NASUAD
National Association of States United for Aging and Disabilities

CURRENT ISSUES IN MEDICAID AND IMPLICATIONS FOR AGING AND DISABILITY PROGRAMS

Damon Terzaghi

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NASUAD Overview

- National association that represents state agencies providing LTSS and other services and supports to older adults and people with disabilities
  - 56 members (50 states, DC, 5 territories)
- Led by a board of directors comprised of state agency officials
- Provides direct technical assistance, research, regulatory and policy analysis to states
- Facilitates state-to-state information sharing via teleconferences/webinars, e-mail surveys, policy committees, and national conferences
- Educates and advocates for state agency interests in front of Congress and the Federal government

Contents

Medicaid Overview

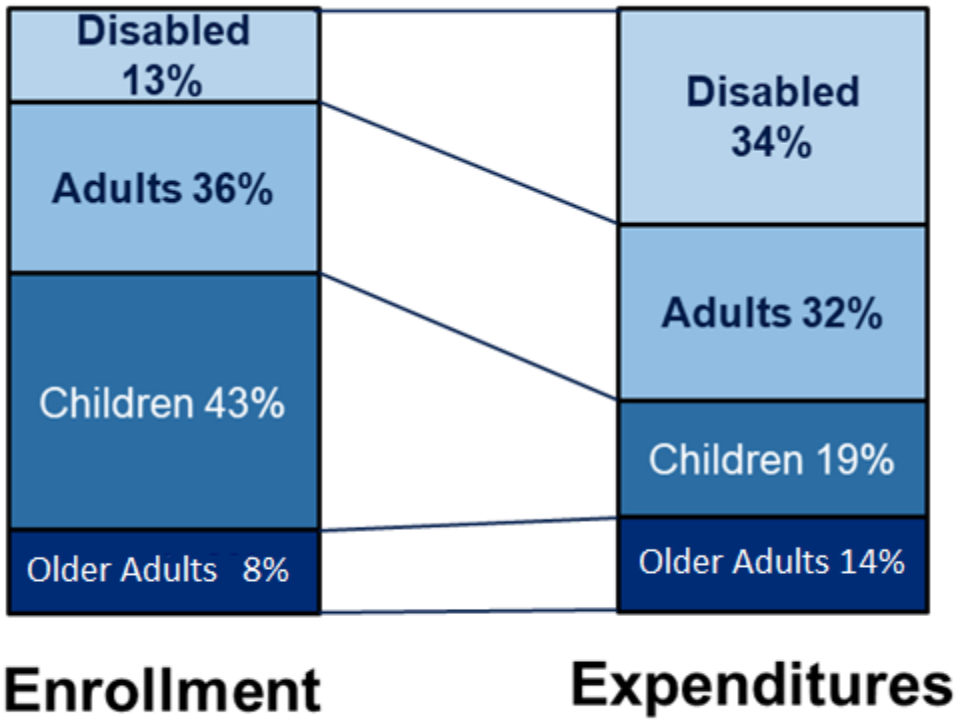
Medicaid Overview

- Created in 1965, along with Medicare (P.L. 89-97), under the Social Security Amendments of 1965;
- State & Federal partnership for funding and policy:
  - Medicaid administration
- Originally intended to be a health plan for low-income individuals on welfare:
  - The role of the program has expanded and changed over its 50+ years
- Does not provide the care – pays medical professionals (providers) to deliver the care;

Medicaid Overview

- Optional program for States – last State (AZ) began participation in 1982;
- Medicaid is unique in that it covers more Americans than any other health insurance program;
- In FY 2015, $545 billion dollars were spent on the Medicaid program in the states & territories;
  - 17% percent of U.S. health care spending in 2015
- Over 57 million Americans were covered by Medicaid in 2012 – grew to 70 million in 2015

Medicaid Enrollment & Expenditures



Source: Center for Budget and Policy Priorities

Medicaid Enrollment & Expenditures

- Older adults and persons with disabilities represent a majority of Medicaid expenditures despite being less than half of enrollees.
- Chronic care and significant health conditions are a major component of these expenses, as are Long-term Services and Supports (LTSS).
- Medicaid is the largest source of LTSS financing in the USA, paying for over $144 billion in 2013 which represented 42% of overall expenditures on LTSS[1]
  - Medicare ($74B) and out-of-pocket ($57B) were the next two largest sources of LTSS expenditures

[1] Congressional Research Service, 2015. See: https://fas.org/sgp/crs/misc/R43483.pdf

Current Status of State Medicaid Expansion

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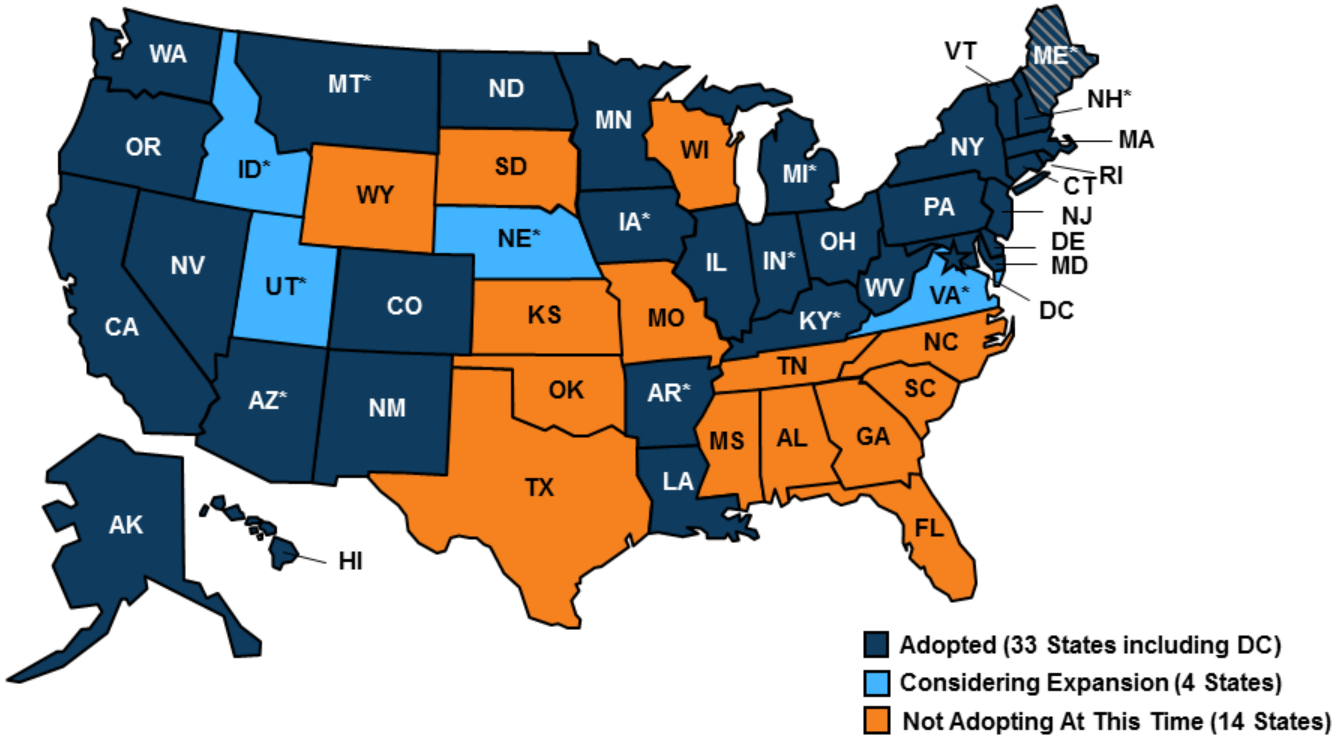
Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. *AR, AZ, IA, IN, KY, MI, MT, and NH have approved Section 1115 expansion waivers. CMS approved the Kentucky HEALTH expansion waiver on January 12, 2018; implementation of some provisions was scheduled to begin in April 2018. VA is considering adopting expansion in their FY 2019 state budget, UT passed a law directing the state to seek CMS approval to partially expand Medicaid to 100% FPL using the ACA enhanced match, and UT also has a measure on the ballot in November to fully expand to 138% FPL. Expansion proponents in ID and NE are collecting signatures to place expansion on their November ballots. ME adopted the Medicaid expansion through a ballot initiative in November 2017, but the Governor failed to meet the SPA submission deadline (April 3). (See the link below for more detailed state-specific notes.)
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated April 27, 2018.
https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

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Role of CMS and the States

- Federal law and regulation (administered by CMS) specify core requirements all states must meet to receive federal funding.
- Within federal guidance, states define how they will run their program:
  - State laws and regulations;
  - State budget authority and appropriations
  - Medicaid State Plan; and
  - Waivers.
- Subject to review/approval by CMS, states have flexibility regarding eligibility, benefits, provider payments, delivery systems and other aspects of their programs.
- Each state must have a “single state agency” that administers Medicaid.

Medicaid Waivers

- Allow the state to “waive” certain Medicaid requirements, including state-wideness, freedom of choice, and comparability;
- Not always an “entitlement” – some can have enrollment limits or waiting lists;
- Cost-neutrality requirements;
- Most common include:
  - 1115: Waiver of variety of Medicaid policies for “research and evaluation”;
  - 1915(b): Waiver of “freedom of choice”;
  - 1915(c): Waiver of comparability allows states to target diagnoses, and option to waive state-wideness.

Current Issues in Medicaid

Current Considerations

- As the push to repeal the ACA has dissipated, focus in health reform has shifted to state-flexibility and state-actions around Medicaid and, to a lesser extent, ACA tax credits
- Questions center around:
  - What is the role of the Medicaid program?
  - Where does Medicaid overlap with private insurance?
  - Where does it have different objectives, goals, and desired outcomes?
- Key policy debates & 1115 proposals testing these philosophical propositions:
  - Work requirements & time-limits on enrollment for adults without disabilities
  - Retroactive eligibility waivers
  - Non-emergency Medical Transportation
  - Exchange-based Medicaid delivery
  - Expansion to “Pre-LTSS” populations
  - Caregiver Support
- Important states to watch (among MANY others):

Indiana	Wisconsin	Kentucky
Arizona	Arkansas	Washington

Medicaid LTSS

Medicaid LTSS

- A variety of programs exist that provide Long-term Services and supports in Medicaid
- LTSS in Medicaid includes institutional services in nursing homes (mandatory) as well as HCBS (optional)
- Each state sets their own standards for clinical eligibility, known as “level of care”
- LTSS can also have different eligibility criteria
  - The “special income group” allows individuals who require LTSS to qualify with income at 300% of SSI (approximately 225% FPL) instead of lower levels for non-LTSS groups
  - Special income group exists in many states, but not all cover up to 300% SSI
  - State-by-state listing of Special Income Rule policies: http://kff.org/other/state-indicator/medicaid-eligibility-for-long-term-care-through-the-special-income-rule/?currentTimeframe=0

HCBS Settings Final Rule

- The Medicaid home and community-based services (HCBS) regulation establishes new criteria and requirements for Medicaid-funded HCBS, with an emphasis on ensuring that services are provided in an integrated and community-based setting
- CMS' compliance activities are a process-based approach using transition plans to outline objectives and milestones towards meeting the rule requirements by the 2022 deadline
- States have, for the most part, not made any final determinations regarding the settings that are allowable and those which violate the integration mandate

Current Status and Issues

- Heightened Scrutiny:
  - What process will states use to identify settings subject to heightened scrutiny, determine whether they are compliant with the rules, and submit evidence of the determination to CMS?
- Assessment of settings:
  - Objective criteria (prongs 1&2): “are they collocated with institutional services?”
  - Subjective criteria (prong 3): “does the setting isolate individuals?”
- CMS workgroup with states to clarify:
  - Ways to identify violations of prong 3
  - Process and information submitted for heightened scrutiny reviews
  - Role of CMS and states in the process
- CMS recently discussed using six states as a pilot (a few settings in each state) to provide feedback on heightened scrutiny packages

Electronic Visit Verification

- The 21st Century CURES Act mandates that state Medicaid programs have electronic visit verification for:
  - Personal care services by 2019;
  - Home health services by 2023.
- If a state does not have the system in place, they receive a decrease in FMAP:
  - Begins at 0.25% and grows to 1% over time;
  - Does not apply to all Medicaid services – FMAP only cut for the noncompliant services

Electronic Visit Verification

- Challenging timeline:
  - 1/1/2019 is less than 8 months from now but no formal CMS guidance has been issued:
    - States may receive a 1 year reprieve from the FMAP cut if they made a "good faith effort" and experienced "unavoidable delays";
    - CMS has not yet defined what a good faith effort entails
  - States must submit an Advance Planning Document to secure approval for increased federal funding to implement EVV or else fund at lower match rates;
  - Competitive procurements and potential appeals will be lengthy;
  - Final design, development, and implementation must follow these processes.
- Key questions remain:
  - What does "in-home visit" mean?
    - Licensed providers (ie: Assisted living/group homes/etc) not included
    - What about shared living arrangements? Family members in the same home?

Health and Welfare

- Several Federal reports have raised concerns about oversight of health and welfare in HCBS, including DD group homes and assisted living
- ACL/OIG/OCR put out a joint report of recommendations, including ensuring that states have:
  - Reliable incident management & investigation processes;
  - Audit protocols to ensure compliance with reporting;
  - Mortality reviews for unexpected deaths; and
  - Quality assurance mechanisms in place
- CMS expects to release guidance (CIBs) on H&W in the near future

Managed Care

Overview – FFS vs. MMC

Fee-for-service (FFS)

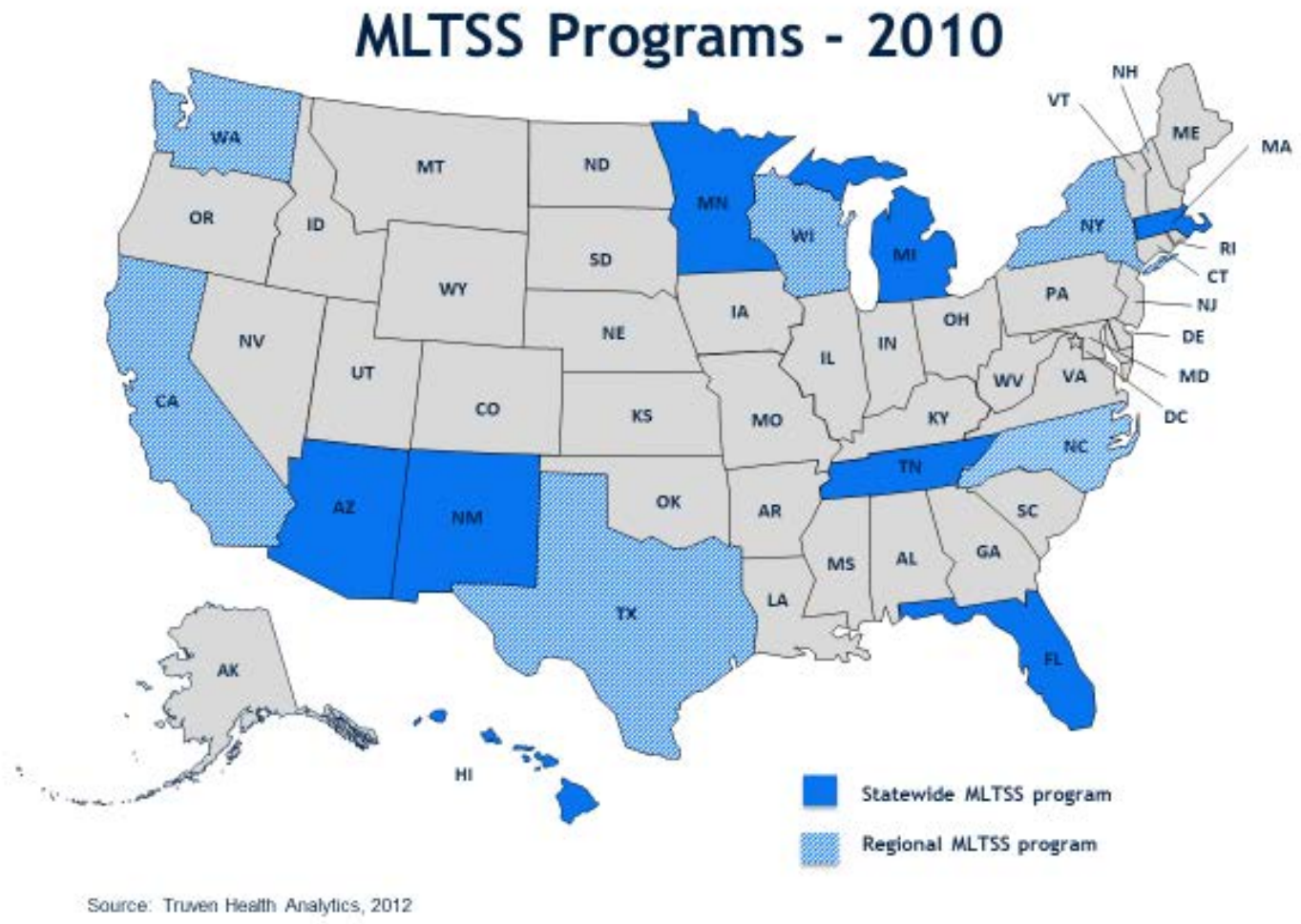
- *Relationship:* State contracts directly with health care providers.
- *Payment:* Providers receive payment for each health care service provided to consumers.
- *Accountability:* Providers do not bear financial risk for the provision of services.
- Note: FFS has historically been the predominant delivery system.

Overview – FFS vs. MMC (Cont.)

Medicaid Managed Care (MMC)

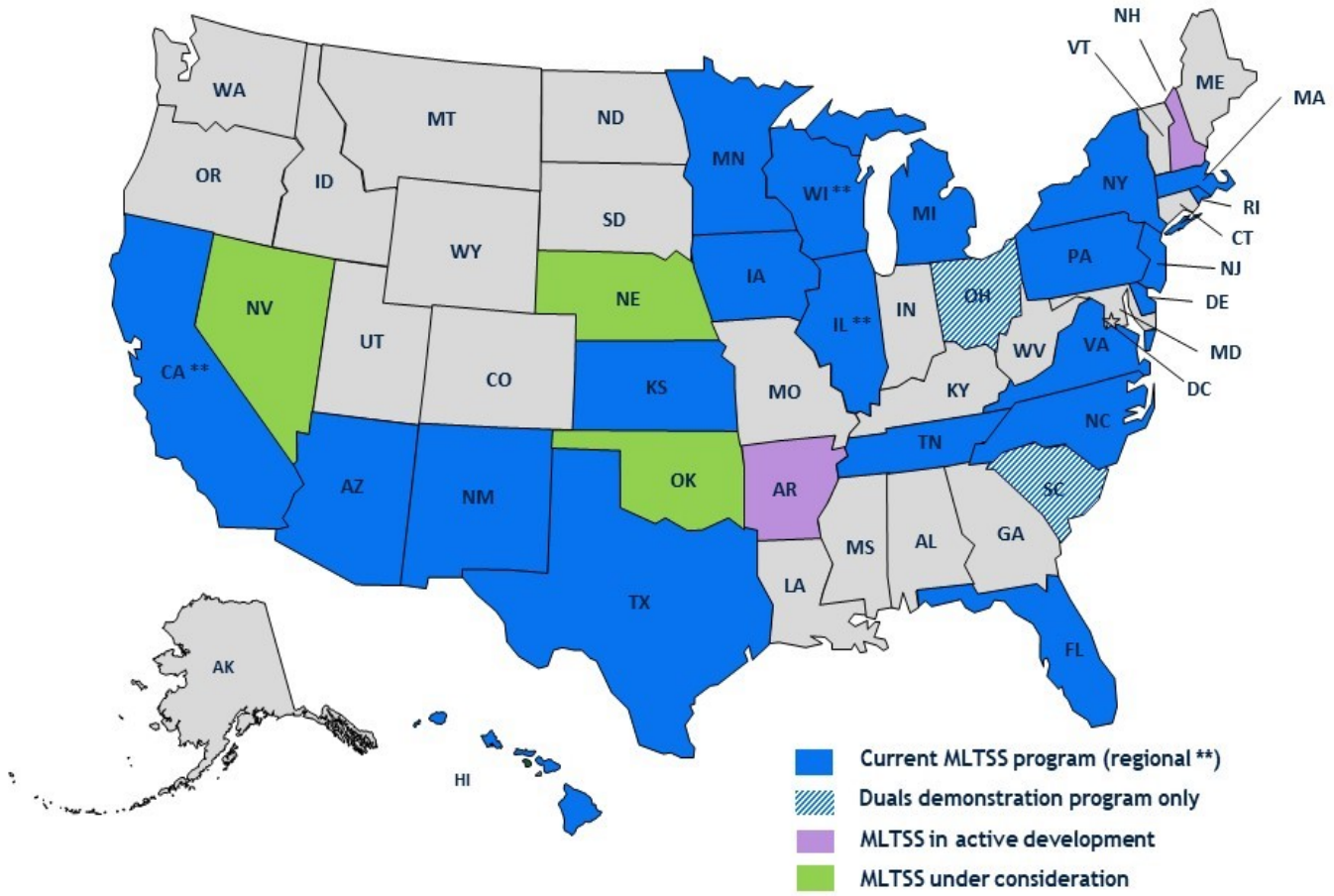
- *Relationship:* State contracts with a Managed Care Organization (MCO), not a direct service provider.
- *Service Delivery:* Consumers receive part or all of Medicaid services from health care providers that are paid by a MCO that is under contract with the state.
- *Payment:* MCOs receive capitated payment from the state for a specified benefit package on a per member per month basis.
- *Accountability:* The MCO is responsible for the provision and coverage of Medicaid services.

MLTSS Programs in 2010



Source: Truven Health Analytics, 2012

Current MLTSS Programs



Source: NASUAD survey; CMS data

What does MLTSS mean for you?

KEY Takeaway: Locus of Control for Medicaid service provision shifts from State to MCO

- In order to keep serving waiver clients, an LTSS provider will have to execute contracts with one (or more) MCOs
- MCOs have contract mandates that full range of HCBS is available to enrollees
  - MCOs will either 'build' it or 'buy' it.
  - What is 'it'? Expertise in delivering high-quality and effective HCBS services

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For additional information:

Damon Terzaghi: dterzaghi@nasuad.org

NASUAD
1201 15th Street, NW
Suite 350
Washington, DC 20005
www.nasuad.org
202-898-2578