



9/2/2015

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# **Everything you wanted to Know about Medicaid....**

But were afraid to ask.

2015 HCBS Preconference Intensive  
August 31, 2015  
Washington, DC

# Contents

- Section 1: Overview & History of Medicaid
- Section 2: How Medicaid is Administered
- Section 3: Overview of Eligibility
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- Section 7: Managed Care and LTSS

# Learning Objectives

- Improve knowledge of key features, terminology, and concepts underlying Medicaid;
- Understand Medicaid's key policy, fiscal, and operational components;
- Increase knowledge of Medicaid's LTSS coverage and options;
- Understand Managed Care and Managed LTSS; and
- Provide a solid foundation for HCBS conference attendees to get the most out of Medicaid and LTSS sessions.

# Key terminology

- ACA - The Affordable Care Act
- ADA - The Americans with Disabilities Act
- CMS- Centers for Medicare and Medicaid
- EPSDT- Early Periodic Screening, Diagnostic, and Treatment
- FMAP- Federal Medical Assistance Percentage
- FPL- Federal Poverty Level
- HCBS - Home and Community-Based Services
- HHS- U.S. Department of Health and Human Services
- LTSS- Long-Term Services and Supports
- MCO- Managed Care Organization
- MLTSS- Managed LTSS

# 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;
- Intended to be a health plan for low-income individuals on welfare;
- Does not provide the care – pays medical professionals (providers) to deliver the care;

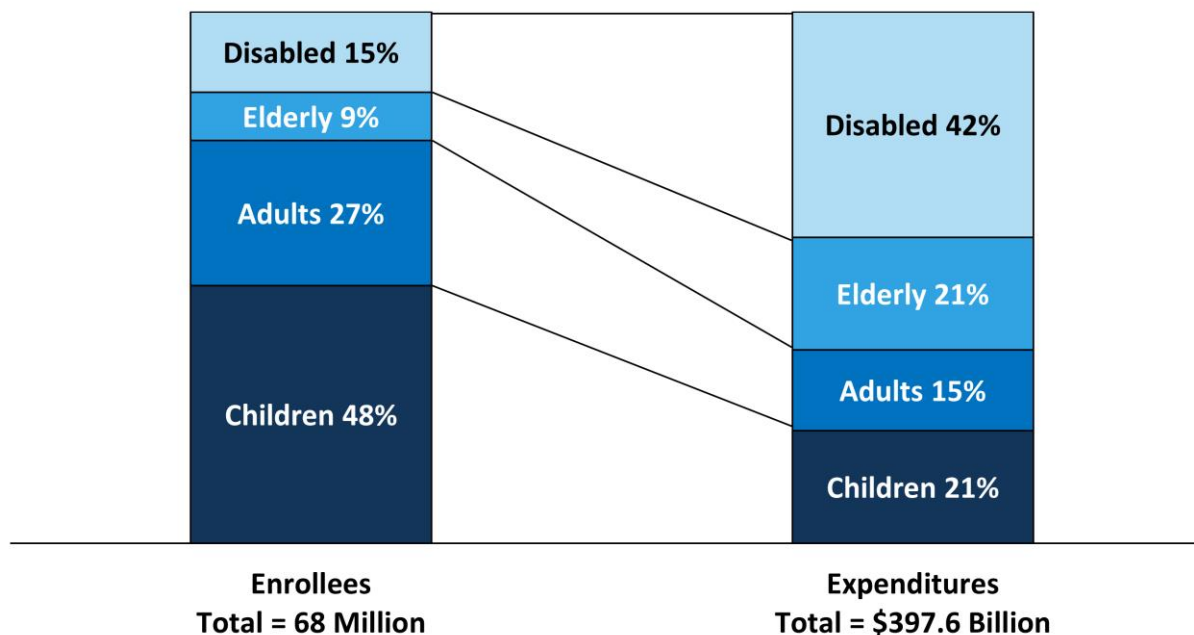
# Medicaid Overview

- 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 FY2014, \$494 billion dollars were spent on the Medicaid program in the states & territories;
  - 15.1 percent of U.S. health care spending in 2012
- Roughly one fifth of all Americans are covered by Medicaid.

# Medicaid Enrollment & Expenditures

Figure 2

## Medicaid Enrollees and Expenditures, FY 2011



SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, TX, UT, OK but adjusted to 2011 spending levels.





# Medicaid Enrollment & Expenditures

- As the previous chart illustrates, the number of enrollees by a specific subgroup *do not* necessarily line up with their share of expenditures.
- Enrollees with disabilities – and to a lesser extent the elderly – make up 42 and 21 percent of expenditures, respectively.
- Meanwhile, the disabled constitute a mere 15 percent of the Medicaid population, and the elderly only 9 percent.

# How Medicaid is Administered

## Medicaid Governing Policy

- Medicaid is funded and administered jointly by the Federal Government and states.
- The Federal Government establishes rules and parameters for the program.
- Primary direction is provided through statute and regulation:
  - Social Security Act (Title XIX);
  - Code of Federal Regulations (Title 42)
- The Centers for Medicare and Medicaid Services (CMS) also issues other guidance to states:
  - State Medicaid Director's Letters;
  - State Health Official Letters;
  - Informational Bulletins; and
  - Frequently Asked Questions (FAQs).

# 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.

# The Medicaid State Plan

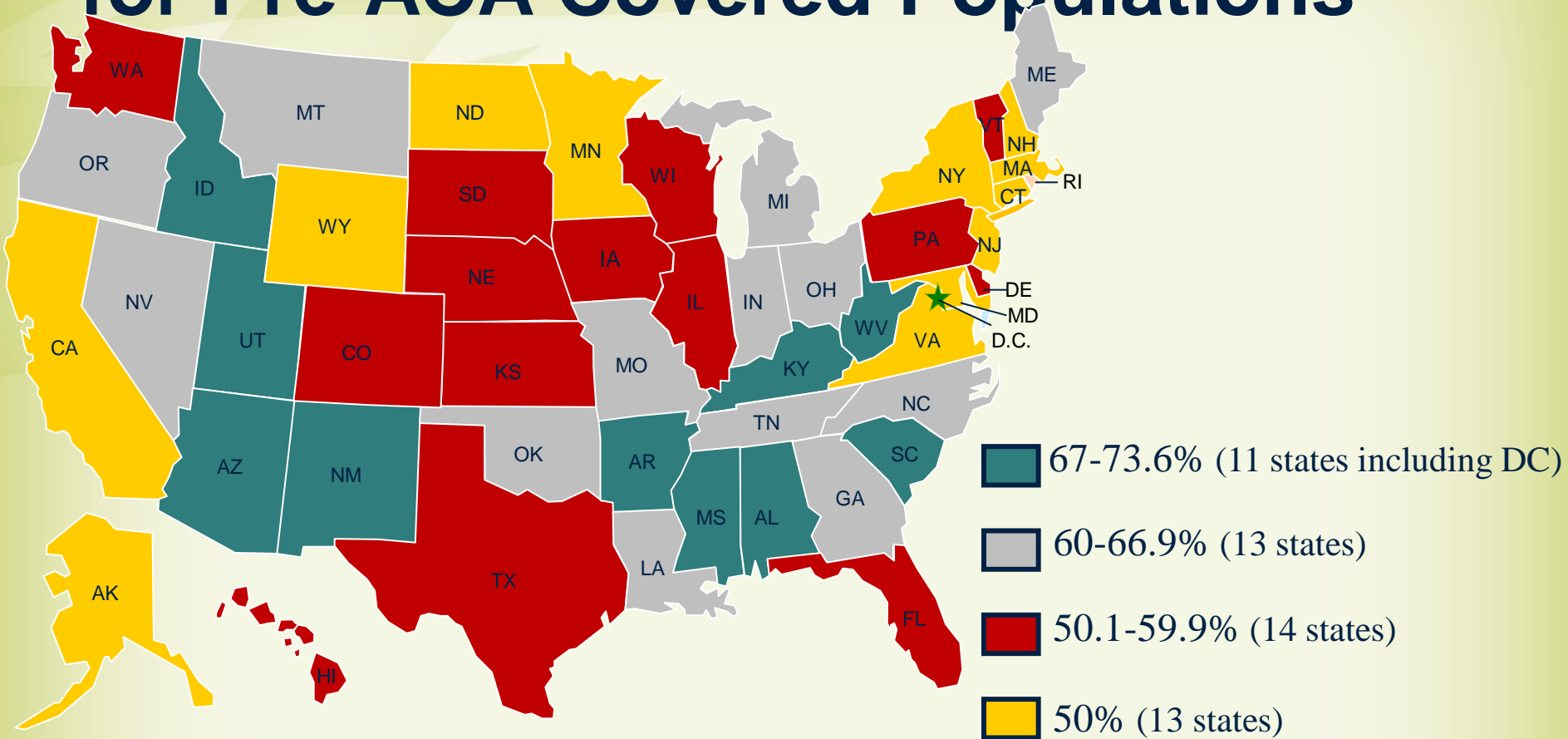
- Every state must have an approved “Medicaid State Plan” that describes its program; the program must be operated according to the State Plan.
- Among other components, state plans include:
  - Groups of individuals to be covered;
  - Services to be provided;
  - Methodologies for providers to be reimbursed; and
  - Administrative activities.
- States must submit and receive approval of a “State Plan Amendment” (SPA) to change how its Medicaid program is operated.

# Medicaid Financing

- HHS calculates a “Federal Medical Assistance Percentage” (FMAP) – the Federal share of any medical costs paid by Medicaid;
  - Different for each state;
  - Based upon per capita income of residents;
  - Minimum of 50% & Maximum of 82%;
    - Average FMAP across the U.S. is 57%. (not including ACA enhanced match rate)
  - Adjusted on a 3-year cycle, and published annually
- All states receive a 50% match for administrative costs.
- Certain other expenses, such as information systems and family planning, receive higher match rates.



# Federal Matching Funds (FFY 2015) for Pre-ACA Covered Populations



Source: Kaiser Commission on Medicaid & the Uninsured, "Medicaid Moving Forward," March, 2015

# ACA Financing of Medicaid Expansion Population

- For newly eligible individuals, states will receive 100% federal funding in 2014-2016; 95% in 2017; 94% in 2018; 93% in 2019; and 90% in 2020 and subsequent years.
- For those previously enrolled, as well as those eligible but not enrolled, states receive pre-ACA federal match funding.

HealthCare.gov

Medicaid.gov  
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# Sources of State Funding to “Draw Down” Federal Financing

- 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; and
  - Certified Public Expenditures.
- CMS verifies that state funding sources meet statutory and regulatory requirements prior to authorizing FMAP payments.



# Role of Providers

- Medicaid contracts with a broad range of providers to care for beneficiaries, including: hospitals, skilled nursing facilities, health centers, physicians, dentists, behavioral health providers, pharmacists, home health providers, durable medical equipment providers, laboratories, transportation, and others.
- Providers must meet state and federal licensing/contracting/enrollment requirements, and adhere to Medicaid program participation guidelines.
- Providers may contract directly with the state or Medicaid managed care organizations (MCOs).
- Depending on the type of service being rendered, reimbursement may be fee-for-service, capitation, an hourly or daily rate, or other payment method.





# Role of Beneficiaries, Families and Advocates

- Beneficiaries
  - Must provide sufficient documentation to meet Medicaid eligibility requirements (e.g., citizenship and identity, income, other assets, health/disability status, etc.)
  - Must also report certain changes in circumstances such as income, household residents, place of residence, etc.
  - Comply with Medicaid/MCO participation requirements, including enrollment procedures, coordination of benefits, applicable cost-sharing provisions, program integrity activities, etc.



# Role of Beneficiaries, Families and Advocates

- Families

- Support and assist beneficiary as appropriate in understanding and complying with Medicaid participation requirements.
- When possible, provide care or other support to allow beneficiary to remain at home rather than receive care in an institutional setting.



- Advocates

- Provide advocacy on a population-wide or individual basis to help beneficiaries navigate Medicaid program.
- May assist beneficiaries in appealing adverse decisions.
- Advocate for improvements in Medicaid benefits, eligibility levels, program administration, etc. with Medicaid agency, Governor's Office and legislature.



# 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 101: Overview Of Eligibility & Coverage of Services



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Ann Kohler, Director Medicaid Practice, Marwood Group

# Medicaid Eligibility

- **Categorical Eligibility** – people must fit into a pre-defined group of individuals:
  - Children;
  - Parents;
  - Pregnant women;
  - Seniors;
  - People with Disabilities; and
  - Childless, non-elderly, adults (ACA expansion)
- **Income Eligibility** – people must also have income below defined limits, usually set by Federal Poverty Level (FPL)
- **Medically Needy Eligibility** – individuals can become Medicaid eligible if they spend their own money on health care expenses (Spend-down)



# Medicaid Eligibility: Mandatory And Optional Groups

- **Mandatory Groups:**
  - Categorical Groups that a State must include if they participate in Medicaid;
  - Over 25 mandatory groups, including:
    - Supplemental Security Income (SSI) eligible (except in 209(b) states);
    - Children 0-5 below 133% FPL; and
    - Children aging out of foster care until age 26
    - Low-income Medicare beneficiaries (not full Medicaid services).
- **Optional Groups:**
  - Groups that a State can choose to include;
  - Includes all Medically Needy Groups;
  - Over 25 optional Categorical groups, including:
    - Medicaid Buy-ins;
    - Affordable Care Act (ACA) expansion;
    - Higher income eligibility for Medicaid categories.





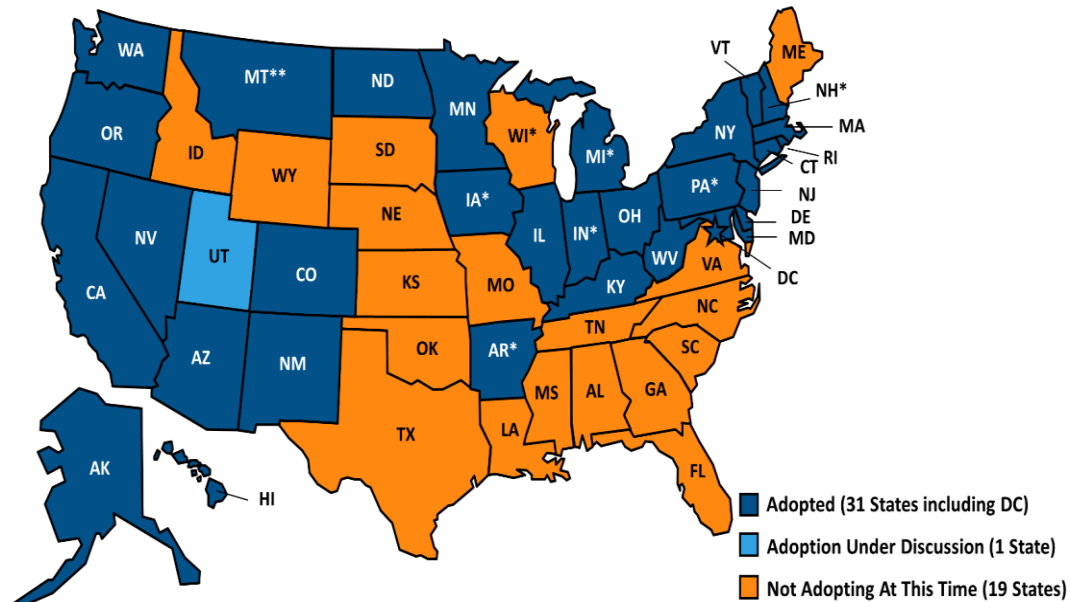
# ACA Changes

- ACA expanded Medicaid eligibility to childless adults and raised eligibility to 138% FPL, and eliminated asset tests
- ACA also changed how income is counted moving to modified adjusted gross income (MAGI)
  - All States must move to MAGI
- Supreme Court rules the eligibility expansion could be at state option
- ACA simplified the eligibility process
  - Electronic verification of income
  - No wrong door



# Current Status of State Medicaid Expansion

## Current Status of State Medicaid Expansion Decisions

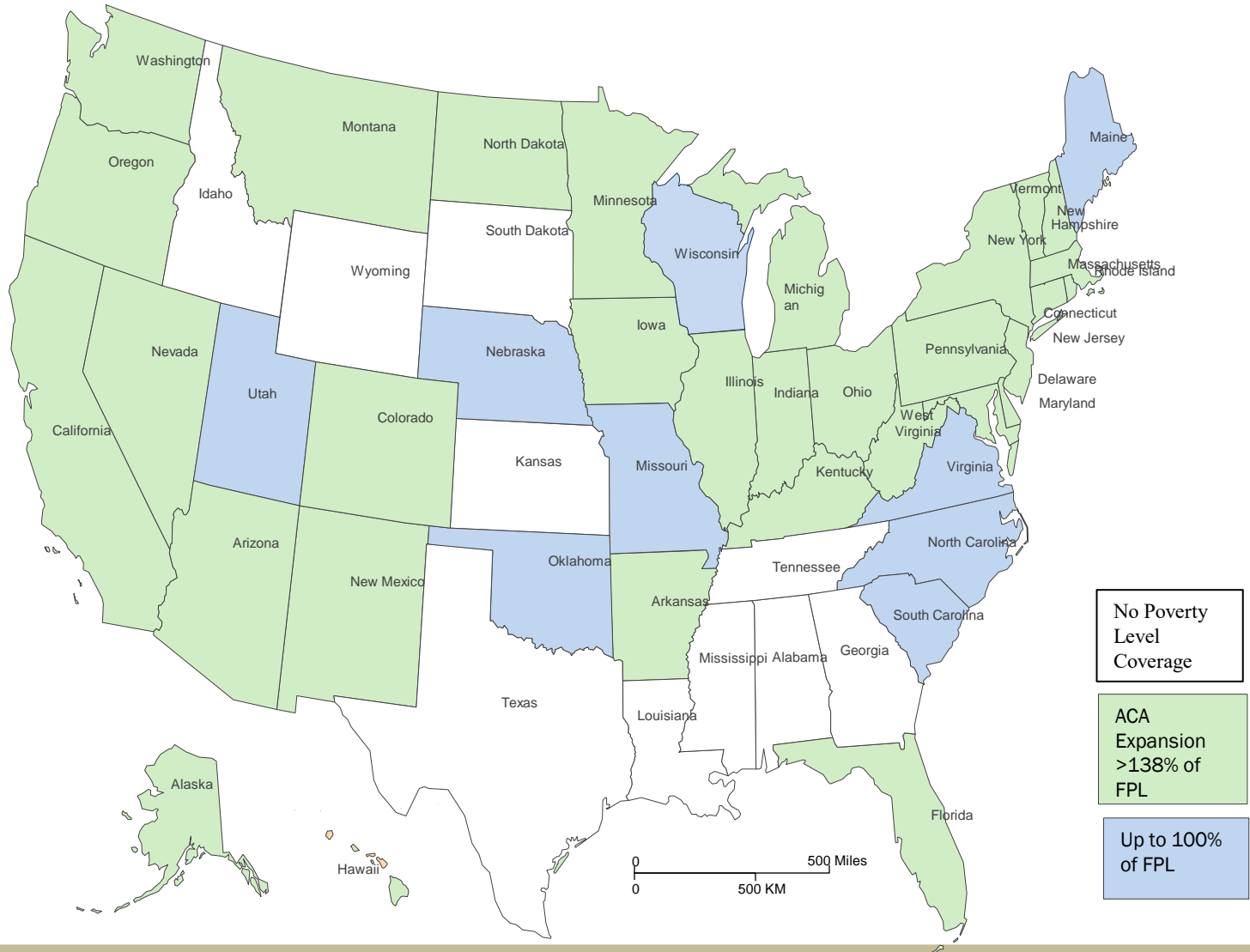


NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. \*\*MT has passed legislation adopting the expansion; it requires federal waiver approval. \*AR, IA, IN, MI, PA and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated July 20, 2015.  
<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



# Distribution Of States With Poverty Level Coverage



# SSI And 209B States

## Most states follow Social Security rules for aged and disabled

- States choose between following Federal Rules (1634 states) or developing their own rules (209b states)
- ACA changes do not affect the eligibility rules for aged and disabled and asset limits remain
- Federal SSI are set annually but states may also add a state supplemental amount which raises eligibility level
- Many states cover aged and disabled up to the federal poverty level





# Eligibility Levels for Long Term Care

- **States may have higher eligibility levels for long term care**
  - Many states use 300% of the federal SSI level for long term care eligibility- both institutional and HCBS
  - Some states, which do not have a medically needy program use the Special Income Rule (Miller Trust) to qualify individuals for long term care
- ACA extended spousal impoverishment protections recipients of Home and Community Based Waivers





- **Mandatory services include:**
  - Hospital services & Nursing homes;
  - Physician Services, nurse practitioners;
  - X-rays, clinics, lab services
  - Free standing birth centers
  - Tobacco cessation for pregnant women
- **Optional services include:**
  - Prescription Drugs;
  - Dental;
  - Case Management;
  - Rehabilitation;
  - Personal Care.
- **Other considerations:**
  - If a person has other coverage (such as Medicare or private insurance), Medicaid only pays for services not provided through the other coverage;
  - Medicaid often assists with copays/premiums associated with other coverage.





# Medicaid Services

- Once a person comes into Medicaid, they have access to all of the services that the state covers and are medically necessary;
- Services must be statewide, comparable, delivered with reasonable promptness, and allow individuals to choose providers;
- States can define the “amount, duration and scope” of services to reasonably achieve their purpose;
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT): Children under 21 can get all medically necessary optional and mandatory services, regardless of whether the state covers them for other individuals.



# Medicaid Waivers

- Waivers consist of Federal statutory authority given to CMS to exempt states from certain Medicaid requirements, including state-wideness, freedom of choice, and comparability
- Not an “entitlement” – 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

# Medicaid Waivers

- 1115 Waivers provide broad flexibility:
  - Can expand coverage to “non-categorical” groups;
  - Can implement managed care;
  - Can obtain federal matching funds for otherwise non-Medicaid state expenses;
  - Can test new service-delivery methods.
- 1915(b) Waivers:
  - Can limit which providers individuals can choose from;
  - Allows states to enroll people in managed care.
- 1915(c) Waivers:
  - Provide Home and Community-Based Services (HCBS), including:
    - Habilitation;
    - Transportation;
    - Personal Care.
  - Allows states to create a robust service package for individuals with an institutional level of care.

# New Class of Federal Waivers: 1332s

	SSA Section 1115 Waivers	ACA Section 1332 Waivers
<b>Scope</b>	<ul style="list-style-type: none"> <li>▪ Medicaid</li> <li>▪ CHIP</li> </ul>	<ul style="list-style-type: none"> <li>▪ Health Insurance Marketplace structure</li> <li>▪ Essential benefits</li> <li>▪ Subsidies, mandates and penalties</li> <li>▪ <i>Other federal health care laws*</i></li> </ul>
<b>Key Requirements</b>	<ul style="list-style-type: none"> <li>▪ Federal budget neutrality -- within Medicaid and CHIP only</li> <li>▪ CMS policy, e.g., beneficiary protections, source of state matching funds, etc.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Federal budget neutrality -- potentially across programs</li> <li>▪ No loss in coverage benefits nor consumer affordability</li> <li>▪ CMS policy?</li> </ul>
<b>Common Uses</b>	<ul style="list-style-type: none"> <li>▪ Coverage expansions</li> <li>▪ Financing alternatives</li> <li>▪ Delivery system transformation</li> </ul>	<ul style="list-style-type: none"> <li>▪ TBD</li> </ul>
<b>Effective Date</b>	<ul style="list-style-type: none"> <li>▪ 1965</li> </ul>	<ul style="list-style-type: none"> <li>▪ <b>January 2017</b></li> </ul>

\*Coordinated Waiver Process: Section 1332 also includes language allowing the HHS Secretary to consolidate 1332s, 1115s and “any other Federal law relating to the provision of health care items or services.”

# Medicaid Rate-Setting

- Process: Most rates are set by formula or amount in a “state plan amendment,” i.e., a change in the state’s CMS-approved plan governing use of Federal matching payments
- Requirements: Federal law requires rates to be sufficient to generate access on a par with general population (*SSA Section 1902(a)(30)(A)*)
  - That same federal law also requires that “payment” secure quality services and provoke efficient use of services
  - Supreme Court recently determined that providers do NOT have legal standing to challenge state payment rates against this federal standard
- Fee for service: Traditional approach to payment was to reimburse for each bit or piece of health care used, i.e., a fee for every service.
  - For pregnancy that could include multiple prescriptions (and fills), a hospital stay, and physician’s services for delivery, prenatal and post-natal visits
- Drugs: “Rate-setting” for prescription drugs entails setting reimbursement formulas for local pharmacies, federally-mandated manufacturer rebates and sometimes a state-negotiated rebate as well
- Institutions: Some hospitals and nursing homes receive lump-sum “supplemental” payments not directly tied to individual services
- Reform: Revisiting the “fee for service” approach has risen to the top of State Medicaid program agendas....

# Value-Based Purchasing

- Goal might be expressed as paying for ***the real or valued product*** (e.g., quality, health outcome, total package of all related care) independent of the number or type of services provided
- Entails pulling together a *collection of services* for combined payment or calculation of incentives
- These collections vary, and each implies a different health-related ***product***
  - Which services included?
  - Which providers included?
  - What time frame included?
  - How is quality factored into payment?
- Lingo: “New Payment Models” v. “Deliver System Redesign”
  - Payments go to those who deliver a service – or package of services
  - Payment innovations that redefine a package of services often directly entail a new model of service delivery
  - These innovations are known *both* as new delivery models *and* new payment models

# New Payment Models (and Delivery System Redesigns)

- Managed care organizations
  - single monthly payment for all services for each enrollee
  - encompasses geographic regions or full states
- Accountable care organizations
  - single monthly payment for all medical services for each assigned patient
  - encompasses patients of a particular health system
- Patient-centered medical homes
  - monthly supplemental payment **and/or** periodic incentive payment
  - supports enhanced primary care, prevention and care coordination
  - encompasses total medical spend for all of a doctor's patients
- Health homes
  - monthly supplemental payment to a provider or care coordinator
  - supports coordination of medical, behavioral and/or long-term care
  - encompasses some combination of care for all of a provider's patients
- Episode-based payments
  - bundled/combined payment or retrospective incentives
  - supports coordination of medical, behavioral and/or long-term care
  - encompasses all condition-related care for all of a provider's patients



# Medicaid Payment Integrity

- Default standard for a proper Medicaid payment
  - Approved service
  - Approved rate
  - Eligible provider
  - Eligible beneficiary
  - ...all sufficiently documented
- External review and audit authorities
  - Medicaid Fraud Control Units (State Attorneys General)
  - State auditors (e.g., legislative, agency, State inspectors general)
  - CMS
  - Federal HHS Office of Inspector General
  - Law enforcement (e.g., prosecutors)
- Internal process and approach
  - Accountability for all payments accrues to the single state Medicaid agency
  - Agency investigators, auditors, compliance and program staff
  - Payment Error Rate Measurement (PERM)
  - MMIS-related Surveillance and Utilization Review System (SURS)
  - *Identifying patterns and developing policy options....*



# Medicaid Payment Integrity

- *Core concepts (not formal definitions)*
  - *Fraud: intentionally improper claims*
  - *Waste: proper but unnecessary claims*
  - *Abuse: intentionally wasteful claims*
- **Core activities**
  - Detection, documentation, disallowance and collection
  - Pattern recognition
  - Referral
  - Avoidance and prevention
- **Overarching aim**
  - **relentlessly pursue sources of errors** (both internally and externally)
  - sustainably remediate errors through appropriate **prevention and recovery** interventions
  - **continually improve** over time

# MEDICAID LONG TERM SUPPORTS AND SERVICES

**JERRY DUBBERLY, PHARMD, MBA**

DEDICATED TO GOVERNMENT HEALTH PROGRAMS





## ■ MYERS AND STAUFFER LC

- Company organized in 1977
- Work exclusively with state/federal agencies operating public health care programs
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#### Extensive Experience with Multiple Provider Categories

- Long-Term Care Facilities
- Hospitals
- Pharmacy
- Home Health Agencies
- Physicians
- Dentists
- Hospice
- FQHC, RHC
- Developmental Disability Providers
- Health Care Delivery System & Payment Transformation
- Fraud and Abuse Detection
- Recovery Audit Contractor
- Managed Care Consulting
- Payment Error Rate Measurement
- WIC Audit
- EHR Audit
- DOJ Fraud Investigations



## ■ TOPICS

- Overview of Medicaid Long Term Supports and Services
- LTSS Authority Options
  - State Plan
  - Waivers
- Deinstitutionalization



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## ■ OVERVIEW OF MEDICAID LTSS



## ■ MEDICAID LTSS

- Includes *Institutional Care* and *Home and Community Based Long Term Services and Supports*
- Services may be defined through state plan authority, waiver authority, or a combination
- Medicaid is the primary payer of LTSS



## ■ LTSS EXPENDITURES

- 2013 National LTSS Expenditures = \$310 Billion\*
- 2013 Medicaid LTSS Expenditures = \$146 Billion\*\*
  - \$71 Billion– Institutional Services
  - \$75 Billion – Home and Community Based Services
- 51.3% of total LTSS spending was on HCBS

\* Source: KCMU Estimate Based on CMS National Health Expenditure Accounts Data for 2013

\*\*Source: <http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf>





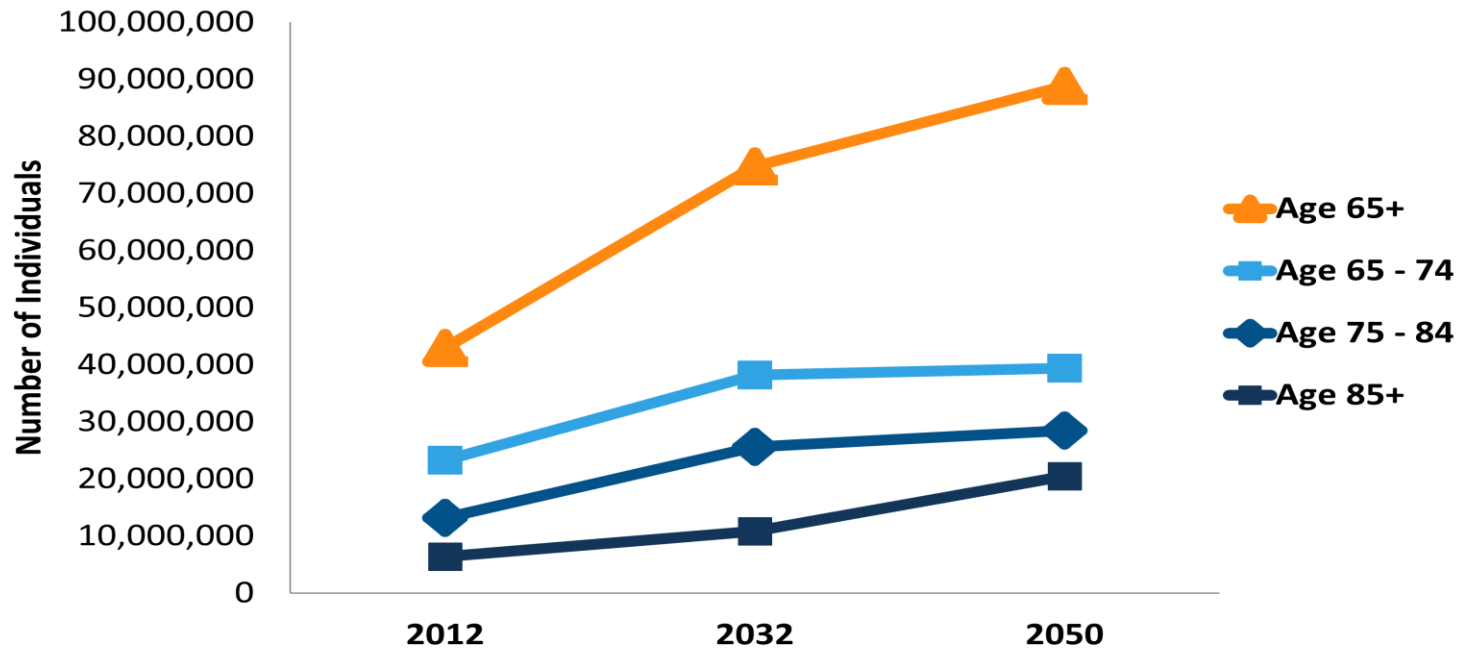
## ■ INSTITUTIONAL BENEFITS

- **Mandatory Benefit**
  - Nursing Facility
  - Hospital
- **Optional Benefit**
  - Independent Care Facility for Individuals with Intellectual Disabilities (ICF/ID)
  - Inpatient psychiatric services <21 or ≥65 yrs
- **Excluded Benefit**
  - Institutions for Mental Disease (IMD) if 21-64 yrs of age
    - Note: Recent CMS SMD letter of July 27, 2015 advising states can ask for FFP for SUD that would have been provided in an IMD.



## AGING POPULATION

65 and Over Population Will More Than Double and the 85 and Over Population Will More Than Triple by 2050



SOURCE: A. Houser, W. Fox-Grage, and K. Ujvari. *Across the States 2013: Profiles of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, September 2012), [http://www.aarp.org/content/dam/aarp/research/public\\_policy\\_institute/ltc/2012/2012-full-report-AARP-ppi-ltc.pdf](http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/2012-full-report-AARP-ppi-ltc.pdf).

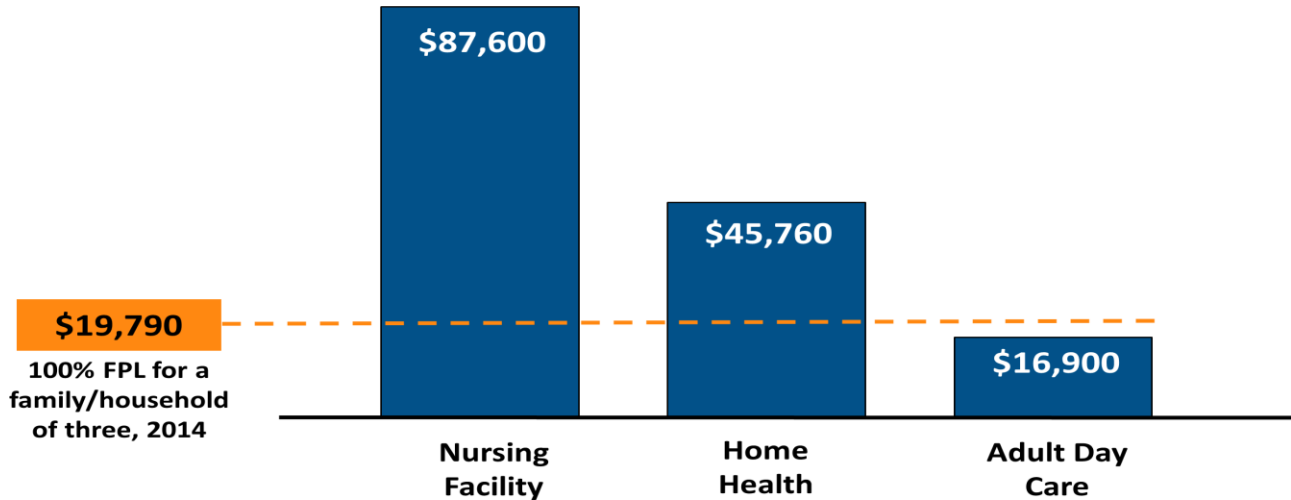




## ■ WHAT DOES IT COST?

**;-Term Services and Supports Are Expensive, Often Exceeding What Beneficiaries and Their Families Can Afford**

Median Annual Care Costs, by Type of Service, 2014



SOURCES: Genworth, *Genworth 2014 Cost of Care Survey* (Richmond, VA: Genworth Financial, Inc., March 2014), [https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568\\_032514\\_CostofCare\\_FINAL\\_nonsecure.pdf](https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf);  
U.S. Department of Health and Human Services, 2014 Poverty Guidelines, <http://aspe.hhs.gov/poverty/14poverty.cfm>.





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## ■ **LTSS AUTHORITY OPTIONS**



## ■ REMINDER

- Waivers
  - 1115 – Research and Demonstration
  - 1915(b) – Waives Freedom of Choice
  - 1915(c) – Home and Community Based Services
- State Plan
  - Operational agreement between state and federal government regarding how Medicaid program will be structured and administered



## ■ 1915(c) WAIVERS

- Introduced by Omnibus Reconciliation Act of 1981
- May waive:
  - Statewideness
  - Comparability
  - Income and resource rules
- Provide services in a home or community based environment that assist in diverting and/or transitioning individuals from institutional settings



## ■ 1915(c) WAIVERS

- State HCBS Waiver programs must:
  - Demonstrate cost effectiveness
  - Protect people's health and welfare
  - Provide adequate and reasonable provider standards to meet the needs of the target population
  - Ensure that services follow an individualized and person-centered plan of care



## ■ 1915(c) WAIVERS

- Can be combined with a 1915 (b) Freedom of Choice waiver to implement managed care
  - 1915(b)/(c) Waiver
- Multiple 1915(c) Waivers
  - Condition/population specific
  - Administered by multiple agencies
  - Medicaid accountability
  - Service silos





## ■ 1915(i) HCBS STATE PLAN OPTION

- Does not require an institutional level of care (LOC)
  - Less stringent needs-based criteria than institutional LOC
  - Proactive approach to institutionalization
- Targets one or more specific populations
- Allows use of self-direction
- Permits “other” services provides flexibility



## ■ 1915(i) HCBS STATE PLAN OPTION

- Restricted to those <150% FPL under DRA but expanded to 300% of Supplemental Security Income under ACA
- ACA removed ability to cap enrollment or maintain waiting list.



## ■ 1915(j) SELF DIRECTED PERSONAL ATTENDANT SERVICES

- Permitted Self-Direction for personal assistance services through State Plan
- States may limit self-direction to geographic areas and limit the number of people eligible to self-direct
- State can permit:
  - Hiring of relatives
  - Purchasing of goods, supports, services or supplies that increase independence



## ■ **1915(k) COMMUNITY FIRST CHOICE OPTION**

- Established under the ACA
- Provide certain HCB services and supports through a State Plan option
  - Personal Attendant services
  - Acquire, enhance, maintain skills to perform ADLs or IADL
  - Backup system to ensure continuity of care
  - Offer voluntary training on hiring, managing, and firing of attendants



## ■ **1915(k) COMMUNITY FIRST CHOICE OPTION**

- Optional Community First Choice Option Services
  - Transition costs associated with moving from an institutional to home/community settings
  - Other services in care plan to increase independence
- 6% increase in federal match for these services
- No waiting list or limit on number served allowed



## ■ **1915(k) COMMUNITIES FIRST CHOICE OPTION**

- Must meet statewideness, comparability, and freedom of choice of provider
- Cannot target specific populations
- Can limit amount, duration and scope
- Must meet institutional level of care
- Income up to 150% FPL
- Maintenance of effort requirement



## ■ LTSS WITHIN 1115 WAIVERS

- States can offer LTSS as part of a research and demonstration waiver
- 1115 waivers allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program
- Managed LTSS service can be provided through an 1115
- Some states have used 1115 plus 1915(b)/(c) waivers to delivery HCBS



## ■ MEDICAID HEALTH HOME

- State Plan option formed under Section 2703 of the ACA
- Providers integrate and coordinate acute, primary, behavioral, and LTSS for individuals with:
  - Two or more chronic conditions
  - One chronic condition and risk of developing a second
  - A severe persistent mental illness
- May target services to a certain group
- Cannot exclude dual eligibles





## ■ MEDICAID HEALTH HOME

- Health Home Services
  - Comprehensive care management
  - Care coordination
  - Health promotion
  - Comprehensive transitional care/follow-up
  - Patient & family support
  - Referral to community & social support services
- States receive 90% federal matching funds for *health home services* for 8 quarters

## ■ DEINSTITUTIONALIZATION



## ■ PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

- Administrative activity created under OBRA 1987
- Mandatory part of the State Plan
- Level I PASRR
  - Screen for evidence of a mental illness, intellectual disability, or related condition
- Level II PASRR
  - If screen positive in Level I PASRR
  - Appropriateness of nursing facility placement
  - Determine need
  - Inform the plan of care



## ■ AMERICANS WITH DISABILITIES ACT (ADA)

- Title II of ADA
  - People with disabilities may not be excluded from participating in, or denied the benefits of, governmental services, programs, or activities



## ■ AMERICANS WITH DISABILITIES ACT

- Integration Mandate implementing regulations requires:
  - Administration of services, programs, and activities in the most integrated setting appropriate to the needs of people with disabilities
  - Reasonable modifications to policies, practices, and procedures to avoid disability-based discrimination, unless such modifications would fundamentally alter the nature of the service, program or activity.
  - Provision of services in the most integrated setting, which enables individuals with disabilities to interact with non-disabled peers to the fullest extent possible.



## ■ OLMSTEAD

- 1999 Supreme Court decision
- Unjustified institutionalization of people with disabilities is illegal and discriminatory
- Requires states to serve individuals in the least restrictive and integrated setting when:
  - Appropriate for individual
  - Not opposed by affected person
  - Can be reasonably accommodated



## ■ OLMSTEAD

- Olmstead Plan recommended to demonstrate compliance
- U.S. Department of Justice role to enforce integration mandate
- Olmstead complaints are investigated by the Office of Civil Rights



## ■ MONEY FOLLOWS THE PERSON INITIATIVE

U.S. Centers for Medicare and Medicaid Services:

*“...system of flexible financing for long-term services and supports that enables available funds to move with the individual to the most appropriate and preferred setting as the individual’s needs and preferences change.”*

Source: <http://www.ncsl.org/print/health/moneyfollowspersonltc.pdf>





## ■ MONEY FOLLOW THE PERSON

- DRA of 2005 created the demonstration opportunity
- Encourages transition of Medicaid enrolled individuals from nursing home to HCB settings
  - Enhanced federal matching funds for 12 months for each transitioned Medicaid beneficiary
- Allows Medicaid funding to 'follow the person' into the community
- ACA extended through 2016 and reduced time must be in institution to 90 days (vs 6 months)

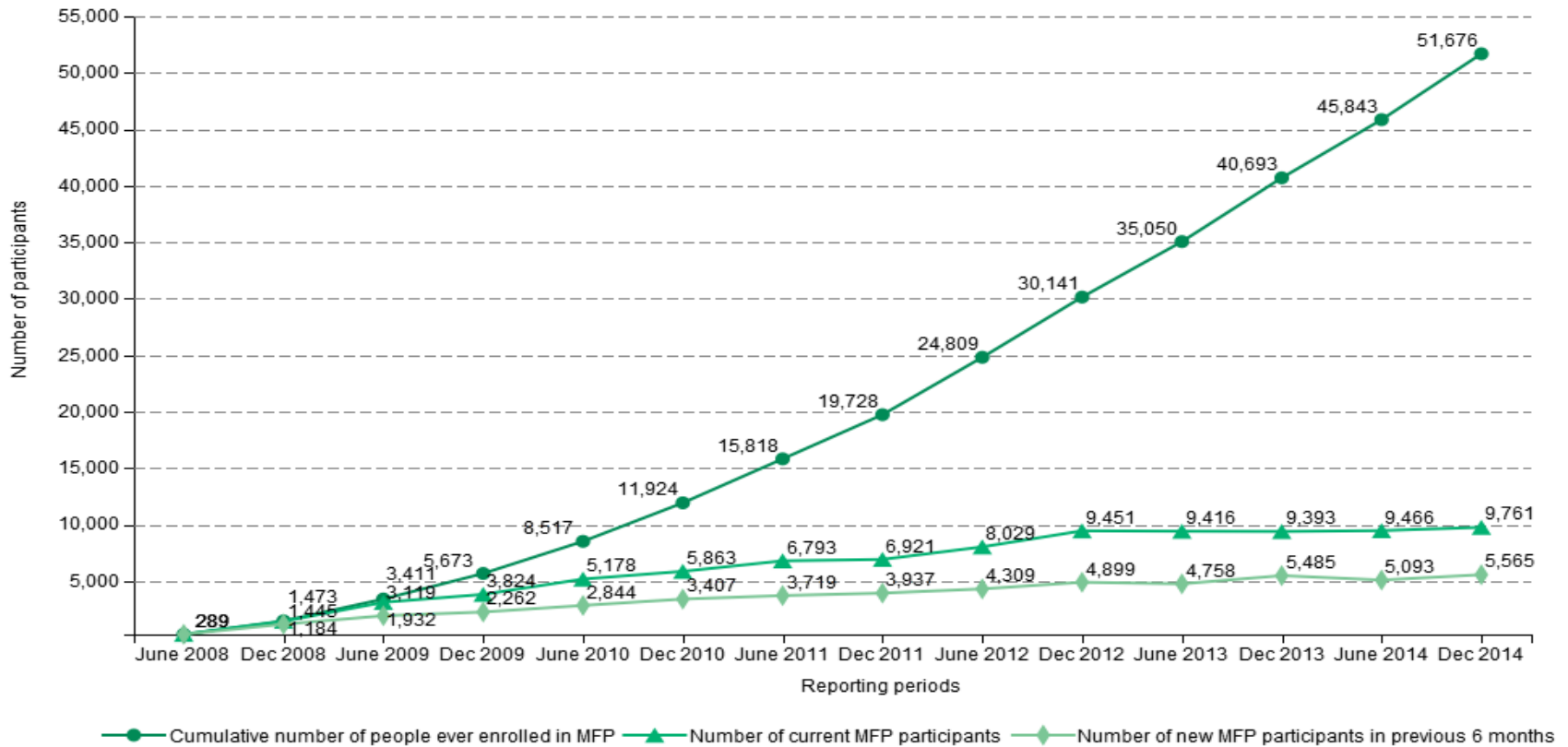


## ■ MONEY FOLLOWS THE PERSON

- MFP provides funds to:
  - Identify nursing home residents interested in making a transition to the community
  - Provides financial resources to cover costs of transitioning back to the community that are not typically allowed in regular LTSS waivers
  - Funds transition coordination services



## MFP TRANSITIONS (JUNE 2008 THROUGH DECEMBER 2014)



Source: <http://medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/balancing/downloads/mfprgranteeprogdec2014.pdf>



## ■ **BALANCING INCENTIVES PAYMENT PROGRAM**

- Established under ACA Section 10202
- Goal: Increase access to non-institutional LTSS
- Structural Changes
  - Single Point of Entry/No Wrong Door
  - Conflict-Free Case Management
  - Single State Assessment for determining eligibility



## ■ **BALANCING INCENTIVE PAYMENT PROGRAM**

- Runs through September 30, 2015
- States may receive additional Medicaid matching funds when they meet certain requirements for expanding the percentage of long-term care spending for home- and community-based services



## ■ BALANCING INCENTIVE PAYMENT PROGRAM

Current Non-institutional Medicaid Expenditures (% of total LTSS Spend)	Eligible?	Goal	% FMAP Increase
>50%	No	--	--
25-50%	Yes	50%	2%
<25%	Yes	25%	5%



## ■ WHAT TO EXPECT GOING FORWARD

- Expansion of Medicaid LTSS
- Increasing movement of Medicaid LTSS to managed care
- Better coordination across physical health, behavioral health, and HCB services
- Greater CMS focus on quality and oversight
- Use of 1115 authority to reach greater flexibility in delivering HCBS services



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# Everything You Wanted to Know about Managed Long Term Services and Supports but *were Afraid to Ask.*

2015 HCBS Conference  
Washington D.C. Hilton

August 31, 2015

# Topics We Will Cover

- Current Trends in MLTSS
- Goals for MLTSS
- Role of the State in MLTSS
- Role of the MCO
- Dual Eligible Programs
- Proposed Medicaid Managed Care Rules



# Movement to Managed Long Term Services and Supports

- Currently 22 states have implemented MLTSS and 11 more are planning
- MLTSS includes nursing facility and community based services and supports
- Goal is to integrated physical, behavioral, and LTSS in a person centered plan of care
- Requirements for service coordination
- Assessment of all members to determine unmet needs
- Flexibility in services – in lieu of services

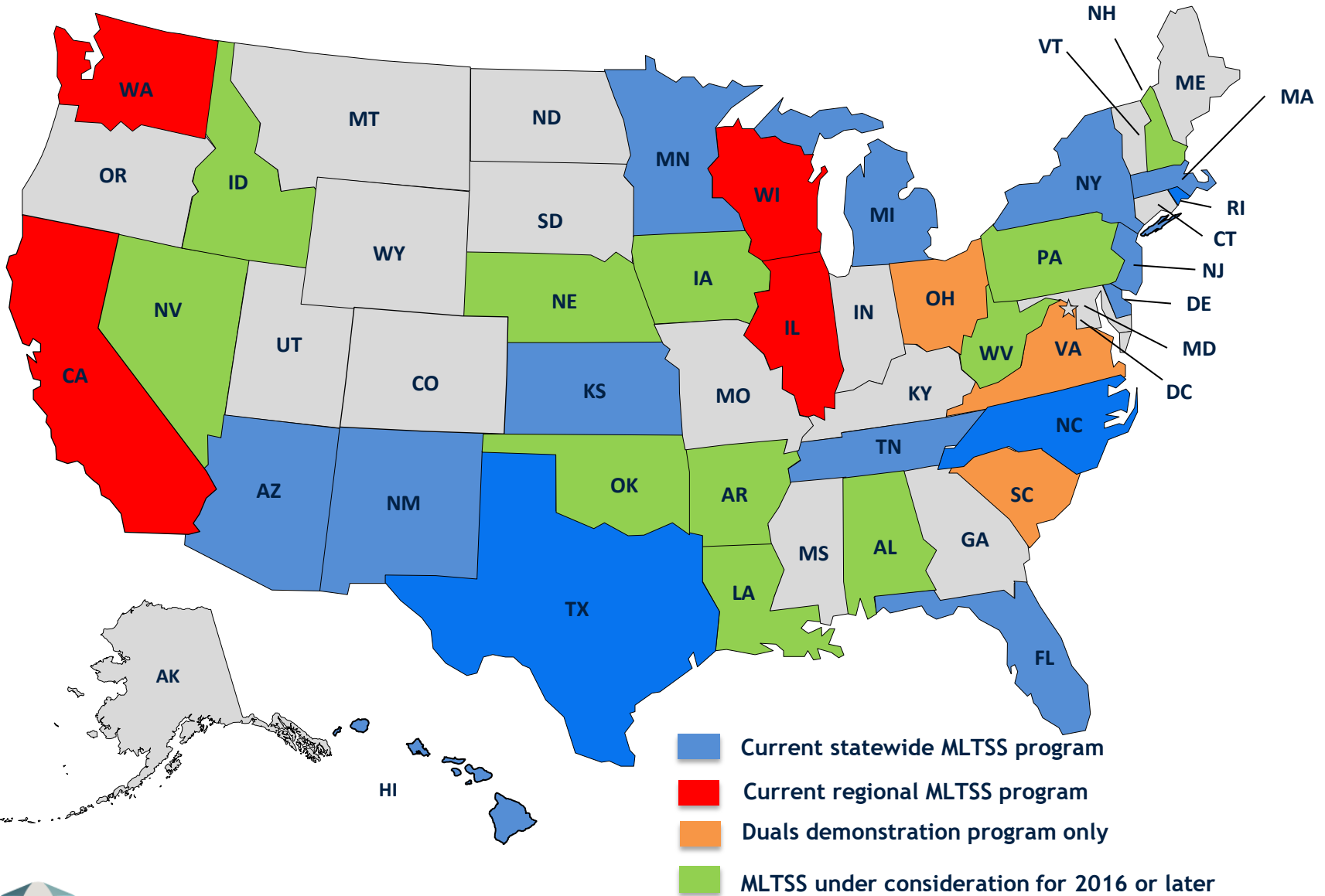


# MLTSS Can Include all Populations and HCBS Waivers

- Medicare/Medicaid dual eligible population
- Adults with disabilities
- Children with Special Health Care Needs
- Persons with Intellectual and Developmental Disabilities
- Foster Care Children



# MLTSS Programs - 2015



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Sources: NASUAD Survey; Discussions with States;  
CMS data

# State Goals for MLTSS

- Expand community LTSS options, and streamline and standardize the way people access them;
- Develop new models of care that integrate financing, care coordination and service delivery;
- Innovate in the LTSS sector with creative housing and other supports, greater use of technology, and new strategies to recruit and retain direct care workers;
- Strengthen the focus on quality measurement, including both quality of life and quality of care, in order to achieve better outcomes; and
- Ensure long-term sustainability of the system as demand for LTSS grows.



# State Initiatives and Innovations

- Use of data to support continuous quality improvement
- Use of technology
  - Electronic visit verification (EVV)
  - Remote monitoring and support
- Enhancing risk management
  - Back-up plans and mitigation strategies
- Integrated provider networks (ACOs)
- Value-based purchasing
- Reduction of Waiting Lists for HCBS



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# How States Promote Rebalancing in MLTSS

- Blended rate for nursing facility and HCBS
- No waiting lists for HCBS
- Higher capitation rates for HCBS
- Transition allowances
- Service Coordinators required to help members with diversion, transition and relocation
- Performance measures that penalize any increased NF utilization





# What do MCOs Know about LTSS?

- Steep learning curve – particularly for concepts like self-direction
- Many MCOs look to hire state LTSS staff
- Need to have good training on the provider community and how they have been doing business with the state
- Need to develop new care management systems
- National MCOs bring staff from one state to start programs in other states
- If they try to inappropriately cut LTSS services – word spreads fast.



# MCOs Innovations and Initiatives for MLTSS

- Reaching hard to locate persons
- Building relationships with Members
- Electric care management systems
- Value based purchasing
- Diversion, transition and relocations
- Person centered service plans that offer increased options



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# Examples of MCO MLTSS Innovations

- When national disaster hits the community...
- Finding housing solutions
- Bringing the services to persons where they live
- Person-centered service substitutions
- Shared savings with Providers
- Telemedicine and telehealth
- Value added services



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# Focus on Quality Improvement and Performance

- Begins with the contract - Value based purchasing concepts
- Performance incentives and disincentive
- Shared savings models
- New quality measures for MLTSS are under development
- Evidence-based, best practices to detect both under and overutilization of LTSS
- Member and Provider Complaints and Grievances analyses
- Member Satisfaction Survey
- MLTSS-oriented Performance Improvement Projects



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# What does MLTSS Mean to HCBS Providers?

- Consolidation and acquisition
- Survival of the fittest
- Competition for members
- Any willing provider no more
- Changing roles for ADRC and AAAs
- This is a game changer – in a good way



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# Options for States to Integrate Care for Duals

- **Capitated or FFS**
  - Allows for shared savings of Medicare dollars
  - State must agree to MOU requirements
  - CMS sets rates for Medicare services – sometimes lower than current D-SNP rates
  - 12 states participating out of original 26
- **D-SNPs**
  - State contracts with Dual Eligible-SNP plan for coordination/specific services
  - State may require MLTSS plans to offer D-SNP (e.g. TX, NM)
  - Funding is not integrated and there is no shared savings agreement with CMS
  - Enrollment, appeals/grievances, and other procedures not integrated
- **State Specific Waivers/MOUs**
  - MN, MA, and WI have other demo prior agreements and are seeking separate MOUs to maintain these arrangements (MN received MOU)
  - Other states that pulled out of FADs (TN, HI, NM, OR and AZ) are seeking alternative to the FADS demo
- **Program for All-Inclusive Care (PACE)**
  - As of 2015 – 114 PACE programs in 32 states and more on the way.





# New CMS Rules for Managed LTSS

The rules codified the “ten key principles” guidelines provided by CMS in 2012 for MLTSS

**1. Adequate Planning**

States must ensure that MCOs have extensive readiness reviews and that enrollees received adequate outreach and educational material to inform enrollment

**2. Stakeholder Engagement**

States must solicit views from beneficiaries, providers and other stakeholders during the development, implementation and ongoing monitoring of MLTSS

**3. Enhanced provision of Home and Community Based Services**

MCOs are required to comply with the ADA and Olmstead decision, and to monitor and report on compliance by their provider networks. A key goal of the MLTSS programs should be to expand HCBS opportunities to ensure that consumers have access to the most integrated setting possible.



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# New CMS Rules for Managed LTSS

The rules codified the “ten key principles” guidelines provided by CMS in 2012 for MLTSS

4. **Alignment of Payment Structures and Goals**

States should develop rates structures that support community integration, enrollees experience of care, and reduce costs. This could be done by a blended capitation rate that pays the same for institutional care as HCBS. Effective programs hold providers accountable through performance-based incentives and/or penalties. On an ongoing basis, states must evaluate their payment structures and make changes necessary to support the goals of their programs.

5. **Support for Beneficiaries**

Support during enrollment and support for filing complaints, grievances and appeals. Service coordination is key to the success of MLTSS

6. **Person-Centered Processes**

MCOs are required to develop person-centered plans in accordance with a needs assessment tool approved by the state. Service plans must reflect members’ preferences and goals and address physical health, behavioral health, long-term supports and services, social, psychosocial, and environmental needs.



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# New CMS Rules for Managed LTSS

The rules codified the “ten key principles” guidelines provided by CMS in 2012 for MLTSS

7. **Comprehensive, Integrated Service Package**

MCOs must coordinate all Medicaid services including primary, acute, behavioral, (both institutional and HCBS), prescription drugs, transportation and dental services. Even when the MCOs is not capitated for particular services, they must support the member in accessing those services.

8. **Qualified Providers**

Network standards for LTSS must include qualified providers within specified time and distance standards similar to acute care services

9. **Participant Protections**

MCOs must participate in efforts to prevent, detect, and remediate critical incidents

10. **Quality**

MCOs must have quality management programs designed to assure and improve the accessibility, availability, and quality of care being provided in its network. New LTSS performance and outcome measures are under development by CMS



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# The Future of MLTSS

- The train has left the station - MLTSS is quickly replacing FFS as state programs look for better ways to deliver LTSS
- More states will explore dual eligible integration programs with the support of CMS
- States will provide more direct oversight and monitoring of MCO performance
- New LTSS performance measures will be implemented and MCO's payment will be more and more based on performance.



# Thank you

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# Concluding thoughts

- If it was not already abundantly clear to the viewer, Medicaid is a highly complex and at times confusing program.
- Since Medicaid is administered at the State level, and states have broad discretion in designing, developing, and implementing their programs, there are significant differences in Medicaid programs across the states. In fact, no two state Medicaid programs are exactly the same.

# Concluding thoughts

- In times of ongoing budgetary constraint, Medicaid remains a key component of most state budgets.
- With health care costs and the number of elderly in the U.S. continuing to rise, pressures on Medicaid and other social service programs can be expected to mount, rather than lessen.
- This means that it is of critical importance for policymakers and citizens all to be informed on Medicaid policies and issues.

# Thank you for your time and attention!

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