



# MEDICAID FINANCING AND PAYMENT INTEGRITY

**Jerry Dubberly, PharmD**

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# Topics for Discussion

- ❑ Medicaid Financing
- ❑ Rate Setting
- ❑ Payment and Program Integrity

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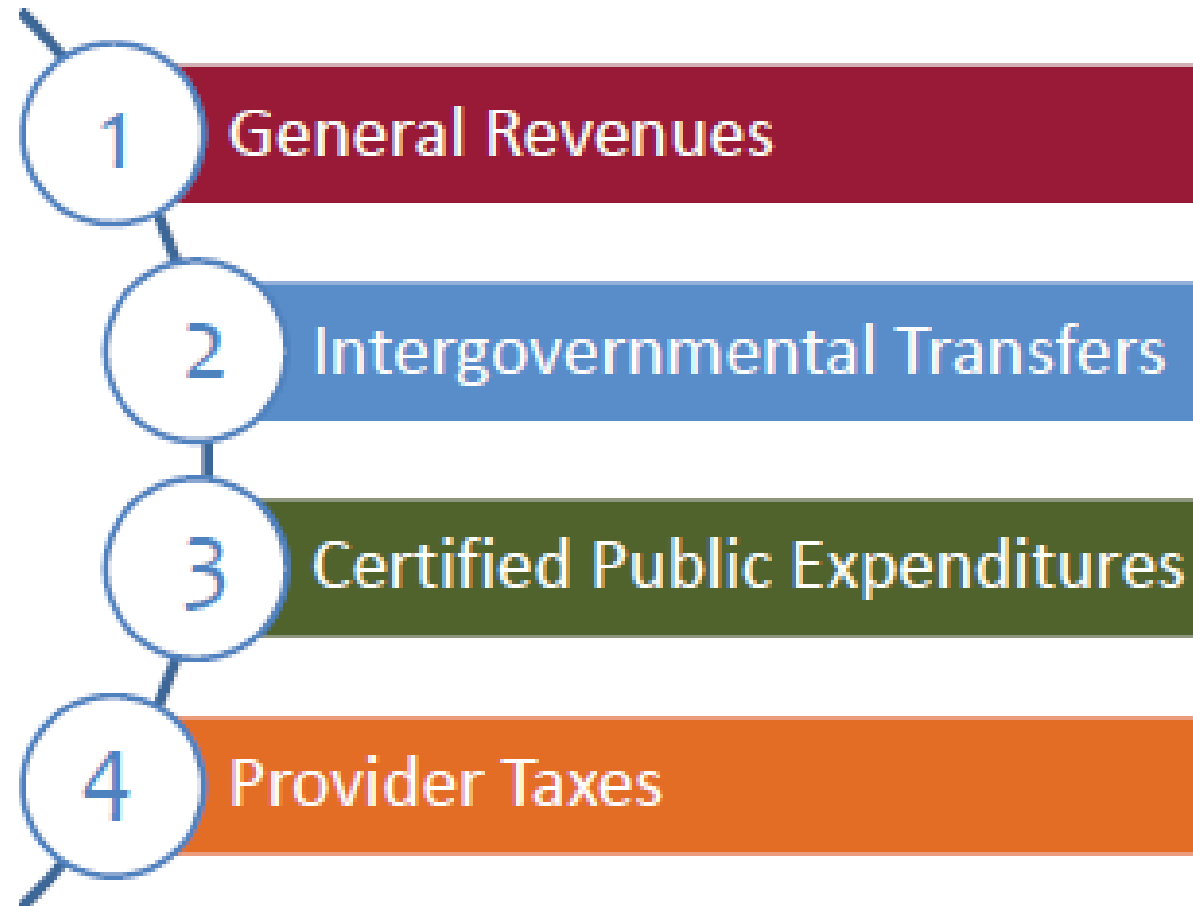
# Medicaid Financing Overview

- Joint state and federal funding.
- States administer Medicaid program but have to abide by federal requirements to receive federal matching funds.
- The federal share, referred to as federal financial participation (FFP), or federal match, is calculated using a Federal Medical Assistance Percentage (FMAP).

# Medicaid Financing Overview (continued)

- FMAP varies by state, can vary from year to year, and is based on per capita income:
  - Lower per capita income = higher FMAP.
  - Minimum FMAP is 50%.
  - Maximum FMAP is 83%.
- Periods of increased FMAP have been authorized (e.g., natural disasters, public health emergencies)
- At least 40% of the non-federal share of total Medicaid expenditures must be financed by the state.

# Sources of Non-Federal (State) Share



# Disproportionate Share Hospital (DSH) Payments

- Established by Congress in the early 1980s to provide some financial relief to hospitals serving the poor.
- Federal law mandates that states make DSH payments to certain hospitals with high Medicaid or low-income inpatient use rates.
- DSH payments are required if the hospital:
  - Has a Medicaid inpatient utilization rate that's one standard deviation or greater above the average for Medicaid hospitals in the state.
  - Has a low-income utilization rate greater than 25%.
- Each state receives an annual DSH allotment.
- Federal statute limits the amount of DSH payments to institutions for mental disease (IMDs) and other mental health facilities.

# Upper Payment Limit (UPL)

- UPL is a federally-authorized program that provides payments to providers to supplement revenue from Medicaid patients so that it is comparable to that for Medicare patients.
- States have established UPL programs a number of provider categories such as nursing facility, ICF/IDD, PRTF.
- UPL dollars have to be redistributed back to providers, but is a source of funds for payment to recognize quality.

# Provider Taxes

- States also use provider taxes to fund the state share of Medicaid Expenditures.
- Provider tax revenue cannot exceed 25% of the State Share of Medicaid expenditures.
- Medicaid providers usually benefit from a provider tax because the additional funds generated are often used to increase Medicaid payment rates for a class of providers.
- Lower volume Medicaid providers may not receive the same benefit from the tax as higher volume Medicaid providers within that class.



# MEDICAID REIMBURSEMENT AND MATCHING RATES



## **GENERAL ADMINISTRATION: 50/50 EXCEPT:**

- Salaries for skilled health care professionals (75%)
- Computer systems

## **COMPUTER SYSTEMS.**

- 90/10 for updates or new systems
- 75/25 for on-going operations.

## **PROGRAMS.**

- The state's Federal Medical Assistance Percentage (FMAP) except:
  - Family planning.
  - Medicaid expansion population.

# MEDICAID RATE-SETTING: OVERVIEW

- **Requirements:** Federal law requires rates to be sufficient to generate access on a par with general population (SSA *Section 1902(a)(30)(A)*).  
*“Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”*
- **State Plan:** Must describe the policy and the methods used in setting payment rates for each type of service.
- **Flexibility:** States have great flexibility in establishing rates and rate methodologies.

# MEDICAID RATE-SETTING: HCBS

- **Fee Schedule**
  - Base fee
  - Acuity factors
  - Geographic adjustments
- **Negotiated Market Price**
- **Tiered Rates:** The characteristic of the individual is often identified by an assessment tool such as:
  - Supports Intensity Scale (SIS),
  - Inventory for Client and Agency Planning (ICAP) or
  - Another tool that classifies the individual's needs on an established scale
- **Bundled Rates**
- **Cost Reconciliation:** Cost-based with a reconciliation process

# MEDICAID RATE-SETTING: INSTITUTIONS (Ex. Hospitals, Nursing Facilities)

- Various payment methods for facility-based care, including:
  - “Cost-based” reimbursement
    - 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, Outpatient Prospective Payment System for outpatient services, and Resource Utilization Group (RUG) based payments for nursing homes.
- Hospitals and nursing homes often receive lump-sum “supplemental” payments not directly tied to individual services (Ex. Upper Payment Limit Payments, Quality Incentive Payments, etc.).

# MEDICAID RATE-SETTING: OTHER EXAMPLES

- **Hospice:** Base Medicaid hospice rates are published annually by CMS.
  - Per diem rate.
  - Linked to intensity of services furnished
  - States may pay more
- **Physicians:** Traditionally a fee-for-service payment based on a rate schedule. Rate schedule is often established as a percent of Medicare rates.
- **Pharmacy:** Two major components: ingredient cost and professional dispensing fee.

# Value-Based Payment (VBP) Overview



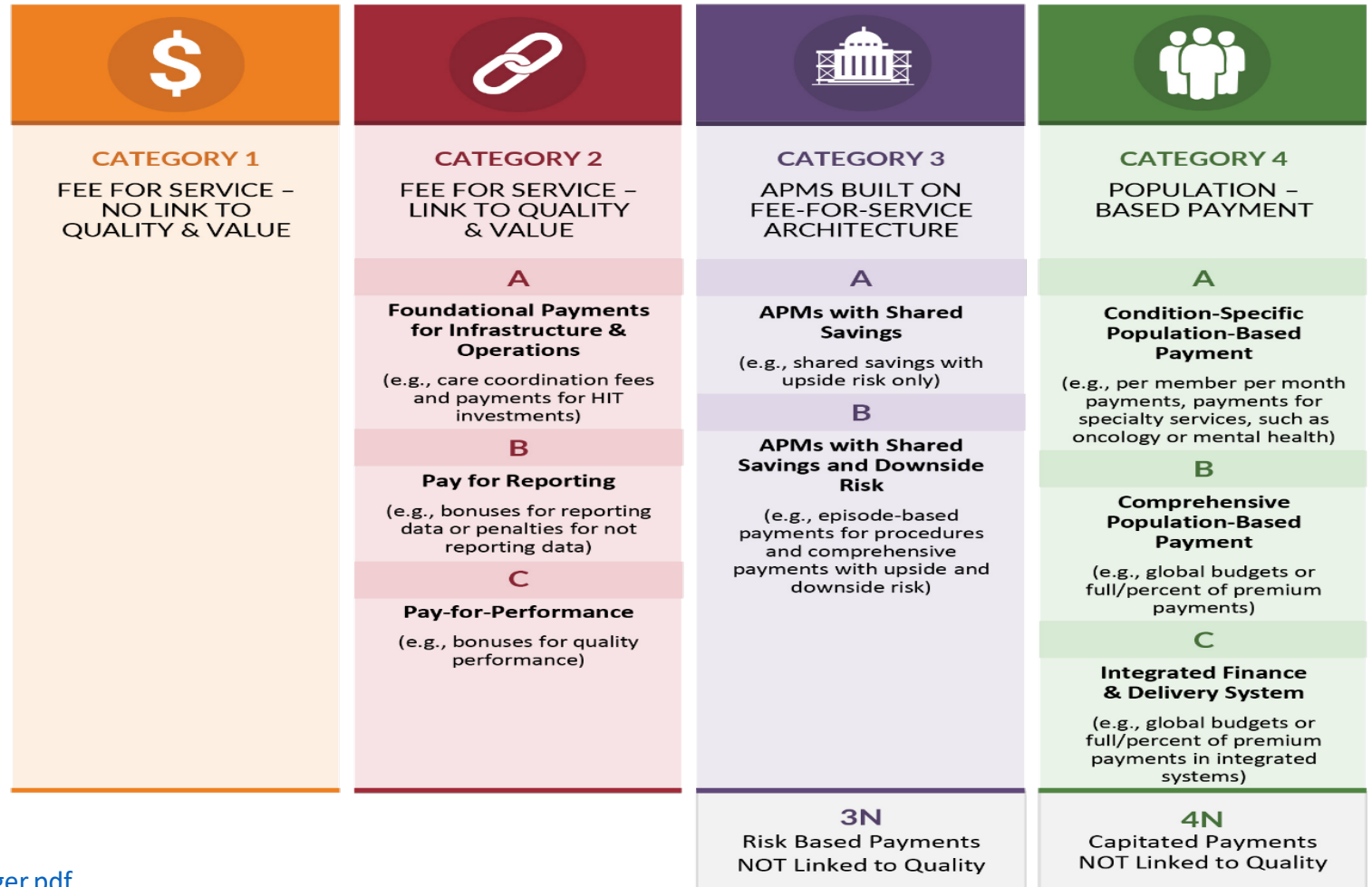
## BACKGROUND

- Traditional Medicaid payments have paid for volume of services – not their value.
- VBPs seek to improve the value of the health care delivery system, by improving the quality of the care provided while at the same time, reducing the costs.

# VBP: Key Definitions

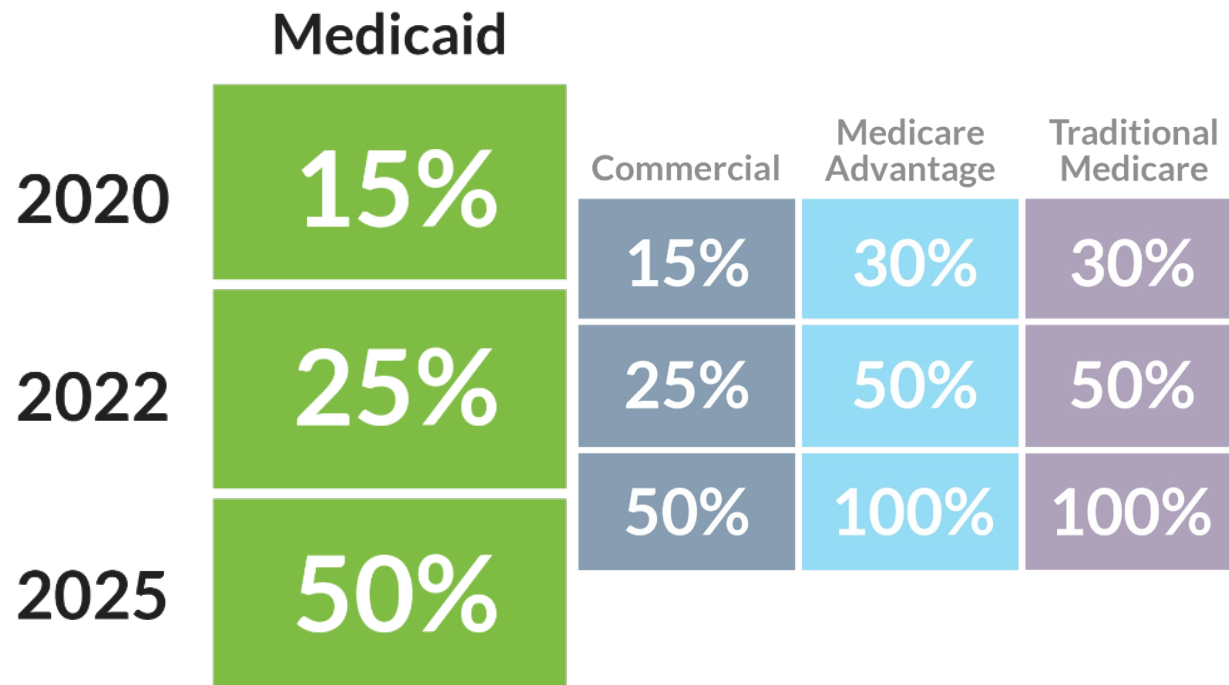
- **Value Based Payments**
  - Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.
- **Alternative Payment Models (APMs)**
  - An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

# HCPLAN Alternative Payment Model Framework





# LAN Goals: Medicaid



Percentage of Medicaid payments flowing through two-sided risk models (Categories 3B & 4\* in the LAN APM Framework)

2017

7.4%

2018

8.3%

\*Category 3B: APMs with Shared Savings and Downside Risk  
 Category 4: Population-Based Payments

# Payment and Program Integrity



## OVERVIEW

- Payment and program integrity consists of initiatives to detect and deter fraud, waste, and abuse and improve program administration.
- Ensures federal and state dollars are spent appropriately
- General payment and program integrity domains:
  - Beneficiaries
  - Providers
  - Services
  - Payments

*State plan requirement for the identification, investigation, and referral of suspected fraud and abuse cases.*

## Definitions

- **Abuse.**  
Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
- **Fraud.**  
When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program
- **Waste.**  
Inappropriate utilization of services and misuse of resources.

**The primary difference between fraud and abuse is intention.**

# Medicaid Payment Integrity Tools and Activities

## RESOURCES AND REQUIREMENT.

- Medicaid agency is responsible for payment integrity. 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).

## CORE ACTIVITIES.

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

# Payment Error Rate Measurement (PERM)

- The purpose of the payment error rate measurement (PERM) program is to measure and report an unbiased national improper payment rate for Medicaid and the State Children's Health Insurance Program (CHIP) as required under the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA, P.L. 112-248).
- PERM reviews are held with each state every three years on a rotating basis.
- PERM findings can be used to identify potential problem areas that can inform corrective actions.
- PERM is not designed to identify fraud.
- Most common cause of improper payments in 2019 PERM was insufficient documentation.

# Medicaid Payment Integrity: Coordination With Other Entities

- Medicaid Fraud Control Units (MFCU).
  - Investigates and prosecutes Medicaid provider fraud
  - Usually a part of the State Attorney General's office
- State auditors (e.g., Legislative, Agency, State Inspectors General).
- Centers for Medicare and Medicaid Services.
- Federal HHS Office of Inspector General.
- Federal Government Accountability Office.
- Law enforcement (e.g., Prosecutors, FBI).

# Medicaid Payment Integrity: Managed Care Organizations (MCOs)

- Nearly 54 Million Americans access health care through a Medicaid MCO.
- Medicaid regulations define fraud and abuse in the same way for fee for service and managed care (42 CFR 455.2).
- States are responsible for exercising oversight over their MCOs.
- Contractual requirements to proactively minimize fraud, waste, and abuse.
- Best MCO payment integrity practices:
  - Clear MCO contractual language.
  - Accountability, coordination, and communication with Medicaid agency payment integrity team.
  - Encounter data validation.
  - Performance reviews.

# Medicaid Payment Integrity: Managed Care Organizations (MCOs)

- Managed Care Program Annual Report (MCPAR)
  - Annual report on each managed care program administered by the State, regardless of the authority under which the program operates.
  - Required under 42 C.F.R. §438.66(e)
  - Promotes improved monitoring and oversight of managed care in Medicaid and CHIP
  - MCPAR reporting includes:
    1. Program characteristics and enrollment
    2. Financial performance
    3. Encounter data reporting
    4. Grievances, appeals, and state fair hearings
    5. Availability, accessibility, and network adequacy
    6. Delegated entities
    7. Quality and performance measures
    8. Sanctions and corrective action plans
    9. Beneficiary support system
    10. Program integrity



# Payment Integrity and Value Based Payment Model Challenges

- Increasing payment complexities require updated payment integrity strategies.
- VBP modeling has to consider the possibility of incentivizing unintended behaviors and payments.
- What is the proper payment integrity strategy to validate payments for activities that were avoided/never occurred?
- What strength of documentation will be required to validate activities that are not individually billable?
- How will we leverage health information technology to validate outcomes?

# Closing Thoughts

- Medicaid financing is complex but can be leveraged to maximize federal funding and provide additional payments to providers and create quality incentive payment programs.
- States have great flexibility in setting reimbursement rates.
- Medicaid is responsible for the accuracy of payments notwithstanding which state agency operationalizes the program.
- Provider reimbursement models are evolving to pay for value of services over the volume of services provided.
- Policy and program staff should work closely with program integrity staff to ensure the integrity of the program and corresponding payments.

# CONTACT US



JERRY DUBBERLY

Principal

Myers and Stauffer LC

[jdubberly@mslc.com](mailto:jdubberly@mslc.com)

404.524.0775



# MEDICAID LTSS

Claudia Schlosberg, JD

Castle Hill Consulting, LLC

CastleHConsulting@gmail.com

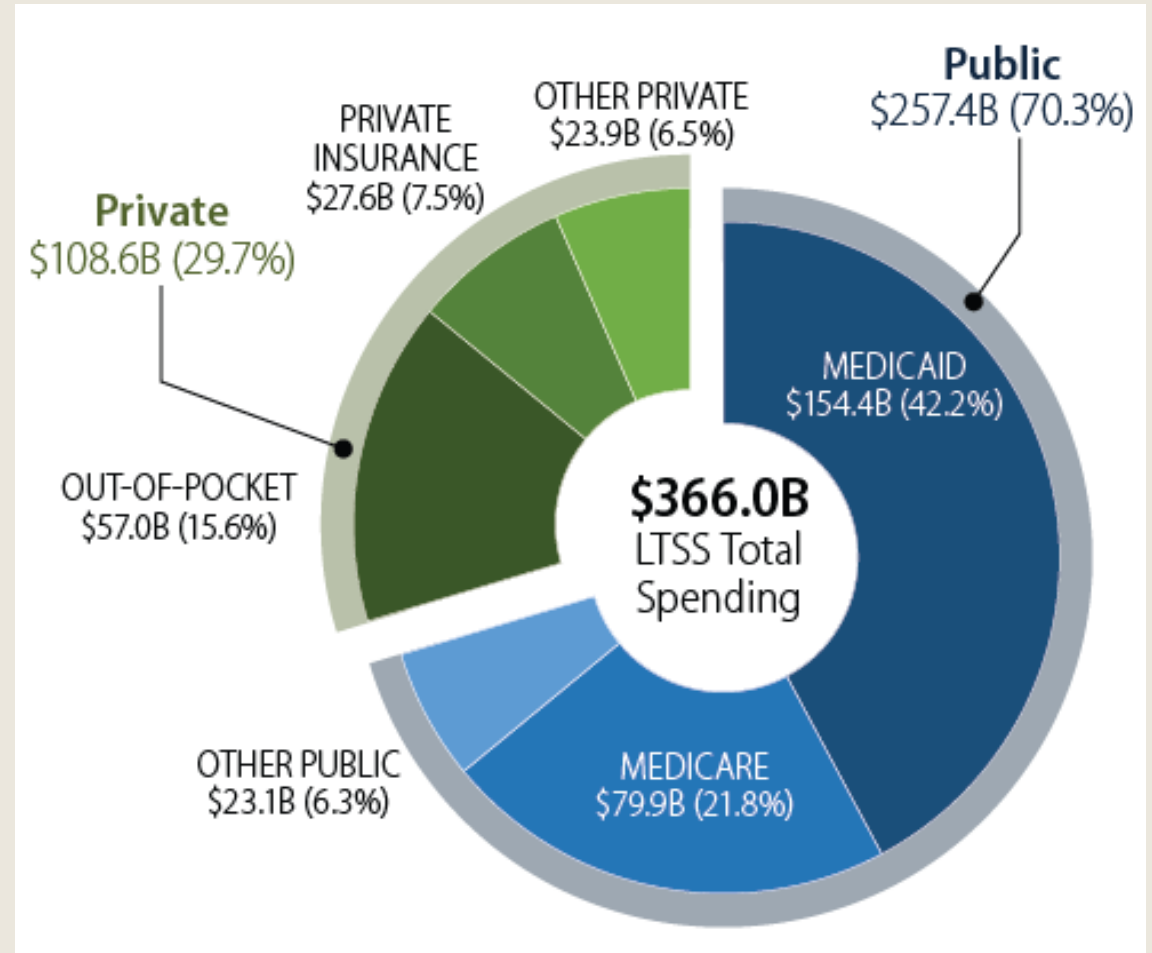
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# AGENDA

- 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

# Who pays for Long-Term Care?

LTSS by Payor, 2016



Source: Who pays for Long Term Services and Supports, Congressional Research Services, August 22, 2018, accessed on November 2, 2020, <https://fas.org/sgp/crs/misc/IF10343.pdf>

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

- Institutional Services are mandatory
- HCBS Services are optional.

## Institutional Services

- \*Inpatient Hospital
- \*Nursing Facility

## HCBS Services

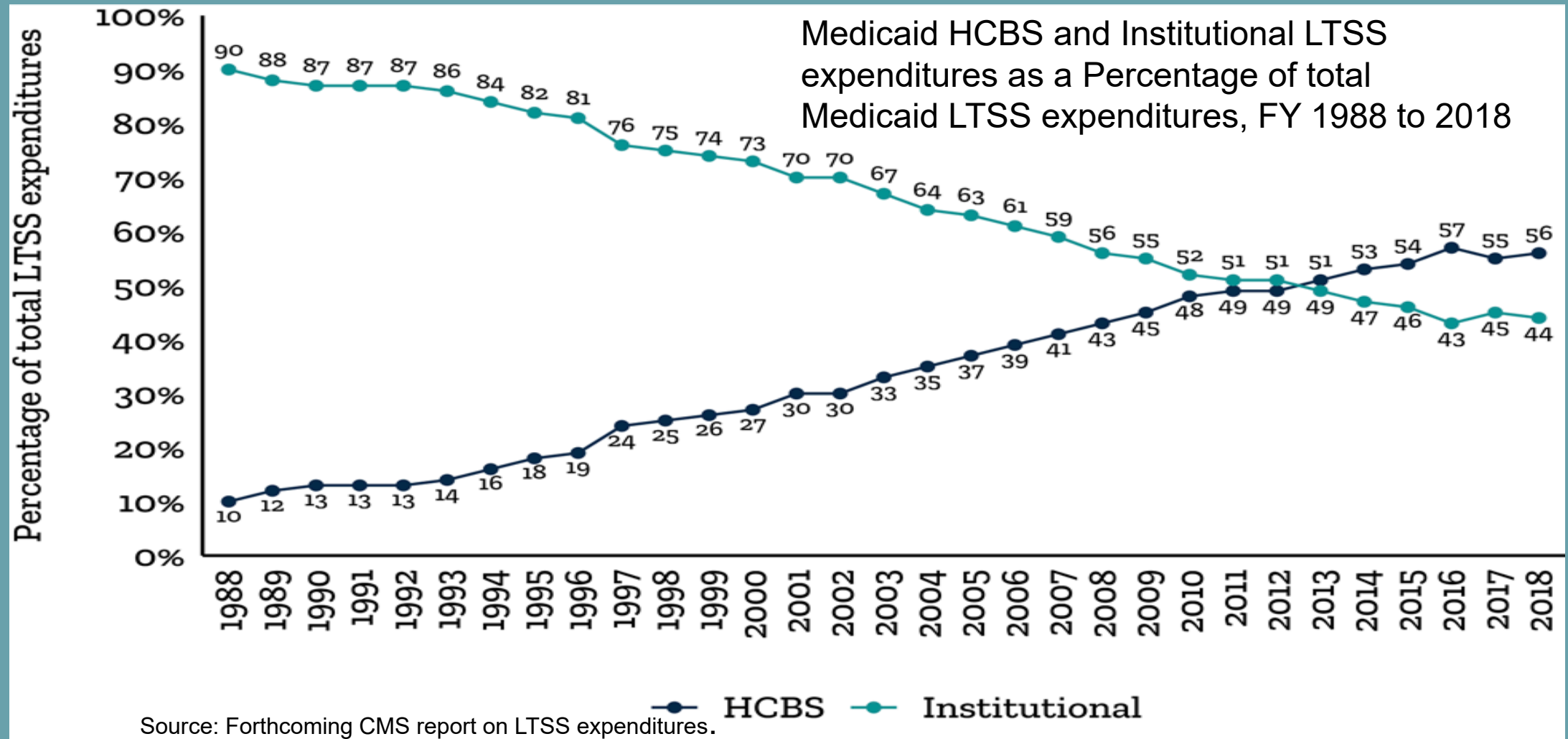
- \*Personal Care Assistance
- \*Case Management
- \*Home Modifications
- \*Personal Emergency Response Systems
- \*Family Support & Training
- \*Respite Care
- \*Assisted Living
- \*Home Delivered or Congregate Care Meals
- \*Home Health Services
- \*Home Safety Assessments
- \*Supported and Shared 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

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

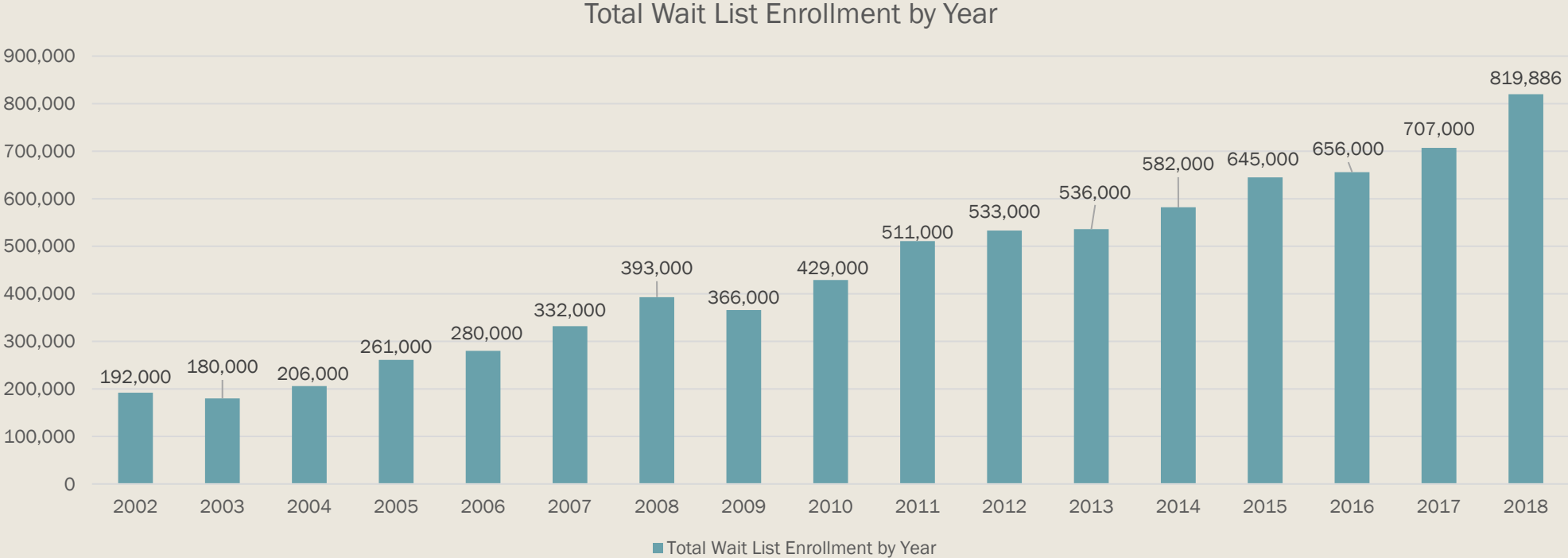
- 1990 – Americans with Disabilities Act (ADA), Title II, prohibits public entities from discriminating against individuals with disabilities in the provision of public services.
- “Integration Regulation” – Requires public entities to administer programs in the most integrated setting appropriate to 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.
- In *Olmstead*, affirmed that 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 others with mental disabilities.*



# Medicaid HCBS Expenditures Have Steadily Increased Over the Past Three Decades



# Growth in Medicaid HCBS Waiting List Enrollment 2002 – 2018



Source: Kaiser Family Foundation, Medicaid HCBS Program Surveys, 2002-2018

# Key Concepts in Understanding State Authority to “Draw Down” Federal Medicaid Dollars to Pay for Services 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
- **Federal Financial Participation or FFP** - The federal share of Medicaid spending.
- **Federal Medical Assistance Percentage or FMAP** – The formula used to determine the amount of a State’s FFP. It is based upon the average per capital income for each State relative to the national average.
  - *FMAP cannot be lower than 50%.*
  - *Some programs and services are eligible for enhanced FMAP rates.*
  - *FMAP for Administrative activities is capped at 50%.*

For every State dollar spent on an allowable service, the federal government will match it at the State’s FMAP rate.

# Medicaid Benefits and Programs that Support Community-based Services

## State plan benefits that include HCBS

- Home health
- Personal care services
- Case management and targeted case management
- Section 1945 Health Home

## HCBS authorities

- Section 1915(c)
- Section 1915(i)
- Section 1915(j) self-directed personal care services
- Section 1915(k) Community First Choice

## Research and demonstration programs

- Section 1115 demonstrations
- Money Follows the Person (MFP) demonstration

## Integrated care programs

- Programs for All-Inclusive Care for the Elderly (PACE)
- Accountable care organizations (ACOs)
- Integrated care for people dually eligible for Medicare and Medicaid

## Managed long term services and supports (MLTSS)

- Including those authorized under Section 1915(a) or 1915(b) waivers

## Medicaid administrative activities

- Partnership development
- Data and information technology

# 1915(c) Home and Community Based Services Waiver

## Who can be served?

- 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.

# 1915(c) Home and Community Based Services Waiver

## What Services can be Offered?

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

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



# 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(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 and implement an HCBS quality improvement strategy.
- Examples of Services offered: Transitional Case Management Services, Assisted Living, Adult Day Health, Behavioral Supports, etc.

# 1915(i) Benefits and Challenges

Benefits	Challenges
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	Financial risk - Difficult to contain costs due to prohibition on enrollment caps
Can provide coverage for specific services: adult day health, self-direction, housing supports	For non-institutional LOC, income limit of 150% FPL adds administrative complexity and limits coverage (especially for children or working adults)
Allows state to tighten criteria for institutional care without tightening access to HCBS	Cannot phase-in or limit geographic reach due to requirement to implement statewide
	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 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 provided 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 (MOE) requirement for first 12 months.
- Mandatory data collection and reporting, quality assurance system and development and implementation Council.

# 1915(k) Benefits and Challenges

Benefits	Challenges
Increased FMAP	Increased FMAP not sufficient to cover new costs associated with implementation, program expenditures and evaluation.
Allows states to consolidate programs and standardize eligibility and needs assessments	Does not eliminate need to maintain multiple HCBS programs
	Complex eligibility requirements
	Financial risk - Difficult to contain costs due to prohibition on enrollment caps
	Viewed as administratively burdensome

# 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 have 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
- Settings that do not meet HCBS settings rule standards are not eligible for Medicaid payments.

# HCBS Settings Rule

- **STATE COMPLIANCE DEADLINE** - For programs in existence on March 17, 2014 states had until March 17, 2019 to submit and receive approval of statewide transition plans. States must then submit settings subject to heightened scrutiny. Final Compliance was extended one year to March 17, 2023 due to COVID.
- **HEIGHTENED SCRUTINY DEADLINE** - Whether a setting subject to heightened scrutiny meets HCBS standards is determined by CMS based upon information presented by the state. Information must be submitted by October 31, 2021.

# Flexibilities Granted to States to Respond to COVID 19

- 1915(c) Waiver Appendix K amendments: Emergency Preparedness and Response and COVID 19 Addendum
- Demonstration opportunity under Section 1115(a) of the Social Security Act
- Medicaid State Plan Disaster Relief State Plan Amendment (SPA) under 1915(i) and 1915(k) benefits;
- Section 1135 Waiver

# COVID 19 Flexibilities Granted

- Modifications to services (i.e. add home delivered meals, assistive technology, allow telehealth, etc.)
- Modification to provider qualifications and/or enrollment process (i.e., allow other practitioners, payments to family etc.)
- Changes to eligibility and recertification to eliminate signatures and in-person requirements or delay/extend dates (i.e. for LOC determinations or recertification, etc.)
- Provide for Provider retainer payments and increase or modify payments
- Modify person-center planning
- Allow HCBS in institutional settings
- Waive settings and conflict of interest requirements or timelines for compliance

# 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.

# Opportunities – American Rescue Plan Act (ARPA)

- ARPA temporarily increases FMAP by 10 percentage points for specific HCBS expenditures from April 1, 2021 through March 31, 2022.
- Estimated additional funding for HCBS is \$34 billion dollars
- The increased FMAP is time-limited, and the federal fund equivalent must be spent by March 31, 2024.
- States may not reduce state HCBS spending as a result of higher federal funds.
- States must spend increased resources on efforts to enhance, expand or strengthen HCBS.

## ARPA Allowable Activities include:

Increase amount, duration, scope of HCBS services	Strengthening Assessment practices
New/Special Provider Payments and Rate Enhancements	Changes to Streamline Eligibility Systems
Provider Workforce Training/Recruitment/Support Activities	Expanding use of technology/telehealth
Quality Improvement/measurement/oversight initiatives	Conducting Care Surveys
Information Technology Implementation	Addressing Social Determinants
	Enhancing Care Coordination Infrastructure

# Challenges - Impact of Families First Coronavirus Response Act (FFCRA) and Unwinding of the PHE

- The Families First Coronavirus Response Act (FFCRA) authorize a 6.2% increase in FMAP for State Medicaid expenditures.
- In exchange, States were required to provide “continuous coverage” effectively ending requirements for annual redeterminations of eligibility during the Public Health Emergency.
- Medicaid enrollment has grown 16% - 81 million enrollees.
- The PHE Medicaid “continuous coverage” requirement has allowed people to retain Medicaid coverage and get needed care during the pandemic.
- When the PHE ends,\* States will have 12 months to complete an unprecedented number of redeterminations/renewals and resume normal processing of applications.
- States must also consider a host of policy questions and address the fiscal impacts.
- Presents huge challenge to States and significant risks to beneficiaries.
- Complicated by fact that the end date of the PHE continues to shift.



# Challenges - 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%.
- COVID 19 has exacerbated the direct care workforce shortage.

Source: 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.

# Additional Resources

- CMS LTSS Toolkit: <https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf>
- 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)
- HSBS Settings: State Responses to COVID 19- <https://www.medicaid.gov/medicaid/home-community-based-services/downloads/covid19-state-implications-reactions-innovations.pdf>
- Kaiser Family Foundation, Key State Policy Choices About Medicaid Home and Community-Based Services, Feb. 4, 2020, <https://www.kff.org/report-section/key-state-policy-choices-about-medicaid-home-and-community-based-services-appendix-tables/>
- Information on State ARPA Plans: <https://www.medicaid.gov/medicaid/home-community-based-services/guidance/strengthening-and-investing-home-and-community-based-services-for-medicaid-beneficiaries-american-rescue-plan-act-of-2021-section-9817-spending-plans-and-narratives/index.html>
- Advancing States Analysis of States ARPA Spending Plans: <http://www.advancingstates.org/slider/advancing-states-analysis-state-arpa-spending-plans>

Questions?

# Medicaid Managed Care and Managed Long Term Services and Supports (MLTSS)

Jennifer Vermeer

HCBS Conference: Medicaid 101 Intensive

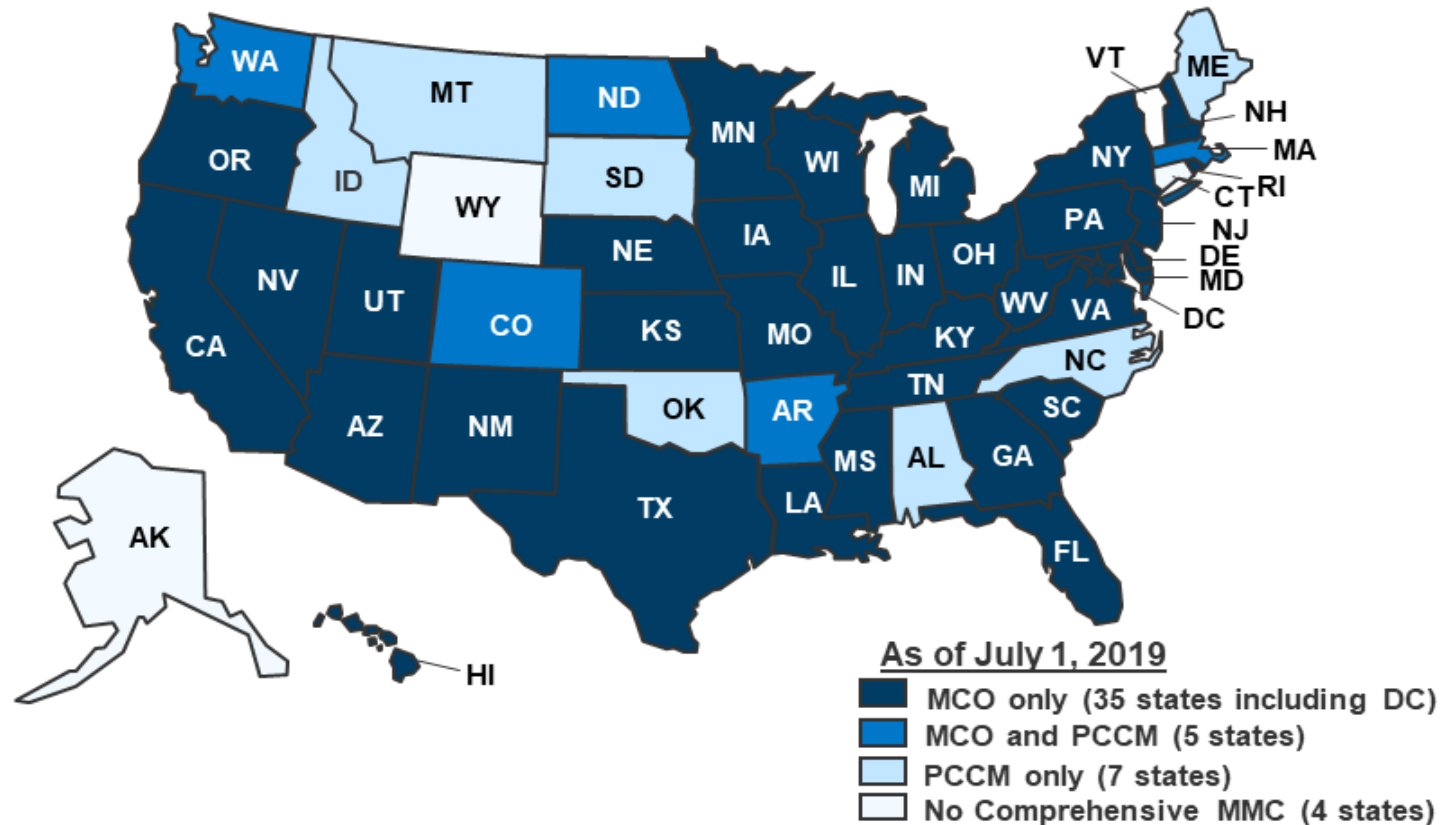
December 7, 2021

# Medicaid Managed Care

- Capitated managed care is the predominant delivery system now employed by state Medicaid programs
  - 40 states utilize comprehensive risk-based managed care organizations (MCOs) to provide services
  - 33 of these 40 states had more than 75% of their Medicaid beneficiaries enrolled in MCOs as of July 1, 2019.
  - Other variants of Medicaid managed care models include limited benefit prepaid health plans (e.g. behavioral health, dental PHPs) and state primary care case management (PCCM) programs
- Over time, States have expanded managed care to include additional populations (e.g. aged, blind, and disabled; ACA expansion populations, kids with special needs) and carve-in additional services (e.g. behavioral health; long term services and supports)

Figure 2

# Comprehensive Medicaid Managed Care Models in the States, 2019



NOTES: ID's Medicaid-Medicare Coordinated Plan has been recategorized by CMS as an MCO but is not counted here as such since it is secondary to Medicare.

SC uses PCCM authority to operate a small, children's care management program and is not counted here as a PCCM.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.



# Medicaid Managed Care vs. Fee for Service

Distinguishing features of the two delivery systems:

- Freedom of Choice
- Comparability of Services
- State-wideness
- Provider Payment Methodologies
- Administrative Functions
- Regulatory Framework

# 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 stand-alone 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.



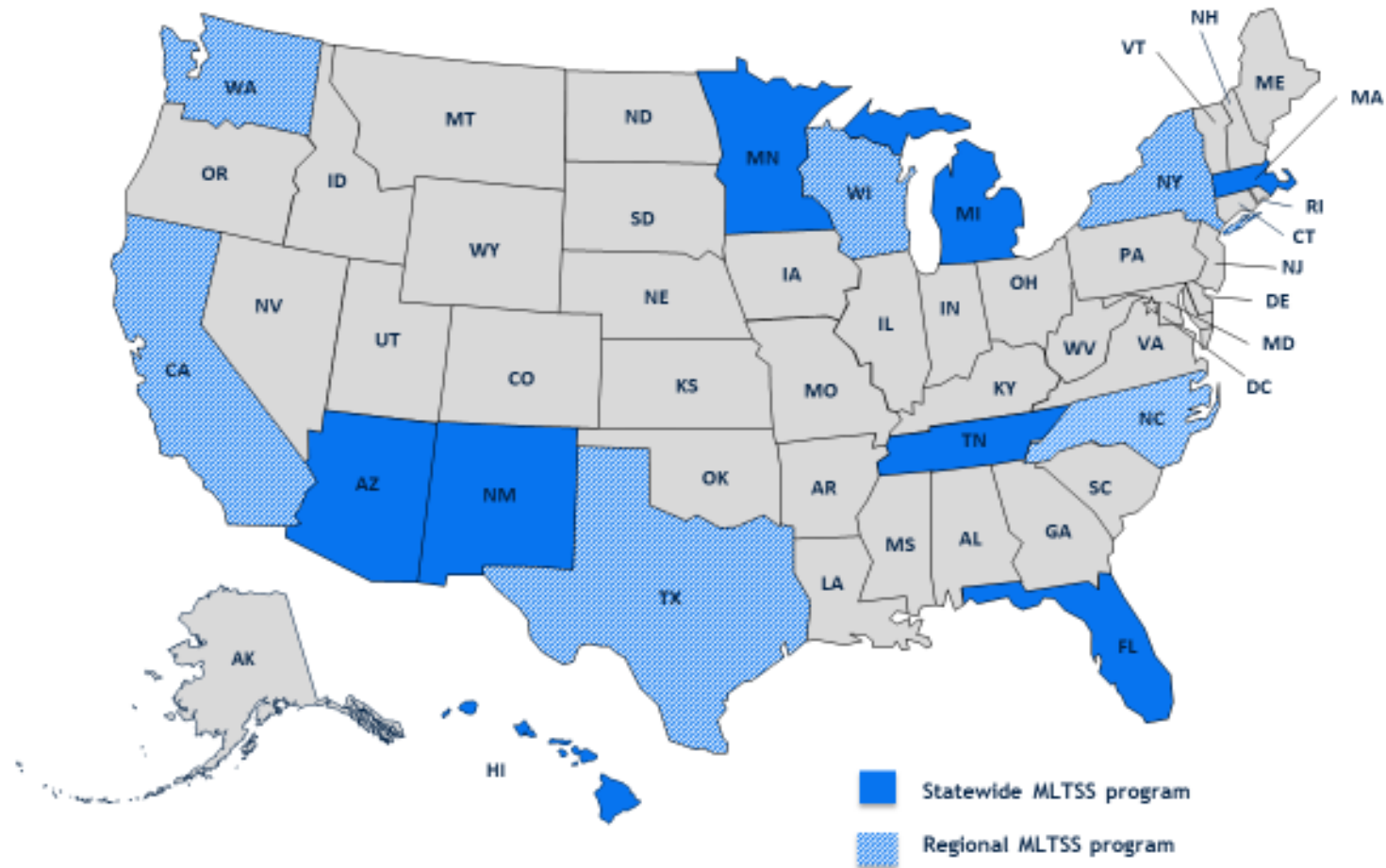
# What is Covered?

- States using MLTSS vary widely in the number and types of LTSS included under the managed care capitation.
- A 2018 Mathematica interim 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.

# MLTSS Adoption

- 25 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; ADvancing States 2020).
- 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 more than 20 years.

# MLTSS Footprint in 2010

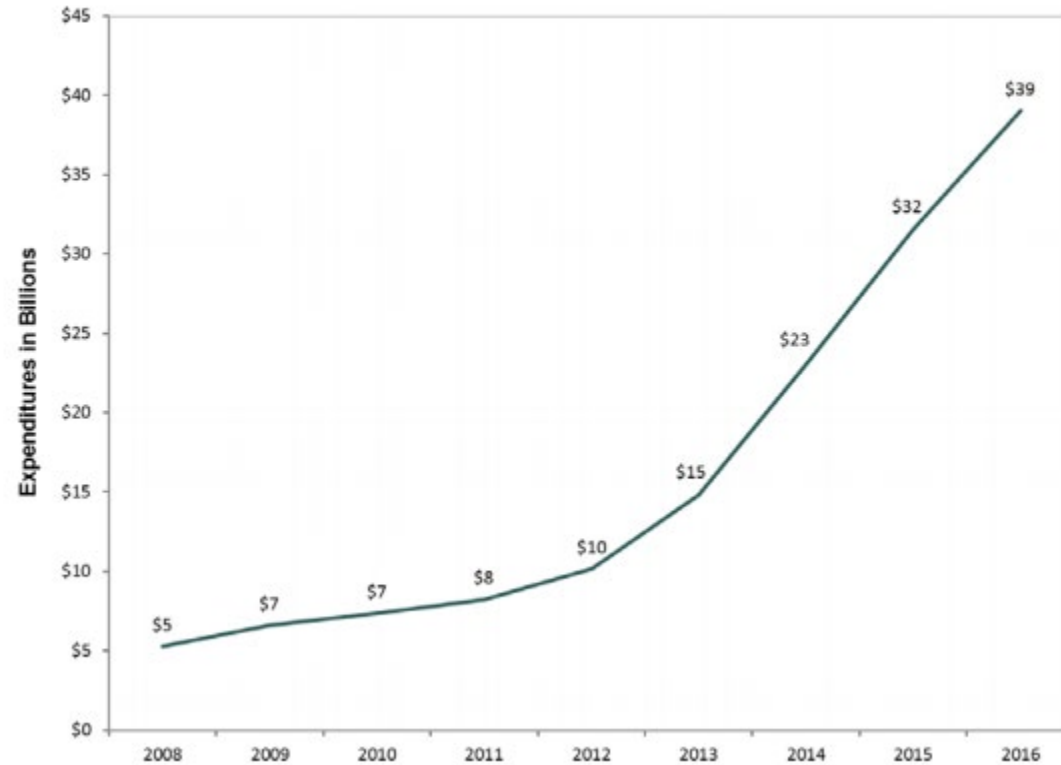


Source: Truven Health Analytics, 2012



# MLTSS Expenditures

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



# States' Goals for MLTSS

- States implement MLTSS for a variety of reasons. In a survey of 12 states with MLTSS (Dobson et al. 2017), 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); and
  - Providing budget predictability and potentially containing costs via rebalancing, efficiencies, and improved quality (7 states)

# Promoting Rebalancing Through MLTSS

- Blended rate for nursing facility and HCBS
- Pay for Performance programs that incent HCBS utilization and/or penalize increased NF utilization
- Contract Provisions that encourage innovation in housing-related activities and other supports
- Housing Transition and Tenancy Sustaining Services
- Service Coordinators to help members with diversion, transition and relocation
- Money Follows the Person

# 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



# Federal Programmatic Requirements

- MLTSS plans must adhere to the same regulations as other Medicaid managed care plans, as well as additional requirements related to MLTSS.
- 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 a substantial update of MCO regulations in 2016. 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, as well as the 2014 HCBS final rule, 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, a beneficiary support system to provide enrollment counseling and access point for complaints or concerns related to MLTSS, as well as member education on grievance and appeals;
  - 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. States required to ensure an adequate provider network and establish minimum credentialing and re-credentialing policies for all providers, including LTSS. Network providers must have capabilities to ensure physical access, reasonable accommodations, and accessible equipment for enrollees with physical and mental disabilities;
  - Participant protections. Managed care plans required to participate in state efforts to prevent, detect and remediate all critical incidents and safeguard beneficiaries from abuse, neglect, and exploitation; and
  - Quality metrics that take into account outcomes related to LTSS, including HCBS rebalancing and mechanisms to assess the quality and appropriateness of care, incorporated into MLTSS quality assurance and program improvement programs.

# Options for States to Integrate Care for Duals

- More than 12 million individuals enrolled in Medicaid and Medicare. These dually eligible individuals experience high rates of chronic illness, with many having long-term care needs and social risk factors. Forty-one percent of dually eligible individuals have at least one mental health diagnosis, 49 percent receive long-term care services and supports (LTSS), and 60 percent have multiple chronic conditions.
- Dually eligible individuals must navigate two separate programs: Medicare for the coverage of most preventive, primary, and acute health care services and prescription drugs, and Medicaid for the coverage of LTSS, certain behavioral health services, and Medicare premiums and cost-sharing.
- Dual eligible individuals account for a disproportionate share of Medicaid and Medicare expenditures – 15% of Medicaid population and 33% of the costs; 20% of Medicare population and 34% of the Medicare program costs
- Goal: Full Integration of Medicaid and Medicare services to meet the needs of dual-eligible individuals
- Several options available to States to accomplish this goal

# 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, RI, SC, TX
    - 402,000 enrollees as of October 2020
  - Managed Fee For Service
    - WA state already demonstrated significant savings through their Health Homes-based model

# Options for States to Integrate Care for Duals

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

- Nearly 3 million enrollees nationally in these Medicare Advantage plans for dual eligible beneficiaries (including FIDE enrollees)
- Opportunities to leverage D-SNPs to provide more integrated care
- Separate Medicaid and Medicare funding streams
- D-SNPs required to sign MIPPA contracts with state Medicaid agencies to operate
- 42 states have D-SNPs

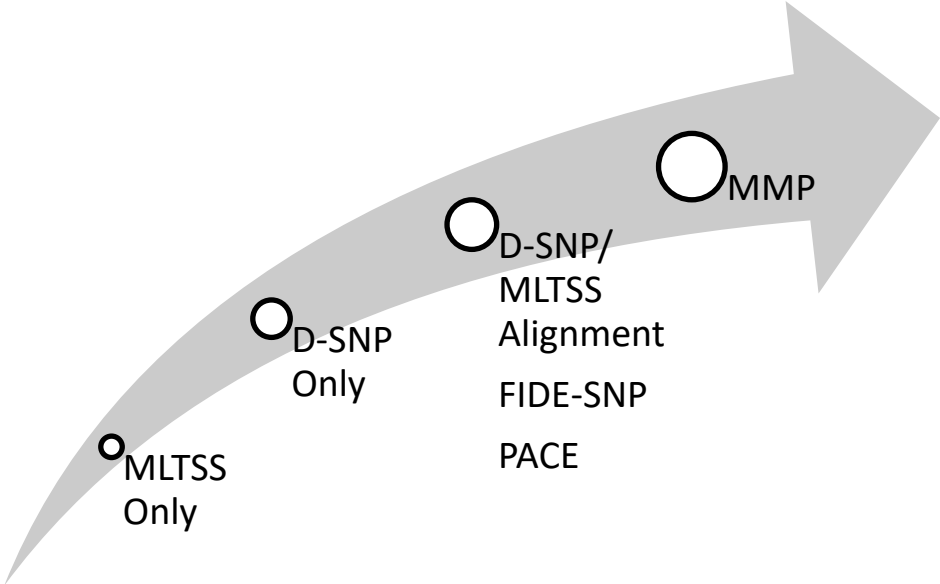
## **Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)**

- 285k 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: AZ, ID, MA, NJ, WI

# Options for States to Integrate Care for Duals

- **Program for All-Inclusive Care (PACE)**
  - Center-based program for adults over 55 who need NF level of care. Members receive all services through PACE provider
  - PACE provider receives capitation payment from Medicare and Medicaid and is at risk for the provision of services
  - As of October 2020 – sites in 31 states served 49,717 enrollees

# Medicaid/Medicare Integration





# The Future of MLTSS

- Development of LTSS quality metrics – In 2019 CMS released several new quality metrics for use by MLTSS plans related to topics such as assessment and care planning and successful transitions from long term care facilities
- Improved data -- To better understand and expand best practices related to MLTSS
- Increasing alignment of Medicaid MLTSS with D-SNPs
- Washington State Managed Fee for Service program may provide an alternative pathway for states to better integrate care for dual eligibles

# Current Hot Topics in Medicaid

December 7, 2021



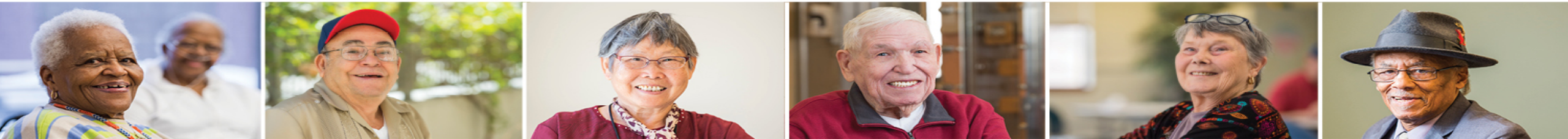
# An Ever-Changing Program

- COVID-19 and all of its variants
- Identification and use of resources for HCBS
  - Telehealth
  - Staffing incentives
- Funding focus on HCBS
- Innovation priorities
- COVID-19 Flexibilities: What Stays?



# Funding Focus on HCBS: ARPA

- 10% Increase to HCBS FMAP
- States must submit plans to the Federal Government (CMS) on how to spend the money
- Key themes in plans include:
  - Provider rate increases/bonuses
  - Recruitment/retention incentives
  - Training and outreach
  - Increased/expanded services



# Funding Focus on HCBS

- Biden “Build Back Better” proposal included \$400 billion for HCBS
- Build Back Better reconciliation bill has reduced the funding to ~\$150 billion
- Provides 6% FMAP increase to all HCBS in perpetuity
- Significant requirements placed on states to qualify for the funds



**Carol H. Steckel, MPH**

Executive Vice President, Government  
Relations

[Csteckel@myinnovage.com](mailto:Csteckel@myinnovage.com)



## **Mission**

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**sustain and enhance the independence and  
quality of life on their terms  
for those we serve**

# THANK YOU!

Thank you!

- We hope you enjoyed the day

See you tomorrow!

- Have a great rest of the conference!