Supports (LTSS)
- Managed Care and LTSS (MLTSS)
- Current Hot Topics in Medicaid



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CERTIFIED PUBLIC ACCOUNTANTS

# OVERVIEW AND HISTORY OF MEDICAID: HOW MEDICAID IS ADMINISTERED

Jerry Dubberly, Principal

DEDICATED TO GOVERNMENT HEALTH PROGRAMS





## ■ MEDICAID HISTORY

- Signed into law July 30, 1965 along with Medicare
- Title XIX of the Social Security Act
- State and Federal Partnership
- Entitles certain individuals to health care coverage





## ■ MEDICAID HISTORY

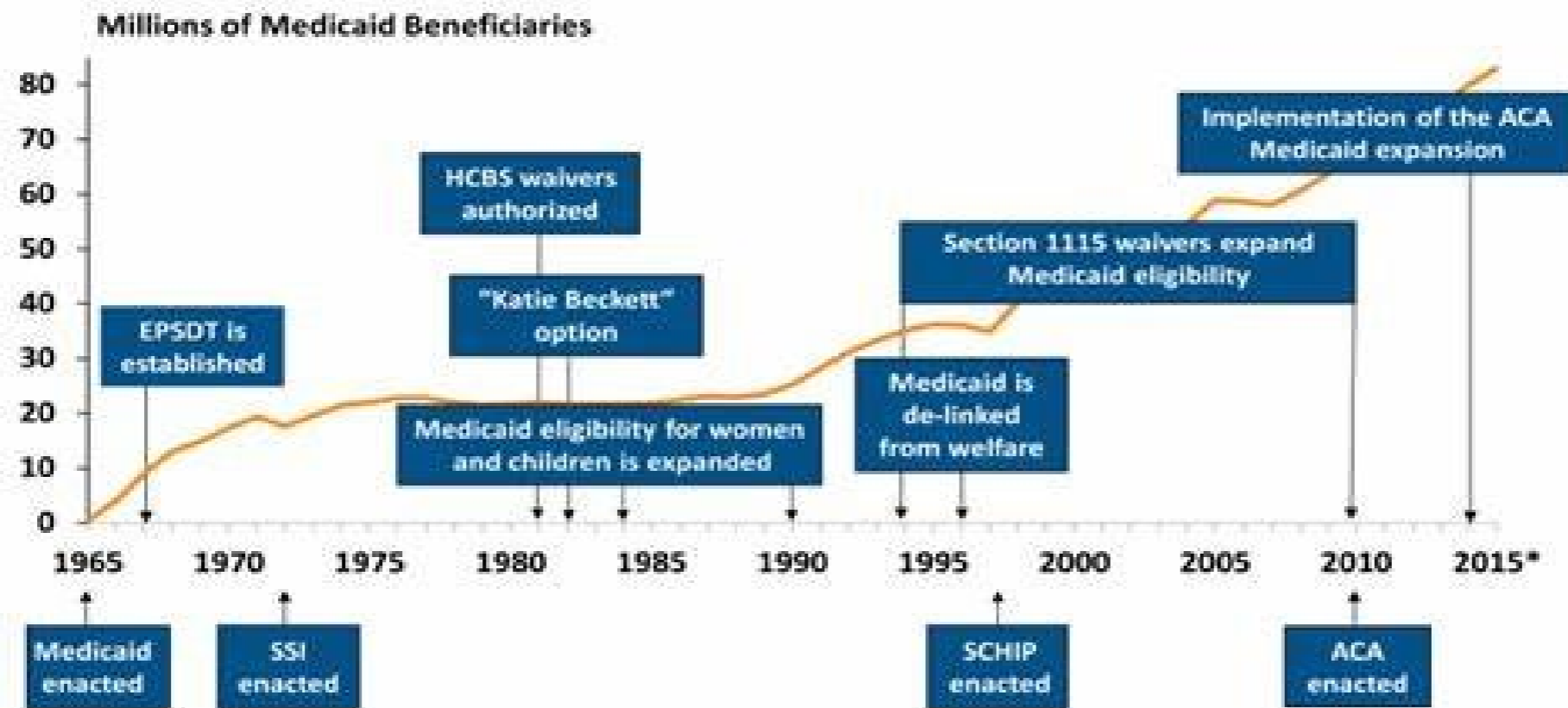
- Originally, health plan for low-income individuals on welfare but delinked from welfare in the 1980's and 1990's.
- Optional program – all states and territories participate today.
- Mandatory and Optional benefits.



## ■ MEDICAID HISTORY

Figure 2

Medicaid has evolved over time to meet changing needs.



NOTE: \*Projection based on CBO March 2015 baseline.

SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2011, as well as March 2015 CBO baseline ever-enrolled counts.







## ■ MEDICAID TODAY

- Medicaid covers 21% of Americans
- Enrollment: 72,295,837
  - Medicaid: 65,663,268
  - Children's Health Insurance Program: 6,632,569
- Medicaid Expenditures \$581.9 Billion in FY2017
  - 17% of total National Health Expenditure
- CHIP Expenditures \$18 Billion in FY2017
- Medicaid is the primary payer across the nation for long-term care services

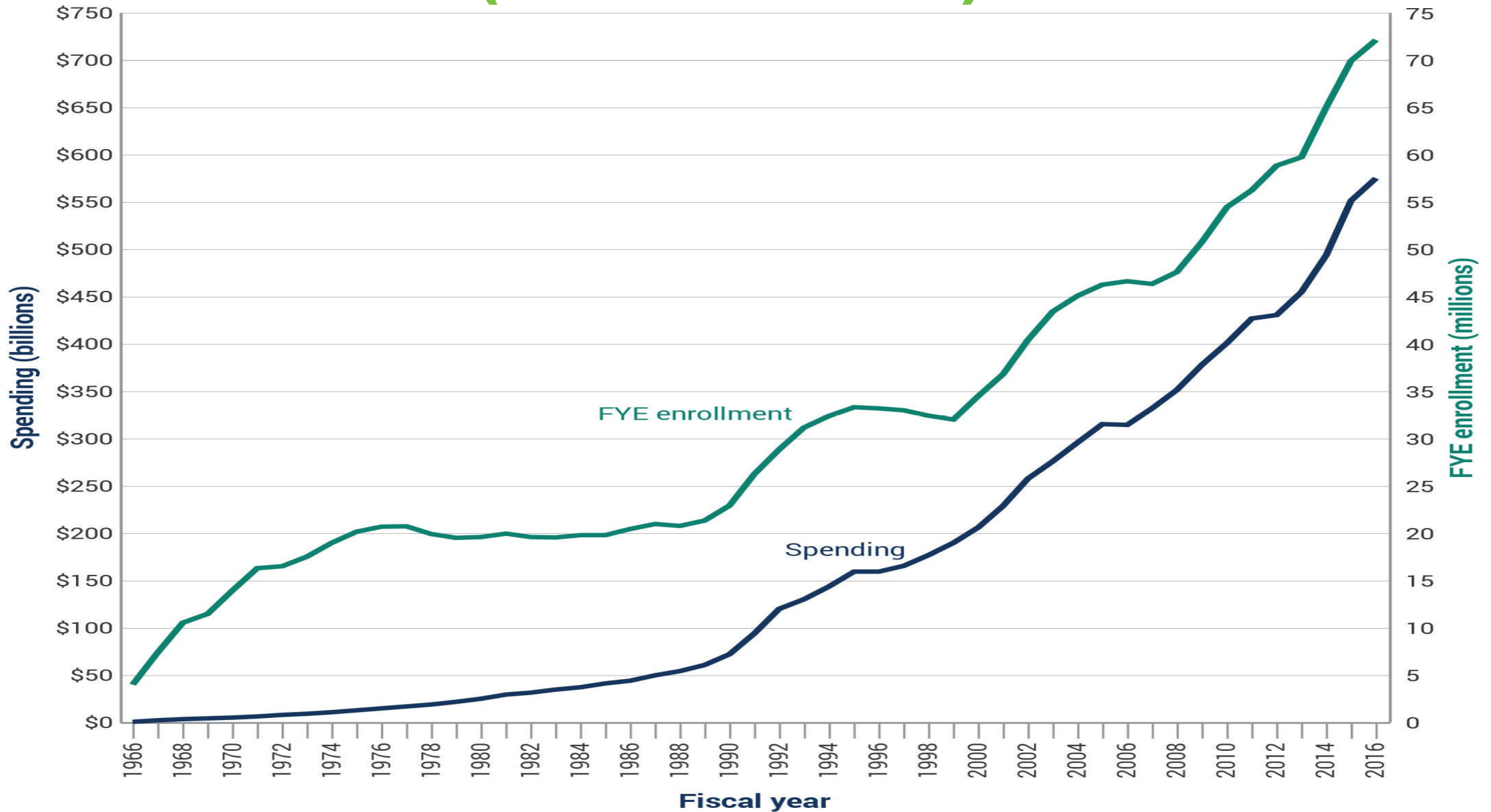
Sources: <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

<https://www.medicaid.gov/state-overviews/scorecard/national-context/annual-expenditures/index.html>

<https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>



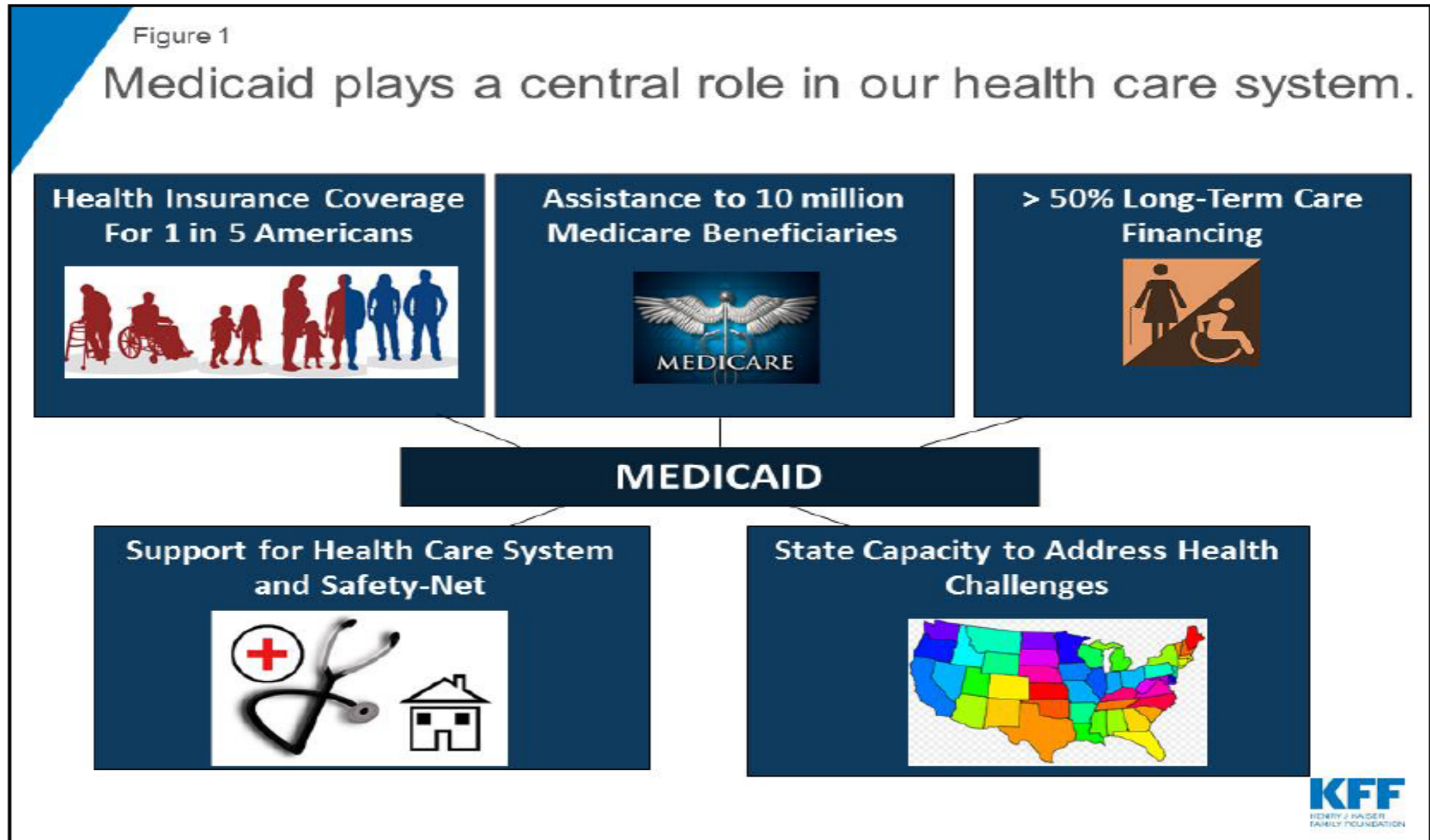
# MEDICAID TODAY - ENROLLMENT AND SPENDING (FY1966-2016)



<https://www.macpac.gov/wp-content/uploads/2015/01/EXHIBIT-8.-Medicaid-Enrollment-and-Spending-FYs-1966-2016.pdf>



## ■ MEDICAID TODAY



<https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/>



## ■ MEDICAID ADMINISTRATION

- State and federal partnership
- Federal government establishes rules and parameters for the program and supplies federal funding streams.
- Federal rules of engagement are defined in statute and regulations
  - Social Security Act (Title XIX)
  - Code of Federal Regulations (Title 42)



## ■ MEDICAID ADMINISTRATION

- The Centers for Medicare and Medicaid Services (CMS) also issues other guidance to states:
  - State Medicaid Director's Letters
  - State Health Official Letters
  - Informational Bulletins
  - Frequently Asked Questions (FAQs)



## ■ MEDICAID ADMINISTRATION – STATE PLAN

- The Medicaid State Plan is the agreement between the state and federal government describing how Medicaid will be administered in a state.
- State Plan includes information such as:
  - Eligible populations
  - Covered benefits
  - Reimbursement methodologies
  - Administrative components
- Can be updated through State Plan Amendments (SPAs)



## ■ MEDICAID ADMINISTRATION – KEY CONCEPTS

- **Stewardness** - States are required to offer the services in their State Plan to all eligible recipients without regard to geographic location.
- **Comparability** - Medicaid benefits must also be comparable across the eligible population, meaning that states may not discriminate by providing different services to individuals within specific eligibility groups or limit services based on diagnosis, type of illness, or condition.
- **Amount, Duration, and Scope** - Each Medicaid service category must be sufficient in amount, duration, and scope to reasonably achieve its purpose.
- **Freedom of Choice** – States must ensure beneficiaries have freedom of choice of providers.



## ■ **MEDICAID ADMINISTRATION – STATE FLEXIBILITY**

- Subject to review and approval by CMS, states have flexibility regarding eligibility levels, benefits, provider payments, delivery systems and other aspects of their programs.
- Flexibility granted through:
  - State Plan Amendments
  - Waivers





## ■ **MEDICAID ADMINISTRATION - WAIVERS**

- States may gain additional flexibility through CMS-approved waivers.
- Subject to review and approval by CMS, states have flexibility regarding eligibility levels, benefits, provider payments, delivery systems and other aspects of their programs.
- Various degrees of flexibility and levels of reporting and accountability to CMS based on the waiver type.



## ■ MEDICAID ADMINISTRATION - WAIVERS

- Types of Medicaid Waivers
  - **1915(b)**: Waives “freedom of choice” and used to implement delivery models, such as mandatory enrollment in managed care, that require eligible beneficiaries to use certain providers to receive services.
  - **1915(c)**: Waives comparability and statewideness and authorizes states to provide home and community-based services (HCBS) as an alternative to institutional care.
  - **1115 Demonstration**: Allows the Secretary of HHS to authorize any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of the program.



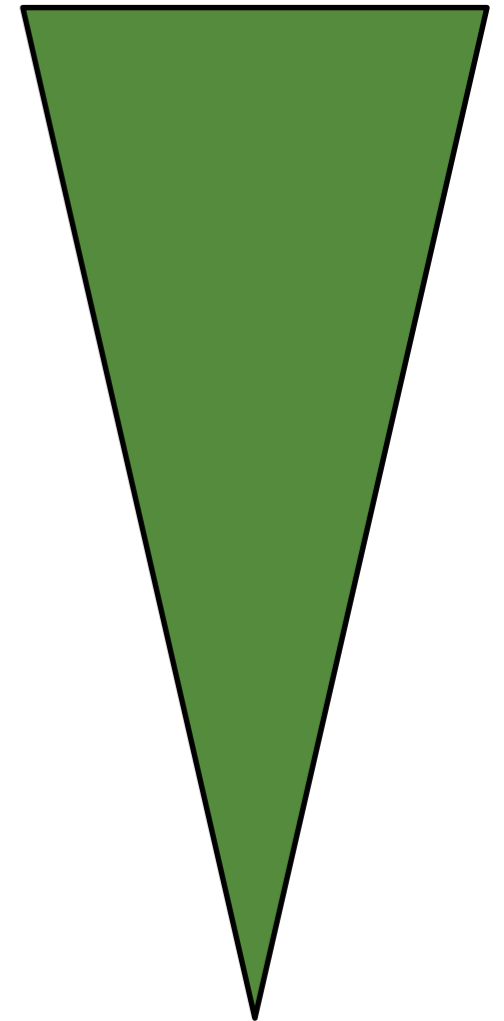
## ■ MEDICAID ADMINISTRATION - WAIVERS

- **1915(b)** waivers must demonstrate **Cost Effectiveness**.
  - Waiver will not cause expenditures to be higher than they would have been without the waiver.
- **1915(c)** waivers must demonstrate **Cost Neutrality**.
  - The average per capita expenditure under the waiver during each waiver year not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care provided in an institution had the waiver **not** been granted.
- **1115** demonstrations must demonstrate **Budget Neutrality**.
  - Federal spending will not be more than what it would have been in the absence of the waiver.



## ■ **MEDICAID ADMINISTRATION – WHERE DO I START?**

- Social Security Act (Title XIX)
- Code of Federal Regulations (Title 42)
- CMS Guidance
- State Plan or Waiver(s)
- State statute and regulations
- State policy manuals and guidance





## ■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF CMS**

- The Centers for Medicaid and Medicare Services (CMS) has federal responsibility for Medicaid administration.
- Ensures appropriate federal matching payments to states.
- Evaluates State Plan Amendments and waiver requests.
- Interprets federal statutory requirements.
- Collects data on expenditure of federal funds.



## ■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF CMS**

- Monitors and enforces state compliance with federal requirements as well as State Plan or waivers.
- Ensures the efficient administration of the program by the state.
- Ensures federal matching funds are not spent improperly or fraudulently.



## ■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF THE STATE**

- Must identify a single-state agency.
- Day-to-day administration of the Medicaid program.
- Define eligible populations and enrollment.
- Determine covered benefits, service settings, and provider types.
- Set reimbursement and pay providers.
- Identify delivery system(s).



## ■ **MEDICAID ADMINISTRATION – PRIMARY ROLE OF THE STATE**

- Ensuring state and federal health care funds are not spent improperly or fraudulently.
- Collecting and reporting information necessary for effective program administration and accountability.
- Resolving grievances by applicants, enrollees, providers and plans.





## ■ MEDICAID ADMINISTRATION - FUNDING

- HHS calculates a “Federal Medical Assistance Percentage” (FMAP) – the Federal share of any medical costs paid by Medicaid;
  - Different for each state
  - Based upon per capita income of residents
  - Inversely proportional to a state’s average personal income relative to the national average
  - FFY 2019 Minimum of 50% & Maximum of 79.39% (not including ACA enhanced match rate)
  - Adjusted on a 3-year cycle, and published annually
- All states receive a 50% match for administrative costs.
- FMAP exceptions for certain populations and services (e.g., Native Americans and Alaska Natives, information systems, family planning, Medicaid expansion population, etc.).



## ■ MEDICAID ADMINISTRATION - FUNDING

- Recognized sources of state funding include:
  - General Fund revenues
  - Special Fund revenues (e.g., special health care fund, tobacco settlement funds, etc.)
  - Permissible Taxes and Provider Assessments
  - Intergovernmental Transfers
  - Certified Public Expenditures
- Federal law does require that at least 40 percent of the non-federal share comes from state funds.
- CMS verifies that state funding sources meet statutory and regulatory requirements prior to authorizing FMAP payments.



## ■ MEDICAID ADMINISTRATION - FUNDING

- Federal funding flow overview:
  - States file a CMS-37 form identifying anticipated quarterly budgeted costs.
  - CMS issues a grant award to the state authorizing federal Medicaid funds for the quarter based on the CMS-37.
  - States file a CMS-64 form identifying actual quarterly expenses.
  - Actual expenses are reconciled to the advance.



## ■ **MEDICAID ADMINISTRATION – DELIVERY SYSTEM**

- Fee-for-Service (FFS)
- Managed Care
  - Covers more than two-thirds of Medicaid beneficiaries
  - Responsible for ensuring access and improving quality
  - Additional flexibility over FFS



## ■ SUMMARY

- Medicaid created in 1965 through Amendments to the Social Security Act.
- Tremendous growth in the program over the years.
- Joint federal and state partnership.
- State Plan is the operational agreement between CMS and the state.
- Majority of funding through CMS with a number of elaborate and complex funding mechanisms.
- State flexibility available through various waivers.
- Medicaid Managed Care has become the predominant delivery system model.



# MEDICAID INTENSIVE: OVERVIEW OF MEDICAID ELIGIBILITY

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August 26, 2019

# Medicaid Eligibility Has Evolved Over Time...And Can Still Be Complex

**MAGI** QMB **Federal Poverty Level** **HCBS**  
**ABD** § 1634 States **ACA** **Mandatory**  
**Assets** **Optional** **SSA** **Spousal**  
**Residency Requirement** **Financial** **Im impoverishment**  
**LTSS** **Medically Needy** **Categorical** **Level of Care**  
**Family Opportunity Act** **SSI** **QI** **SLMB**  
**CFR** **Disabilities** **Renewal** **Special Income Rule**  
**Medicare** **209(b) states** **Dual Eligible**

# Residency Requirement

- Medicaid eligibility determination includes a residency requirement:
  - Beneficiaries generally must be residents of the state in which they are receiving Medicaid.
  - They must be either citizens of the United States or certain qualified non-citizens, such as lawful permanent residents.
- Eligibility determinations also include financial and non-financial criteria

**Medicaid.gov**  
Keeping America Healthy

**CMS**  
CENTERS for MEDICARE & MEDICAID SERVICES



# CMS Lists Over 25 Mandatory & 30 Optional Categorically Needy Groups



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## ■ Examples of Mandatory Categorically Needy Groups include:

- Children
- Pregnant women
- Low-Income Families
- Individuals receiving Supplemental Security Income (SSI)
- Medicare beneficiaries with limited income and resources

## ■ Examples of Optional Categorically Needy Groups include:

- Individuals receiving Home & Community-Based Services (HCBS)
- Children in Foster Care (who are not otherwise eligible)
- Individuals Receiving Hospice Care
- Individuals at or below 133% Federal Poverty Level (FPL) Age 19 through 64

# States Have the Option to Establish Medically Needy Categories of Eligibility



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- *Medically Needy* programs are for individuals with significant health needs whose income is too high to otherwise qualify for Medicaid under other eligibility groups
- Individuals can become eligible by “spending down” the amount of income that is above a state's medically needy income standard
- Individuals spend down by incurring expenses for medical and remedial care for which they do not have health insurance
- Once an individual’s incurred expenses exceed the difference between the individual’s income and the state’s medically needy income level (the “spenddown” amount), the person can be eligible for Medicaid
- The Medicaid program then pays the cost of services that exceeds the expenses the individual had to incur to become eligible

# CMS Identifies Nine (9) Medically Needy Eligibility Groups

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- Pregnant Women
- Children under 18
- Children Age 18 through 20
- Parents and Other Caretaker Relatives
- Aged
- Blind
- Disabled
- Individuals in HMOs Guaranteed Eligibility
- Blind or Disabled Individuals Eligible in 1973

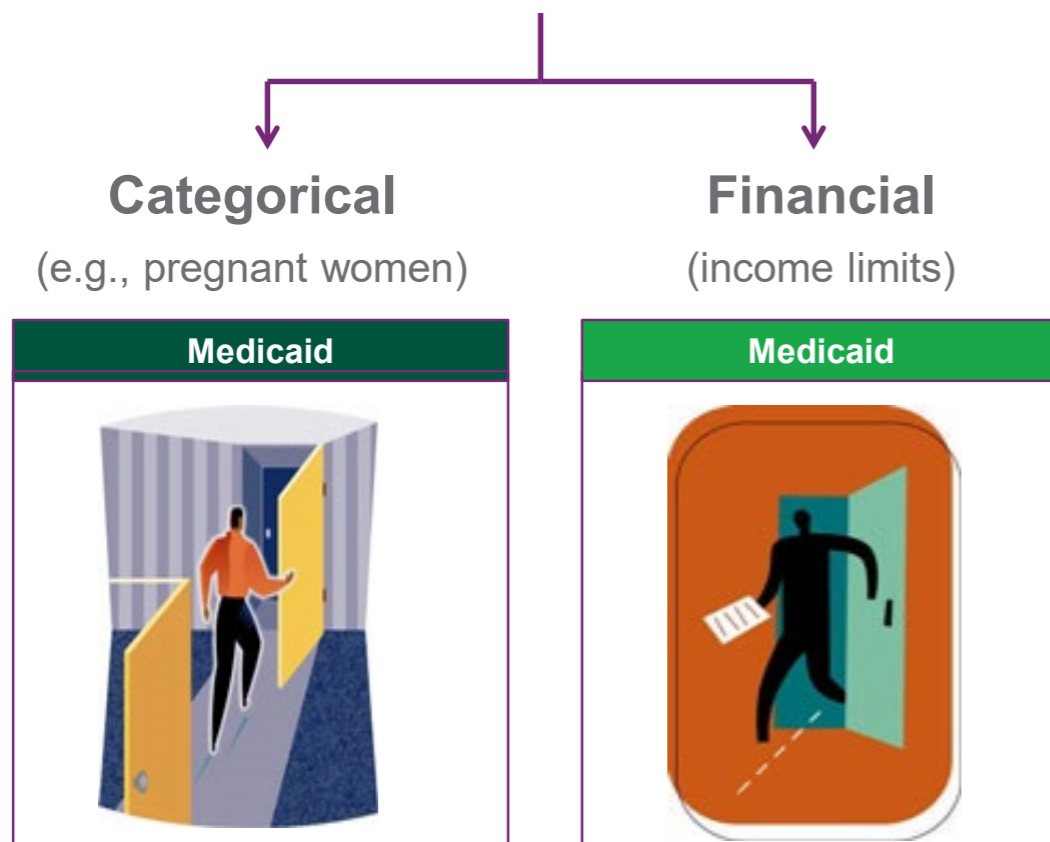


# Determining Medicaid Eligibility: Pre- and Post-Affordable Care Act (ACA)

## Eligibility Determination Process (Non-Medicare Eligible Individuals <65)

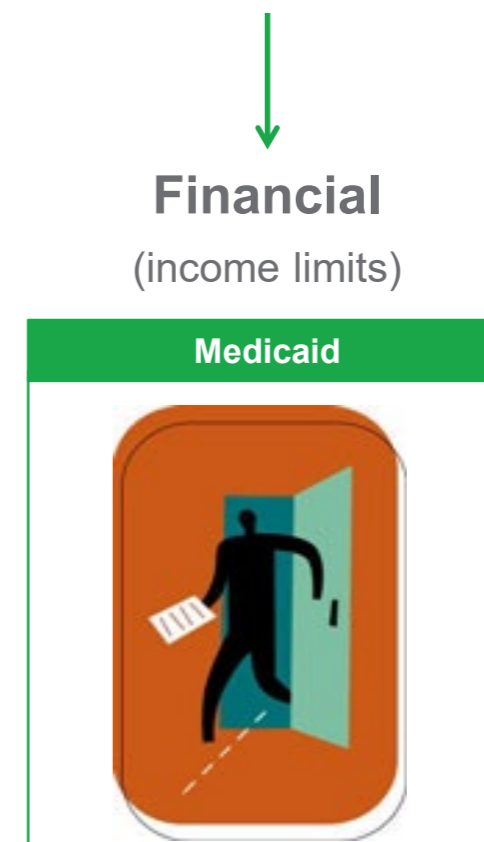
### All States Prior to ACA Expansion and Non-Expansion States

*Two Doors to Eligibility*



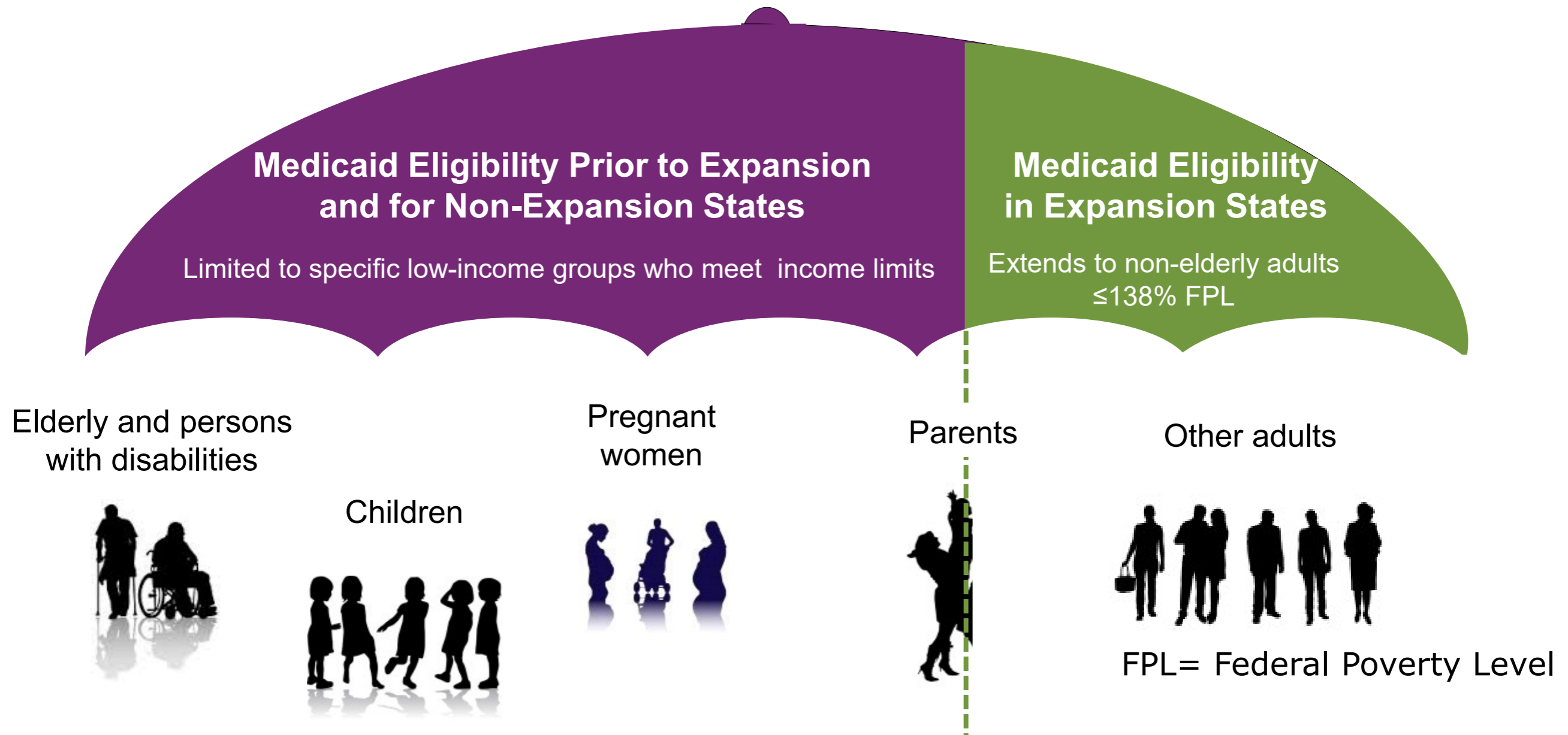
### Expansion States

*One Door to Eligibility*



# Medicaid Eligibility Before and After ACA Expansion

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# 2019 Federal Poverty Level Guidelines



Family Size	Annual Family Income				
	100% FPL	133% FPL	185% FPL	200% FPL	300% FPL
1	\$12,490	\$16,612	\$23,107	\$24,980	\$37,470
2	\$16,910	\$22,490	\$31,284	\$33,820	\$50,730
3	\$21,330	\$28,369	\$39,461	\$42,660	\$63,990
4	\$25,750	\$34,248	\$47,638	\$51,500	\$77,250
5	\$30,170	\$40,126	\$55,815	\$60,340	\$90,510

# Modified Adjusted Gross Income (MAGI)

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- Affordable Care Act required states to change their method of counting income and determining household size for determining eligibility for Medicaid
- MAGI is a methodology for determining household size and income based on tax law
- MAGI rules apply to all states even if the state has not opted to expand Medicaid
- MAGI-based standards apply only to certain eligibility categories of Medicaid, including children, pregnant women, parents and the new adult expansion group.



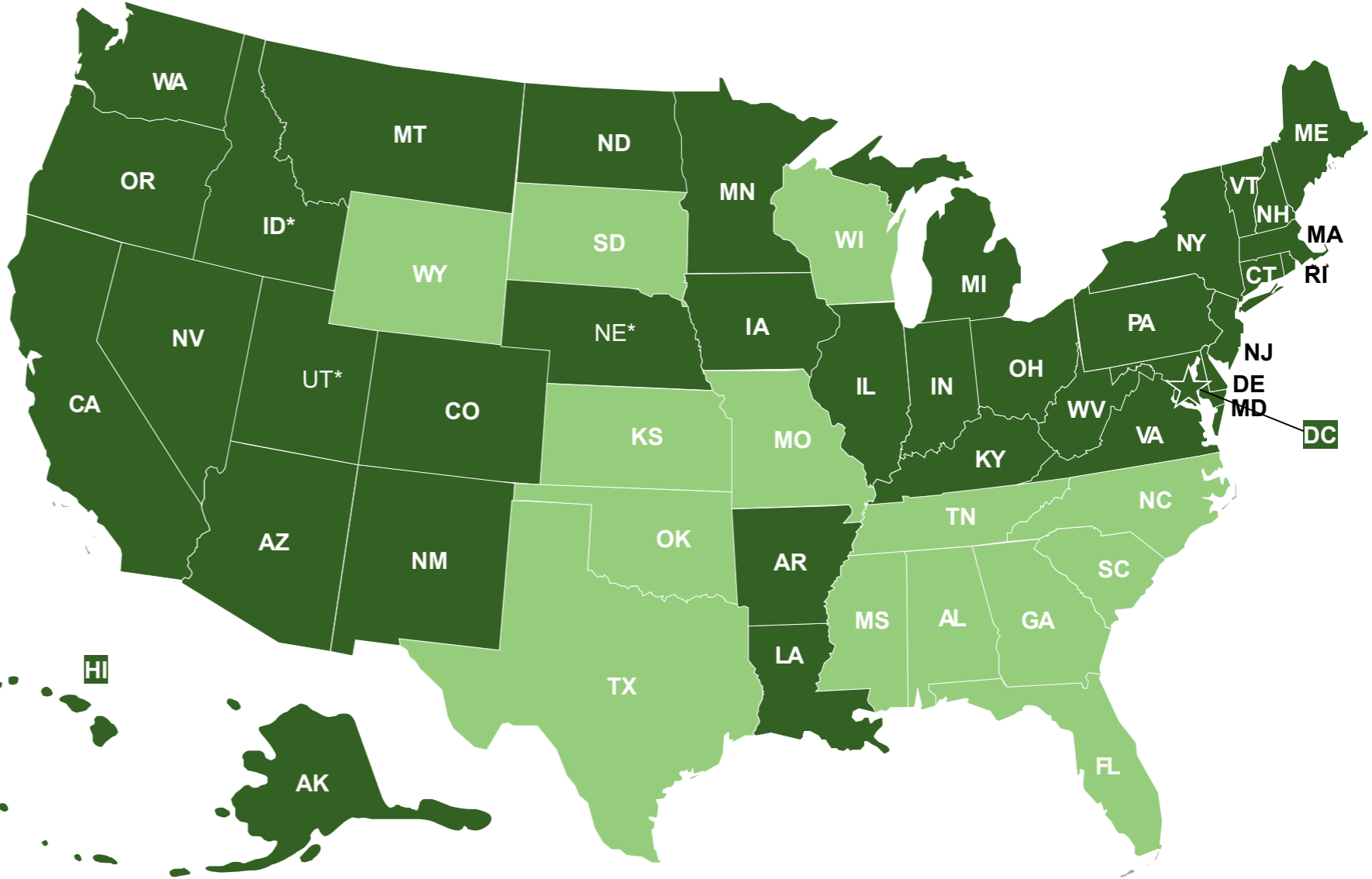
# 37 States (Including D.C.) Have Expanded Medicaid Under the ACA



■ Adopted (37 states including DC)

■ Not Adopted (14 states)

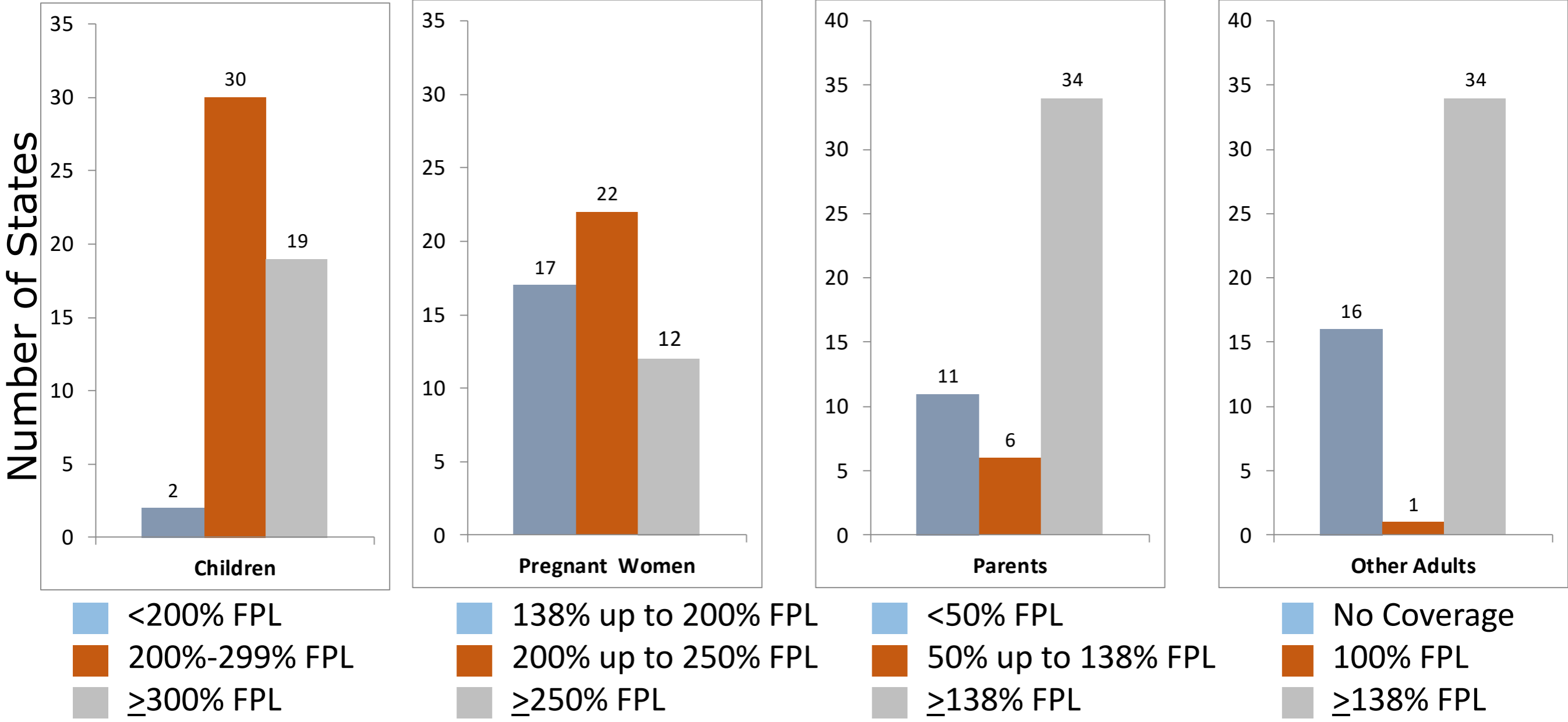
- States' expansion decisions determine:
  - ❑ Who is eligible for Medicaid
  - ❑ Levels of state and federal funding for Medicaid
  - ❑ Benefits and enrollee cost-sharing
- Federal government pays 93% in 2019; 90% 2020 & beyond
  - ❑ Federal Medicaid match rate for non-expansion beneficiaries is between 50 and 77%



NOTES: Current status for each state is based on KFF tracking and analysis of state activity.  
\* Expansion is adopted but not yet implemented in ID, NE, and UT. (See link below for additional state-specific notes).

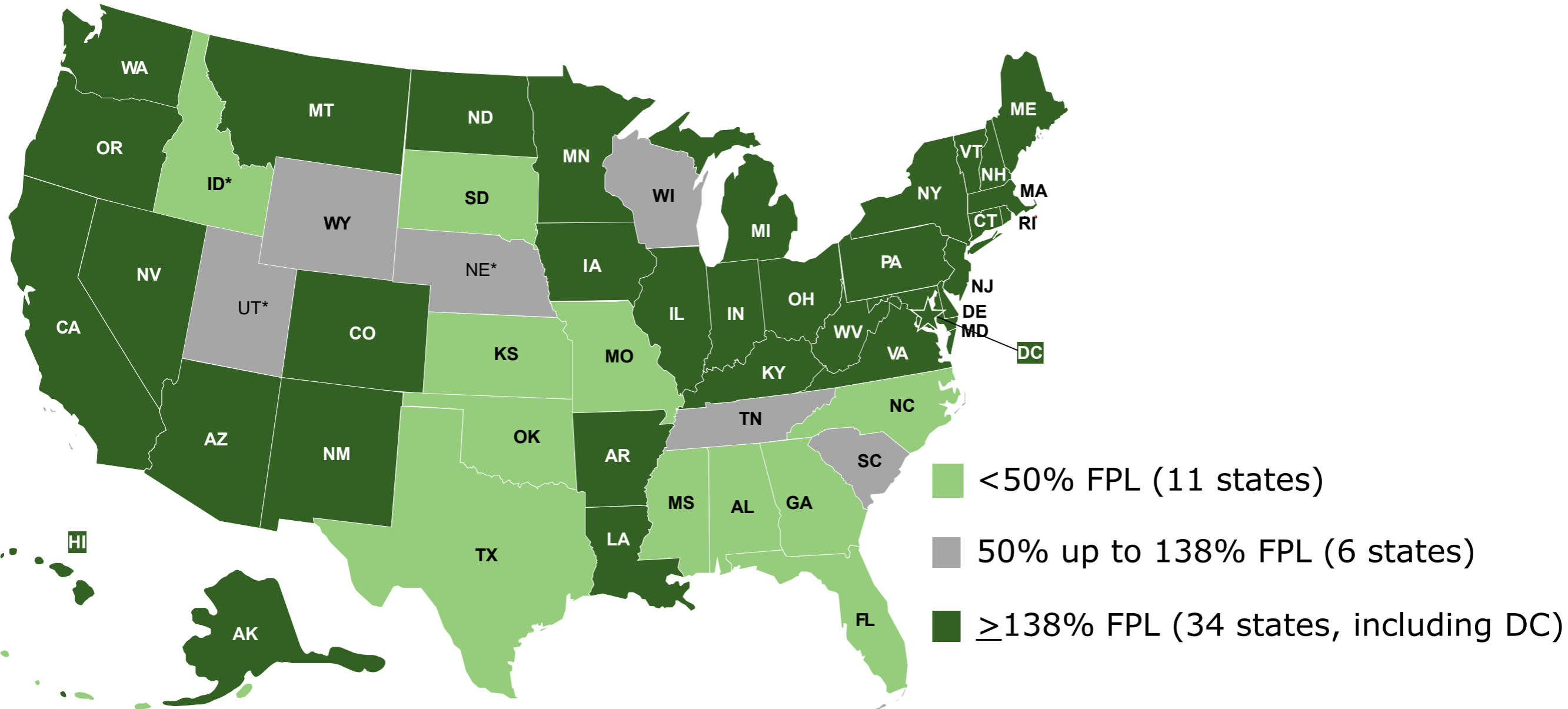


# Medicaid/CHIP Income Eligibility Levels by State (Jan. 1, 2019)



Source <https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicare-and-chip/>

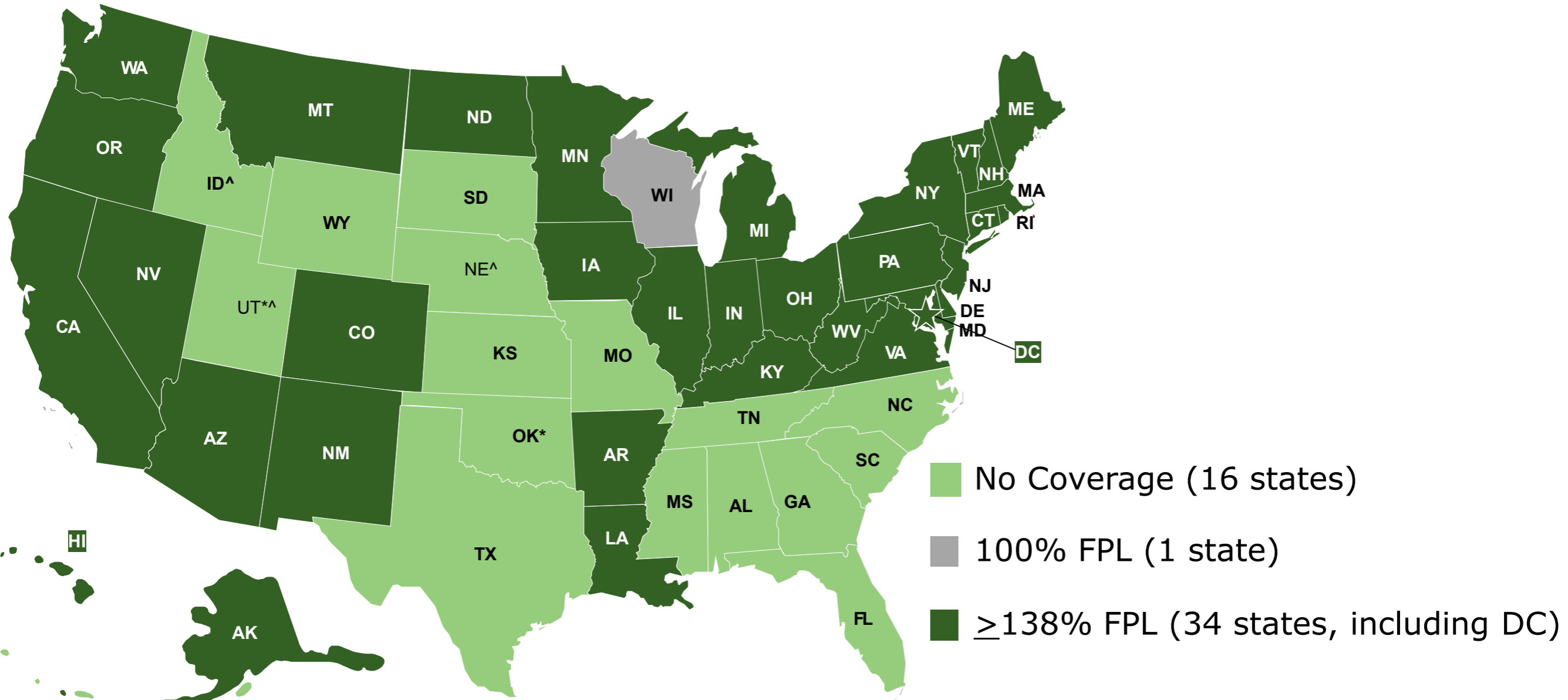
# Medicaid Income Eligibility Levels for Parents, Jan. 2019



NOTE: Eligibility levels are based on 2019 federal poverty levels (FPLs) for a family of three. In 2019, the FPL was \$21,330 for a family of three. Thresholds include the standard five percentage point of the FPL disregard. \* ID, NE, and UT passed ballot initiatives requiring the state to implement the ACA Medicaid expansion, but it was not implemented as of January 2019.

SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019. <http://files.kff.org/attachment/Fact-Sheet-Where-are-States-Today-Medicaid-and-CHIP-Eligibility-Levels-for-Children-Pregnant-Women-and-Adults>

# Medicaid Income Eligibility Levels for Childless Adults, Jan. 2019



NOTE: Eligibility levels are based on 2019 federal poverty levels (FPLs) for an individual. In 2019, the FPL was \$12,490 for an individual. Thresholds include the standard five percentage point of the FPL disregard. \*OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority. ^ ID, NE, and UT passed ballot initiatives requiring the state to implement the ACA Medicaid expansion, but it was not implemented as of January 2019.

SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019. <http://files.kff.org/attachment/Fact-Sheet-Where-are-States-Today-Medicaid-and-CHIP-Eligibility-Levels-for-Children-Pregnant-Women-and-Adults>

# “Eligibility” Factors for Medicaid Home and Community-Based Waivers



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## ■ Meet Medicaid Categorical and Financial Eligibility

- For group included in Medicaid State Plan and specified in Waiver

## ■ Meet Institution-Equivalent Level of Care (LOC)

- In absence of waiver services, would require Medicaid payable services provided by nursing facility, ICF/DD facility, or hospital
- Clinical determination that looks at functional ability/need for assistance with personal activities of daily living like bathing, dressing, eating and transferring

## ■ Be a Member of the Waiver Target Group

- Three broad target groups are 1 ) Aged and/or Disabled, 2)I/DD, and 3) Persons with Mental Illness (may be called Serious Emotional Disturbance (SED))
- May be much more narrowly targeted e.g., (autism, HIV)
- Cost can be a factor, depending on whether waiver cost limit is individual or aggregate

# States Have Three Options for Determining Medicaid Eligibility of SSI Beneficiaries



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## ■ Section § 1634 States—SSA Administration (33 states and DC)

- Same eligibility criteria as SSI
- Contract with SSA via a “1634 agreement” to also determine **Medicaid** eligibility for SSI
- No separate application required—eligibility files transmitted to state
- Referral to state for final determination in rare cases (Medicaid qualifying trusts, transfer of resources, TPL, refusal to assign rights)

## ■ SSI Criteria States—State Administration (7 states and Northern Mariana Islands)

- Same eligibility criteria as SSI for income, resources and disability
- Categorically eligible for Medicaid but separate application is required

# States Have Three Options for Determining Medicaid Eligibility of SSI Beneficiaries (cont.)



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## ■ Section § 209(b) States (10 states)

- Can have own rules; use at least one eligibility criterion more restrictive than SSI
- Separate application is required
- Criteria cannot be more restrictive than standards in effect July 1, 1972
- All but HI have income limit close to SSI limit; asset limit can be lower (or higher)
- Must provide for deducting incurred medical expenses (Spend-down)

# Findings from 2019 Kaiser Survey: Medicaid Financial Eligibility for Seniors & People w/ Disabilities



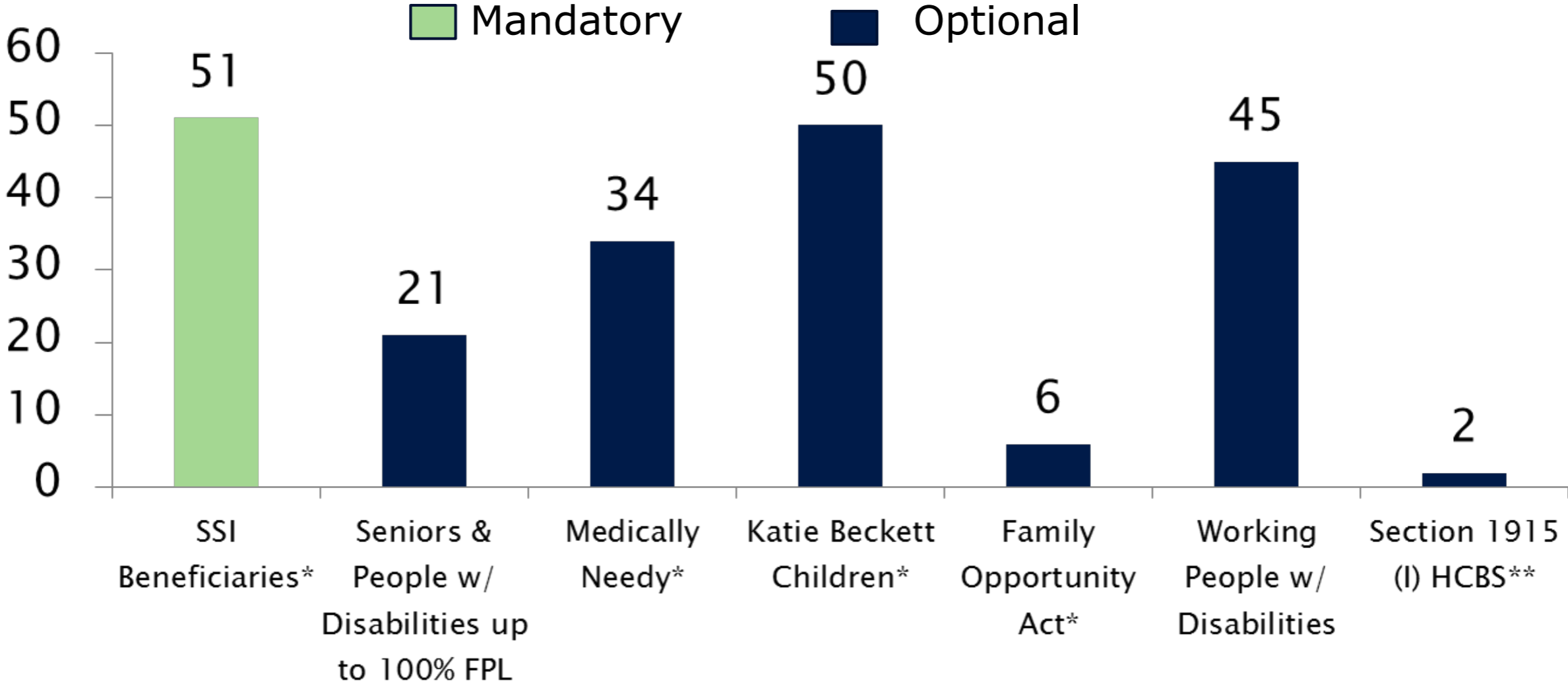
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- While adoption of the major optional age and disability-related Medicaid eligibility pathways varies substantially across states, state choices about these pathways have remained stable since the time of last survey in 2015
- The income limits associated with the age and disability-related pathways vary across states but generally remain low, with a notable minority of states opting to eliminate asset tests in certain pathways
- Greater shares of states that have adopted the ACA Medicaid expansion also have adopted key optional age and disability-related pathways, compared to non-expansion states
- All states elect at least some options to expand financial eligibility for Medicaid LTSS
- An increasing number of states are opting to apply the ACA's streamlined eligibility renewal provisions to age and disability-related pathways, which can help retain eligible people in coverage and strengthen continuity of care.

# State Adoption of Key Medicaid Eligibility Pathways Based on Old Age or Disability, 2018



## Number of States Adopting Pathway



NOTES: \*8 states elect the 209 (b) option to apply financial and/or functional eligibility rules that are more restrictive than federal SSI rules when determining Medicaid eligibility for SSI beneficiaries. States electing the medically needy pathway must cover pregnant women and children and may cover seniors, people with disabilities, and/or low-income parents. Katie Beckett and Family Opportunity Act states include those electing the state plan option as well as comparable waivers. \*\*Additional states use 1915 (i) to provide HCBS to those who are eligible for Medicaid through another pathway.

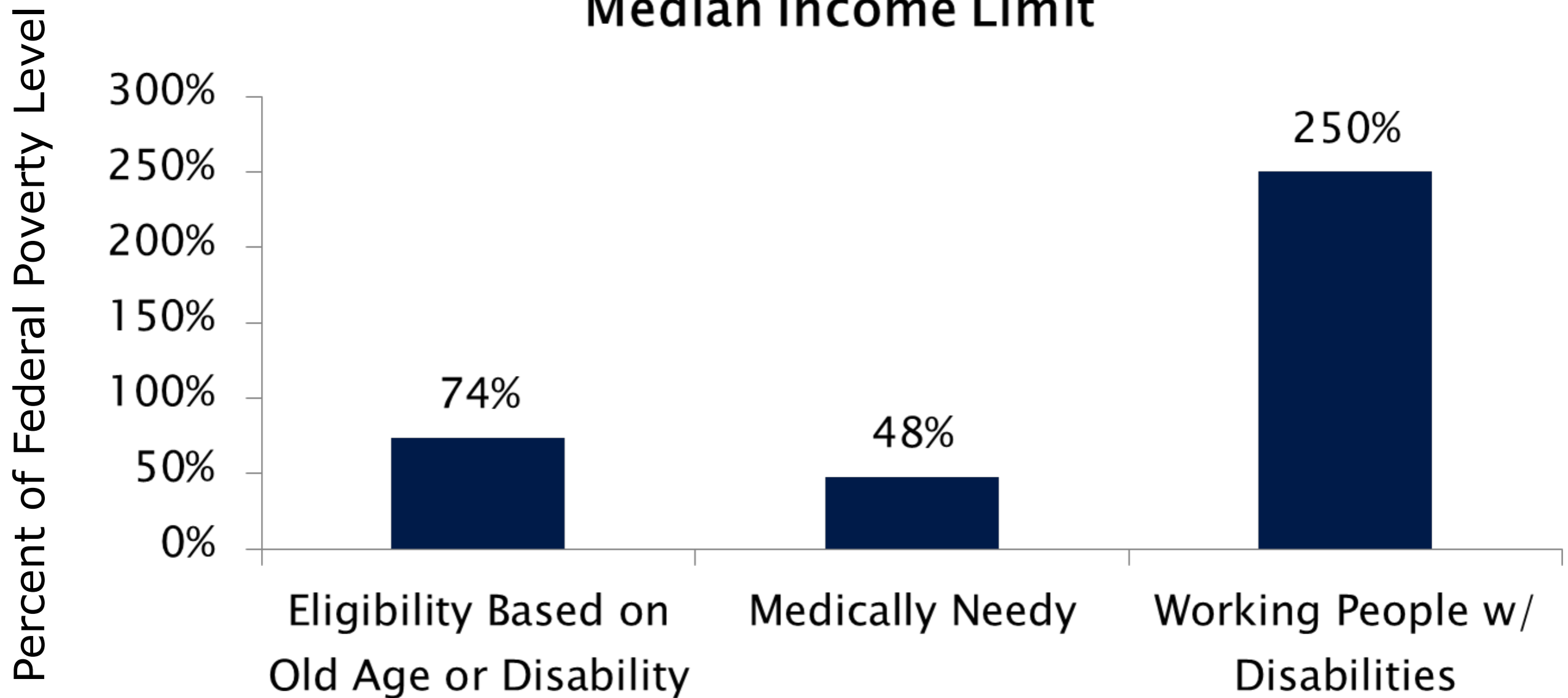
SOURCE: KFF Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018. <http://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey>



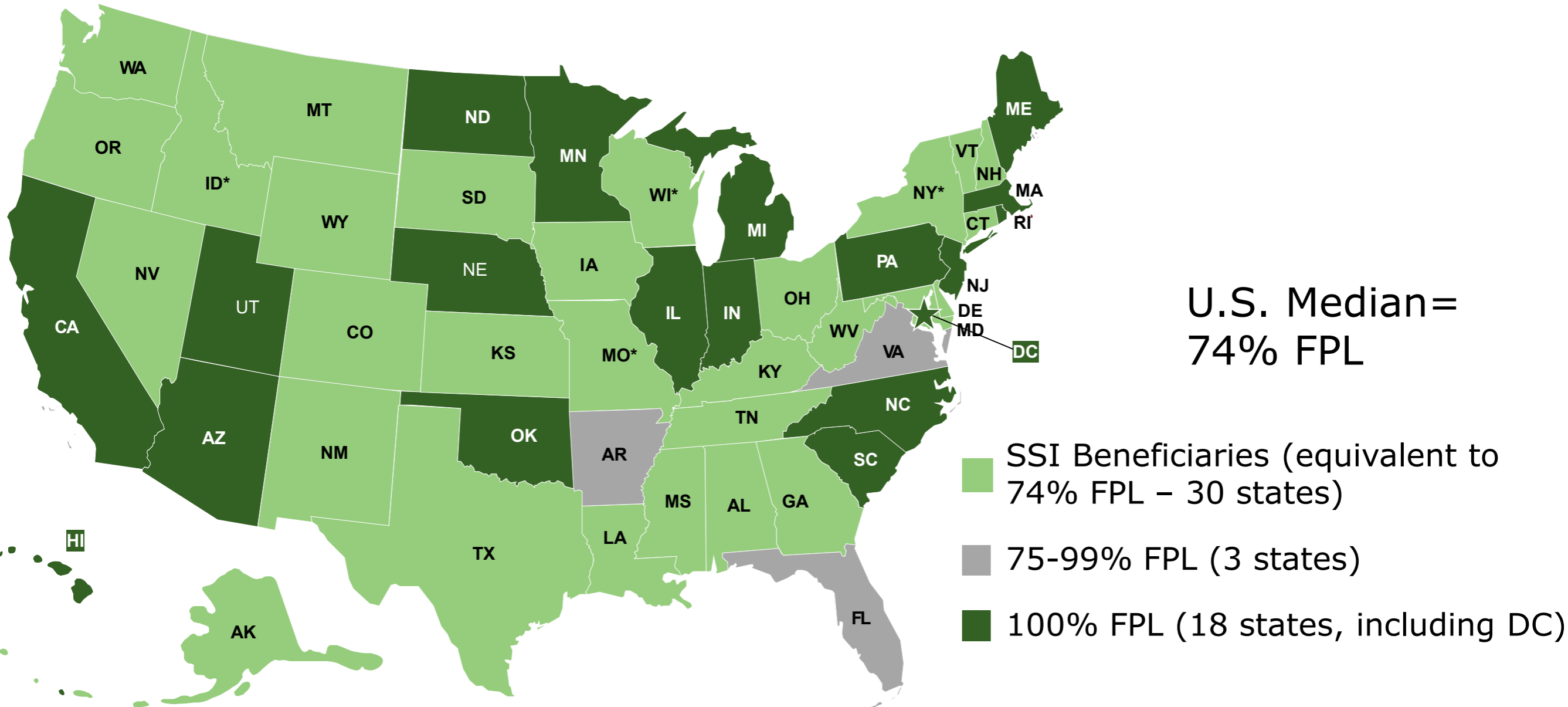
# Median Income Limits for Age & Disability Pathways



### Median Income Limit



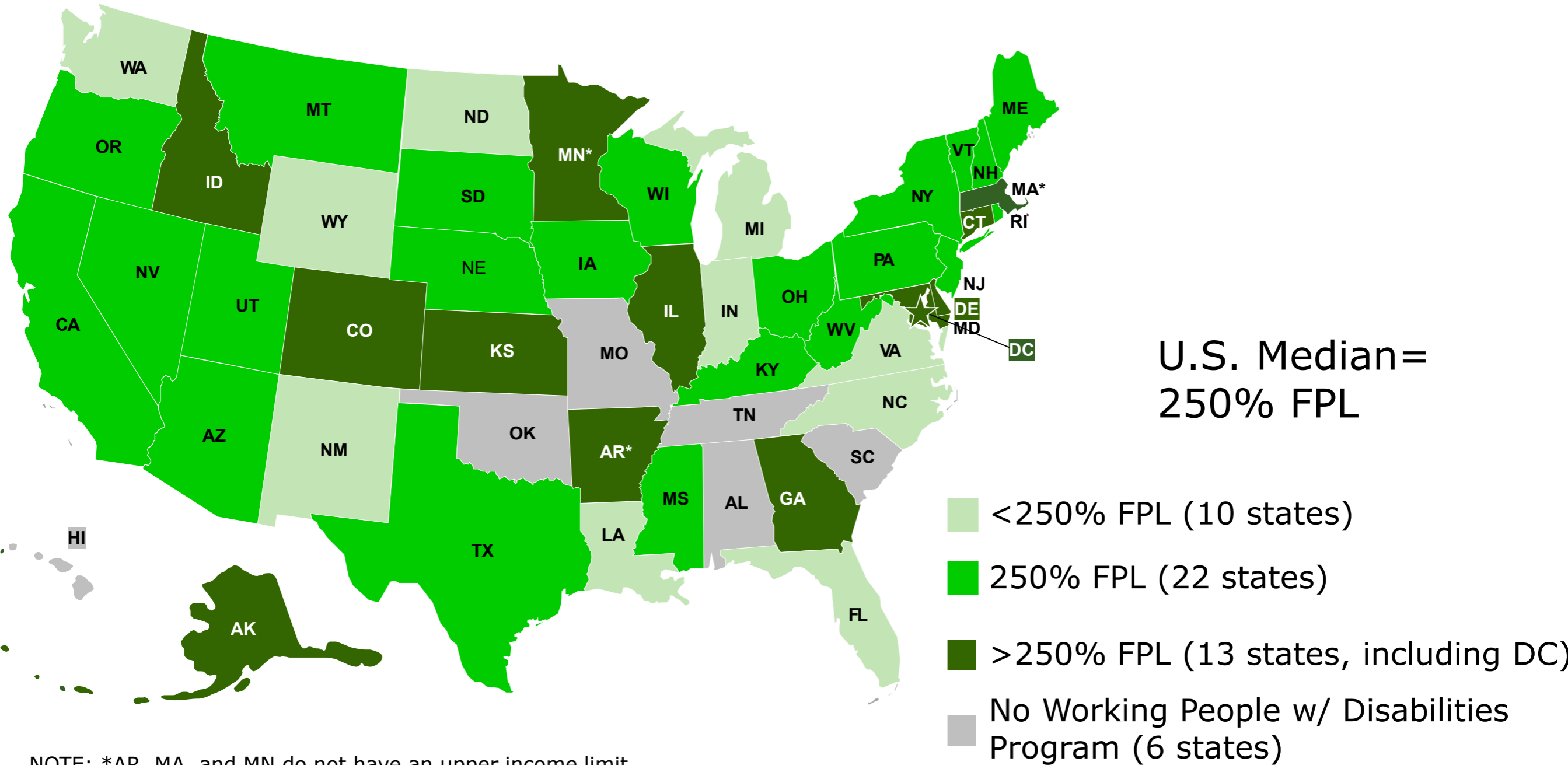
# Medicaid Eligibility for Seniors & People w/ Disabilities, 2018



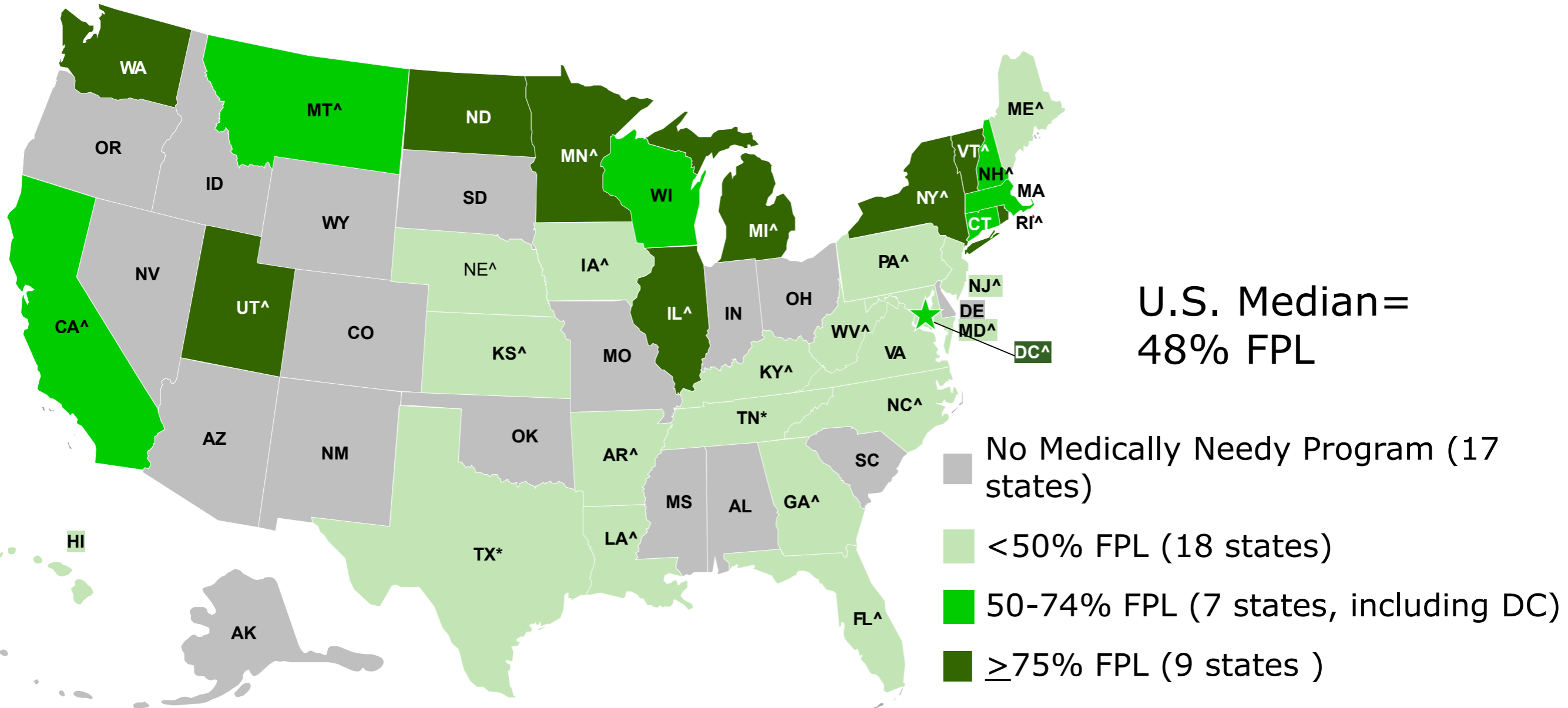
NOTES: Includes pathways for SSI beneficiaries and state option to cover seniors and people with disabilities up to 100% FPL. Eligibility limits are for an individual. States generally must cover SSI beneficiaries, who receive a maximum federal benefit equivalent to 74% FPL. \*The maximum SSI benefit exceeds 74% FPL in ID, MO, NY, and WI, due to state supplemental payments and/or additional income disregards. CT uses Section 209 (b) to apply a more restrictive income limit than the federal SSI rules (63% FPL).

SOURCE: KFF Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018. <http://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey>

# Medicaid Eligibility for Working People w/ Disabilities, 2018



# Medicaid Eligibility for Medically Needy Populations, 2018



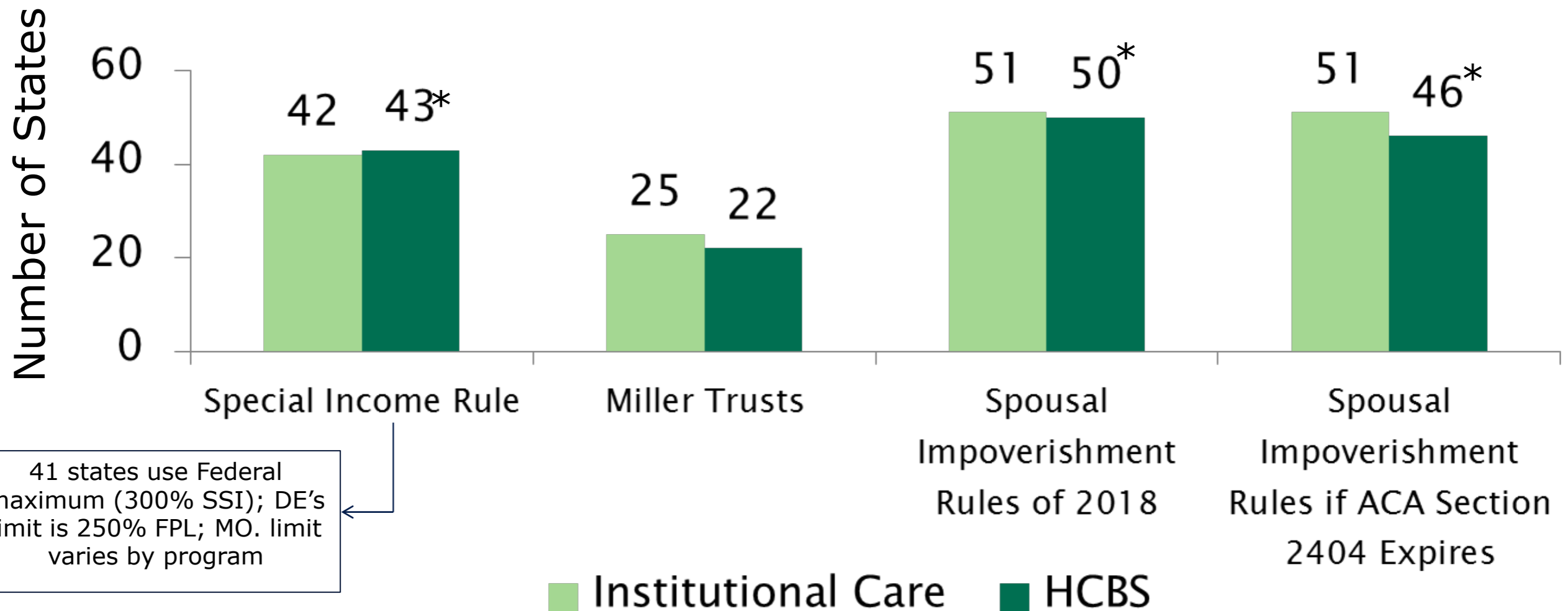
NOTE: \*TN and TX cover only medically needy pregnant women and children; all other states cover these populations in addition to medically needy seniors and people with disabilities. ^State also covers medically needy low income parents.

SOURCE: KFF Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018. <http://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey>

# All States Elect at Least Some Options to Expand Financial Eligibility for People Who Need Medicaid LTSS



### Number of States With Policy



NOTES: \*MA applies the special income rule to HCBS but not institutional care. MN applies the special income rule to institutional care but only one of its HCBS waivers. Application of MO's special income rule varies by program. IL applies the spousal impoverishment rules to some but not all HCBS waivers as of Dec. 2018. ACA 2404 requires states to apply spousal impoverishment rules to all HCBS. At the time of our survey, 2404 was set to expire at the end of 2018, but subsequently has been extended through Sept. 2019. If 2404 expires, AR, IL, and MN plan to apply the spousal impoverishment rules to some but not all HCBS waivers, and ME and NH do not plan to apply the rules to any HCBS waivers.

SOURCE: KFF Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018. <http://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey>

# “Dual Eligibles” ... Approximately 12 million in 2017

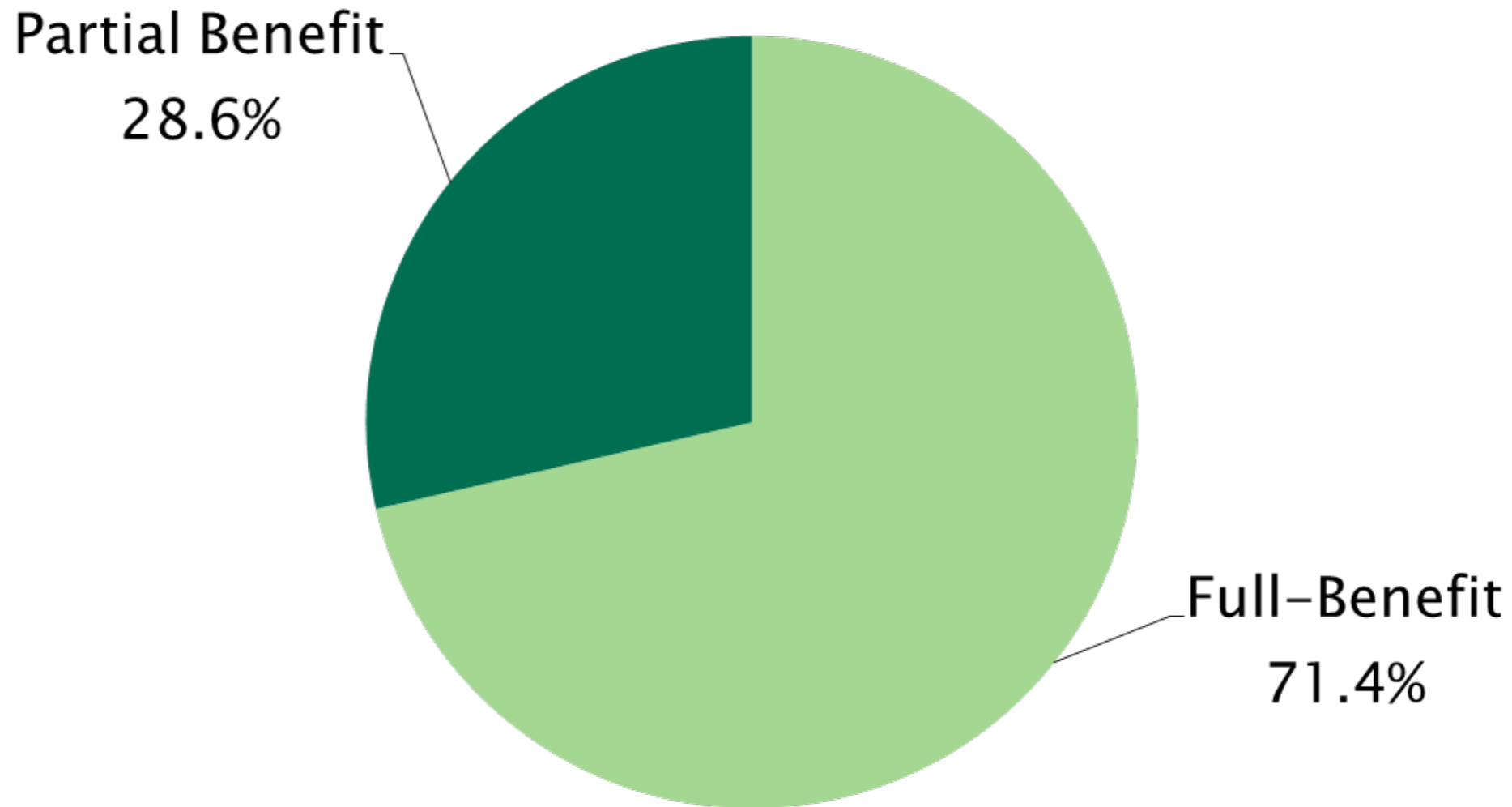


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## Medicare Savings Plans

- **Full Benefit Dual Eligible**
- **Qualified Medicare Beneficiary (QMB) Program:** Helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs
- **Specified Low-Income Medicare Beneficiary (SLMB) Program:** Helps pay Part B premiums
- **Qualifying Individual (QI) Program:** Helps pay Part B premiums
- **Qualified Disabled Working Individual (QDWI) Program:** Pays the Part A premium for certain disabled and working beneficiaries

# Full-Benefit vs. Medicare Savings Programs (Partial Benefit) Duals



# Full Benefit “Dual Eligibles”



## Full Medicaid

Benefits & Qualifications	Description
<p><b>Benefits</b></p>	<ul style="list-style-type: none"> <li>• Full Medicaid coverage</li> <li>• Medicaid pays Part A (if any) and Part B premiums, and may pay deductibles, coinsurance, and copayments consistent with the Medicaid State Plan (even if the Medicaid State Plan payment is unavailable for these charges, the QMB is not liable for them)</li> </ul>
<p><b>Qualifications</b></p>	<ul style="list-style-type: none"> <li>• Income may be up to 100% of the FPL</li> <li>• States determine resources criteria</li> <li>• To qualify as a QMB Plus, the individual must be enrolled in Part A (or if uninsured for Part A, have filed for premium Part A on a conditional basis). For more information on this process, refer to Section HI 00801.140 of the <u>Social Security Administration Program Operations Manual System</u>.</li> <li>• To qualify for full Medicaid benefits, an individual must meet financial and other criteria</li> </ul>



# Medicare Savings Programs: “Dual Eligibles”



57

## QMB Only

Benefits & Qualifications	Description
<p><b>Benefits</b></p>	<ul style="list-style-type: none"> <li>• Medicaid pays Part A (if any) and Part B premiums</li> <li>• Medicaid may pay deductibles, coinsurance, and copayments for Medicare services furnished by Medicare providers consistent with the Medicaid State Plan (even if the Medicaid State Plan payment is unavailable for these charges, the QMB is not liable for them)</li> </ul>
<p><b>Qualifications</b></p>	<ul style="list-style-type: none"> <li>• Income may be up to 100% of the Federal Poverty Level (FPL)</li> <li>• Resources must be no more than 3 times the SSI resource limit, adjusted annually according to Consumer Price Index (CPI) increases</li> <li>• To qualify as a QMB Only, the beneficiary must be enrolled in Part A (or if uninsured for Part A, have filed for premium Part A on a conditional basis). For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System.</li> </ul>

# Medicare Savings Programs: “Dual Eligibles” (cont.)



58

## QMB Plus

Benefits & Qualifications	Description
<p><b>Benefits</b></p>	<ul style="list-style-type: none"> <li>• Full Medicaid coverage</li> <li>• Medicaid pays Part A (if any) and Part B premiums, and may pay deductibles, coinsurance, and copayments consistent with the Medicaid State Plan (even if the Medicaid State Plan payment is unavailable for these charges, the QMB is not liable for them)</li> </ul>
<p><b>Qualifications</b></p>	<ul style="list-style-type: none"> <li>• Income may be up to 100% of the FPL</li> <li>• States determine resources criteria</li> <li>• To qualify as a QMB Plus, the individual must be enrolled in Part A (or if uninsured for Part A, have filed for premium Part A on a conditional basis). For more information on this process, refer to Section HI 00801.140 of the Social Security Administration Program Operations Manual System.</li> <li>• To qualify for full Medicaid benefits, an individual must meet financial and other criteria</li> </ul>

# Medicare Savings Programs: “Dual Eligibles” (cont.)



## SLMB Only

Benefits & Qualifications	Description
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Medicaid pays Part B premiums</li> </ul>
<b>Qualifications</b>	<ul style="list-style-type: none"> <li>• Income must be more than 100% but less than 120% of the FPL</li> <li>• Resources must be no more than 3 times the SSI resource limit, adjusted annually according to CPI increases</li> <li>• To qualify as an SLMB Only, individuals must be enrolled in Part A. Part A coverage is not a factor for full Medicaid eligibility.</li> </ul>

# Medicare Savings Programs: “Dual Eligibles” (cont.)



## SLMB Plus

Benefits & Qualifications	Description
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Full Medicaid coverage</li> <li>• Medicaid pays Part B premiums</li> </ul>
<b>Qualifications</b>	<ul style="list-style-type: none"> <li>• Income must be more than 100% but less than 120% of the FPL</li> <li>• States determine resources criteria</li> <li>• To qualify as a SLMB Plus, individuals must be enrolled in Part A. Part A coverage is not a factor for full Medicaid eligibility.</li> <li>• To qualify for full Medicaid benefits, an individual must meet financial and other criteria</li> </ul>

# Medicare Savings Programs: “Dual Eligibles” (cont.)



61

## Qualifying Individual (QI)

Benefits & Qualifications	Description
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Medicaid pays Part B premiums</li> </ul>
<b>Qualifications</b>	<ul style="list-style-type: none"> <li>• Income must be at least 120% but less than 135% of the FPL</li> <li>• Resources must be no more than 3 times the SSI resource limit, adjusted annually according to CPI increases</li> <li>• To qualify as a QI, individuals must be enrolled in Part A. Part A coverage is not a factor for full Medicaid eligibility.</li> <li>• Beneficiaries under this program are not otherwise eligible for full Medicaid coverage through the State</li> </ul>

# Medicare Savings Programs: “Dual Eligibles” (cont.)



## Qualified Disabled Working Individual (QDWI)

Benefits & Qualifications	Description
<b>Benefits</b>	<ul style="list-style-type: none"> <li>• Medicaid pays Part A premiums</li> </ul>
<b>Qualifications</b>	<ul style="list-style-type: none"> <li>• Income must be no more than 200% of the FPL</li> <li>• Resources must be no more than 2 times the SSI resource limit</li> <li>• The individual with a qualifying disability lost free Part A coverage upon returning to work and now must enroll in and purchase Part A coverage</li> </ul>

# Suggested Resources

- Medicaid.Gov Eligibility Resource <https://www.medicaid.gov/medicaid/eligibility/index.html>
- Centers for Medicare and Medicaid Services (CMS)
  - Medicare Learning Network: Dual Eligible Beneficiaries Under Medicare and Medicaid [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare\\_Beneficiaries\\_Dual\\_Eligibles\\_At\\_a\\_Glance.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare_Beneficiaries_Dual_Eligibles_At_a_Glance.pdf)
  - Listing of Medicaid Eligibility Groups <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf>
  - People Dually Eligible for Medicare and Medicaid [https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO\\_Factsheet.pdf](https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf)
- Kaiser Family Foundation:
  - Medicaid Financial Eligibility Survey for Seniors and People with Disabilities, 2018. <http://files.kff.org/attachment/Issue-Brief-Medicaid-Financial-Eligibility-for-Seniors-and-People-with-Disabilities-Findings-from-a-50-State-Survey>
  - Where are State Today? Medicaid and CHIP Eligibility Level for Children, Pregnant Women, and Adults <http://files.kff.org/attachment/Fact-Sheet-Where-are-States-Today-Medicaid-and-CHIP-Eligibility-Levels-for-Children-Pregnant-Women-and-Adults>



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# Medicaid Pays for a Full Range of Services

*Outpatient Hospital*

**Tobacco Cessation** **Physician Services** *Family Planning Services*

*Rural Health Clinic Services* **Nursing Facility Services** **Federally Qualified Health Center Services**

**EPSTD: Early and Periodic Screening, Diagnostic, and Treatment Services** *Freestanding Birth Center Services* *Laboratory and X-ray Services* *Certified Pediatric and Family Nurse Practitioner*

**Home Health Services**

*Transportation* **Inpatient Hospital**

# States Required to provide Certain Mandatory Services

- Inpatient Hospital
- Outpatient Hospital
- Physician Services
- Laboratory & X-rays
- Home Health
- Nursing Facility
- EPSDT
- Rural Health Clinics
- Federally Qualified Health Centers
- Transportation
- Family Planning



# States Have Choice to Provide Certain Optional Services

- Prescription Drugs
- Clinic Services
- Physical Therapy
- Occupational Therapy
- Speech, hearing & language disorder
- Podiatry
- Optometry
- Dental
- Chiropractic
- Dentures
- Prosthetics
- Eyeglasses
- Other practitioner services



# Most Long Term Services and Supports in the Community are Optional

- Personal Care
- Private Duty Nursing
- Hospice
- Case Management
- Home & Community Based Services (1915 i, j, k)
- PACE
- Community Mental Health
- Health Homes for Chronic Conditions
- Institutes for Mental Disease (65+)
- Inpatient psychiatric services (<21 yrs)
- TB related services



Figure 5

# Medicaid's benefits reflect the needs of the population it serves.

<p><b>Low-Income Families</b></p>	<ul style="list-style-type: none"><li>•Pregnant Women: Pre-natal care and delivery costs</li><li>•Children: Routine and specialized care for childhood development (immunizations, dental, vision, speech therapy)</li><li>•Families: Affordable coverage to prepare for the unexpected (emergency dental, hospitalizations, antibiotics)</li></ul>
<p><b>Individuals with Disabilities</b></p>	<ul style="list-style-type: none"><li>•Child with Autism: In-home therapy, speech/occupational therapy</li><li>•Cerebral Palsy: Assistance to gain independence (personal care, case management and assistive technology)</li><li>•HIV/AIDS: Physician services, prescription drugs</li><li>•Mental Illness: Prescription drugs, physicians services</li></ul>
<p><b>Elderly Individuals</b></p>	<ul style="list-style-type: none"><li>•Medicare beneficiary: help paying for Medicare premiums and cost sharing</li><li>•Community Waiver Participant: community based care and personal care</li><li>•Nursing Home Resident: care paid by Medicaid since Medicare does not cover institutional care</li></ul>

# Key Areas of Focus for Medicaid in FY 2018 and FY 2019

## Quality, Value, and Outcome Initiatives

- Alternative Payment Models (APMs)
- Focus on social determinants of health
- Care coordination for enrollees in the criminal justice system

## Program Expansions and Enhancements

- Provider rate increases
- Expansion of community-based LTSS
- Expansion of behavioral health services and other efforts to address the opioid epidemic
- ACA Medicaid expansion ballot initiatives: ID, NE, & UT

## Eligibility Changes Through Section 1115 Waivers

- Work / community engagement waivers
- Premiums and coverage lock-outs for non-payment
- Waivers of retroactive eligibility

# Medicaid SPAs and 1115 Waivers Cover a Variety of Administrative and Service Topics

- Eligibility and Enrollment Enhancements
- Medicaid Expansion
- Work Requirements, Co-Pays, Healthy Behaviors
- Benefit Changes
- Home and Community Based Care
- Behavioral Health and Opioids
- Managed Long Term Services and Supports
- Delivery System Reforms



- The Medicaid State Plan is a comprehensive written statement that 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
  - 90 days initial review process
  - No cost or budget requirement
  - Proposal permanent



# 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

# What Are Medicaid Waivers?

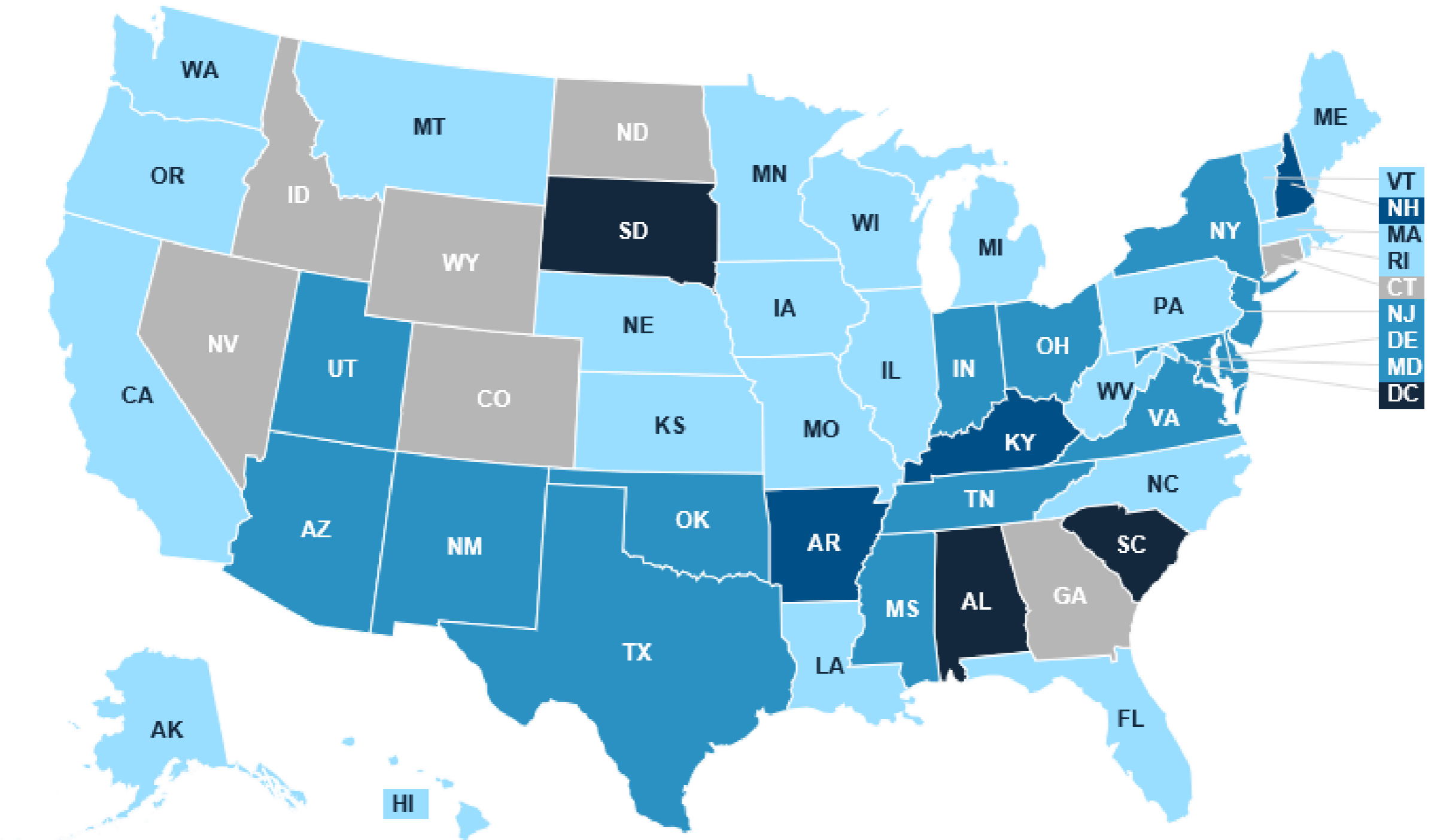
A Medicaid waiver is a provision in Medicaid law which allows the federal government to waive rules that usually apply to the Medicaid program. The intention is to allow individual states to accomplish certain goals, such as reducing costs, expanding coverage, or improving care for certain target groups such as the elderly or women who are pregnant.

- **Section 1115 waivers** – Often referred to as research and demonstration waivers, these allow states to temporarily test out new approaches to delivering Medicaid care and financing.
- **Section 1915(c) waivers** – Home and Community-Based Services (HCBS) waivers are designed to allow states to provide home and community-based services to people in need of long-term care.

- **Section 1915(b) waivers** – “Freedom of choice waivers” allow states to provide care via managed care delivery systems.
- **Combined Section 1915(b) and 1915(c) waivers** – These waivers allow states to provide home and community-based services by contracting with the managed care organizations that are defined in Section 1915(b).

- 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
- Must be cost effective or budget neutral

# Status of 1115 Waivers

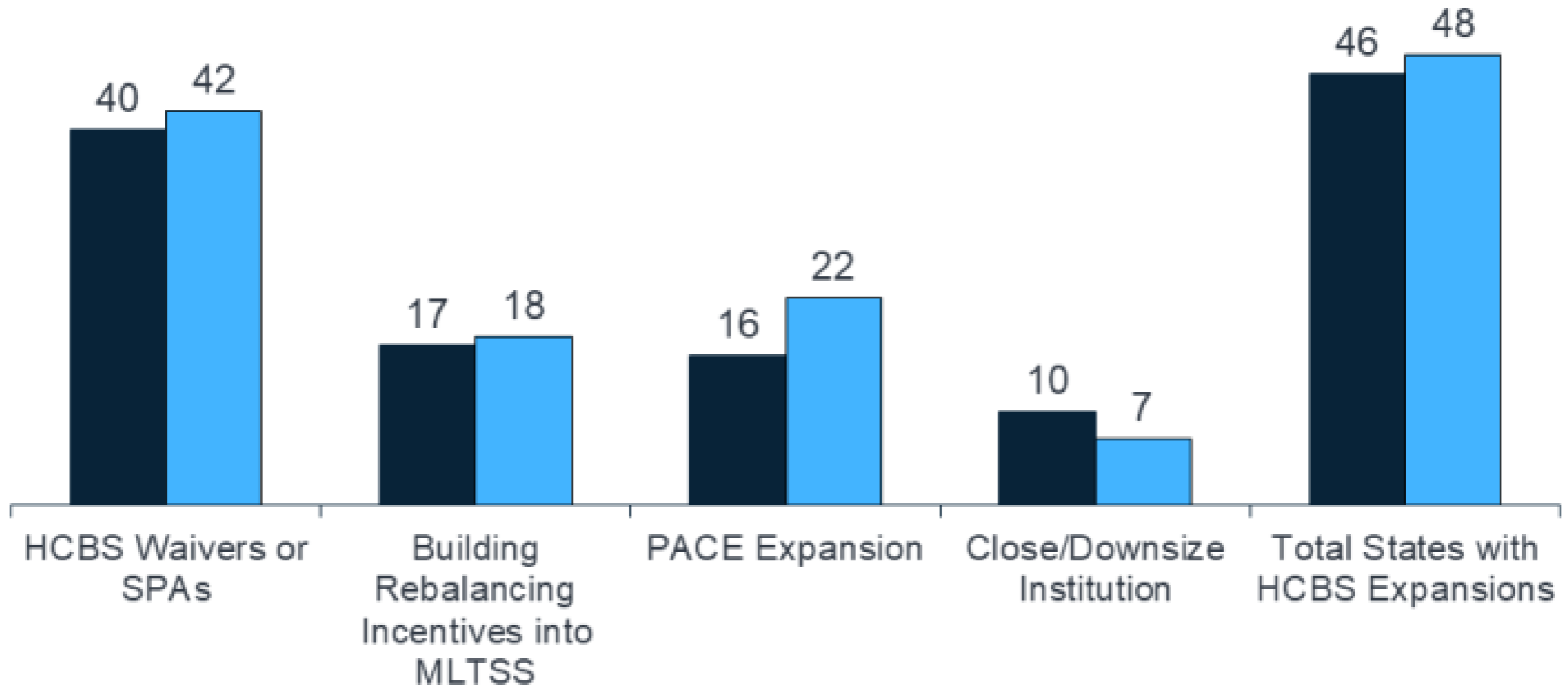


# States Use SPAS and Waivers for HCBS

Figure 6

## Long-Term Care Actions to Serve More Individuals in Community Settings, FYs 2018-2019

■ FY 2018      ■ FY 2019



- 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)



Over two-thirds of all Medicaid beneficiaries receive their care in comprehensive risk-based MCOs.

### Share of Medicaid beneficiaries enrolled in risk-based managed care plans

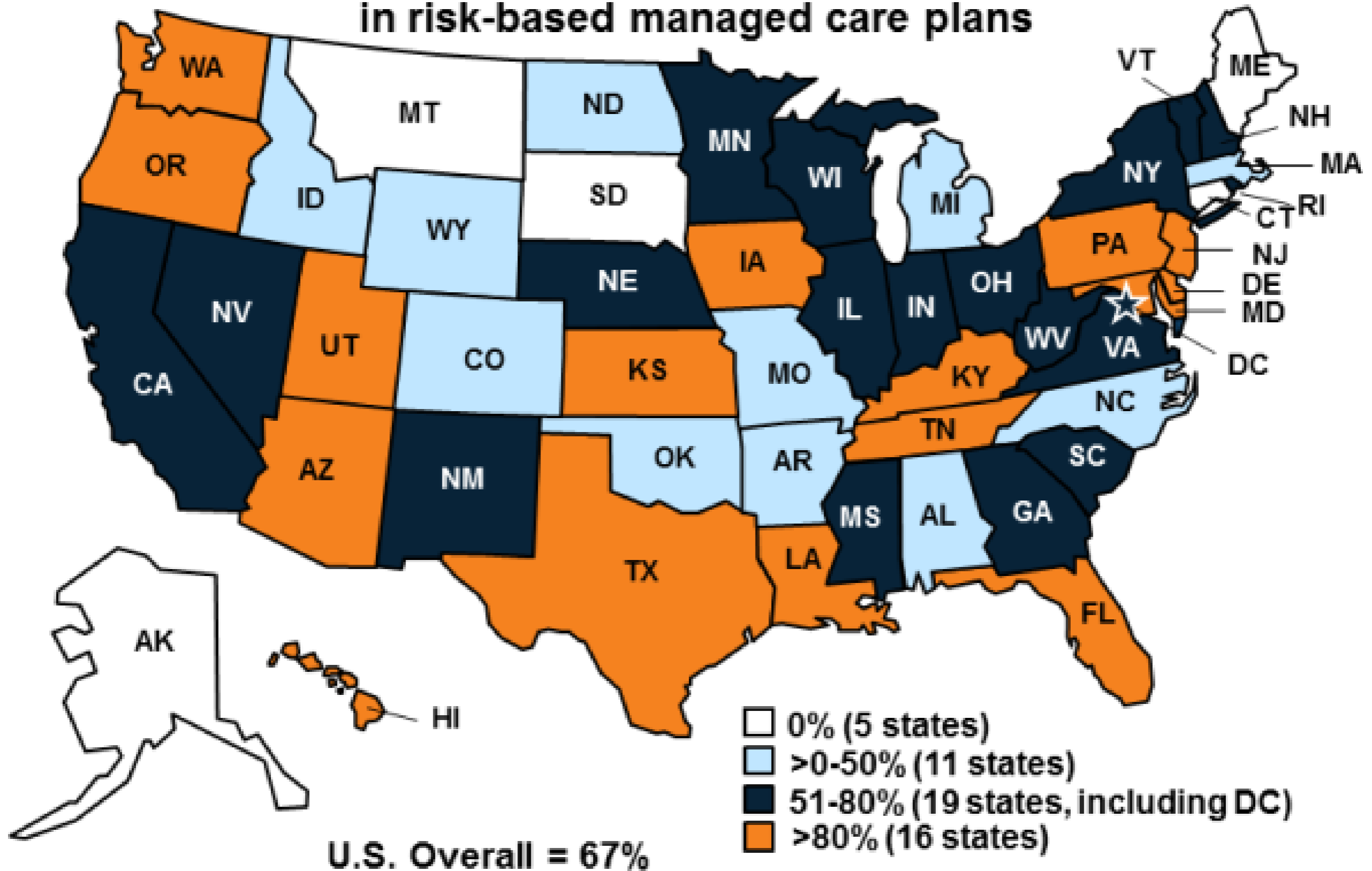
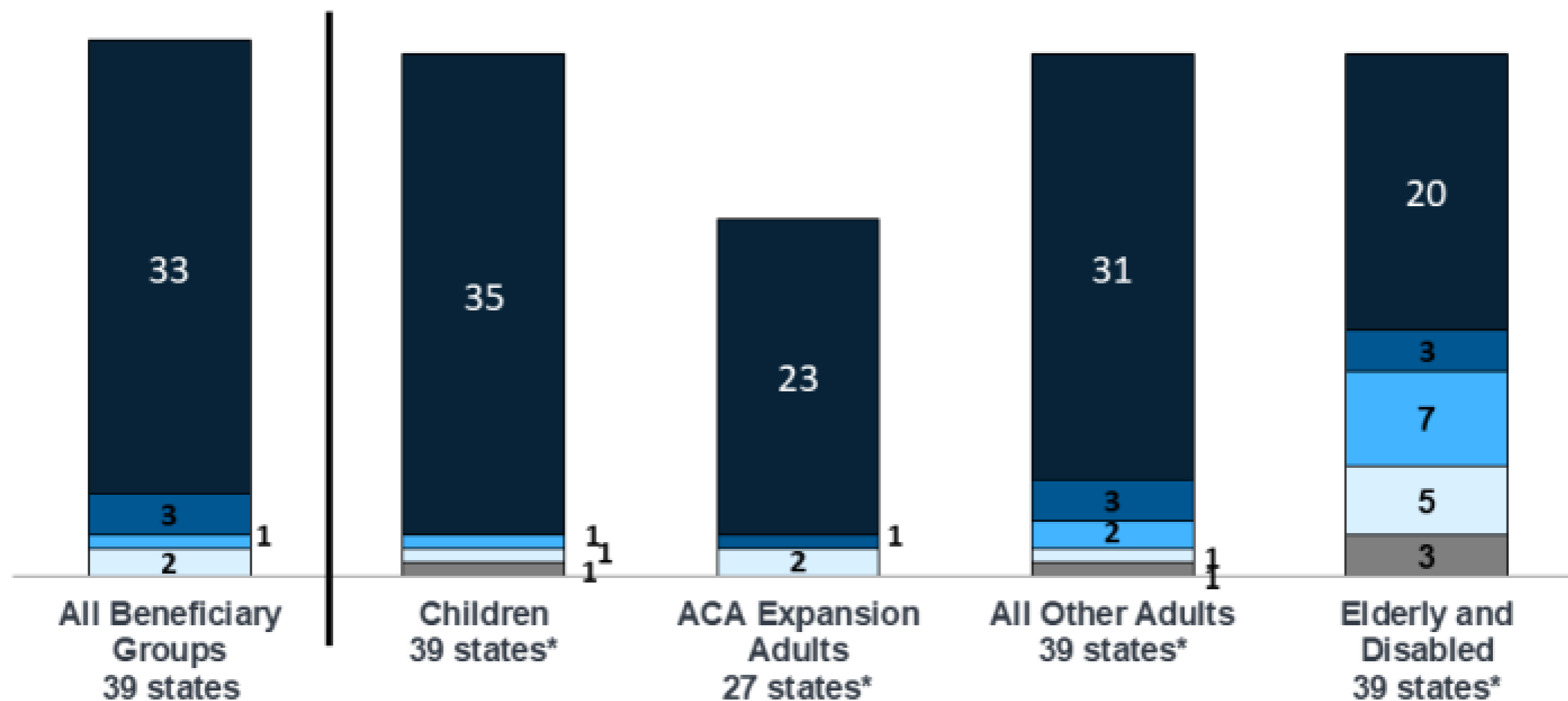


Figure 3

## MCO Managed Care Penetration Rates for Select Groups of Medicaid Beneficiaries as of July 1, 2018

■ Excluded    □ <25%    ■ 25-49%    ■ 50-74%    ■ 75+%



NOTES: Limited to 39 states with MCOs in place on July 1, 2018. Of the 32 states that had implemented the ACA Medicaid expansion as of July 1, 2018, 27 had MCOs in operation. North Dakota's rate for "All Beneficiary Groups" was estimated from a state Quarterly Budget Insight report. Illinois reported the MCO penetration rate for "All Beneficiary Groups" but did not report penetration rates for the individual eligibility categories; therefore, state counts in individual eligibility category bars above do not sum to totals below the bars.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2018.

- ✓ Significant coverage gains
- ✓ Improved access to care, utilization of services, affordability of care, and financial security
- ✓ Positive economic measures on state budgets, revenue gains, and overall economic growth

KFF 2019

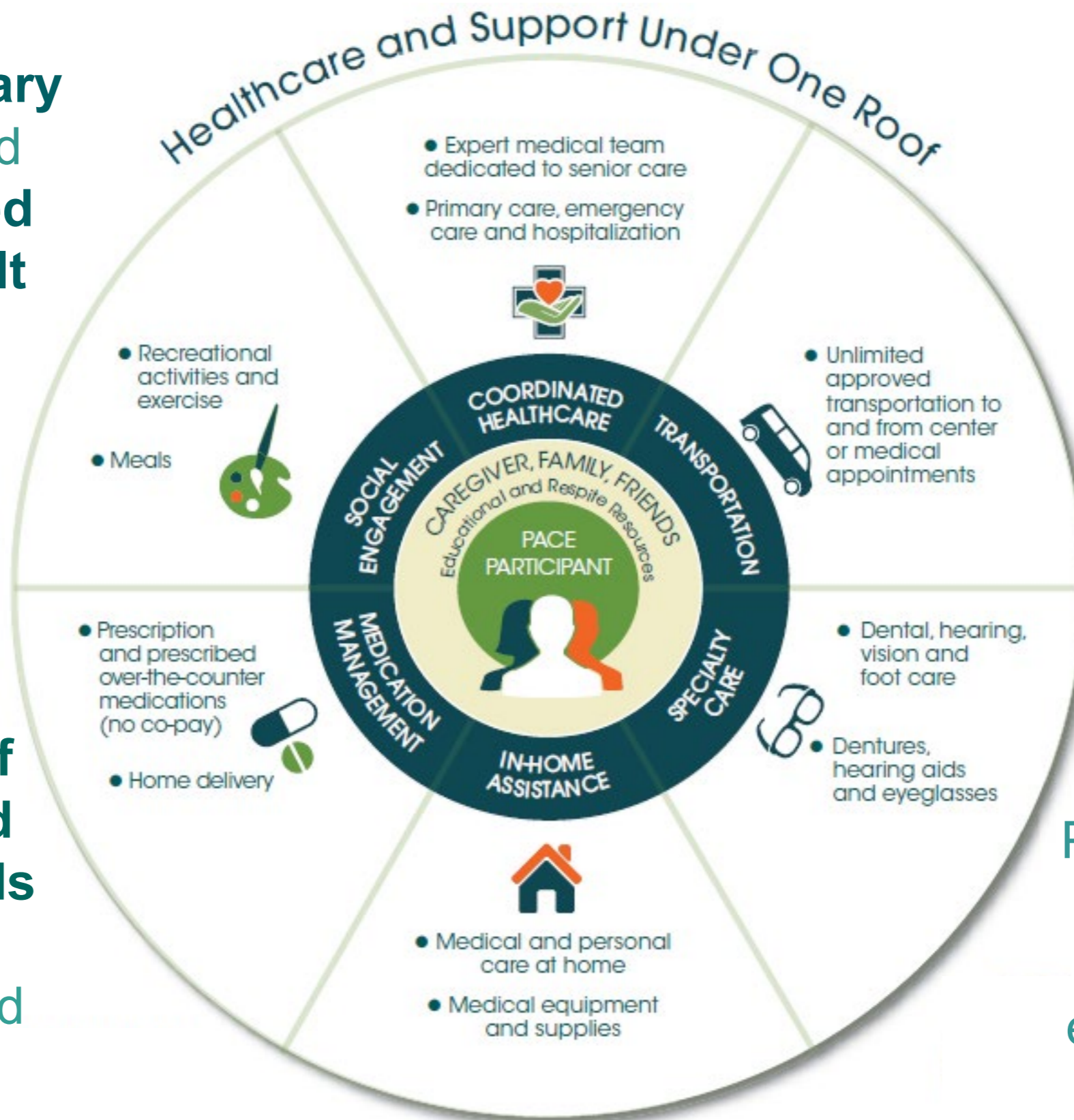
# Program of All-Inclusive Care for the Elderly (PACE)



# What is PACE?

Interdisciplinary team directed care delivered from an adult day center

Integration of Medicare and Medicaid funds allows whole person focused care



Preferred option to nursing facilities

There are **121 PACE** providers with **242 PACE** centers in **31** states

PACE programs serve **>45,000** nursing-home eligible **seniors** nationwide

# PACE Services

## Many Services Are Provided at the PACE Center

- Primary care, including physician, nursing services, and mental health and psychiatric as needed
- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals
- Speech therapy
- Dental service (most InnovAge facilities have full dental suites)
- Lab / X-Ray
- Medical Equipment
- Activities (yoga, dance, cards, trivia, computers, etc.)

## Employed Interdisciplinary Care Team Develops Individualized Care Plans

- The interdisciplinary care team at each PACE center comprehensively assesses and meets the individual needs of each participant. Each participant is assigned to an interdisciplinary care team. These individuals are focused exclusively on PACE and are either employed by InnovAge or in the case of physicians sometimes contracted given regulatory dynamics
- Team members include: primary care physician, registered nurse, Master's-level social worker, physical therapist, occupational therapist, recreational therapist or activity coordinator, dietician, PACE center manager, Home Care coordinator, Personal Care attendant, driver

## Flexible Home Support Provided to Keep Participants at Home

- Transportation is provided to and from the center and appointments (InnovAge vans complete >30,000 one way trips per month)
- Home Care (skilled, unskilled, personal care etc.) is provided in the home
- Total flexibility of funds means InnovAge can install an air conditioner or grab bars or a ramp, adjust the height of the microwave, anything to facilitate keeping a participant at home

## Services Also Covered Outside PACE Center and Home

- Hospital services (inpatient, ER, etc.) are covered as well as specialist visits
- If a participant is no longer able to live independently in the home safely, InnovAge covers the cost of a nursing home or facilitates assisted living

# PACE Participant Profile



## Eligibility for PACE

- Live in a PACE service area
- Age 55 or over
- **Certified to need nursing home care**
- Able to live safely in the community with PACE support at the time of enrollment (can not be enrolled in a nursing home)

## Average InnovAge Colorado PACE Participant

- 94% dually eligible for Medicaid and Medicare
- 75 years old (83% 65+, 17% 55-64)
- 69% women, 31% men
- 2.2 risk score; higher acuity compared to Medicare average of 1.0
- 37% of ambulatory, community-dwelling participants diagnosed with dementia, and 36% have 5 or more chronic conditions on the FCI
- Average gait speed of 0.64 m/s (1.0 m/s is considered at high risk of functional impairment, hospitalization and LTC placement)
- Top diagnoses: diabetes w/chronic complications; major depressive, bipolar, and paranoid disorders; COPD; polyneuropathy; dementia w/o complication; chronic kidney disease; CHF; vascular disease
- In an average month: 6 prescriptions; 4 visits to PACE center; 7 personal contacts; 2 therapy (PT/OT) encounters; 11 trips per participant

# PACE Positioned to Grow

- PACE is the **best policy alternative** to treat **low-income frail elderly**
- Delivers **integrated acute and long-term care** under a **unique full risk model** to the **highest cost, frailest Medicare and Medicaid beneficiaries**
- **Extends life, reduces institutionalization, and improves quality of life**
- PACE has a **long history of successfully providing community-based, high quality, integrated health and long-term care** to the highest-risk, most costly subpopulation of dual eligibles; **improving quality and reducing overall program expenditures**
- **Numerous studies of PACE have demonstrated positive health outcomes** for PACE enrollees, and there is research and data on the **cost-saving nature of the PACE model for states and government**
- **Lack of data** coupled with **limited awareness** has **kept PACE's reach narrow**



# About InnovAge

Leader in  
senior care  
services

**16**  
PACE  
centers

**1989**

Established as one  
of the original PACE  
pilot programs

**Largest**  
PACE provider  
in the country  
based on the number of  
participants  
served

Almost  
**6,000**  
participants  
served daily

Operate in  
**5**  
states

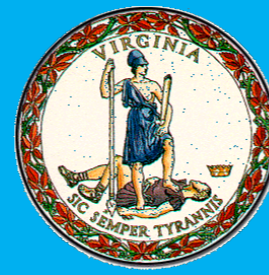
Paid Actor Portrayal

# Our Mission

- **Our mission is to sustain and enhance the independence and quality of life for those we serve, on their terms.**
- **At InnovAge we have one goal. To help people age independently in their own home and community for as long as possible.**
- **InnovAge is committed to empowering seniors and caregivers by creating a personalized roadmap for aging based on an individual's unique and evolving needs**
- **InnovAge has supported and cared for thousands of seniors since 2001 and currently operates centers in California, Colorado, New Mexico, Pennsylvania and Virginia**

# Best in Class Facilities





# **VIRGINIA MEDICAID SUBSTANCE USE DISORDER TRANSFORMATION TO INCENTIVIZE ACCESS TO TREATMENT**



# Background on Virginia's Opioid Epidemic

## Impact on Medicaid Beneficiaries

### *The opioid epidemic disproportionately affects Medicaid beneficiaries*

- Medicaid beneficiaries age 18–64 have a higher rate of opioid use disorder than privately insured individuals, comprising about 12 percent of all civilian, non-institutionalized adults in this age group but about one-quarter of those with an opioid use disorder.
- Medicaid beneficiaries are prescribed pain relievers at higher rates than those with other sources of insurance.
- They also have a higher risk of overdose and other negative outcomes, from both prescription opioids and illegal opioids such as heroin and illicitly manufactured fentanyl.

Source: MACPAC (June 2017), *Report to Congress on Medicaid & CHIP, Chapter 2: Medicaid and the Opioid Epidemic.*

# Addiction and Recovery Treatment Services (ARTS) Benefit

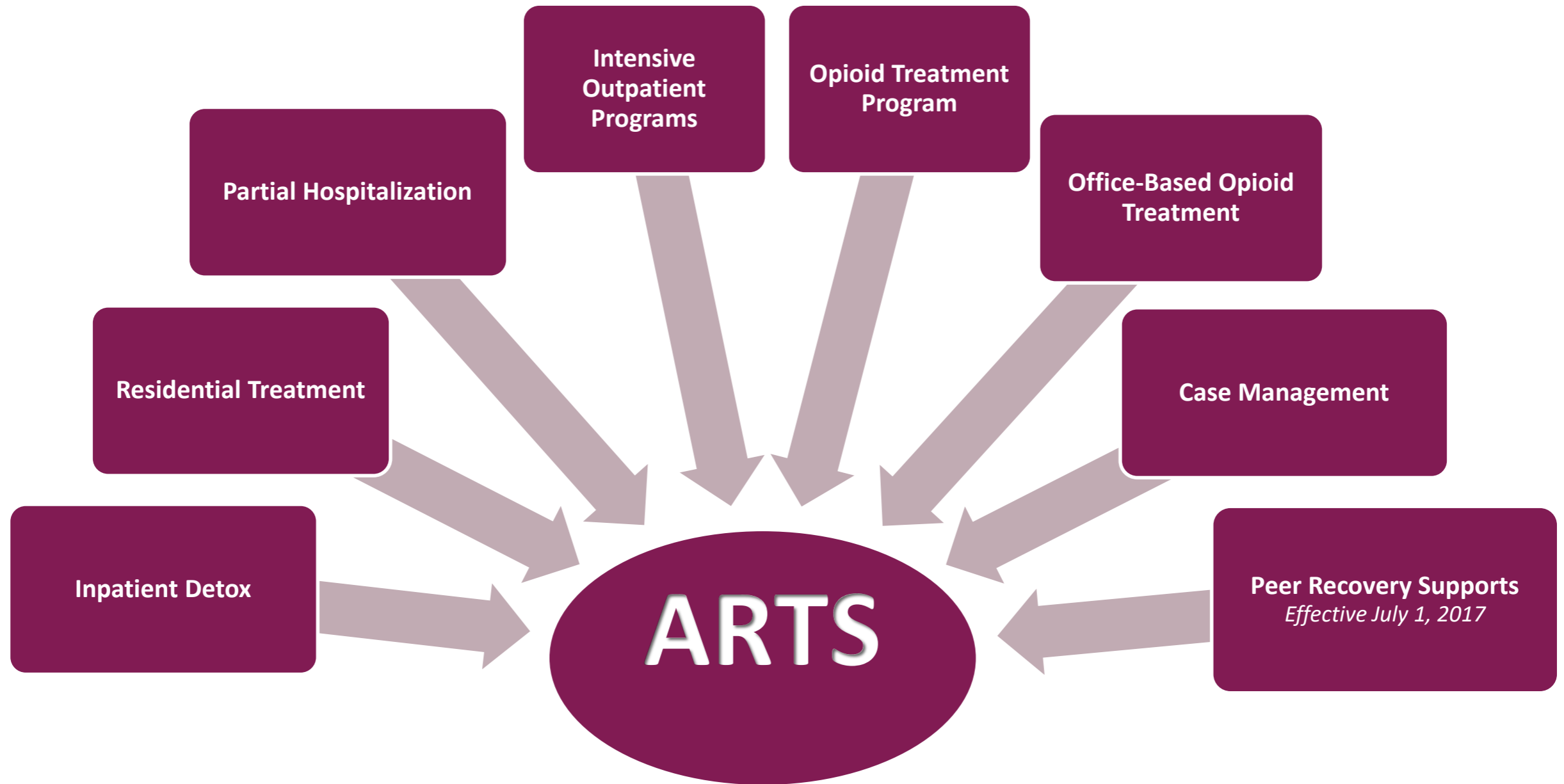
## *Changes to DMAS' Substance Use Disorder (SUD) Services for Medicaid and FAMIS Members approved by General Assembly in Spring 2016*

- 1** Expand short-term SUD inpatient detox to all Medicaid /FAMIS members
- 2** Expand short-term SUD residential treatment to all Medicaid members
- 3** Increase reimbursement for existing Medicaid/FAMIS SUD treatment services
- 4** Add Peer Support services for individuals with SUD and/or mental health conditions
- 5** Require SUD Care Coordinators at DMAS contracted Managed Care Plans
- 6** Organize Provider Education, Training, and Recruitment Activities

# Addiction and Recovery Treatment Services (ARTS)

## Transforming the Delivery System of Medicaid SUD Services

Effective April 1, 2017 - All ARTS services are covered by managed care plans






ARTS offers a fully integrated physical and behavioral health continuum of care

# VCU Evaluation:

## Highlights from the second year post ARTS (Apr 2018-Mar 2019)

### Substance Use Disorder Prevalence and Treatment among Non-Expansion Population

	SUD	OUD	AUD
Number of members	 52,020	 22,155	 17,987
Total number and percent receiving treatment	48% 25,007	63% 13,937	43% 7,747



# SUD in Expansion Population

Prevalence of SUD among the Expansion Population, Jan-Mar 2019



6% (16,518)  
of members  
have **SUD**



3% (7,125)  
of members  
have **OUD**



2% (5,620)  
of members  
have **AUD**

Expansion population is disproportionately affected by Substance Use Disorders (SUD), Opioid Use Disorder (OUD) and Alcohol Use Disorder (AUD)

# Increases in Addiction Providers Due to ARTS

Over 440 new Addiction Treatment Provider Sites in Medicaid as of August 2019

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	87	↑ 2075%
Partial Hospitalization Program (ASAM 2.5)	0	22	NEW
Intensive Outpatient Program (ASAM 2.1)	49	137	↑ 180%
Opioid Treatment Program	6	38	↑ 533%
Preferred Office-Based Opioid Treatment Provider	0	115	NEW

# Medicaid Financing and Program Integrity

- Thanks to Andy Allison
- Financing today is not Financing tomorrow
- You will NEVER be bored....

# Medicaid Reimbursement and Matching Rates

- General Administration: 50/50 EXCEPT
  - Salaries for skilled health care professionals – doctors and nurses
  - Computer systems
- Computer Systems
  - 75/25 on going operations
  - 90/10 for updates or new systems
- Programs: The state's Federal Medical Assistance Percentage (FMAP) EXCEPT
  - Family planning
  - Medicaid expansion population

# Medicaid Rate-Setting

- Process: Most rates are set by formula or amount in a “state plan amendment,” i.e., a change in the state’s CMS-approved plan governing use of Federal matching payments
- Requirements: Federal law requires rates to be sufficient to generate access on a par with general population (*SSA Section 1902(a)(30)(A)*)
- Fee for service: Traditional approach to payment was to reimburse for each bit or piece of health care used, i.e., a fee for every service.
  - For pregnancy that could include multiple prescriptions (and fills), a hospital stay, and physician’s services for delivery, prenatal and post-natal visits
  - Fee-for-service now also means “not managed care”
- Prescription Drugs: “Rate-setting” for prescription drugs entails setting reimbursement formulas for local pharmacies, federally-mandated manufacturer rebates and sometimes a state-negotiated rebate as well
  - All approved drugs must be covered (so long as manufacturer participates in federal drug rebate program) but NOT all drugs must be “preferred” nor covered without guidelines or conditions, such as prior authorization
  - The potential for establishing preferred or unconditional prescribing helps leverage state-negotiated rebates
- Institutions: There are various payment methods for facility-based care, including “cost-based” reimbursement and “price-based” reimbursement
  - Cost-based usually includes cost reporting, interim payments, and cost reconciliation
  - Price-based methodology is based on payments using a fixed-fee methodology, generally DRGs for hospital inpatient, OPPS for outpatient services, and RUG-based payments for nursing homes
  - Some hospitals and nursing homes receive lump-sum “supplemental” payments not directly tied to individual services
- Reform: Revisiting the “fee for service” approach has risen to the top of State Medicaid program agendas....

# Medicaid Rate-Setting

## Medicaid's Minimum Access Requirements

- Requirements: Federal law requires rates to be sufficient to generate access on a par with general population (*SSA Section 1902(a)(30)(A)*)
  - That same federal law also requires that “payment” secure quality services and provoke efficient use
  - Supreme Court recently determined that providers do NOT have legal standing to challenge state payment rates against this federal standard (*Armstrong v. Exceptional Child Center, Inc.*)
- Following the Supreme Court decision, CMS published regulations establishing the process states must go through to assure sufficient access
- Medicaid services covered under the new regulations include:
  - Primary care and physician services
  - Behavioral health services
  - Obstetric services
  - Home health
  - Other services for which the state or CMS has received unusually high number of complaints, or which is experiencing **a change in payment that could diminish access**
- Beginning July 2016 States were to required create and maintain “access monitoring plans” for each service
  - Stakeholder input and public notice
  - Comparison of Medicaid rates to other payers
  - Measurement of access versus established metrics such as time and distance to participating providers
- However, in 2019 CMS issued new regulations and a corresponding information bulletin that repealed the Access regulations and discussed a collaborative process with states and other stakeholders to establish a better way to ensure and monitor access

# Value-Based Purchasing

## Overview

### Overarching objective

One way to express a state's goal might be to **pay for a valued outcome** (e.g., quality of life or survival) independent of the number or type of services provided

### Core idea

VBP pays for (or incents) end-to-end or comprehensive care that *should be* managed together, e.g., by a coordinated team, instead of paying each service discretely on a volume basis

### Basic approach

Identify a *collection of related services* attached to a distinct health condition or outcome and incentivize or combine all payments for these related services.

Approach the “patient centered approach” that manages care for the entire range of services, including social services needed by a patient

### VBP opportunities

Bundled Payments

Managed Care with Carve-Outs

Managed Care without Carve-Outs

Provider Led Entities (PLEs)

# Value-Based Purchasing

## Examples of Common and Emerging Payment Models and Delivery System Redesigns

- **Managed care organizations**
  - Service package: comprehensive care for each enrollee
  - New payment model: single monthly payment for all services for each enrollee
  - Scale: encompasses geographic regions or full states
- **Accountable care organizations**
  - Service package: comprehensive care for each enrollee
  - New payment model: single monthly payment for all medical services for each assigned patient
  - Scale: encompasses patients of a particular health system
- **Patient-centered medical homes**
  - Service package: comprehensive care for each enrollee
  - New payment model: monthly supplemental payment **and/or** periodic incentive payment
  - Scale: incentives encompass total medical spend for all of a doctor's patients
- **Health homes**
  - Service package: variable, but might include all specialized services (e.g., behavioral health care) or both specialized and physical health services
  - New payment model: monthly supplemental payment to a provider or care coordinator
  - Scale: encompasses some combination of care for all of a provider's patients
- **Episode-based payments**
  - Service package: all services associated with an episode of sinusitis, pregnancy and delivery, etc.
  - New payment model: bundled/combined payment or retrospective incentives
  - Scale: encompasses all condition-related care for all of a provider's patients



# Medicaid Payment Integrity

## Basic concepts

- **General requirements for a proper Medicaid payment**

- Approved service
- Approved payment rate and methodology
- Enrolled provider
- Eligible beneficiary
  - All sufficiently documented

## **Core concepts**

*(not formal definitions)*

- *Fraud: intentionally improper claims*
- *Waste: proper but unnecessary claims*
- *Abuse: intentionally wasteful claims*

# Medicaid Payment Integrity

## Tools and Activities

- **Resources and Requirements**

- Accountability for all payments accrues to the single state Medicaid agency
  - Operating agencies and contractors assist with payment integrity, but CMS ultimately holds the designated single state Agency accountable
- Agency investigators, auditors, compliance and program staff all contribute
- CMS efforts are now consolidated in the Payment Error Rate Measurement (PERM)\* program
- All states implement MMIS-related Surveillance and Utilization Review Systems (SURS)

- **External review and audit authorities**

- Medicaid Fraud Control Units (State Attorneys General)
- State auditors (e.g., legislative, agency, State inspectors general)
- CMS
- Federal HHS Office of Inspector General
- Federal Government Accountability Office
- Law enforcement (e.g., prosecutors, FBI)

- **Core activities**

- Reporting and investigation
- Pattern recognition
- Referral and prosecution
- Recovery
- Remediation, avoidance and prevention

\*Under final federal regulations published July 5, 2017, PERM will supercede/encompass statewide eligibility accuracy measurement previously conducted by state Medicaid Eligibility Quality Control (MEQC ) units, and MEQC would be reshaped to compliment PERM as an off-year state-driven analytic pilot program

# Contact

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# MEDICAID LTSS

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# AGENDA

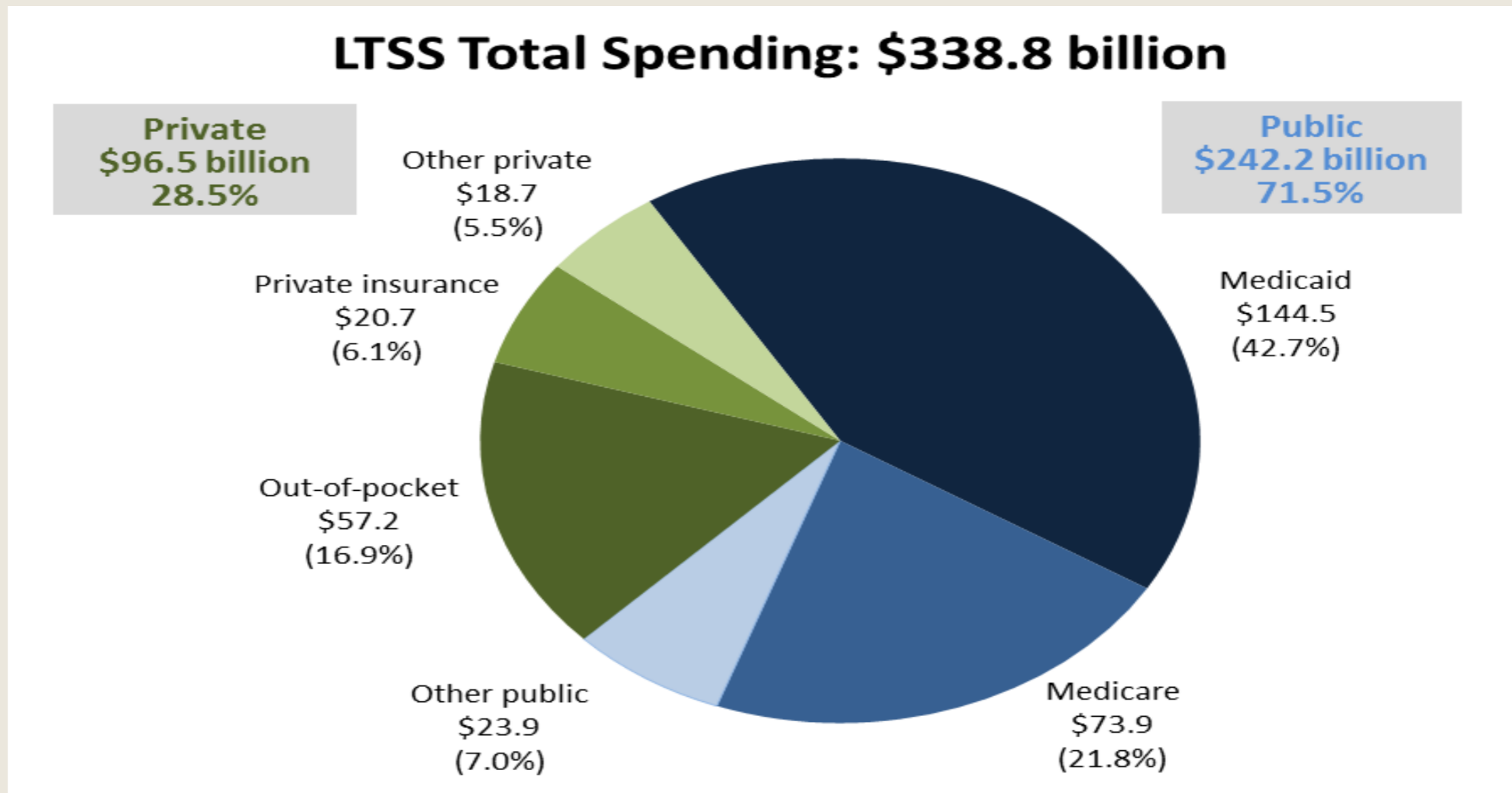
- **Costs and Medicaid's Role in LTSS**
- **Institutional and Home and Community-based benefits**
- ***Olmstead v. LC* and the Evolution of Home and Community-Based Services**
- **Authorities: State Plan Amendments, Waivers and Demonstrations**
- **Challenges and Opportunities**

# What Do LTSS Services Cost?

Service Type	National Monthly Average	Low	High
Nursing Facility (Private)	\$8,365	\$5,293 (OK)	\$27,537 (AK)
Nursing Facility (Semi-Private)	\$7,441	\$4,639 (OK)	\$29,291 (AK)
Assisted Living	\$4,000	\$2,844 (AR)	\$9,266 (DC)
Adult Day Health	\$1,560	\$758 (AL,MI,TX)	\$2,947 (VT)
Home Maker	\$4,004	\$3,051 (LA)	\$5,339 (WA)
Home Health Aide	\$4,195	\$3,051 (LA)	\$5,720 (HA)

Genworth, 2018 Cost of Care Survey, <https://www.genworth.com/aging-and-you/finances/cost-of-care.html> (accessed August 8, 2019).

# Who Pays for LTSS?



Source: CRS analysis of National Health Expenditure Account (NHEA) data obtained from the Centers for Medicare & Medicaid Services (CMS), Office of the Actuary, prepared December, 2014. Accessed at: <https://fas.org/sgp/crs/misc/R43483.pdf> on July 26, 2018.

# Medicaid LTSS includes Both Institutional and Home and Community-Based Services

- Institutional Services include Nursing Facility (NF), Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IDs).
- Home and Community-based Services include a wide-range of supports and services designed to help individuals live full lives in the community. Examples include:
  - \*Personal Care Assistance \*Case Management \*Home Modifications*
  - \*Personal Emergency Response Systems \*Family Support & Training\* Respite Care*
  - \* Assisted Living \*Home Delivered or Congregate Care Meals \*Home Health Services*
  - \*Home Safety Assessments \* Supported and Shared Living \* Supported Employment \* Pre-vocational Training \*Assistive Devices and Supplies \*Transition Assistance*
  - \*Consumer-directed Care \* Homemaker and Chore Service \*Crisis services \*Transportation*
  - \*Behavioral Supports. \*Diet and Nutrition Services*
- NF Services and Home Health Services are Mandatory; while ICF/ID and HCBS Services are Optional.



# The Impact of the ADA and *Olmstead V. LC, 527 U.S. 581 (1999)*

- 1990 – Americans with Disabilities Act (ADA), Title II, prohibits public entities from discriminating against individuals with disabilities in the provision of public services.
- “Integration Regulation” – Requires public entities to administer programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities. (28 CFR 35.130(d))
- Public entities further must make “reasonable modifications” to avoid discrimination based upon disability.

## ***OLMSTEAD V L.C. cont.***

- The US. Supreme Court ruled (1999)
- Unjustified isolation is properly regarded as discrimination based upon disability. States *must* place persons with disabilities in community settings rather than in institutions:
  - *When the States treating professionals have determined that community placement is appropriate,*
  - *The transfer is not opposed by the affected individual, and*
  - *The placement can be reasonably accommodated, taking into account the resources available to State and the needs of other with mental disabilities.*

# The Parameters of the Integration Mandate

- But, states obligation to provide community-based care is not unlimited.
- States need not make changes that fundamentally alter the States services and programs.
- States must be allowed to show that, in the allocation of available resources, immediate relief for the plaintiffs would be inequitable, given the responsibility the State has undertaken for the care and treatment of a large and diverse population of persons with disabilities.

*“If, for example, the State were to demonstrate that it had a comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace, not controlled by the State’s endeavors to keep its institutions fully populated, the reasonable-modifications standard would be met.”*

# Turning The Olmstead “DEFENSE” into a Tool to Promote Community Integration

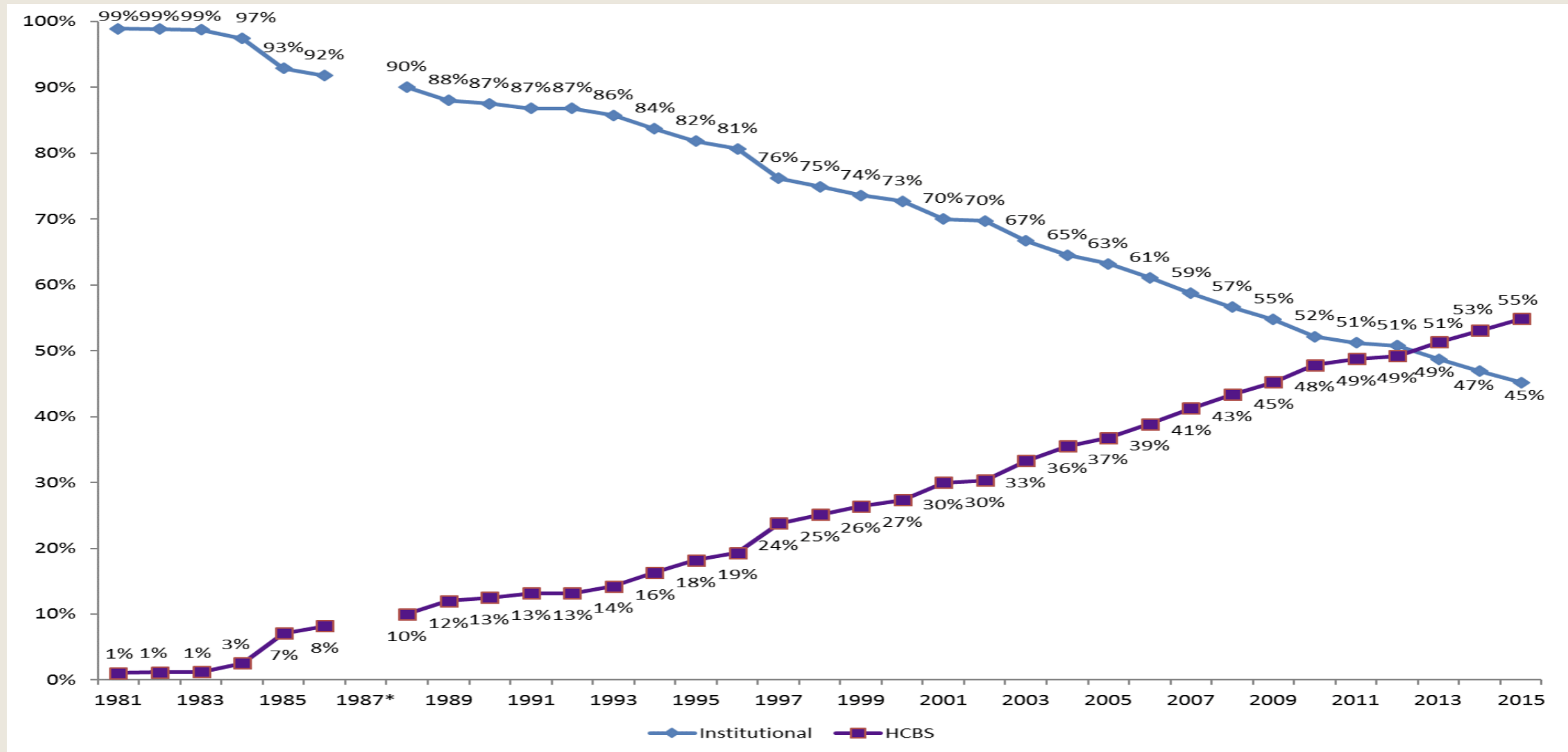
*The Supreme Court’s dicta led to an unprecedented Federal effort to proactively promote State Olmstead plans and advance community integration:*

- Guidance and Technical Assistance
- Grants – System Change, Balancing Incentives, Money Follows the Person
- Policy Initiatives to Eliminate “Institutional Bias” in Medicaid
- President Bush’s New Freedom Initiative
- HCBS Settings Rule

# OLMSTEAD PLANS REMAIN IMPORTANT!

- On July 5, 2019, *Ivy Brown, v. District of Columbia*, the US Court of Appeals for the DC Circuit reversed a decision in favor of Washington, DC, finding that the absence of systemic deficiencies in the services provided by the District did not absolve the defendants' of liability for the failure to move people out of nursing homes and into community placements.
- In the absence of an effectively working Olmstead Plan, the State *must* make each accommodation Plaintiffs have requested *unless* it can show that an accommodation would be so *costly* to implement that it would be unreasonable to require the State to transfer its limited resources from other disabled individuals.
- Plaintiffs are not required to establish that requested accommodations are facially reasonable and necessary.
- The Court also seemingly rejected the notion that cost is only one factor to be considered.

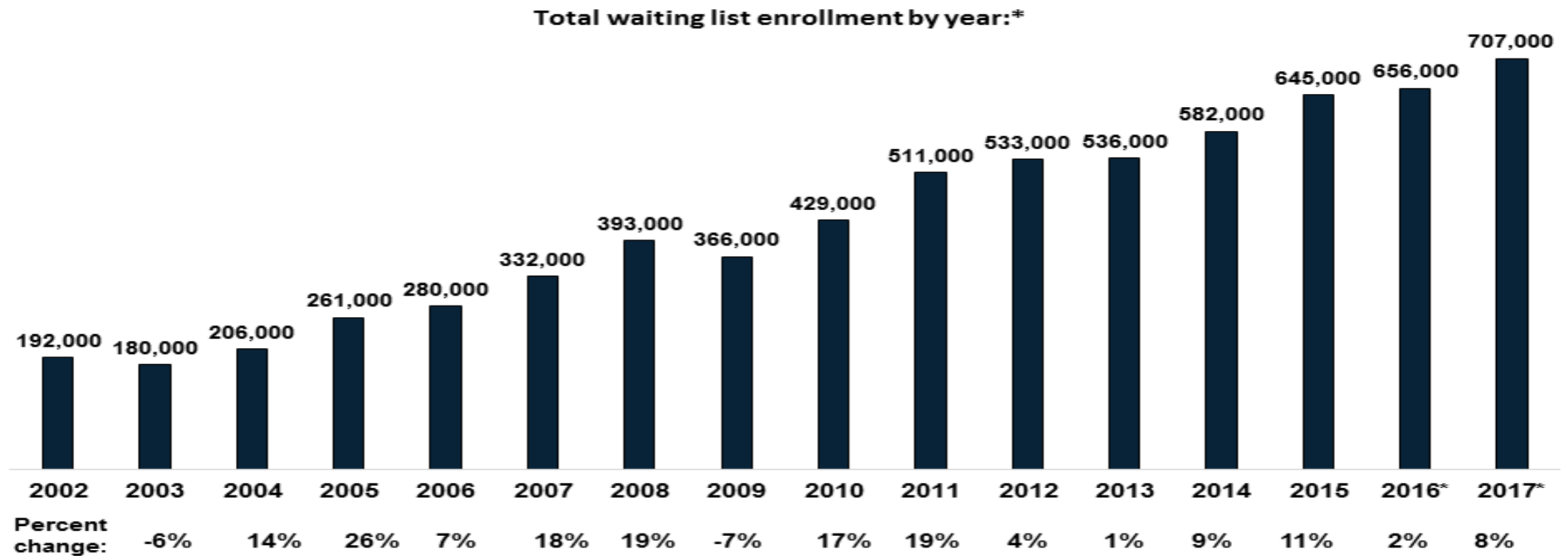
## Medicaid HCBS and Institutional LTSS Expenditures as a Percentage of Total Medicaid LTSS Expenditures, FY 1981–2015



Truven Health Analytics, **Medicaid Expenditures for Long-Term Services and Supports (LTSS) in FY 2015**, April 14, 2017

# Demand for HCBS Exceeds Supply

Figure 1  
Medicaid HCBS waiver waiting list enrollment, 2002-2017.

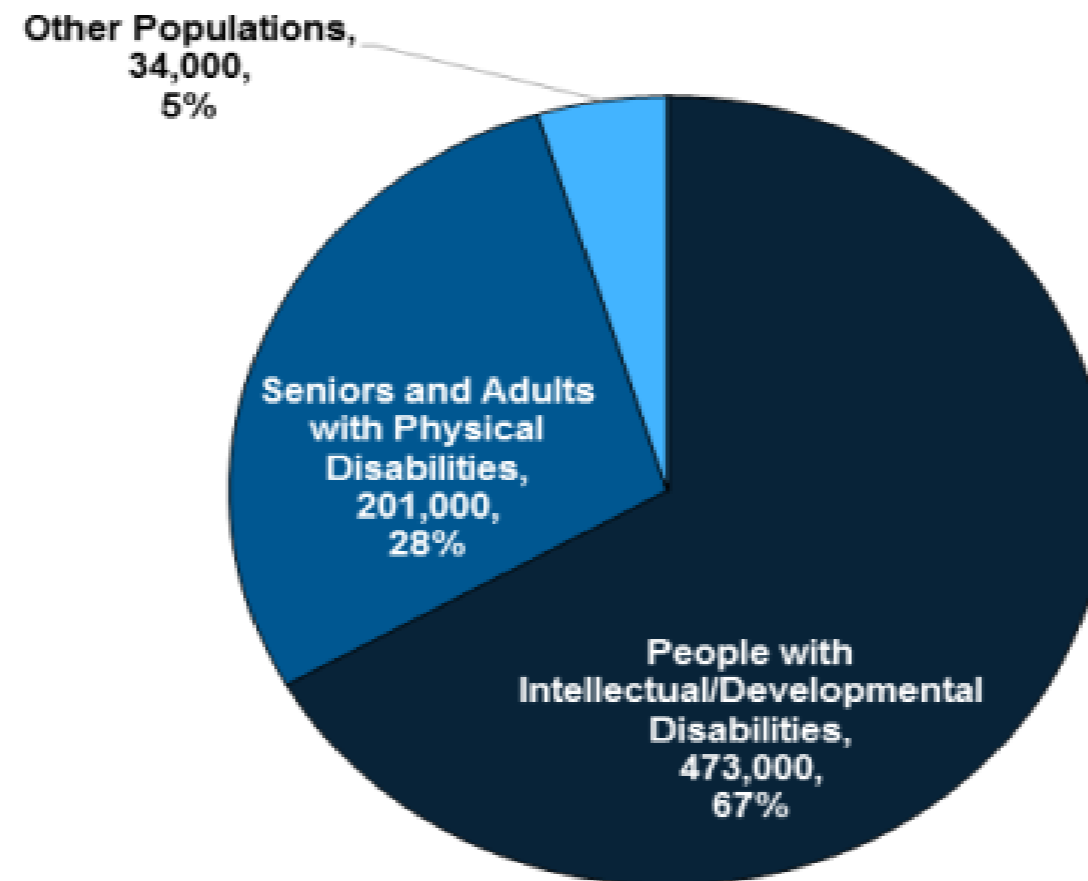


NOTES: Percent change is calculated using unrounded totals. \*Beginning in 2016, totals include Section 1916 (c) and Section 1115 HCBS waiver waiting lists except that CA and NY did not report enrollment for Section 1115 waiting lists; prior years include only Section 1915 (c) waiver waiting lists.

SOURCE: Kaiser Family Foundation Medicaid FY 2002-2017 HCBS program surveys.

Figure 2

## Medicaid HCBS waiver waiting list enrollment, by target population, 2017.



**Total waiting list enrollees = 707,000**

NOTES: Numbers may not sum to totals due to rounding. Data include Section 1915 (c) and Section 1115 HCBS waiver waiting lists except that CA and NY did not report Section 1115 waiting list enrollment, and AL reports its Section 1915 (c) IDD waiting list as "unknown." Other Populations include children who are medically fragile or technology dependent, people with HIV/AIDS, people with mental health needs, and people with traumatic brain or spinal cord injuries. SOURCE: Kaiser Family Foundation Medicaid FY 2017 HCBS program survey conducted in 2018.



# Authorities that Support HCBS Services

- **Medicaid State Plan** – Operational Agreement between Federal Government and State that gives State authority to draw down federal match for approved services.
- **Waivers** – Allows Federal Government to exempt States from specific Medicaid statutory requirements:
  - *Section 1115 – Research and Demonstration Waivers*
  - *Section 1915(b) Freedom of Choice*
  - *Section 1915(c) Home and Community Based Services (1981)*

*(Title 42 of Social Security act (SSA))*
- **New(er) State Plan Options**
  - *1915(i) HCBS State Plan Option (2005)*
  - *1915(j) Self-Directed PCA (2005)*
  - *1915(k) Community First Choice (2010)*

# Section 1115 Research & Demonstration Waivers

- Give HHS Secretary broad authority to approve experimental, pilot or demonstration projects to promote the objectives of the Medicaid program.
- Demonstrations must be “cost neutral” to the Federal government meaning Federal Medicaid expenditures will not be more than Federal spending without the demonstration over the life of the project.
- Generally approved for an initial FIVE year period and can be extended an additional 3-5 years.
- Evaluation/Reporting requirements.
- Examples:
  - (1) “Cash and Counseling” in 1990(S), lead to inclusion of Participant-Directed Services in 1915(c) Waivers which led to DRA, Section 1915(i), 1915(j) and later 1915(k).
  - (2) Managed Care
  - (3) Comprehensive SUD Services
  - (4) Services to individuals not yet eligible for Medicaid LTSS
  - (5) Pre-ACA – Services to Childless adults
  - (6) Financial Alignment

# 1915 (c) Home and Community-Based Waivers

What can be waived under Section 1915(c)?

- Comparability (Section 1902(a)(10)(B)) – This permits a state to limit the HCBS waiver services to Medicaid beneficiaries who require an institutional level of care and are in the specified target group(s).
- Statewideness (Section 1902(a)(1)) – This permits a state to limit the operation of a waiver to specified geographic areas of the state, and
- Income and Resources for Medically Needy (1902(a)(10)(i)(III)– This allows a state to apply institutional income and resource “eligibility” rules for medically needy in the community (if they otherwise qualify for services).
- States combine a 1915(c) waiver with a 1915(b) Freedom of Choice waiver – This permits a state to mandate enrollment or limit the beneficiary’s ability to choose any participating provider. Can be used for managed LTSS, Carve Outs, etc.
- INITIAL THREE-YEAR APPROVAL; RENEWED EVERY FIVE YEARS (EXCEPT WAIVERS THAT INCLUDE DUALS MAY RECEIVE INITIAL FIVE YEAR APPROVAL)

# Who can be served in a 1915(c) Waiver?

- Individuals who require an institutional level of care (hospital, nursing facility or ICF/ID).
- Are a member of a target group that is included in the waiver. (States may include multiple target groups in a single waiver).
- Meet applicable financial eligibility criteria.
- Require one or more waiver services in order function in the community, and
- Exercise freedom of choice by choosing to enter the waiver in lieu of receiving institutional care
- State must specify the unduplicated number of individuals to be served.

# What Services can be Offered under Section 1915(c)?

- State may offer services enumerated in the statute or propose other services that assist individuals to remain in the community – there are no required services.
- Waiver services compliment State Plan Services; a waiver participant must have full access to State Plan Services.
- States can offer extended State Plan Services that exceed the limits that apply under a State Plan.
- There is no limit to the number of services that a state may offer in a waiver.
- States may not claim Federal Match (FFP) for Room and Board

# 1915(c) HCBS Waivers Assurances

- States must assure CMS that HCBS Waiver programs will:
  - *Be cost neutral (cannot cost the federal government more than providing services in an institution).*
  - *Protect the health and safety of individuals in the program.*
  - *Provide adequate and reasonable provider standards to meet the needs of individuals served in the waiver.*
  - *Ensure that services follow an individualized and person-center plan of care.*
  - *Develop and implement a quality improvement strategy.*
  - *Comply with HCBS settings rule requirements.*

# A Note on Cost Neutrality

- States must ensure that the average per capita expenditure under the waiver does not exceed 100 percent of the average per capital expenditures that would have been made had the waiver not been granted.
- Cost neutrality formula looks at total Medicaid costs, not just waiver costs.

Factor D – Per Capita Medicaid Cost for HCBS Services

Factor D' – Per Capita Medicaid cost for all other services provided to Waiver Participants

Factor G – Per capital Medicaid cost for NF or ICF/ID care

Factor G'- Per Capita Medicaid Costs for all Services other than those in G

- Formula:  $D+D'$  Compared to  $G+G'$

# 1915(c) Quality Improvement Strategy (QIS)

There are SIX waiver assurances that must be included in the QIS

- Administrative Authority – State retains ultimate authority
- Level of Care (LOC) – State evaluates and re-evaluates LOC
- Qualified Providers – State ensures that providers meet qualifications.
- Service Plan – State must monitor adequacy of of service plans, ensures they are updated and that services are delivered in accordance with the plan.
- Health and Welfare – State must have system for preventing abuse, neglect, exploitation and unexplained deaths, managing incidents, overseeing use and prohibition of restrictive interventions and for monitoring overall healthcare standards
- Financial Accountability – Claims must be coded correctly and rates are paid consistent with the approved rate methodology.



# 1915(i) HCBS State Plan Option

- Does not require cost neutrality or an institutional level of care (LOC)
  - Eligibility based upon needs-based criteria ascertained through independent, individualized assessment.
- Targets one or more specific populations defined by age, diagnosis or Medicaid Eligibility Group.
- **ELIGIBILITY: INDIVIDUALS WITH** Income up to 150% FPL (NO RESOURCE TEST) or may include individuals with income up to 300% SSI but must **BE ELIGIBLE FOR EXISTING 1915(C)** or demonstration.
- Can waive comparability, but not statewideness.
- Enrollment CAPS and Waiting lists are prohibited.
- Allows use of self-direction and presumptive payment.
- State must have implement an HCBS quality improvement strategy.
- Examples of Services offered: Transitional Case Management Services, Assisted Living, Adult Day Health, Behavioral Supports, etc.

# Benefits and Challenges to 1915(i)

## Benefits

- Can fill gaps in Medicaid coverage for targeted populations including people with serious mental illness and/or SUD, people in transition from criminal justice system, children with special conditions such as autism
- Can provide coverage for specific services: adult day health, self-direction, housing supports
- Allows state to tighten criteria for institutional care without tightening access to hcbs

## Challenges

- Financial risk - Difficult to contain costs due to prohibition on enrollment caps
- Cannot phase-in or limit geographic reach due to requirement to implement statewide
- For non-institutional IOC, income limit of 150% FPL adds administrative complexity and limits coverage (especially for children or working adults)
- Viewed as administratively burdensome

# 1915(j) Self Directed Personal Care Attendant Services State Plan Option

- Permits Self-Direction for PCA services. At state option,
  - *Legally responsible Relatives (spouses/parents) may provide care and be paid.*
  - *Allows participants to manage a cash disbursement and/or purchase goods, services and supplies to support community living.*
  - *Use a discretionary amount of the budget to purchase items not otherwise listed in the budget.*
- State may limit geographic area and cap the number of people who can enroll.
- Can include people already enrolled in 1915(c).

# 1915(k) Community First Choice State Plan Option

- Allows State to establish Personal Care Attendant or Participant Directed Care Program through State Plan Amendment for individuals with institutional LOC
- State must provide support and backup systems including voluntary training
- State may provide transitional services to help individuals move from institutions to the community and services that increase independence including assistive technologies, medical supplies/equipment and home modifications.
- Provide 6% INCREASE in FMAP for services provided
- Enrollment caps/waiting lists prohibited
- Must be offered statewide, benefits must be comparable for all and participants must have freedom of choice (cannot target specific populations)
- Can limit amount duration and scope as long as limits are sufficient to achieve program purpose.
- Eligible individuals include individuals eligible for NF Services under the State plan or, if not in such an eligibility group, have income at or below 150% of FPL.
- MAINTENANCE OF EFFORT Requirement for first 12 months.
- Mandatory data COLLECTION AND REPORTING, QUALITY ASSURANCE SYSTEM AND development and implementation council

# Benefits and Challenges to 1915(k)

## Benefits

- Allows states to consolidate programs and standardize eligibility and needs assessments
- Increased FMAP

## Challenges

- Does not eliminate need to maintain multiple HCBS programs
- Complex eligibility requirements
- Increased FMAP not sufficient to cover new costs associated with implementation, program expenditures and evaluation.
- Financial risk - Difficult to contain costs due to prohibition on enrollment caps
- Burdensome administrative requirements

# HCBS Program Design Considerations

- First, identify your goals and objectives.
- Second, identify the needs of the target population – claims analysis, historical spending, key informant interviews, stakeholder input, research into other state and payor practices.
- Third, identify the key design features that will help attain the goals and objectives.
- Design programs around those identified goals and objectives.
- Then, look to the authority that best supports what you hope to achieve.
- There is no right answer and there always will be trade-offs.

# HCBS Final Rule

January 16, 2014

- Applies to 1915(C) waivers and 1915(I) AND 1915(K) State Plan Options
- MLTSS/1115 Waiver States (i.e. Arizona) however, also had to comply.
- Designed to promote full access to benefits of community living in the most integrated setting appropriate.
- Mandates conflict-free assessments and case management services.
- Mandates a person-centered planning process and plan for services.
- Establishes mandatory requirements that define an HCBS setting.

# HCBS Settings Rule

- General requirements focus on individual choice, autonomy and integration into the broader community.
- Additional requirements for Provider controlled settings
- Settings that are not HCBS include: Nursing Homes, IMDs, ICF/IDs and Hospitals
- Settings that are presumed not to be HCBS and subject to CMS heightened scrutiny review include:
  - Settings in a publicly or privately-owned facility providing inpatient treatment
  - Settings on grounds of, or adjacent to, a public institution
  - Settings with the effect of isolating individuals from the broader community of non-Medicaid individuals
- State compliance deadline - For programs in existence on March 17, 2014 states have until March 17, 2019 to submit and receive approval of statewide transition plans. States must then submit settings subject to heightened scrutiny with final compliance due March 17, 2022.
- State must have communication strategy with beneficiaries who are currently in settings that will not be compliant by March 17, 2022.



# HCBS Settings Rule – New Construction

- Issued August 2, 2019
- Applies to settings that are presumed to have the qualities of institution.
- Allows State to submit a setting for heightened scrutiny review while only non-Medicaid beneficiaries are receiving services in the new setting.
- Heightened scrutiny review process is not available until after a building is complete and has begun serving non-Medicaid individuals.
- CMS encourages States, providers, developers and other stakeholders to thoughtfully consider alternatives to new development of presumptively institutional settings
- Potential chilling effect on ability of developers to secure financing for new construction– may reduce access.

# Challenges and Opportunities Ahead

- CMS is focusing on policies and projects to increase flexibility, state accountability and program integrity.
- In managed care: states must have a comprehensive managed care quality strategy
- Recently released: Medicaid & CHIP scorecard 1.0 – Includes measures voluntarily reported by states, as well as federally reported measures in three domains
  - *State health system performance*
  - *State administrative accountability*
  - *Federal administrative accountability*
- Future iterations will include measures that focus on LTSS and program integrity
- Intent it to use the scorecard as an accountability tool for state performance and outcomes

Scorecard link: <https://www.Medicaid.gov/state-overviews/scorecard/index.html>

# Program Integrity

The Office of Inspector General (OIG) has found significant and persistent compliance, payment and fraud vulnerabilities in Medicaid PCA services.

- From FY 2013 to FY 2015, Medicaid improper payments for PCS grew from \$14.4 billion to \$29.1 billion
- OIG has made recommendations to improve program vulnerabilities detected in more than two dozen published audits and evaluations and hundreds of investigations.
  - *Establish minimum Federal qualifications and screening standards for PCS workers, including*
  - *Require states to enroll or register all PCA attendants and assign them unique numbers.*
  - *Require that PCA claims to identify the dates of service and the PCA attendant who provided the service\**

Source: HHS OIG, Investigative Advisory on Medicaid Fraud and Patient Harm Involving Personal Care Services, October 3, 2016, accessed at <https://oig.hhs.gov/reports-and-publications/portfolio/is-mpcs2016.pdf>.

# Electronic Visit Verification (EVV)

- *21<sup>st</sup> Century Cures Act mandates States to use EVV for PCA and Home health services. Anticipated to save \$290 million over 10 years.*
- *Original deadline for implementation extended to January 1, 2020 for PCA services. Deadline for home health services remains January 1, 2023.*
- *EVV System must electronically verify: type of service performed, who received service, date of service, location, individual providing service and the time service began and ended.*
- *States subject to penalty for non-compliance – penalty is incremental reductions in Federal match for services – 0.25 percentage points in 2020 to 1.0 percentage points in 2023 and thereafter.*
- *Limited exception– States that have made good faith effort to comply and have encountered unavoidable delays in implementation can avoid penalty in first year.*
- *Enhanced (90:10) funding is available to states to design, develop and implement EVV if EVV system is operated by the State or by a contractor on behalf of the state. [States must follow advanced planning document requirements to secure approval for enhanced match.*

# Workforce Issues

- As the baby boom ages and the elderly population grows, more individuals will be called upon to provide unpaid/informal care. Today, informal caregivers provide an estimated 75% of all long-term care to elderly friends and family.
- Demand for informal care givers and paid home health aides and personal care aides will continue to increase.
- According to DOL/BLS, Demand for home health and personal care aides is projected to grow 41% from 2016 to 2026.\*
- Yet, number of direct care workers is projected to increase by only 20%.

\*Bureau of Labor Statistics, US Department of Labor, Occupational Outlook Handbook, Home Health Aides and Personal Care Aides, accessed at <https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm>, visited on July 30, 2018.

# Better Medicare

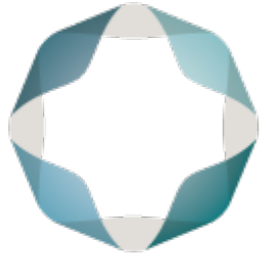
- BiPartisan Budget Act (2018) and CMS regulations (April 16, 2019) are promoting increased integration between Medicare and Medicaid for duals.
- New standards for Medicare and Medicaid for D-SNPS.
  - *All D-SNPS must meet minimum criteria for D-SNPs for 2021:*
    - Be A FIDE SNP, or
    - Provide LTSS and/or behavioral health under a capitated contract with the State or with the MA organization's parent organization and the Medicaid Agency.
    - Adopt and use unified procedures for grievance and appeals.
- Expanded definition of Supplemental Benefits that allows all MA plans (including D-SNPS) to offer benefits that meet members' long-term support needs including in-home assistance, support to family caregivers and adult day health.
- Provides for expanded use of telehealth.

# Additional Resources

- CMS Waiver List – <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>
- CMS 1915(c) Waiver Technical Guidance – <https://www.Medicaid.gov/Medicaid-chip-program-information/by-topics/waivers/downloads/technical-guidance.pdf>
- CMS Technical Assistance Webpage for HCBS – <https://www.Medicaid.gov/Medicaid/hcbs/technical-assistance/index.html>
- CMS SPA and Waiver Processing page – <https://www.Medicaid.gov/state-resource-center/spa-and-1915-waiver-processing/index.html>
- NASUAD, Electronic Visit Verification: Implications for States, Providers, and Medicaid Participants, May 2018 - [http://nasuad.org/sites/nasuad/files/2018%20Electronic%20Visit%20Verification%20Report-%20Implications%20for%20States%2C%20Providers%2C%20and%20Medicaid%20Participants\\_0.pdf](http://nasuad.org/sites/nasuad/files/2018%20Electronic%20Visit%20Verification%20Report-%20Implications%20for%20States%2C%20Providers%2C%20and%20Medicaid%20Participants_0.pdf)

Questions?





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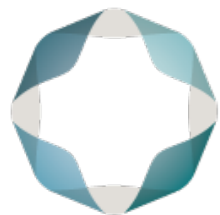
# Managed Long-term Services and Supports (MLTSS)

August 26, 2019

Gary Jessee

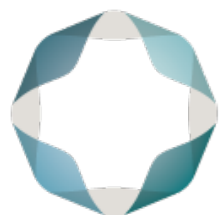
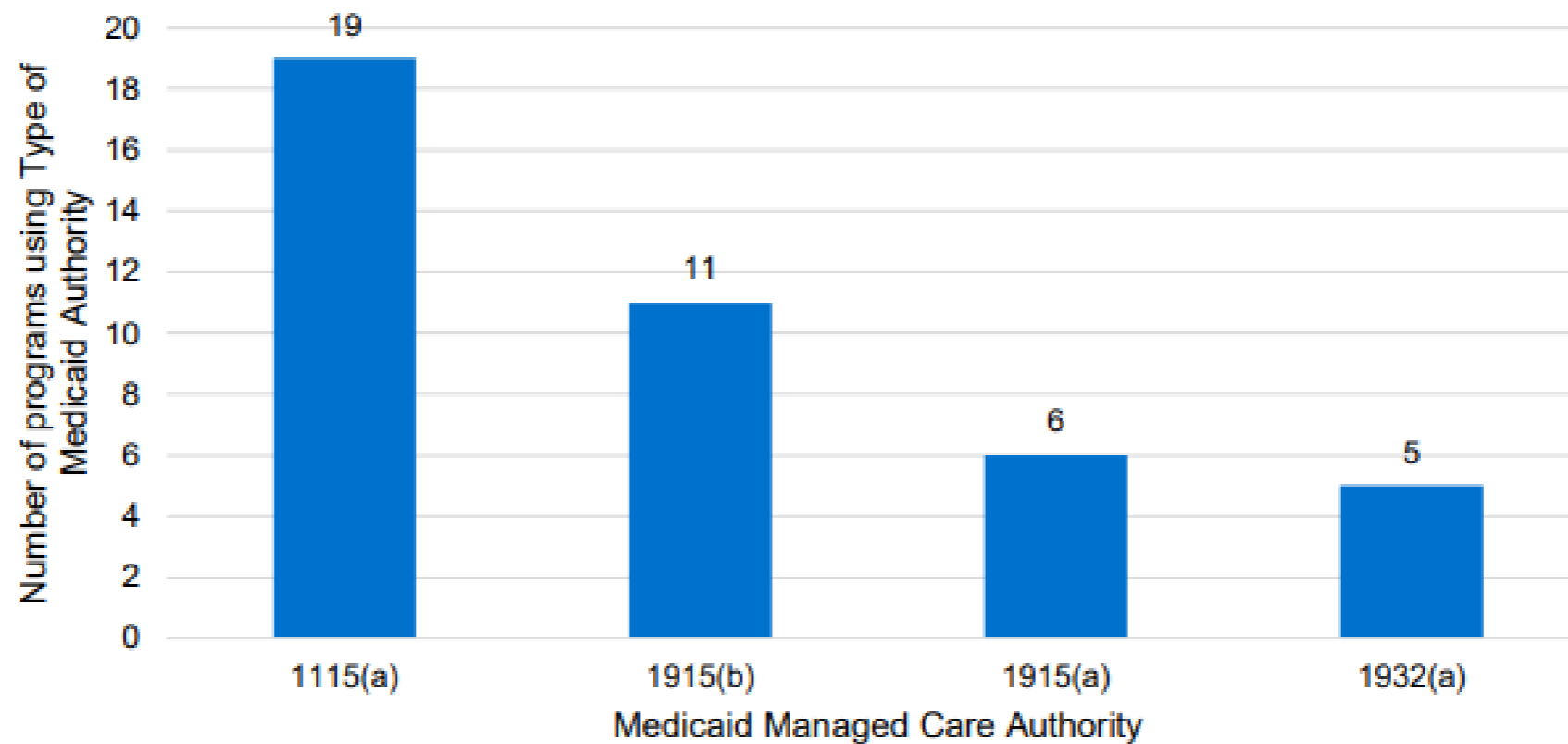
# What is MLTSS?

- Managed Long-term Services and Supports (MLTSS) refers to institutional and home and community based long-term services and supports delivered through a managed care model. LTSS are often delivered by a single managed care organization (MCO) as part of an overall benefit package that includes acute care, pharmacy, and behavioral health services.
  - Although some states use standalone plans that solely include LTSS and not other benefits, this model is less common today than in the past
- Services delivered through a managed care model can include nursing facility care, home nursing, attendant care, habilitation, and specialized therapies.
- MLTSS may be authorized on the federal level using an 1115 demonstration waiver, or through combining the authorities of either 1115 or 1915(b) waivers, or 1932 State Plan authority, with one or more 1915(c) waiver.
  - The 1115 waiver is the most common vehicle for MLTSS.



# How is MLTSS Authorized?

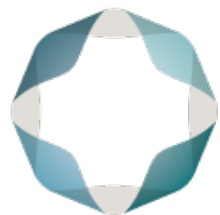
Figure 2.4: Number of MLTSS Programs by Medicaid Managed Care Authority, 2017



# What is Covered?

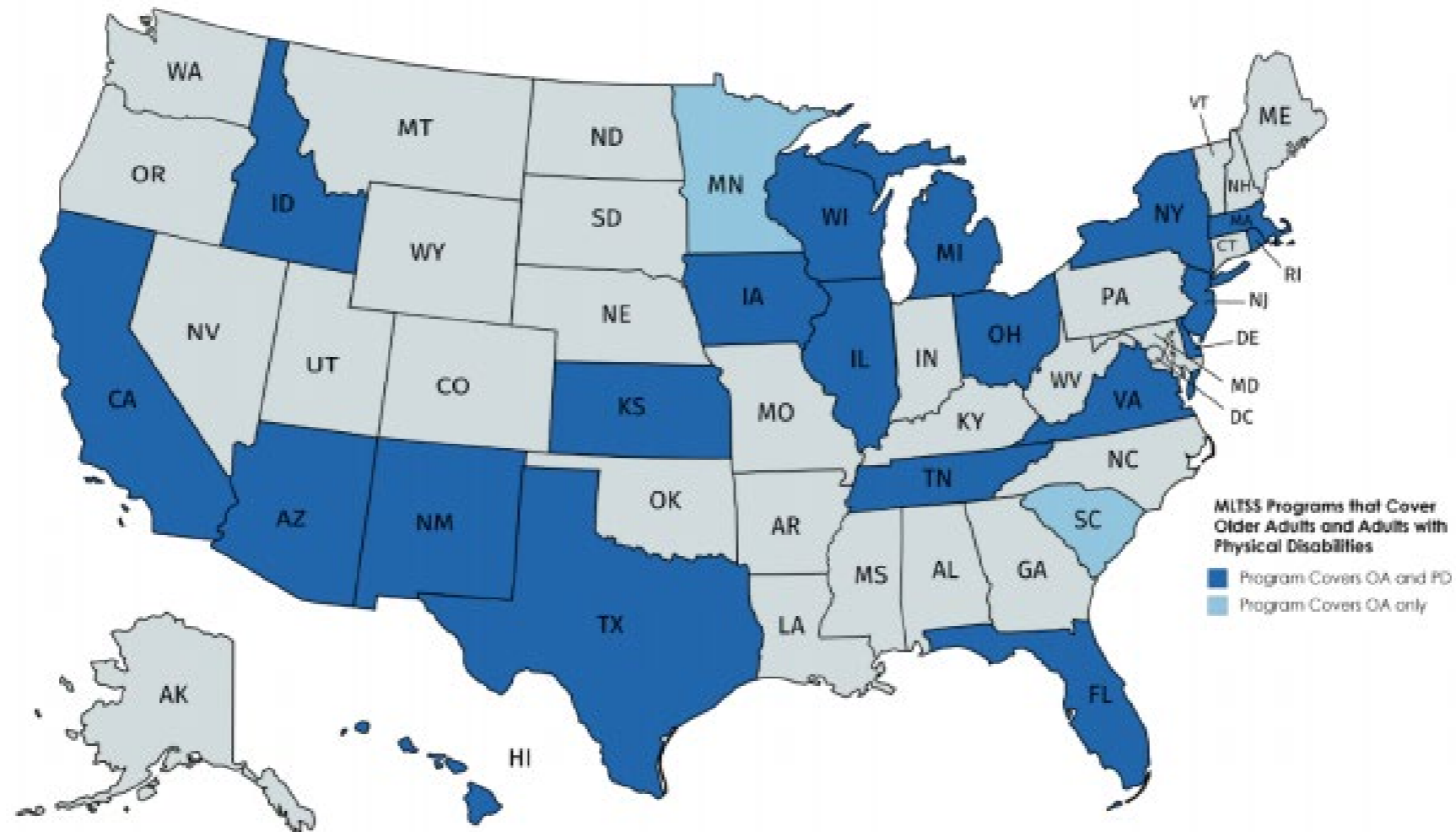
- States using MLTSS vary widely in the number and types of LTSS included under the managed care capitation.
- A 2018 Mathematica program evaluation found that Home and Community Based Services (HCBS) comprised nearly 70% of total MLTSS expenditures.
- Currently, it is more common for states to cover services for the older adults and those with physical disabilities than to cover HCBS for individuals with IDD in MLTSS programs. A 2017 Mathematica/Truven study found that

*Only three MLTSS programs covered all Medicaid covered benefits within the managed care capitation rate: Arizona Long-Term Services and Supports, Kansas KanCare, and Wisconsin Family Care Partnership. All other programs carved out one or more benefits from the managed care capitation rate. Most programs excluded LTSS for people with I/DD—institutional care and/or HCBS—from the managed care capitation rate.*

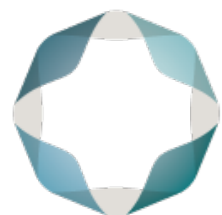


# What is Covered?

Figure 3.1: MLTSS Programs Serving Older Adults and Adults with Physical Disabilities, 2017



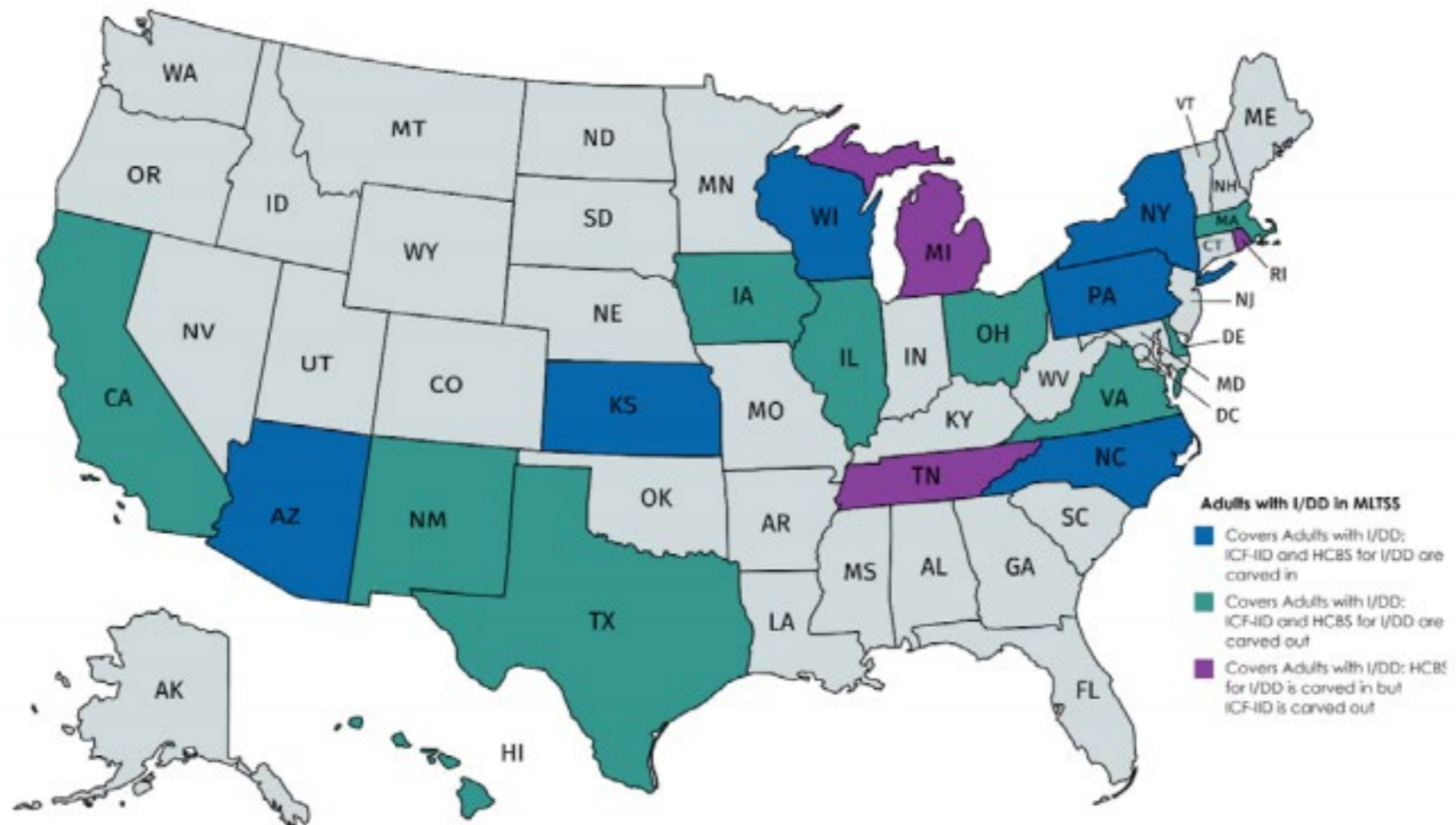
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# What is Covered?

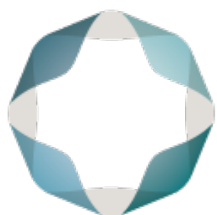
Figure 3.2: MLTSS Programs Serving Adults with I/DD, 2017



Created with mapchart.net ©

**Note:**

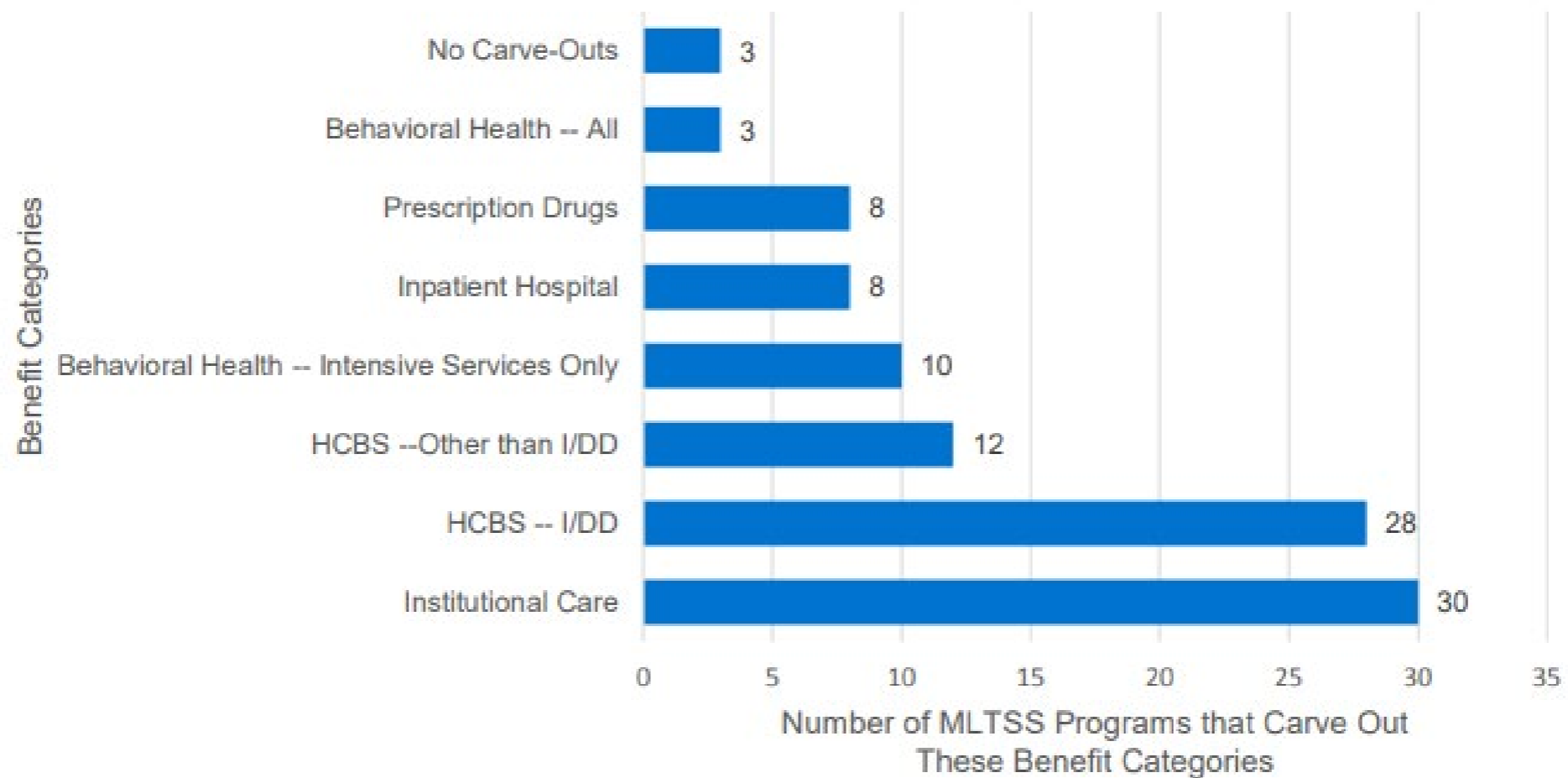
Michigan and Rhode Island both enroll adults with I/DD in two programs: one carves out ICF/IID but carves in HCBS for I/DD; the other carves out both ICF/IID and HCBS for I/DD.



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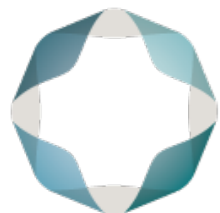
# What is Covered?

Figure 5.1: Benefits Carved Out of Managed Care Capitation Rates, 2017



# MLTSS Adoption

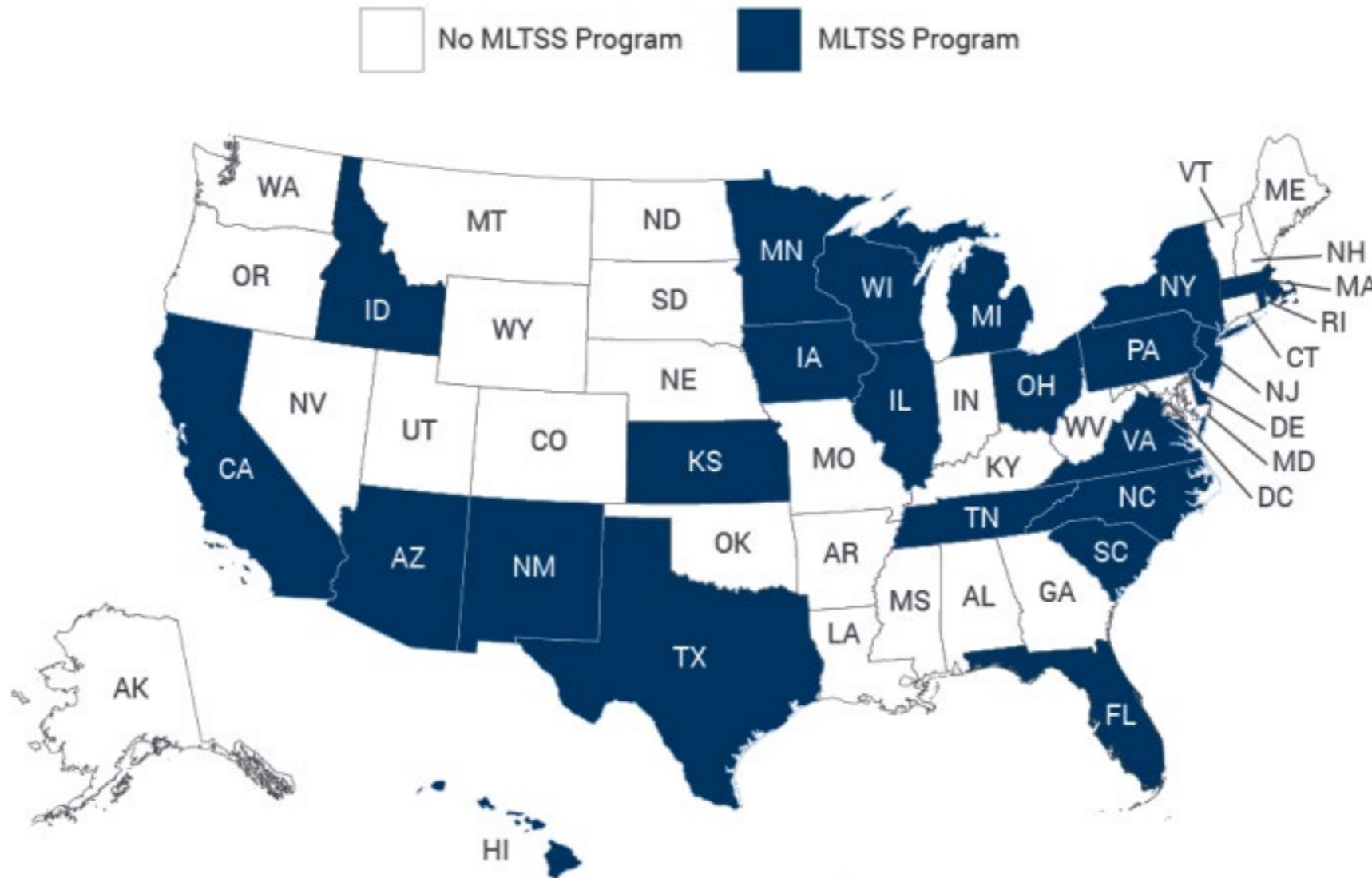
- As of June 2019, 24 states operate managed long-term services and supports (MLTSS) programs, in which state Medicaid agencies contract with managed care plans to deliver long-term services and supports (LTSS), up sharply from just 8 states in 2004 (Lewis et al. 2018; NASUAD 2019).
- Concurrently, expenditures for MLTSS have sharply increased, from about \$5 billion in FY 2008 to about \$39 billion in FY 2016.
  - Reported MLTSS expenditures were \$39 billion in FY 2016, a 24 percent increase from \$32 billion in FY 2015. A 2018 IBM Watson Health/Medicaid Innovation Accelerator Program report attributes much of the recent to expansions in New York (\$5 billion) and Texas (\$1 billion).
- Although much of this growth has been recent, a few states have operated MLTSS programs for many years, and in some cases, several decades.





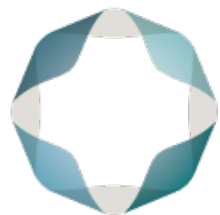
# MLTSS Adoption

State Adoption of Managed Long-Term Services and Supports Programs, June 2019



Note: MLTSS is managed long-term services and supports.

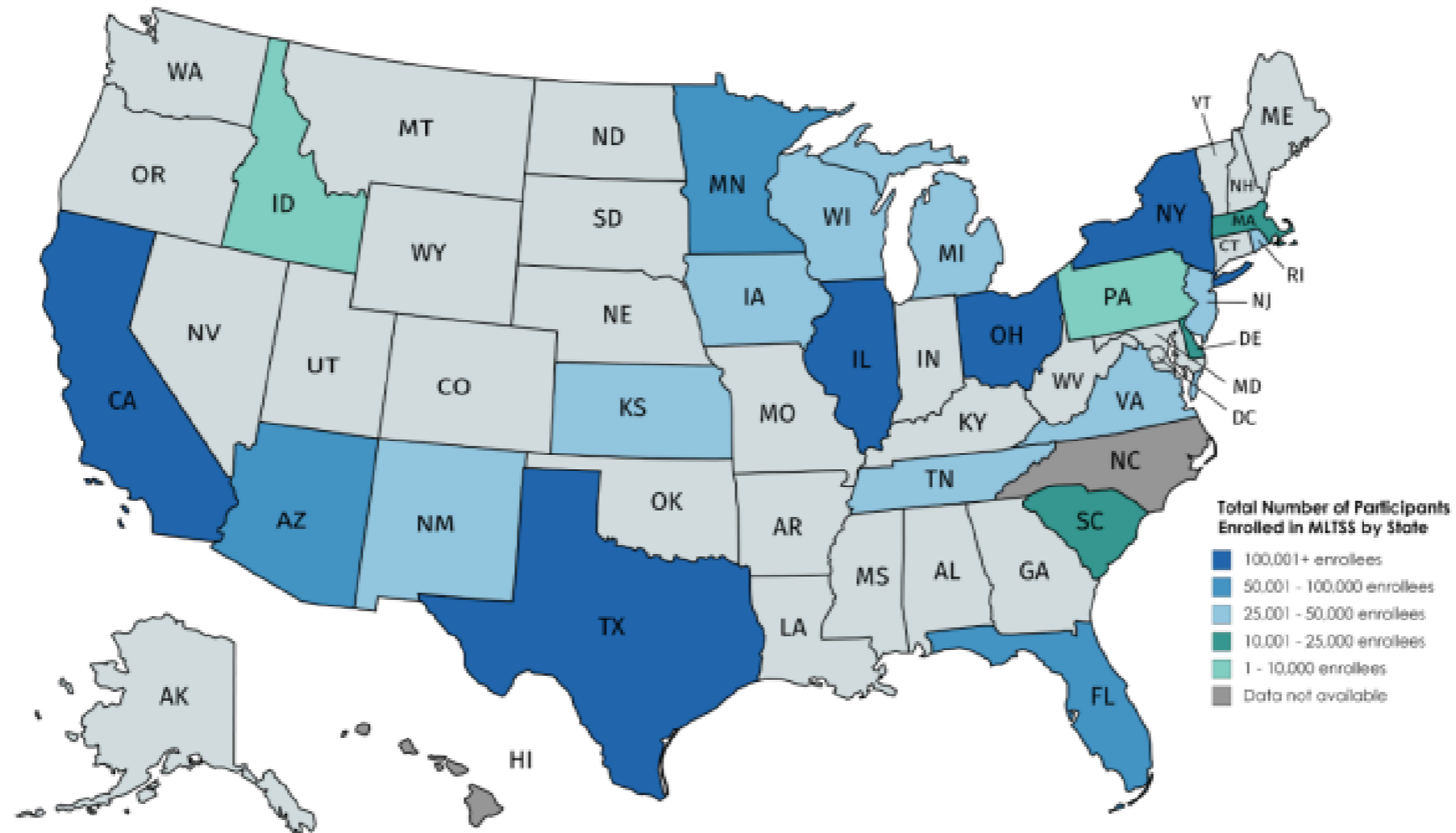
Source: MACPAC, 2018, analysis of [NASUAD 2019](#) and Lewis et al. 2018



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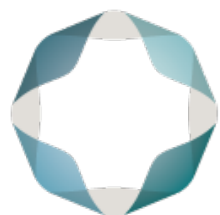
# How Many People are Served?

Figure 2.3: Total Number of Participants Enrolled in MLTSS by State, 2017



Created with mapchart.net

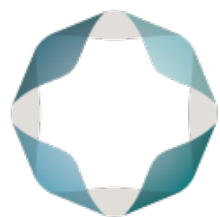
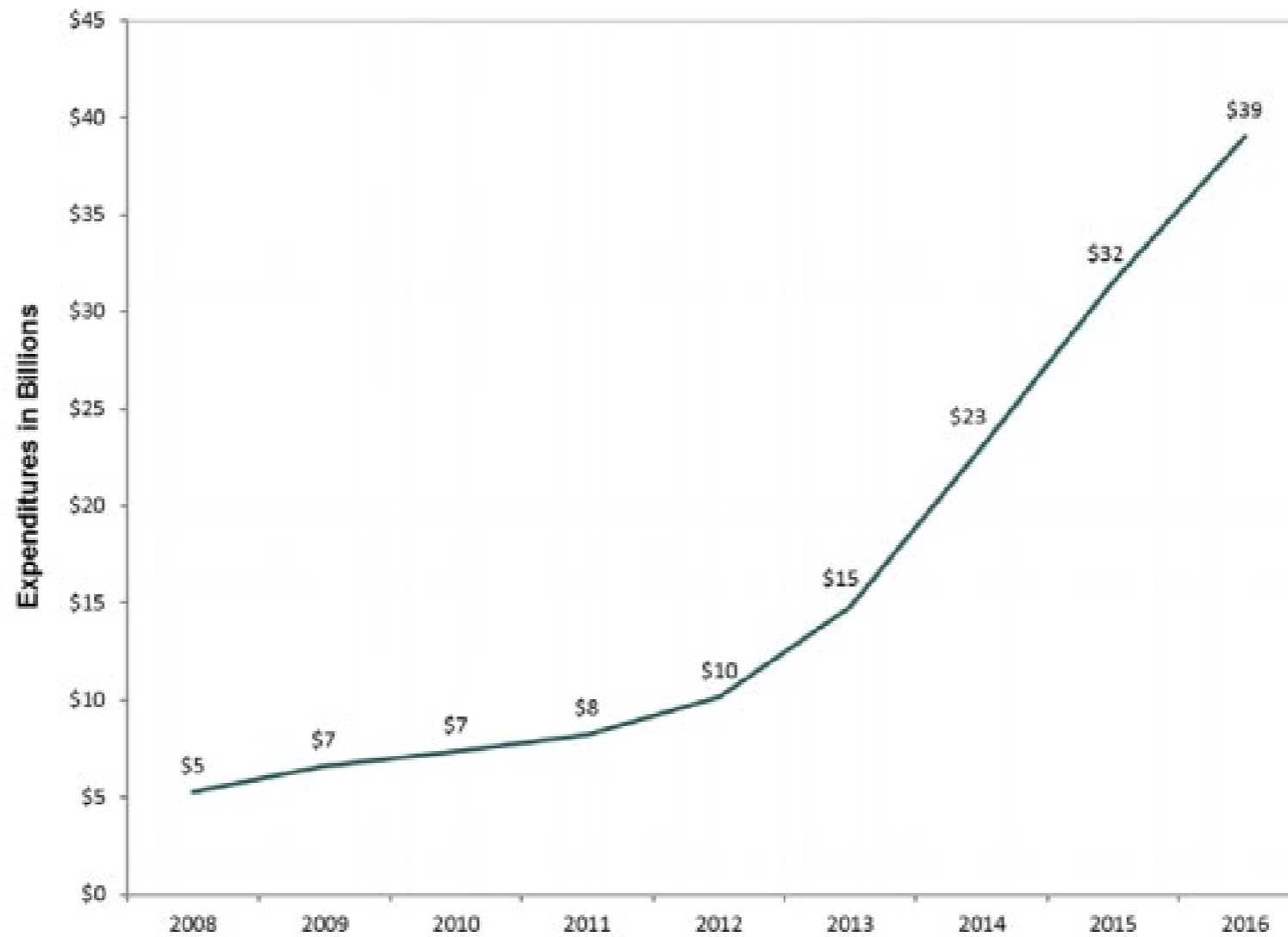
California, Massachusetts, Michigan, and Texas enrollment data do not include programs for which data were not available in sources reviewed for this study.



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# MLTSS Expenditures

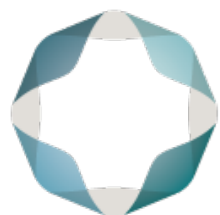
Figure 11. Medicaid Managed LTSS Expenditures, in billions, FY 2008–2016



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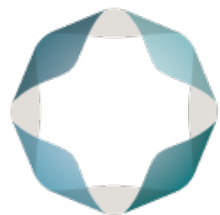
# States' Goals for MLTSS

- States implement MLTSS for a variety of reasons. In a recent MACPAC survey of 12 states with MLTSS, states reported that their goals included:
  - Rebalancing LTSS spending—increasing the proportion of Medicaid LTSS spending used for HCBS while decreasing the proportion of spending for institutional services (12 states);
  - Improving beneficiary care experience by increasing care coordination to improve health and quality of life (12 states);
  - Reducing or eliminating HCBS waiver waiting lists to address access gaps and to provide care in the setting that the beneficiary chooses (6 states);<sup>12</sup> and
  - Providing budget predictability and potentially containing costs via rebalancing, efficiencies, and improved quality (7 states) (Dobson et al. 2017).



# MCO MLTSS Initiatives

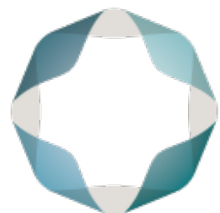
- Reaching hard to locate persons
  - Building relationships with members
  - Meeting members “where they are”
- Electronic care management systems
- Value based purchasing, shared savings initiatives
- Diversion, transition and relocations
- Housing supports
- Whole person centered service plans that offer increased options



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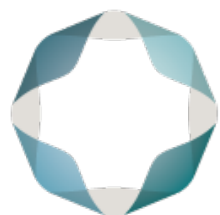
# Innovation in Action: How States Can Promote Rebalancing in MLTSS

- Blended rate for nursing facility and HCBS
- No waiting lists for HCBS
- Higher capitation rates for HCBS
- Replacing 1915(c) waiver “slots” with 1115-authorized LTSS for plans to administer based on need, cost-effectiveness
- Transition allowances
- Service Coordinators required to help members with diversion, transition and relocation
- Performance measures that penalize increased NF utilization
- Money Follows the Person and Balancing Incentive Program



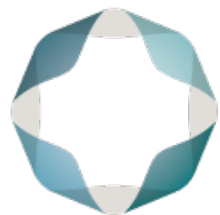
# What can MLTSS Mean to HCBS Providers?

- Managed care organizations have historically had little experience contracting and working with LTSS providers, particularly in the IDD space. Conversely, many LTSS providers have had little experience contracting with MCOs and serving individuals in managed care programs. There is a learning curve on both sides.
- The integration of LTSS into managed care has several downstream impacts on providers:
  - Consolidation and acquisition
  - Survival of the fittest
  - Competition for members
  - Any willing provider changes
  - Changing roles for ADRC and AAAs
  - New relationships with different MCOs
    - Need for innovation and creativity



# Federal Programmatic Requirements

- MLTSS plans must adhere to the same regulations as other Medicaid managed care plans.
- CMS released guidance released in 2013 outlined what CMS referred to as key elements of an effective MLTSS program (CMS 2013). Most of these items were later codified into regulation in 2016. These key elements included:
  - Adequate planning and transition strategies, including the solicitation and consideration of stakeholder input; education of program participants; assessment of readiness at both the state and managed care plan level; and development of quality standards, safeguards, and oversight mechanisms to ensure a smooth transition and effective ongoing implementation of MLTSS.
  - Stakeholder engagement in the planning, implementation, and ongoing oversight processes;
  - Enhanced provision of HCBS, including alignment and compliance with the requirements of the ADA and the Olmstead decision to provide services in the most integrated setting and progress toward community integration goals;





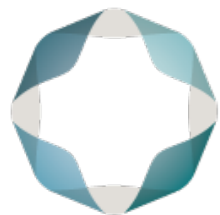
# Federal Programmatic Requirements

- CMS key elements, continued:
  - Alignment of payment structures with MLTSS programmatic goals, which include improving the health and care experiences of beneficiaries, and reducing costs;
  - Support for beneficiaries, such enrollment counseling and access to an ombudsman, ideally from an independent and conflict-free source;
  - Person-centered processes, including participation by the individual in the service planning and delivery process, meaningful choices of service alternatives, holistic service plans based on a comprehensive needs assessment which include goals that are meaningful to the beneficiary, and the opportunity to self-direct their community-based services;
  - Comprehensive and integrated service package, either fully integrated plan that covers acute care, behavioral health, pharmacy, and LTSS, or a mechanism to ensure appropriate coordination and referrals when a benefits package is not fully comprehensive;



# Federal Programmatic Requirements

- CMS key elements, continued:
  - Qualified providers, an adequate provider network that includes credentialed providers, including those who provide services that support community integration, such as employment supports;
    - CMS has not specified any particular standards that states must use for HCBS network adequacy, nor has the agency required that states set different standards for different HCBS provider types. Instead, CMS commented that “states should establish standards based on their unique mix of services and characteristics and evaluate and amend these standards, as appropriate” (CMS 2016).
  - Participant protections to safeguard beneficiaries from abuse, neglect, and exploitation; and
  - Quality metrics that take into account outcomes related to LTSS, as well as a holistic quality and oversight strategy that takes into consideration the acute and primary care, behavioral health, as well as LTSS needs of beneficiaries can provide a framework for states to incorporate more meaningful goals into the program that focus on quality of care and quality of life for individuals.



# Federal Programmatic Requirements

Application of HCBS regulations to all managed care programs

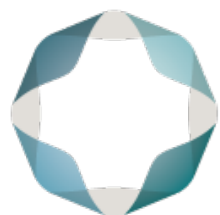
- Settings (with appropriate transition period)
- Conflict of interest



Allow MCO change if NF/residential/ employment provider leaves network



Network time and distance standards required (or other standards for LTSS providers that travel to beneficiaries)



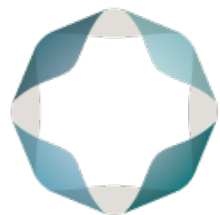
# Federal Programmatic Requirements

## Person-Centered Processes

- Service plan must be developed by individuals who are trained in person-centered planning and who meet State's LTSS service coordination requirements
- HCBS characteristics in the HCBS final rule apply to managed care networks
- State must permit, as part of time-limited transition of care policy, consumer to continue services they had prior to MCO enrollment with current providers (if not in MCO network)

*eff. 7/1/17*

*eff. 7/1/18*

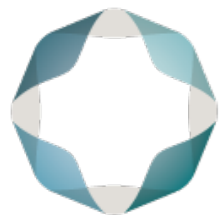


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# Federal Programmatic Requirements

## Beneficiary Supports

- States must assure choice counseling, an ombudsman-like function, other supports
- States must assure that prior authorization and performance expectations reflect LTSS goals (community integration)
- States and plans must establish stakeholder advisory groups
- Clarified that services continue during appeal of denial
- Members must complete internal appeals before State Fair Hearing (standardized timeframes for internal processes)



# Options for States to Integrate Care for Duals

- **Financial Alignment Demos**
  - Allows for shared savings of Medicare dollars
  - Capitated
    - Utilizes three-way contracts between CMS, state, and plans
    - 9 states participating: CA, IL, OH, MA, MI, NY (2 demos), RI, SC, TX
    - 379,047 enrollees as of July 2018
  - Managed Fee For Service
    - WA state already demonstrated significant savings through their Health Homes-based model
- **Program for All-Inclusive Care (PACE)**
  - Integrated programs for adults 55+ who need NF level of care
  - As of July 2018 – sites in 31 states served 42,326 enrollees



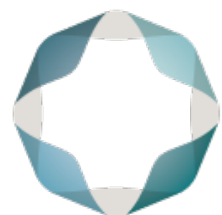
# Options for States to Integrate Care for Duals

## **Dual Eligible Special Needs Plans (D-SNPs)**

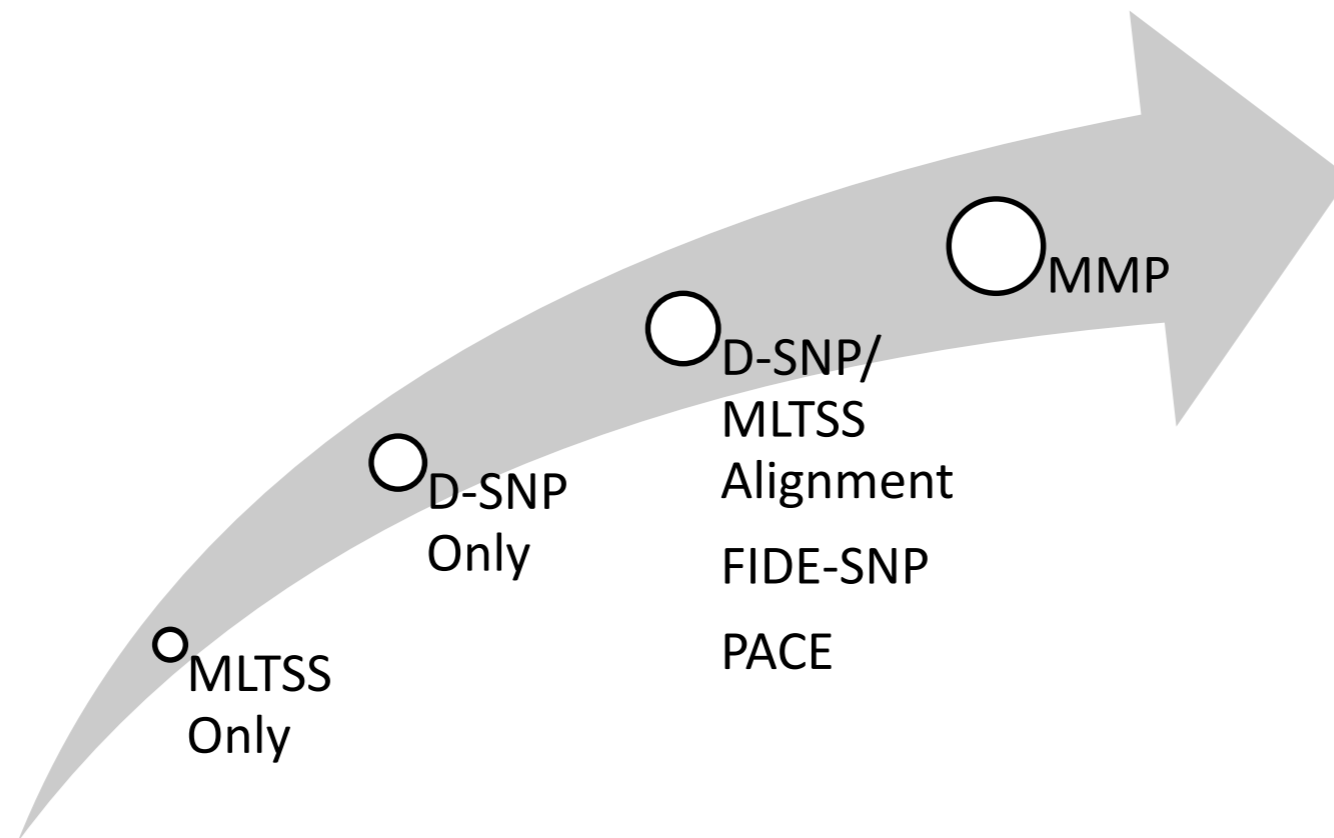
- 1.9M enrollees (including FIDE enrollees) nationally
- D-SNPs (Medicare Advantage plans) required to sign MIPPA contracts with state Medicaid agencies to operate
- Varying levels of integration with Medicaid
- Separate Medicaid and Medicare funding streams
- 41 states have D-SNPs

## **Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)**

- 146k enrollees nationally
- Highest level of integration on the D-SNP platform that incorporates LTSS, primary, acute, and behavioral healthcare into a single plan
- FIDE-SNPs must be at risk for coverage of Medicaid LTSS and have procedures for administrative alignment of Medicare and Medicaid
- May be eligible to receive additional MA payments that reflect frailty of enrollees
- Examples: ID, MA, NJ, WI

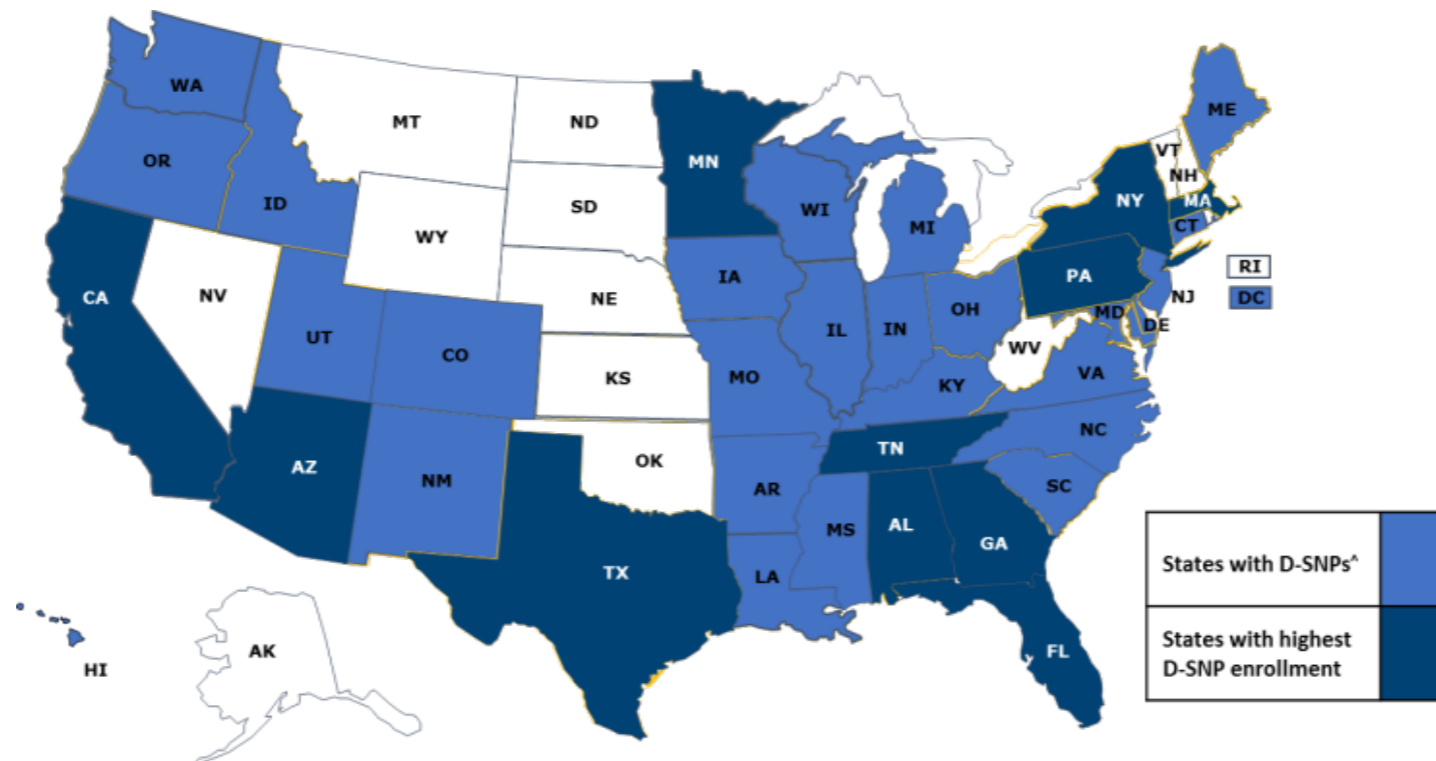


# Medicaid/Medicare Integration

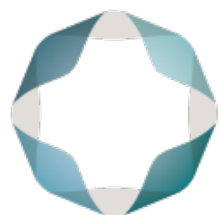




# National D-SNP Enrollment



<sup>^</sup> D-SNP contracts for Puerto Rico as well as those with no enrollment as of February 2014 are not included.  
Source: CMS SNP Comprehensive Report for February 2014 – Found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDenrolData/Special-Needs-Plan-SNP-Data.html>



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# The Future of MLTSS

- Collecting better data
  - Research on MLTSS outcomes has been limited by the availability, consistency, and quality of data. To better understand and expand best practices related to MLTSS, states and CMS will need to collect better data.
- Development of LTSS quality metrics
  - CMS has contracted with several organizations to develop new LTSS quality measures related to topics such as care planning and rebalancing LTSS toward HCBS.
- Increasingly alignment of Medicaid MLTSS with D-SNPs
- Integration of IDD waiver services
  - States that have included IDD waiver services in an MLTSS model include Arizona, Iowa, Kansas, Michigan, New York, North Carolina, Tennessee, and Wisconsin.



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# Current Hot Topics in Medicaid

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## ■ Medicaid for *more*

- Expansion states
- Voter initiatives
- Buy-in

## ■ Medicaid *personal responsibility*

- Work requirements
- Cost sharing

## ■ Medicaid as **the** state health issue *response program*

- Opioid epidemic
- Obesity
- Maternal and Child health outcomes
- Aging & LTSS

## ■ Value Based Initiatives

- Fully capitated Managed care
- Price transparency
- ACOs
- Episodes of Care

## ■ Technology

- Data driven decision making
- IT procurements in a modular environment
- Consumer software and hardware

## ■ SDOH

- Community based integrated care and social services delivery
- Risk adjusting MMCOs
- Housing
- Food security
- Environmental factors

## ■ State Waivers

- Every state has more than one
- More to come

# Thank you to our Fantastic Speakers!



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- **Jerry Dubberly**, Principal, Myers & Stauffer LLC, Former Georgia Medicaid Director;
- **Patrick Finnerty**, Owner, PWF Consulting, Former Virginia Medicaid Director;
- **Cindi Jones**, Senior VP, Government Relations InnovAge, Former Virginia Medicaid Director;
- **Carol Steckel**, Kentucky Medicaid Director, Former Alabama & North Carolina Medicaid Director, Former Senior Advisor, Louisiana Dept. of Health & Hospitals;
- **Claudia Schlosberg**, President, Castle Hill Consulting, Former DC Medicaid Director;
- **Gary Jessee**, Managing Director, Sellers Dorsey, Former Texas Medicaid Director; and
- **Joshua Slen**, President, Health System Transformation, LLC, Former Vermont Medicaid Director.



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