

# ADVANCING STATES



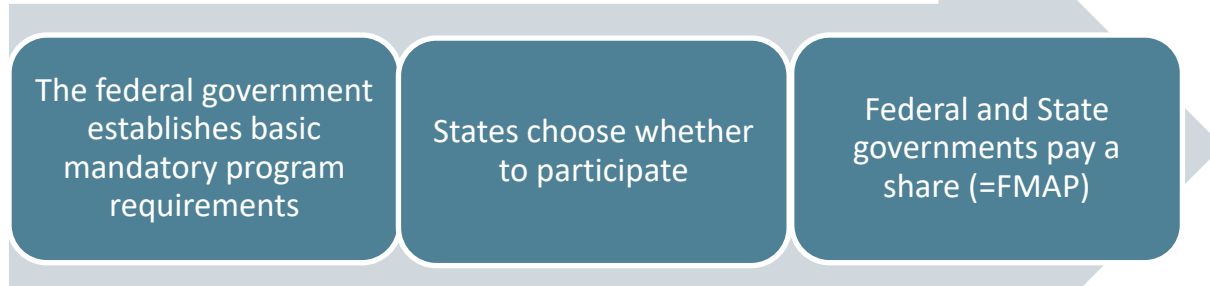
Leadership, innovation, collaboration  
for state Aging and Disability agencies

## Overview, History, and How Medicaid is Administered

**Medicaid 101 Intensive  
2021 HCBS Conference  
December 7, 2021**

# What is Medicaid?

- Medicaid provide health care coverage to low-income adults, children, pregnant women, elders, and people with disabilities.
- Medicaid is administered by States, according to Federal requirements



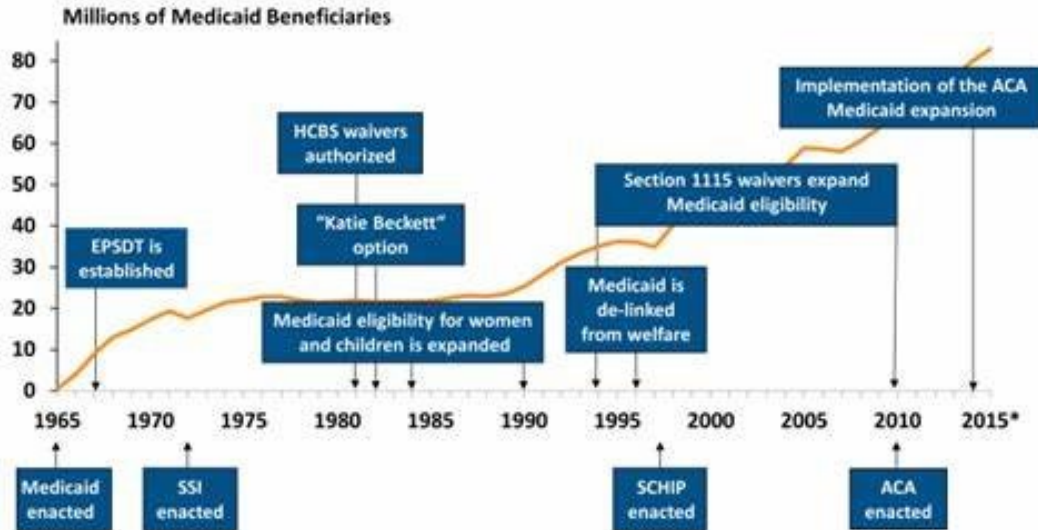
- Medicaid is a State and Federal Partnership

**States develop their unique Medicaid programs based on federal rules –each program must be approved by the Federal Centers for Medicare and Medicaid Services (CMS).**

# Medicaid History: Big Picture

Figure 2

Medicaid has evolved over time to meet changing needs.

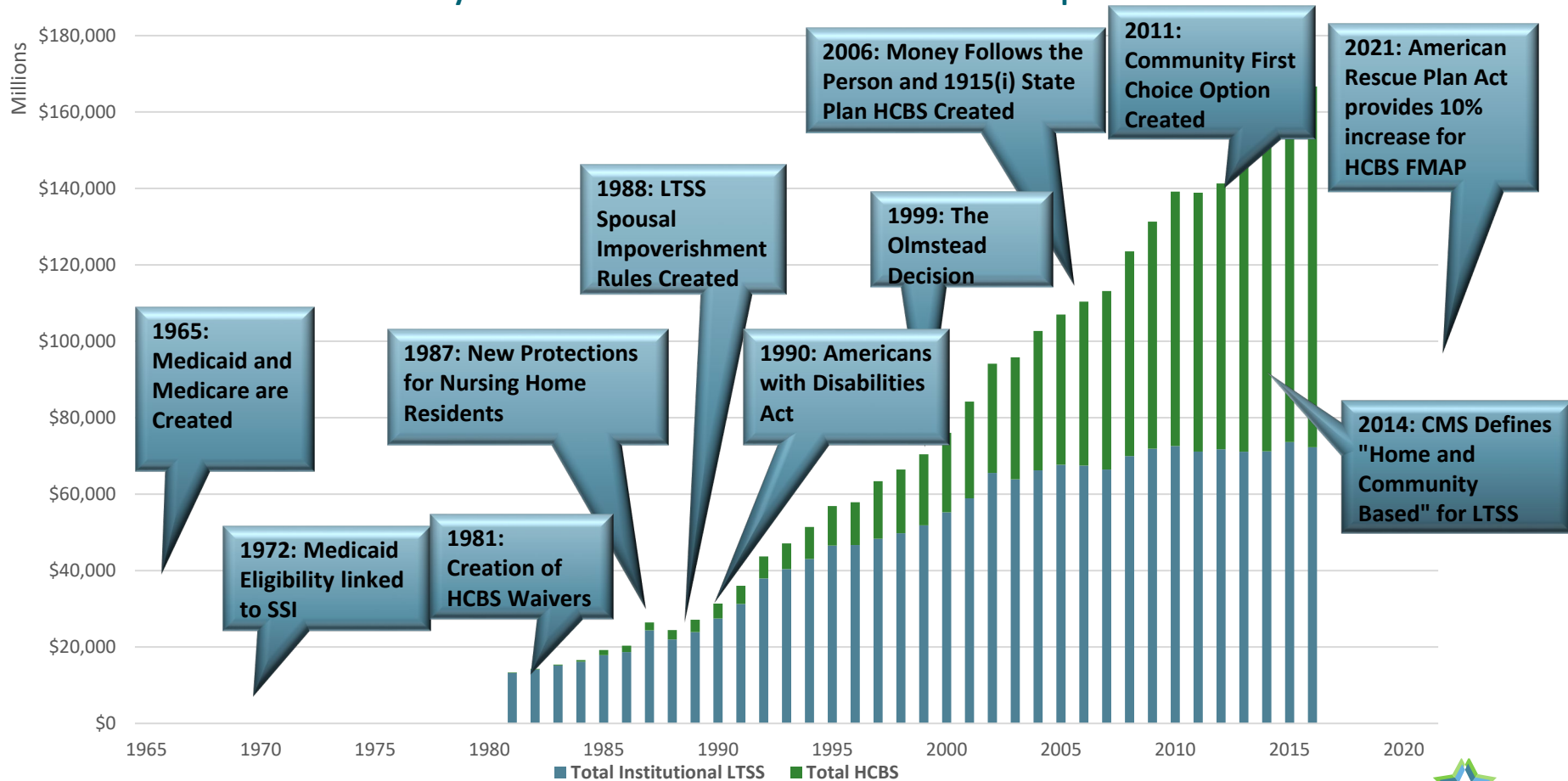


NOTE: \*Projection based on CBO March 2015 baseline.

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 History: HCBS Milestones and Distribution of LTSS Expenditures



# Federal Requirements

- Congress and the federal government set basic mandatory requirements for all state Medicaid programs. These include:
  - Administrative requirements for states
  - Minimum coverage populations and services
  - Rules for receipt of federal matching funds
- The US Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) is responsible for administering the Medicare and Medicaid programs.

# Medicaid Governance

- Federal Rules of engagement are defined in statute and regulations
  - Social Security Act -- Title XIX – Medicaid, Title XX1 – CHIP
  - Code of Federal Regulations (CFR) -- Title 42
- Subregulatory Guidance
  - State Medicaid Director’s Letters
  - State Health Official Letters
  - Informational Bulletins
  - Frequently Asked Questions (FAQs)
- Medicaid State Plan
  - State Plan Amendments (SPAs)
- Medicaid Waivers

# Medicaid Waivers

- State Medicaid plans or state plan amendments often indicate who and what is covered by a State Medicaid program.
- Key Medicaid Concepts:
  - Statewideness
  - Comparability
  - Amount, Duration, and Scope
  - Freedom of Choice
- Under a Medicaid waiver, a state can waive certain Medicaid requirements.

# 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.



# 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.
- Identify delivery system(s).
- Set reimbursement and pay providers.

# Federal Mandatory Groups and Services

- “Mandatory” Eligibility Groups
  - States must cover people in these groups up to federally defined income thresholds
- “Mandatory” Services
  - States’ Medicaid programs must offer medical assistance for certain basic services to most eligible populations in order to receive federal matching funds.
- “Optional” Groups and Services
  - States may choose to cover additional groups or add additional services, based on federal approval.

# Medicaid Funding Sources

- 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.

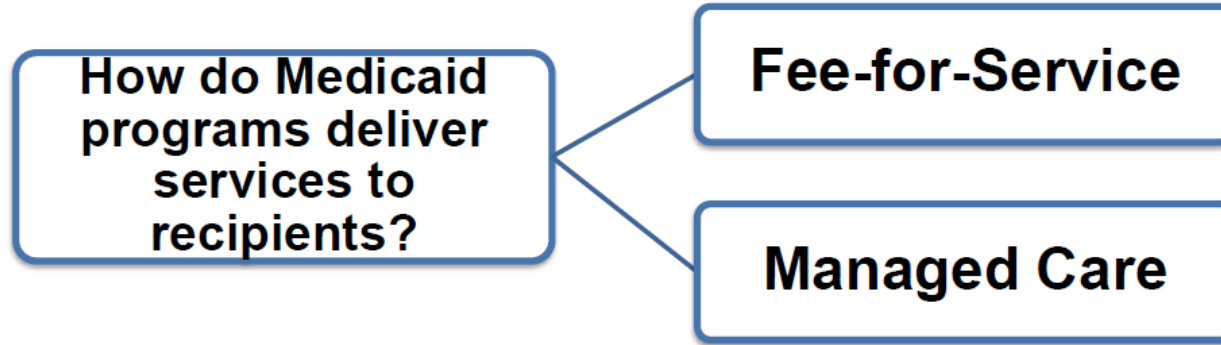
# Medicaid Funding Flow

- 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.

# Federal Medical Assistance Percentage

- The Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of federal share of state Medicaid program expenditures.
  - Varies from state-to-state
  - Updated annually
- The FMAP formula is based on the ratio of the state per capita income to the national per capita income.
- Uses three most recent calendar years for which satisfactory data are available from the Department of Commerce, Bureau of Economic Analysis.
  - The lower the state's average per capita income, the more FMAP and vice versa.
  - All states receive at least 50% FMAP.

# Medicaid Delivery Systems

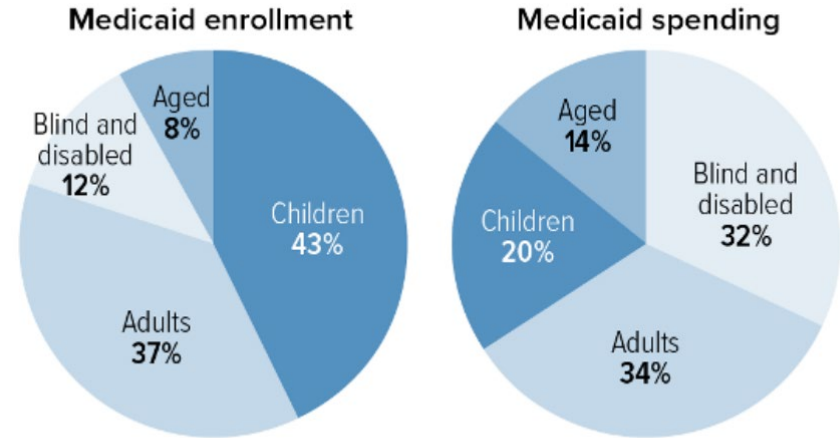


- States may choose from a number of different systems through which to deliver Medicaid services.
- The two main “delivery systems” are:
  - Fee-for-Service
  - Managed Care

# Medicaid Today

- Medicaid covers 19.8% of Americans.
  - Medicaid: 75,888,651
  - CHIP: 6,872,427
- Medicaid comprises 16% of the National Health Expenditure.
  - Medicaid Expenditures: \$613 billion in FY 19
  - CHIP Expenditures \$19.9 in FY 19

## Enrollment and Spending in Medicaid



Source: Spending and enrollment estimates for FY2018 from the Congressional Budget Office's May 2019 Medicaid baseline. Figures may not sum to 100 percent due to rounding.

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# Medicaid Today (cont.)

- Medicaid is the primary payer for long-term services and supports (LTSS).
- Total Medicaid LTSS spending was \$129 billion in FY 2018.
- Older adults and people with physical or other disabilities accounted for the majority of total LTSS spending in and 2018, representing about 56 percent of total expenditures.
- The share of LTSS out of total Medicaid expenditures declined from 47 percent in FY 1988 to 32 percent in FY 2018.
- The percentage of HCBS expenditures of total Medicaid LTSS expenditures has steadily increased over the last three decades.
- The absolute amount spent on MLTSS programs increased more than threefold in the past 20 years, climbing from \$6.7 billion in FY 2008 to \$30.1 billion in FY 2018

Source: Murray, Caitlin, Alena Tourtellotte, Debra Lipson, and Andrea Wysocki. "Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Years 2017 and 2018." Chicago, IL: Mathematica, January 7, 2021



# Summary

- Medicaid created in 1965 through Amendments to the Social Security Act.
- Medicaid is a joint federal and state partnership.
- Medicaid has experienced tremendous growth over the years.
- Medicaid State Plan is the operational agreement between CMS and the state, but State flexibility available through various waivers.
- Programs vary dramatically from state to state and the program has changed throughout its history
- Majority of funding through CMS with a number of elaborate and complex funding mechanisms.
- Medicaid Managed Care has become the predominant delivery system model.

# Medicaid Intensive: Overview of Medicaid Eligibility

Patrick W. Finnerty  
PWF Consulting  
(Former Virginia Medicaid Director)

# Medicaid Eligibility Has Evolved Over Time...And Is Still Complex

**MAGI**  
**ABD**  
**Residency Requirement**  
**Federal Poverty Level**  
**Financial**  
**COFA Migrants**

**§ 1634 States**  
**Assets**  
**Maintenance of Effort**  
**QMB**  
**Disabilities**  
**Medicare**

**ACA**  
**CFR**  
**optional**  
**Medically Needy**  
**Family Opportunity Act**  
**Renewal**  
**209(b) states**

**Redeterminations**  
**Mandatory**  
**SSA**  
**Categorical**  
**SSI**  
**Special Income Rule**  
**Afghan Evacuees**

**HCBS**  
**Spousal Impoverishment**  
**Level of Care**  
**LTSS**  
**SLMB**  
**Dual Eligible**

# Key Eligibility Requirements

- Eligibility determinations include financial and non-financial criteria
- 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.
  - In addition, some eligibility groups are limited by age, or by pregnancy or parenting status.
- Eligibility re-determinations must occur at least **annually** (cannot be more frequently for individuals whose eligibility is based on Modified Adjusted Gross Income (MAGI))
  - Re-determinations have been suspended during COVID-19 Public Health Emergency

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- Temporary FMAP increase due to COVID-19 public health emergency requires states to adhere to certain **“Maintenance of Effort” requirements**; including **maintaining eligibility levels and providing continuous eligibility**

# 2021 Federal Poverty Level Guidelines\*

Family Size	Annual Family Income				
	100% FPL	133% FPL	185% FPL	200% FPL	300% FPL
1	\$12,880	\$17,774	\$23,828	\$25,760	\$38,640
2	\$17,420	\$24,040	\$32,227	\$34,840	\$52,260
3	\$21,960	\$30,305	\$40,626	\$43,920	\$65,880
4	\$26,500	\$36,570	\$49,025	\$53,000	\$79,500
5	\$31,040	\$42,835	\$57,424	\$62,080	\$93,120

\* 2021 Poverty Guidelines for 48 Contiguous States & District of Columbia. Separate FPL Guidelines are published for Alaska & Hawaii. 100% FPL for Family of 1 is \$16,090 in Alaska and \$14,820 in Hawaii.

# Modified Adjusted Gross Income (MAGI)

- Affordable Care Act requires states to **change their method of counting income and defining household size** when 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.



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

- 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 thro 64



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

- **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



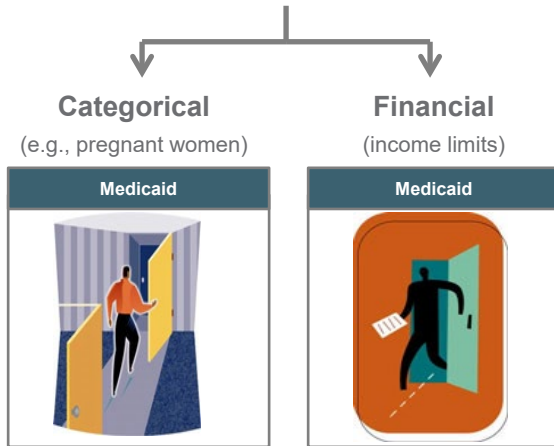


# Determining Medicaid Eligibility: Pre-and Post-Affordable Care Act (ACA)

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

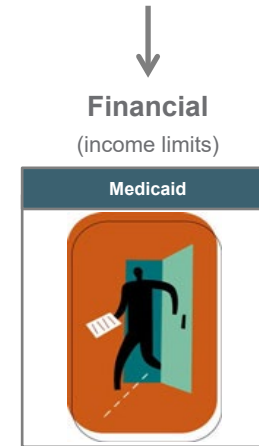
### All States Prior to ACA Expansion and Non-Expansion States

*Two Doors to Eligibility*

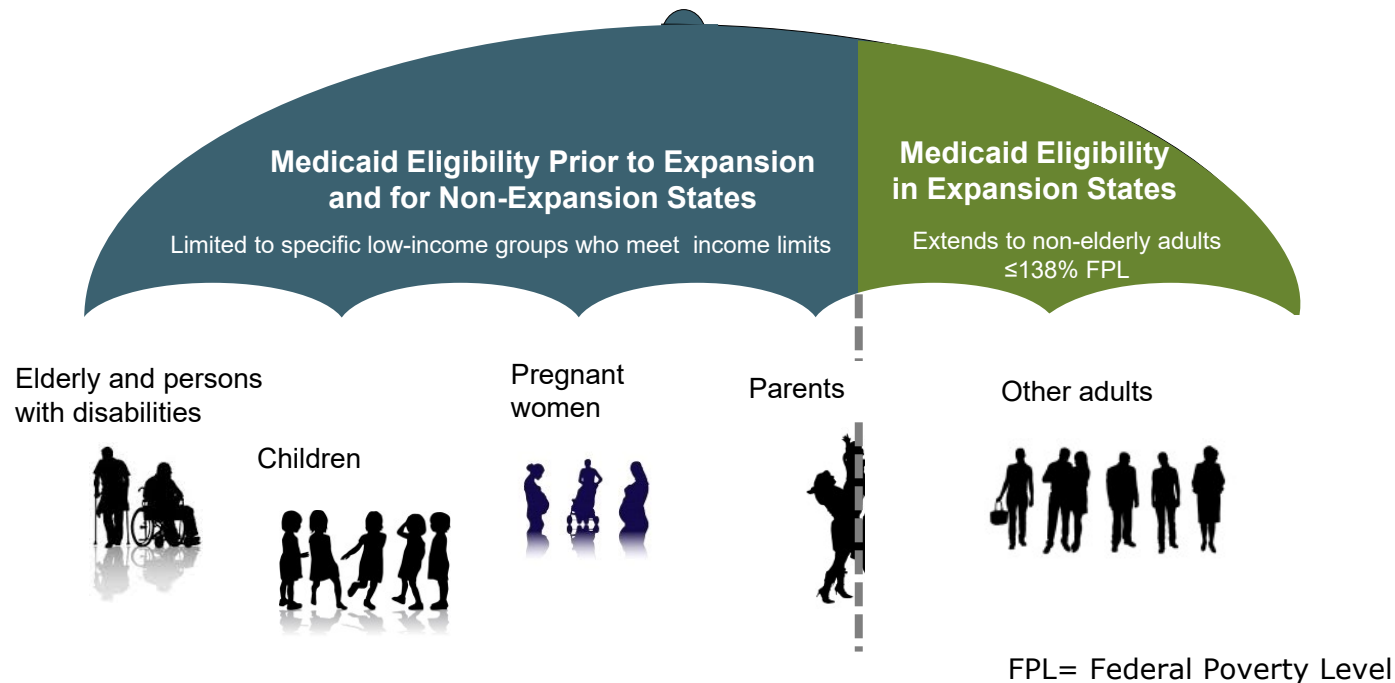


### Expansion States

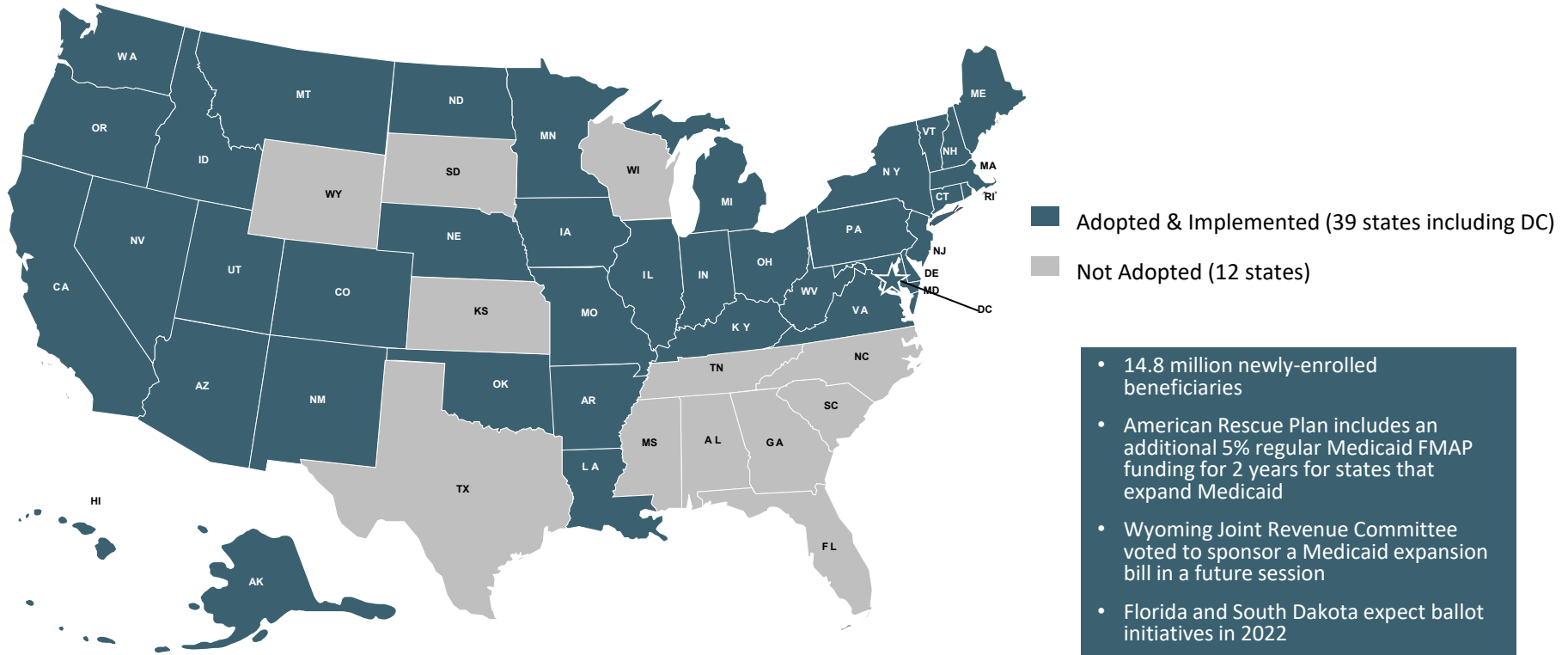
*One Door to Eligibility*



# Medicaid Eligibility Before and After ACA Expansion



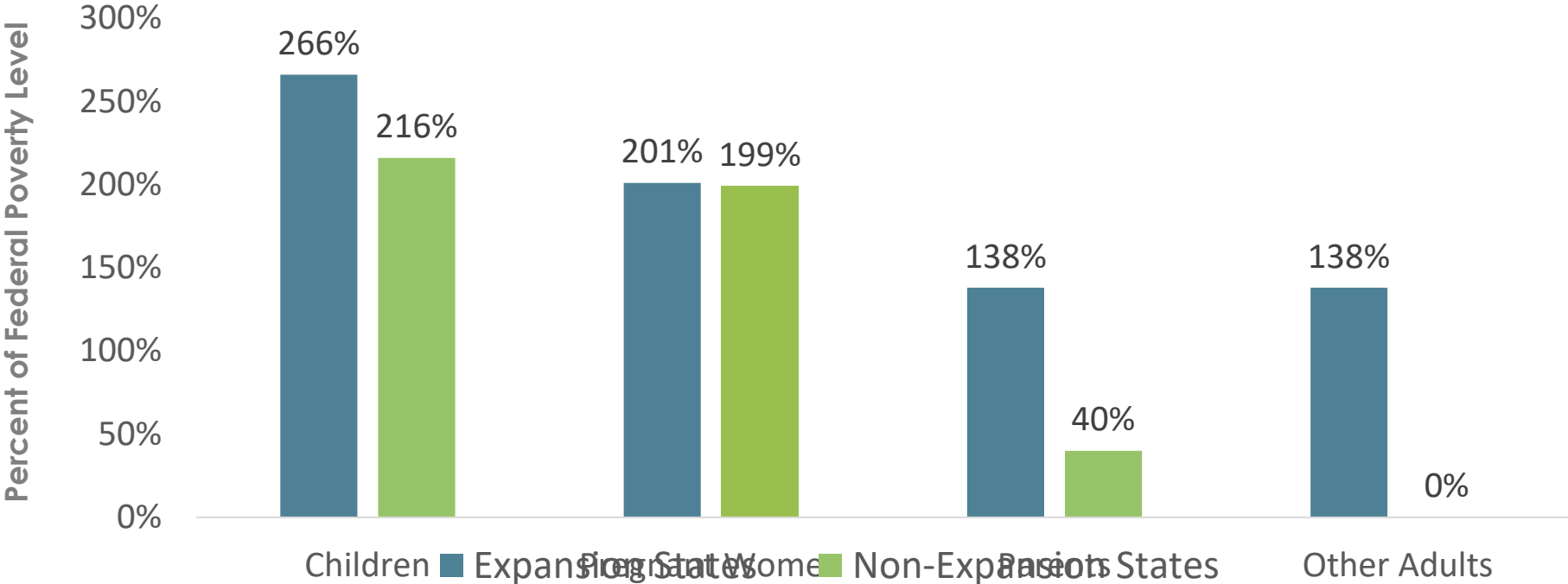
# Medicaid Expansion: Now 39 States (Including D.C.)



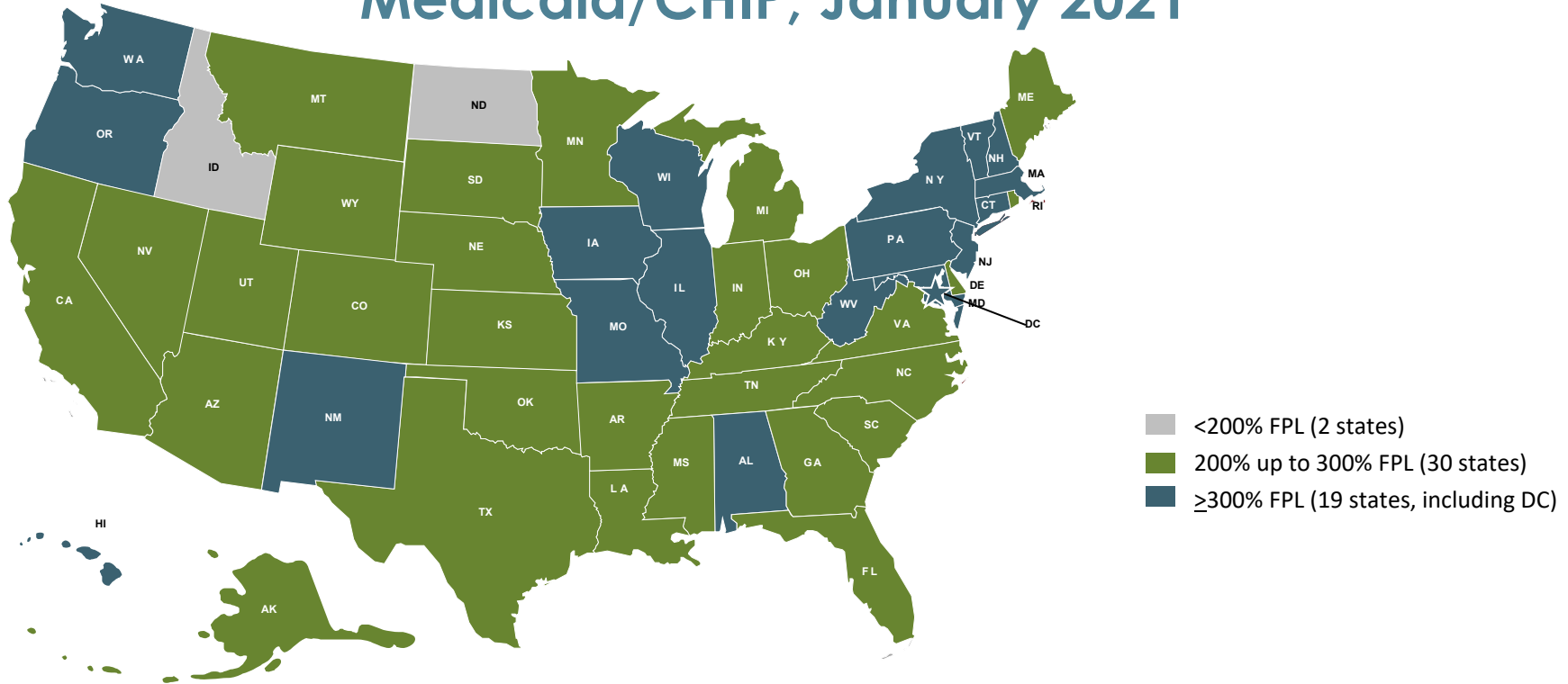
- 14.8 million newly-enrolled beneficiaries
- American Rescue Plan includes an additional 5% regular Medicaid FMAP funding for 2 years for states that expand Medicaid
- Wyoming Joint Revenue Committee voted to sponsor a Medicaid expansion bill in a future session
- Florida and South Dakota expect ballot initiatives in 2022

- Wisconsin covers adults up to 100% FPL in Medicaid with regular FMAP but did not adopt the ACA expansion.

# Median Medicaid Eligibility Levels Based on Implementation of Medicaid Expansion as of January 2021

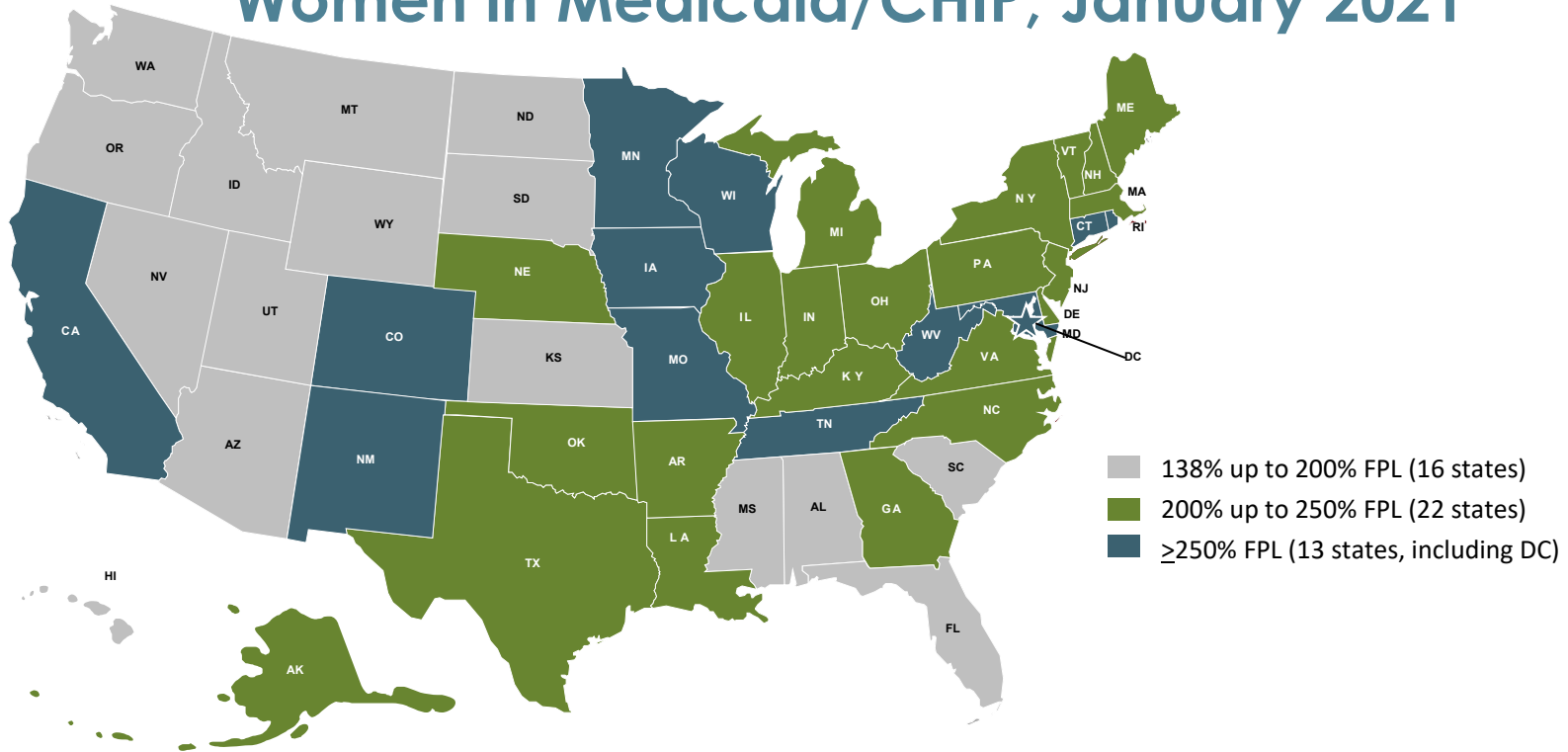


# Income Eligibility Levels for Children in Medicaid/CHIP, January 2021



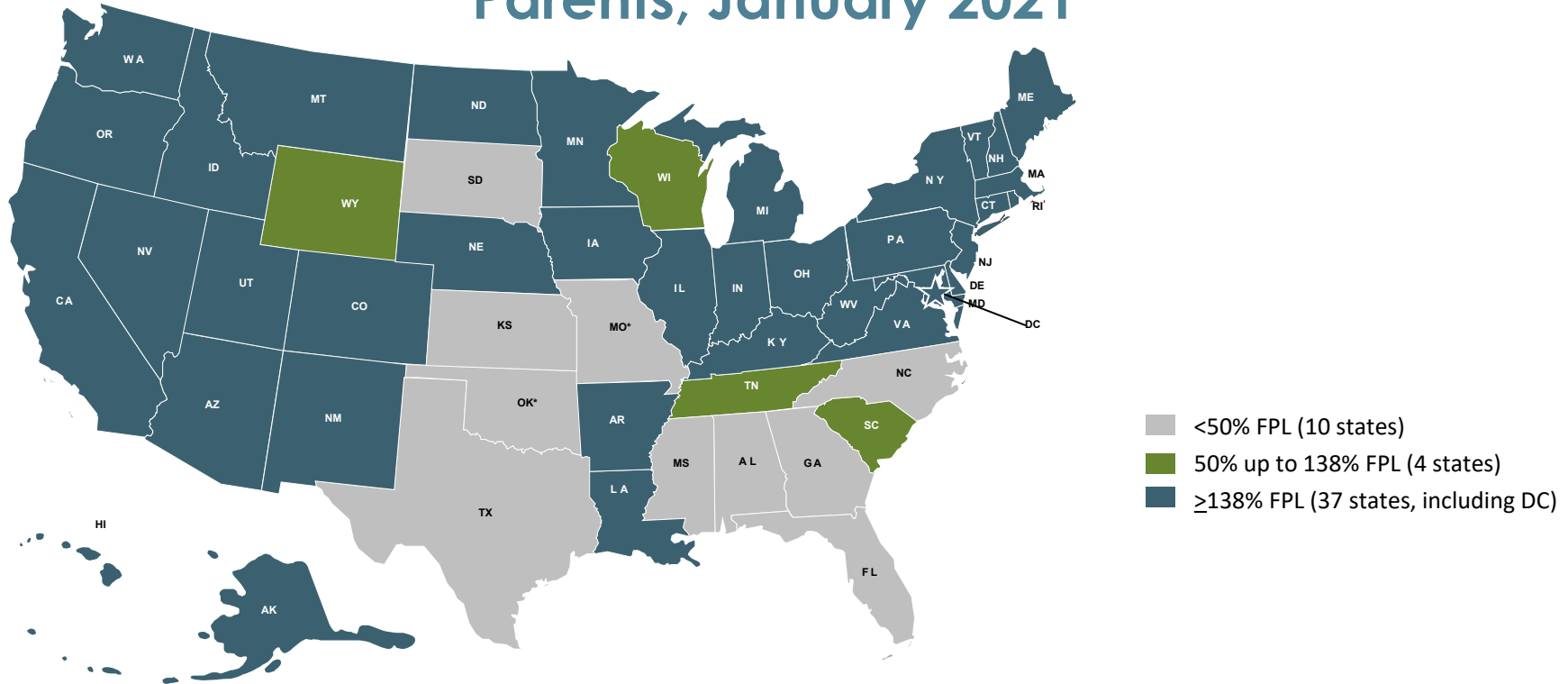
NOTE: Eligibility levels are based on 2021 federal poverty levels (FPLs) for a family of three. In 2021, the FPL was \$21,960 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.

# Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2021



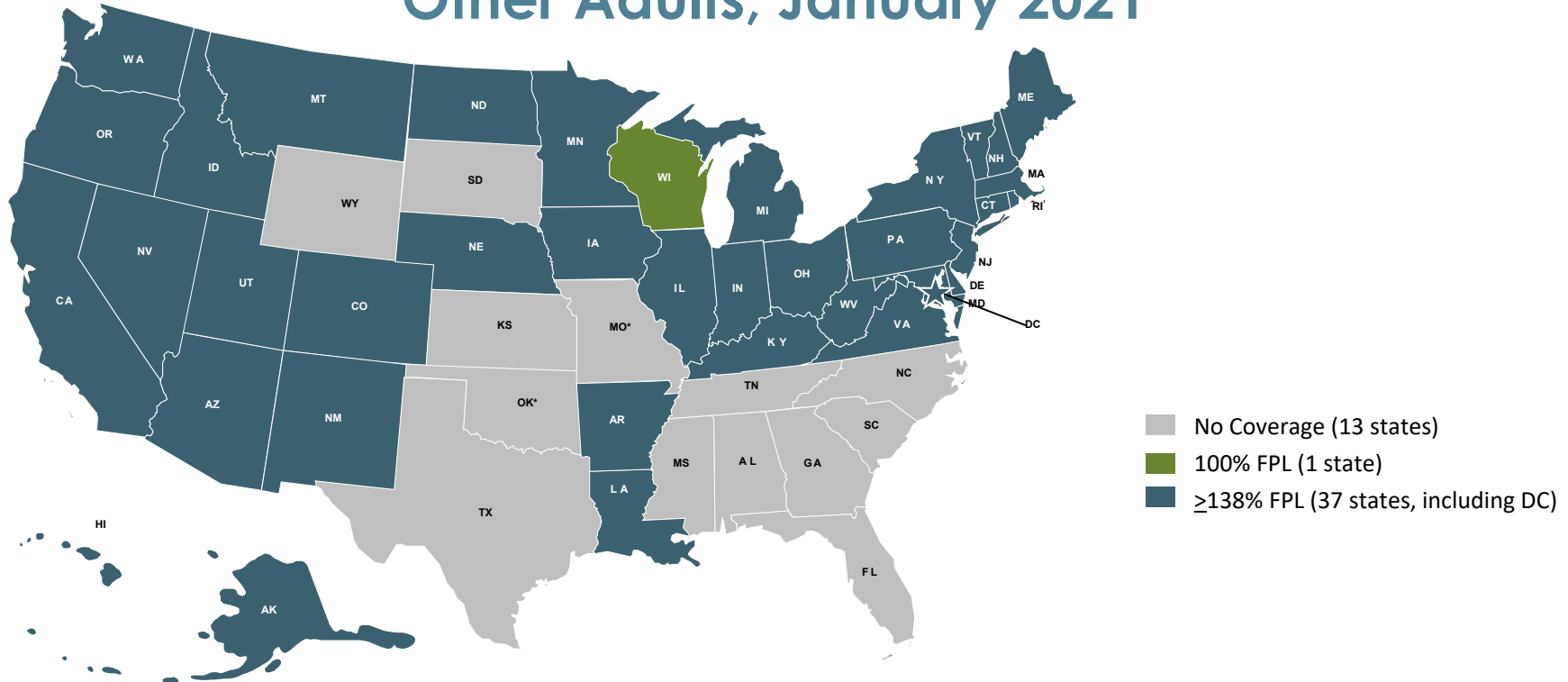
NOTE: Eligibility levels are based on 2021 federal poverty levels (FPLs) for a family of three. In 2021, the FPL was \$21,960 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.

# Medicaid Income Eligibility Levels for Parents, January 2021



NOTES: \*Missouri and Oklahoma implemented Medicaid Expansion in 2021 which raised the eligibility level to 138% FPL.. Eligibility levels are based on 2021 federal poverty levels (FPLs) for a family of three. In 2021, the FPL was \$21,960 for a family of three. Thresholds include the standard five percentage point of the FPL disregard. Wisconsin provides coverage to 100% FPL but does not receive enhanced federal matching dollars

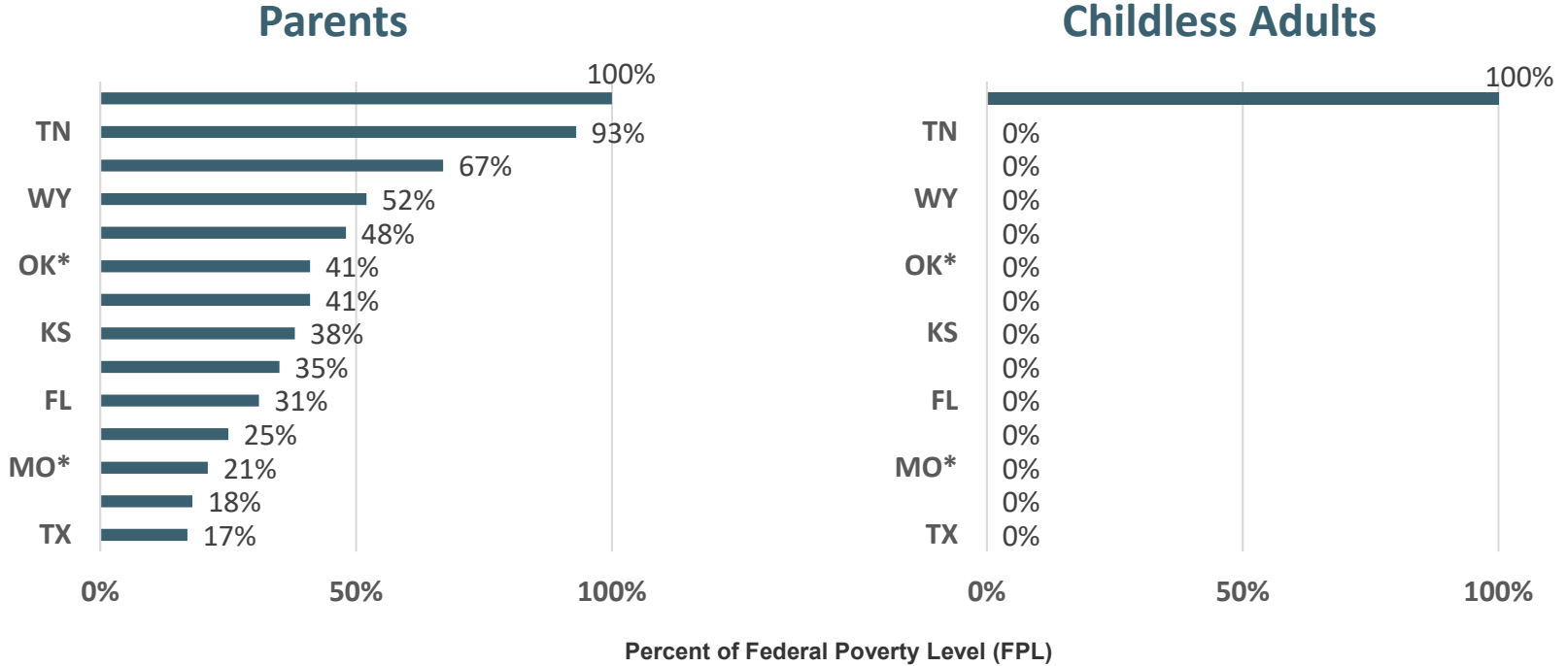
# Medicaid Income Eligibility Levels for Other Adults, January 2021



NOTES: \*Missouri and Oklahoma implemented Medicaid Expansion in 2021 which raised the eligibility level to 138% FPL. Eligibility levels are based on 2021 federal poverty levels (FPLs) for a family of three. In 2021, the FPL was \$21,960 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.. \*OK provides more limited coverage to some childless adults under Section 1115 waiver authority. Wisconsin provides coverage to 100% FPL but does not receive enhanced federal matching dollars

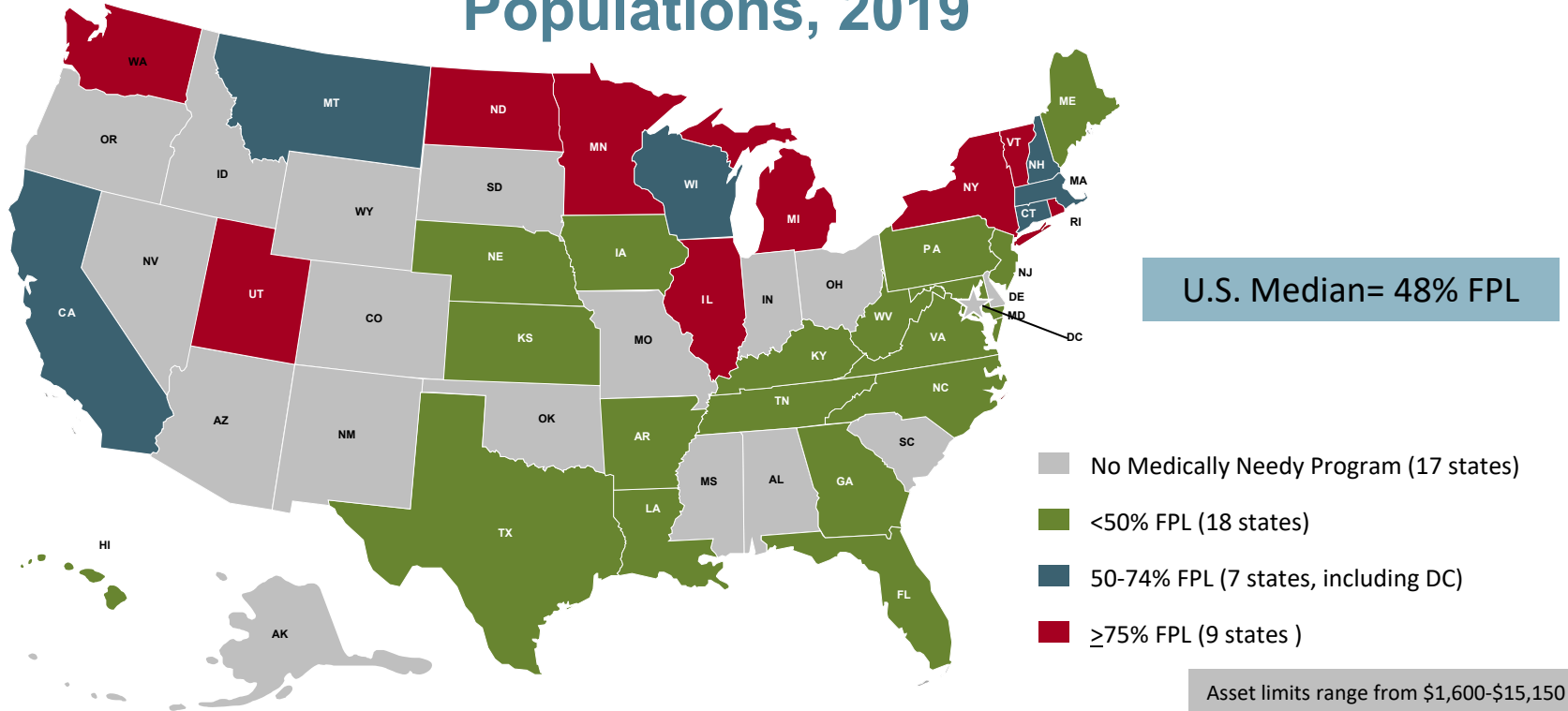


# Medicaid Income Eligibility Limits for Adults in States That Have Not Implemented Medicaid Expansion, January 2021



NOTES: \*Missouri and Oklahoma implemented Medicaid Expansion in 2021 which raised the eligibility level for Parents and Childless Adults to 138% FPL.

# Medicaid Eligibility for Medically Needy Populations, 2019



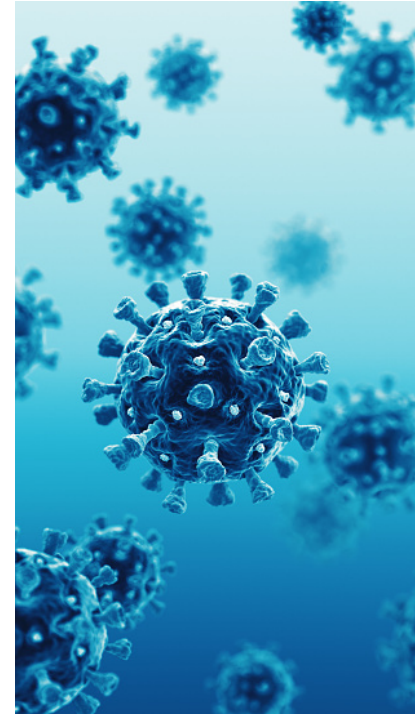
NOTE: \*TN covers only medically needy pregnant women and children; all other states cover these populations in addition to medically needy seniors and persons with disabilities.

# States Must Redetermine Eligibility for All Beneficiaries Enrolled in Medicaid/CHIP

- The state agency must begin the renewal process early enough in order complete a redetermination **prior to the end of the eligibility period**.
- States must first attempt to redetermine eligibility based on reliable information available to the agency without requiring information from the individual (***ex parte* renewal**)
  - If available information is insufficient to determine continued eligibility, agency **sends a renewal form and requests additional information** from the beneficiary.
- Redetermination Timeframe:
  - **MAGI Beneficiaries & CHIP:** Once every 12 months (and no more frequently than once every 12 months)
  - **Non-MAGI Beneficiaries:** At least once every 12 months (states can elect shorter eligibility periods)

# Eligibility Re-Determinations “Suspended” During COVID-19 Public Health Emergency

- To receive the Families First Coronavirus Response Act’s 6.2-percentage-point increase in their federal Medicaid matching rates, **states cannot terminate most enrollees’ Medicaid coverage while the federal public health emergency (PHE) is in place.** This continuous coverage requirement has kept millions of people covered during the COVID-19 pandemic.
- The Biden Administration has notified states that the PHE will last at least through 2021 and that states will get 60 days advance notice before it ends.
- When the PHE ends, **states will have to resume full renewals** and other activities they have changed or suspended during the PHE.
- CMS guidance to states: **pending applications** must be completed within four months, and **post-enrollment verifications**, changes in circumstance, and renewals must be completed within six months of the end of the PHE.



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

- **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)Intellectual/Developmental Disability, 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

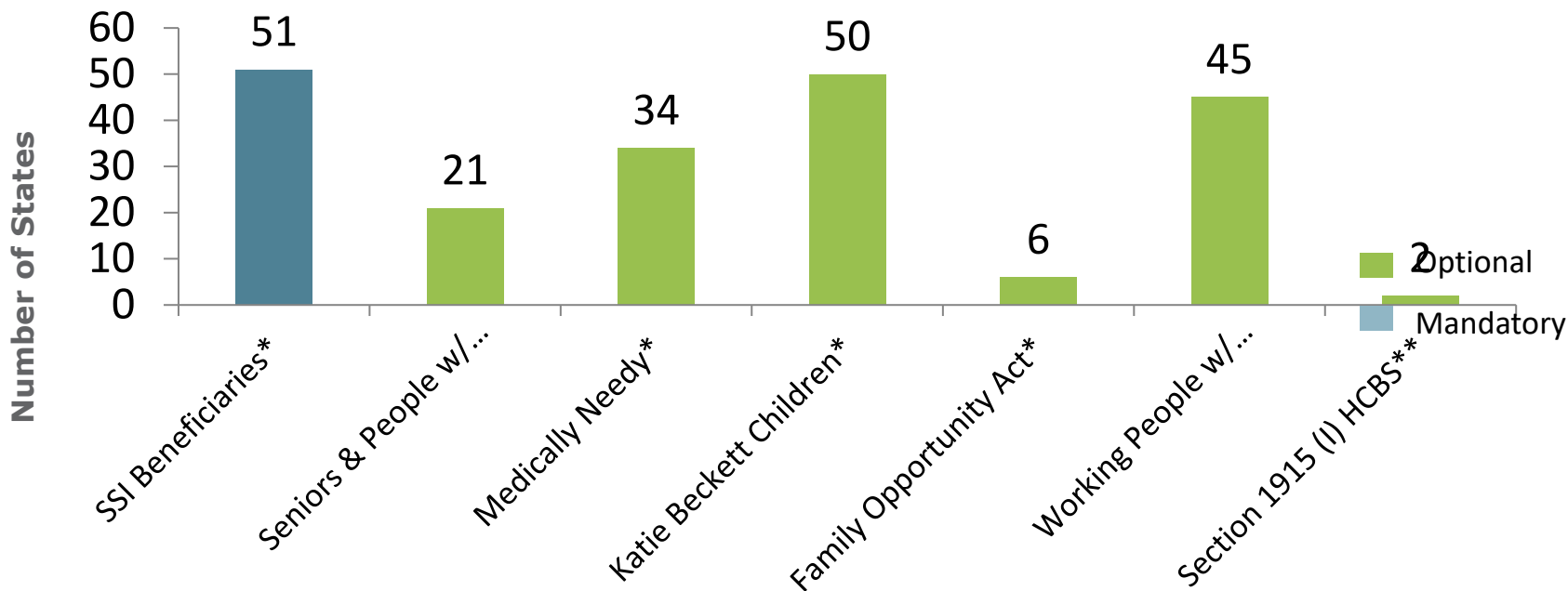
- **Section 1634 States—SSA Administration (33 states and DC)**
  - Same eligibility criteria as SSI
  - Contract with SSA via a “1634 agreement” to also determine Medicaid eligibility for SSI
  - No separate application required—eligibility files transmitted to state
  - Referral to state for final 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
- **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

- 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.



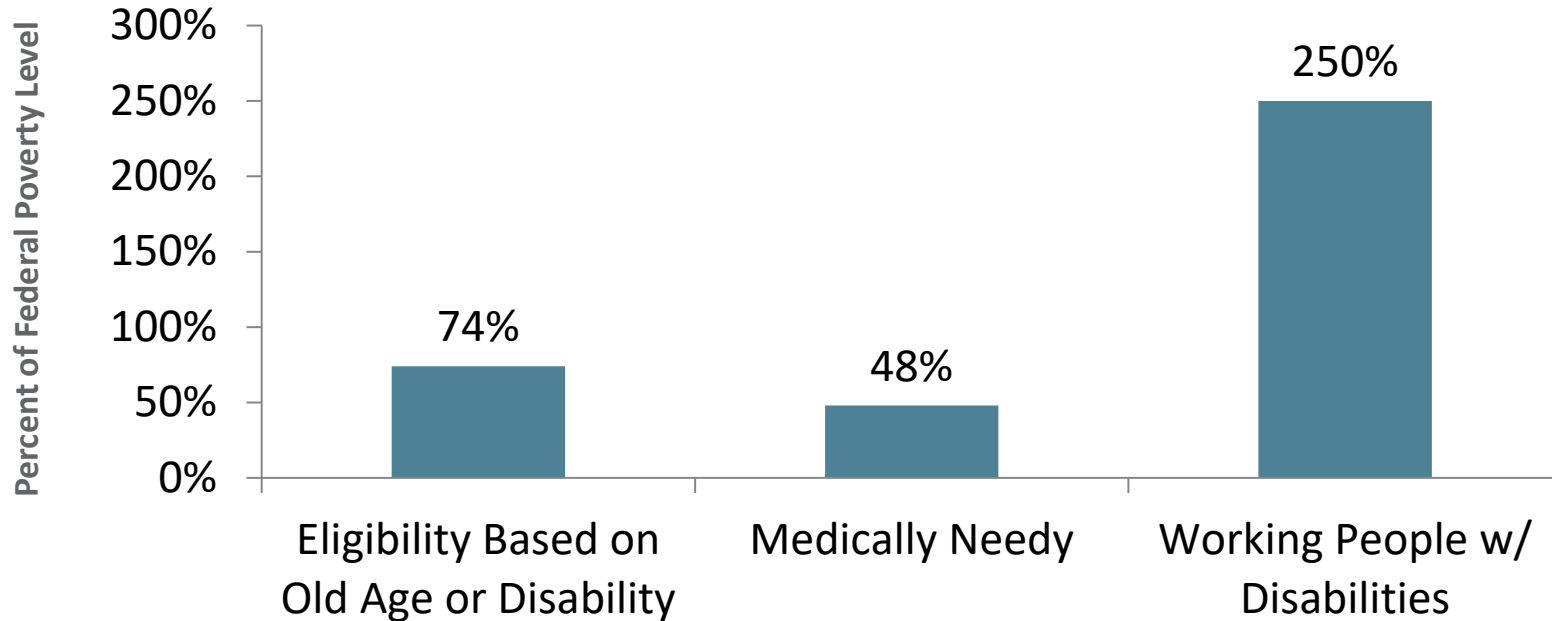
# State Adoption of Key Medicaid Eligibility Pathways Based on Old Age or Disability, 2018



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.

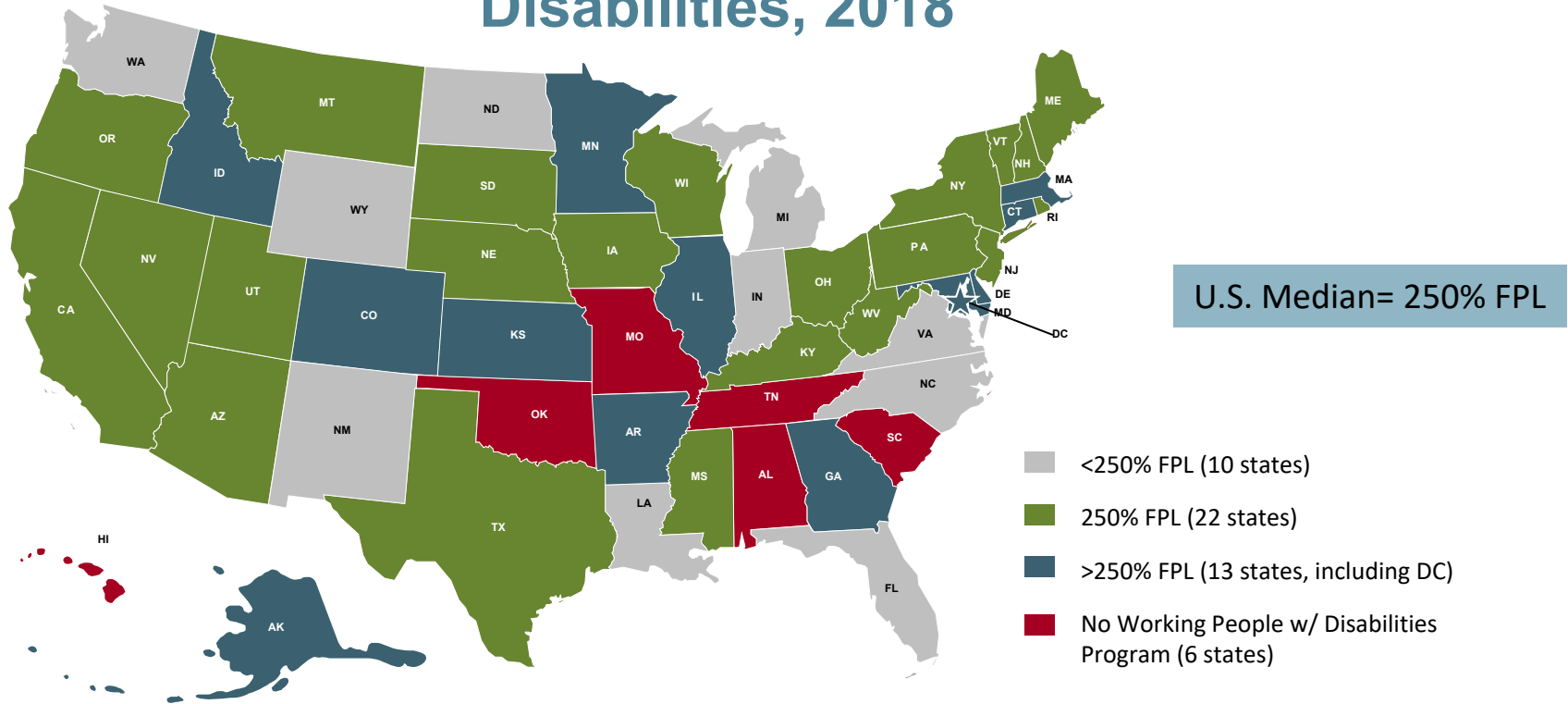


# Median Income Limits for Age & Disability Pathways, 2018



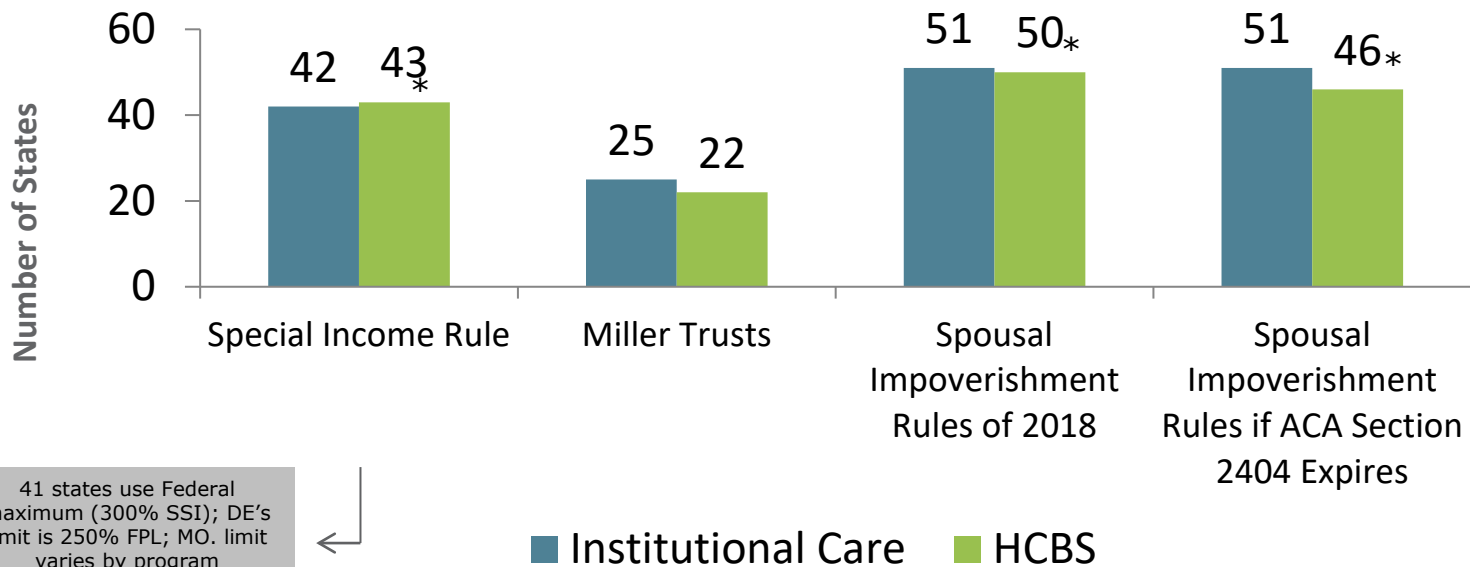


# Medicaid Eligibility for Working People w/ Disabilities, 2018



NOTE: \*AR, MA, and MN do not have an upper income limit.

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



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.

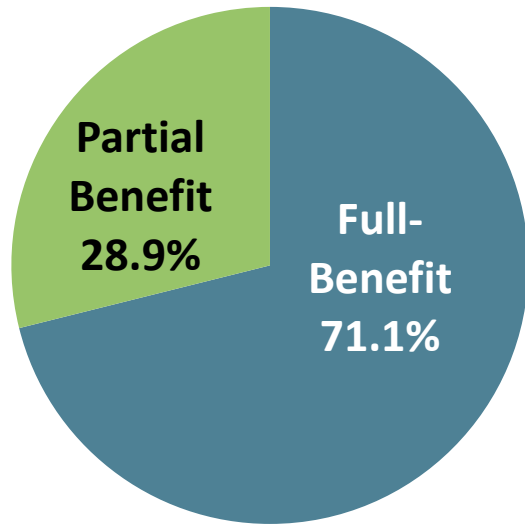
# 12.3 million “Dual Eligibles” in 2020

- **Full Benefit Dual Eligible:** Beneficiary receives full Medicaid & Medicare benefits
- **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

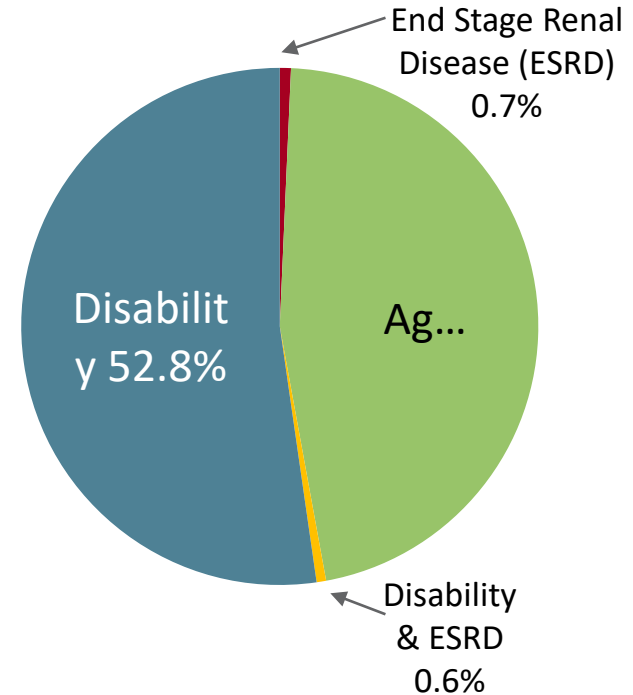
## Medicare Savings Plans



## Full-Benefit vs. Partial Benefit Duals



## Medicare Eligibility by Age vs. Disability?



# Full Benefit “Dual Eligibles”

## Full Medicaid

Benefits & Qualifications	Description
<b>Benefits</b>	<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>
<b>Qualifications</b>	<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><a href="#">Social Security Administration Program Operations Manual System</a></u>.</li><li>• To qualify for full Medicaid benefits, an individual must meet financial and other criteria</li></ul>

# Medicare Savings Programs: “Dual Eligibles”

## Qualified Medicare Beneficiary (QMB) Only

Benefits & Qualifications	Description
<b>Benefits</b>	<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>
<b>Qualifications</b>	<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.)

## Qualified Medicare Beneficiary (QMB) Only 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.)

## Specified Low-Income Medicare Beneficiary (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.)

## Specified Low-Income Medicare Beneficiary (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.)

## 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/sites/default/files/2019-12/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>
  - Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2021: Findings from a 50-State [Survey Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey \(kff.org\)](#)

# Medicaid 101: Benefits & Services

*Calder Lynch*

*VP & Chief of Staff*

*Commonwealth Care Alliance*

*Former CMCS Director*

*Former Nebraska Medicaid Director*

Dec. 7, 2021



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Improving care for people with disabilities and chronic health needs



## Today's Discussion

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- General principles of Medicaid benefits & services
- Overview of mandatory and optional services
- How Medicaid benefits & services are governed – the “State Plan”
- Waiver authority and state flexibility
- Medicaid benefits and the Public Health Emergency
- Medicaid benefits and Managed Care



# General Principles of Medicaid Benefits & Services

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- Some benefits & services are federally mandated, while some are optional. In general:
  - Benefits must be equivalent in amount, duration and scope for all enrollees in the state (**comparability rule**)
  - Benefits must be the same throughout the state (**statewideness rule**)
  - Beneficiaries must have choice of which (participating) providers or health plan they receive care though (**freedom of choice rule**)
- States can generally define to what extent a benefit is available by defining medical necessity criteria or the amount, duration, and scope of a benefit.
  - The scope of covered benefits and services is generally defined in the “**State Plan**” – essentially the contract between CMS and the states.
  - States can also seek different types of “**waiver**” **authority** to gain additional flexibility from these requirements.
  - *One key exception is **EPSDT**, which requires states to cover any medical necessary service (including optional benefits) without limit for children under age 21.*

## States Required to provide Certain Mandatory Services

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- 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

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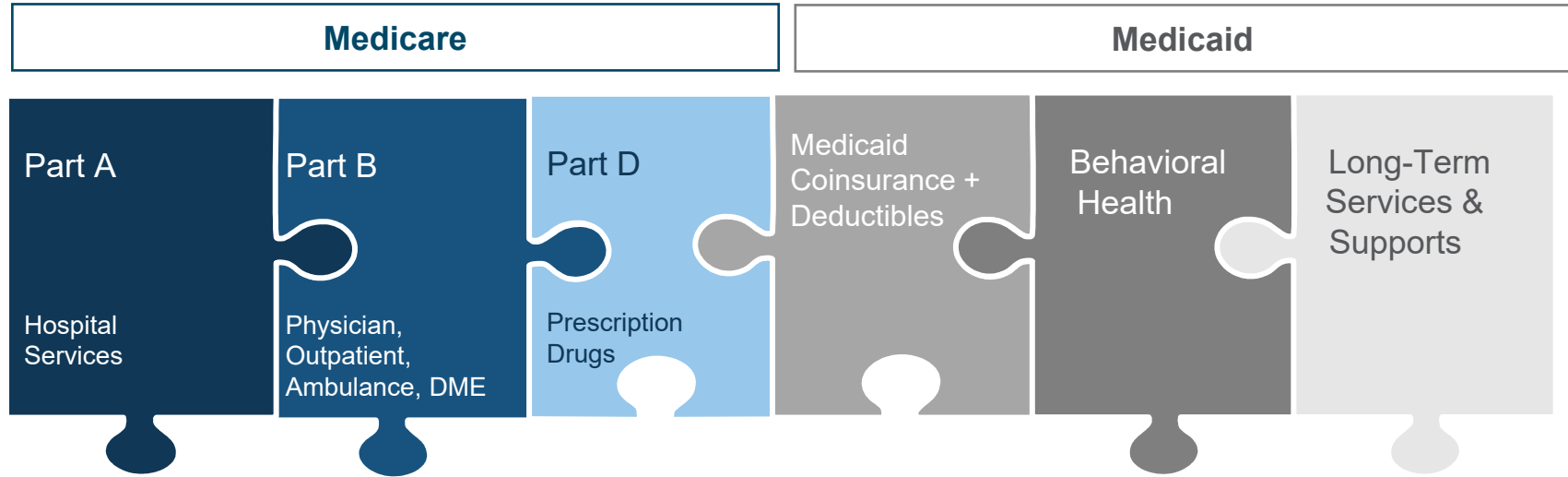
- Prescription Drugs
- Clinic Services
- Physical Therapy
- Occupational Therapy
- Speech, hearing & language disorder
- Podiatry
- Optometry
- Dental
- Chiropractic
- Dentures
- Prosthetics
- Eyeglasses
- Other practitioner services

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

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- 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

# Medicaid Benefits Can Compliment Medicare Coverage for Dually Eligible Individuals



Some dually eligible beneficiaries only qualify for assistance with payment of Medicare premiums and cost sharing, and do not receive full Medicaid benefits.

# The Medicaid State Plan

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- The Medicaid State Plan is a comprehensive written statement that describes the nature & scope of the Medicaid program, including:
  - Assurances that the program will be operated per federal requirements
  - Which optional groups, services, or programs the state has chosen to cover
  - State-specific eligibility standard methodologies
  - Methodologies for provider reimbursement
  - Other administrative processes
- The State Plan is managed with CMS through the “State Plan Amendment” process:
  - 90 days initial review process
  - No cost or budget requirement
  - Once approved, becomes a permanent change until amended again

## Waivers and Demonstrations

- There are a variety of types of waivers that states can employ to administer their programs with greater flexibility.

Waiver Type	Purpose
1115 Demonstration	Demonstration authority to test new eligibility, coverage, or delivery system models that promote the objectives of Medicaid. Must be budget neutral.
1915(b)	Allows states to waive comparability, statewideness, and freedom of choice requirements to operate managed care programs (which can now generally also be implemented through state plan authority.)
1915(c)	“Home and Community-Based Services (HCBS)” Waiver Authority- allows for long term care services outside of institutional settings
Combined 1915(b) and 1915(c)	Allows for managed care for HCBS and other long-term supports and services (LTSS) (“often called Managed LTSS or MLTSS)

## 1115 Demonstrations

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- Demonstration projects are intended to test a new or existing approach to financing or care delivery, subject to federal approval and ongoing evaluation.
- This waiver authority includes two primary mechanisms:
  - 1115(a)(1) allows states to waive various and specific provisions of the Medicaid statute
  - 1115(a)(2) can authorize the state to receive federal matching funds for benefits, services, or populations typically not eligible for federal reimbursement
    - Sometimes called “expenditure authority” or “costs not otherwise matchable (CNOM)”
  - The demonstration as a whole must be budget neutral to the federal government.



## Benefits and the Public Health Emergency

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- The PHE allowed states to access several emergency waiver authorities and other flexibilities to make temporary changes or enhancements to their programs, including actions such as:
  - Expanding access to telehealth (e.g., increase/parity in reimbursement, greater range of covered services, allow audio-only, removal of geographic restrictions)
  - Expanding LTSS benefits
  - Relaxed medication quantity limits and suspension of other utilization management limitations
- These authorities will expire at different points as the PHE ends, and states will need to assess and make plans for which changes it can and will make permanent, which will require additional action.



# Medicaid Benefits and Managed Care

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- MCOs are generally required to provide benefits consistent with state plan coverage but have flexibility to provide benefits beyond minimum requirements:
  - **“Value-added services”** – could be part of plan’s bid & designed to improve outcomes or lower costs (e.g, an adult dental benefit, Weightwatchers membership, non-medical transportation)
  - **“In lieu of services”** – offered in place of other contracted services if such alternative services or settings are medically appropriate, cost-effective, and are offered on an optional basis for both the MCO and its enrollees
- Additional benefits can be designed to support member “social determinants of health (SDOH). In FY 2021, at least 33 states report leveraging MCO contracts to promote strategies to address the SDOH (e.g., behavioral health screening, providing referrals to social services, partnering with community-based organizations (CBOs), and screening enrollees for social needs.
- Some benefits can be “carved out” of managed care and administered through fee-for-service or contracts with other vendors (e.g., dental, behavioral health, transportation).

# Questions

# Break:

## Next Session

- The lunch and plenary will begin at 12pm
- Presenter: Daniel Tsai, CMCS Director
- The session is in the Grand Ballroom on the 3<sup>rd</sup> Floor (down one level)

## Medicaid 101 Resumes

- The Intensive Resumes at 2pm
- Return to this room for the 2<sup>nd</sup> half of the day