



Medicaid 101: Everything You Wanted to Know

National Association of States United
for Aging and Disabilities

Preconference Intensive

August 29, 2016

- Section 1: Overview & History of Medicaid
- Section 2: How Medicaid is Administered
- Section 3: Overview of Eligibility
- Section 4: Overview of Services
- Section 5: Medicaid Waivers
- Section 6: Medicaid Payments
- Section 7: Medicaid Payment Integrity
- Section 8: Medicaid LTSS
- Section 9: Managed Care and LTSS

- 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.

- Andy Allison, McKinsey and Company (KS and AR Medicaid)
- Pat Finnerty, PWF Consulting (VA Medicaid)
- Ann Kohler, Marwood Group (NY, NJ Medicaid)
- David Parrella, Last Best Hope Consulting (CT Medicaid)
- Doug Porter, Senior VP, Government Programs Consultant (WA, CA Medicaid)
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- 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

- Created in 1965, along with Medicare (P.L. 89-97), under the Social Security Amendments of 1965;
- State & Federal partnership for funding and policy;
- Originally 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;
- Optional program for States – last State (AZ) began participation in 1982;
- Medicaid is unique in that it covers more Americans than any other health insurance program;
- In FY 2015, \$556 billion dollars were spent on the Medicaid program in the states & territories;
 - 16.8% percent of U.S. health care spending in 2014
- Over 57 million Americans are covered by Medicaid (2012).

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 levels, 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

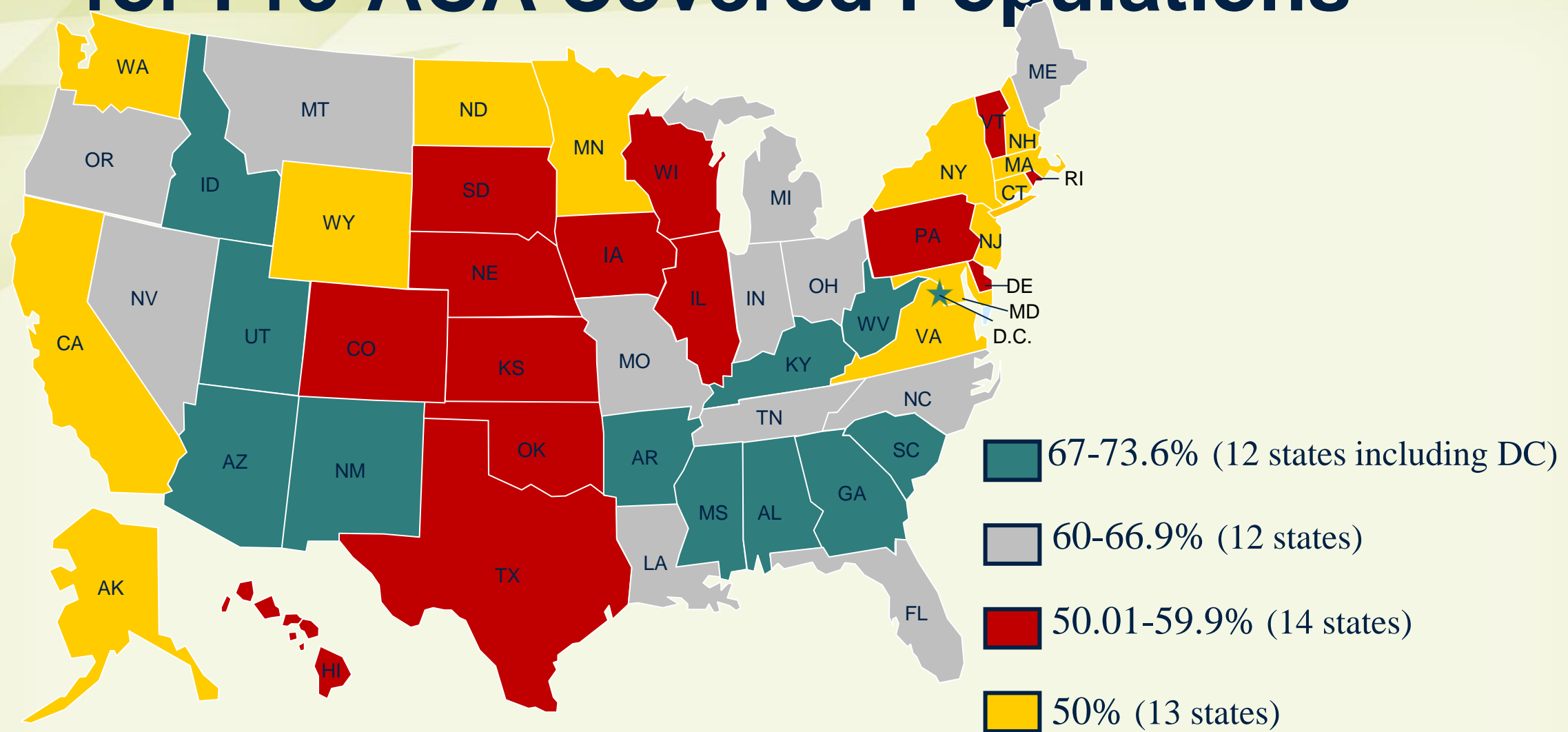
- Every state must have an approved “Medicaid State Plan” that describes its program; the program must be operated according to the State Plan.
- Among other components, the state plan delineates:
 - Groups of individuals to be covered;
 - Services to be provided;
 - Methodologies for providers to be 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;
 - FFY17: Minimum of 50% & Maximum of 74.63%;
 - Average FMAP across the U.S. is 59.4% (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 2017) for Pre-ACA Covered Populations



Source: Office of the Secretary, DHHS "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, CHIP, and Aid to Needy Aged, Blind or Disabled Persons for October 1, 2016 Through September 30, 2017;" Federal Register, Vol 80., No. 227

ACA Financing of Medicaid Expansion Population

- For newly eligible individuals, states 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 previously eligible but not enrolled, states receive pre-ACA federal match funding.

HealthCare.gov

Medicaid.gov
Keeping America Healthy

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.

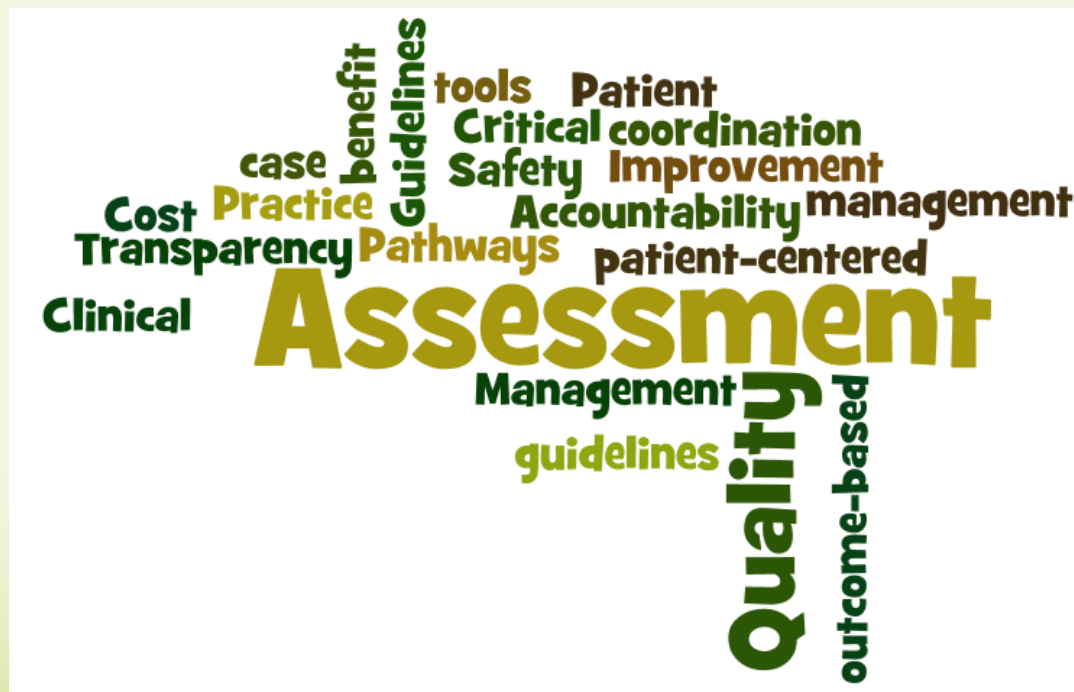
Role of Providers

- 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, Medicaid managed care organizations (MCOs), or other similar benefit management entities.
- 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 Providers

- Participate and support Medicaid/MCO quality improvement activities, periodicity schedules, and program initiatives.
- Providers are subject to various federal and state auditing requirements to ensure the operational and fiscal integrity of the program.



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.

Medicaid 101: Overview Of Eligibility & Coverage of Services



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



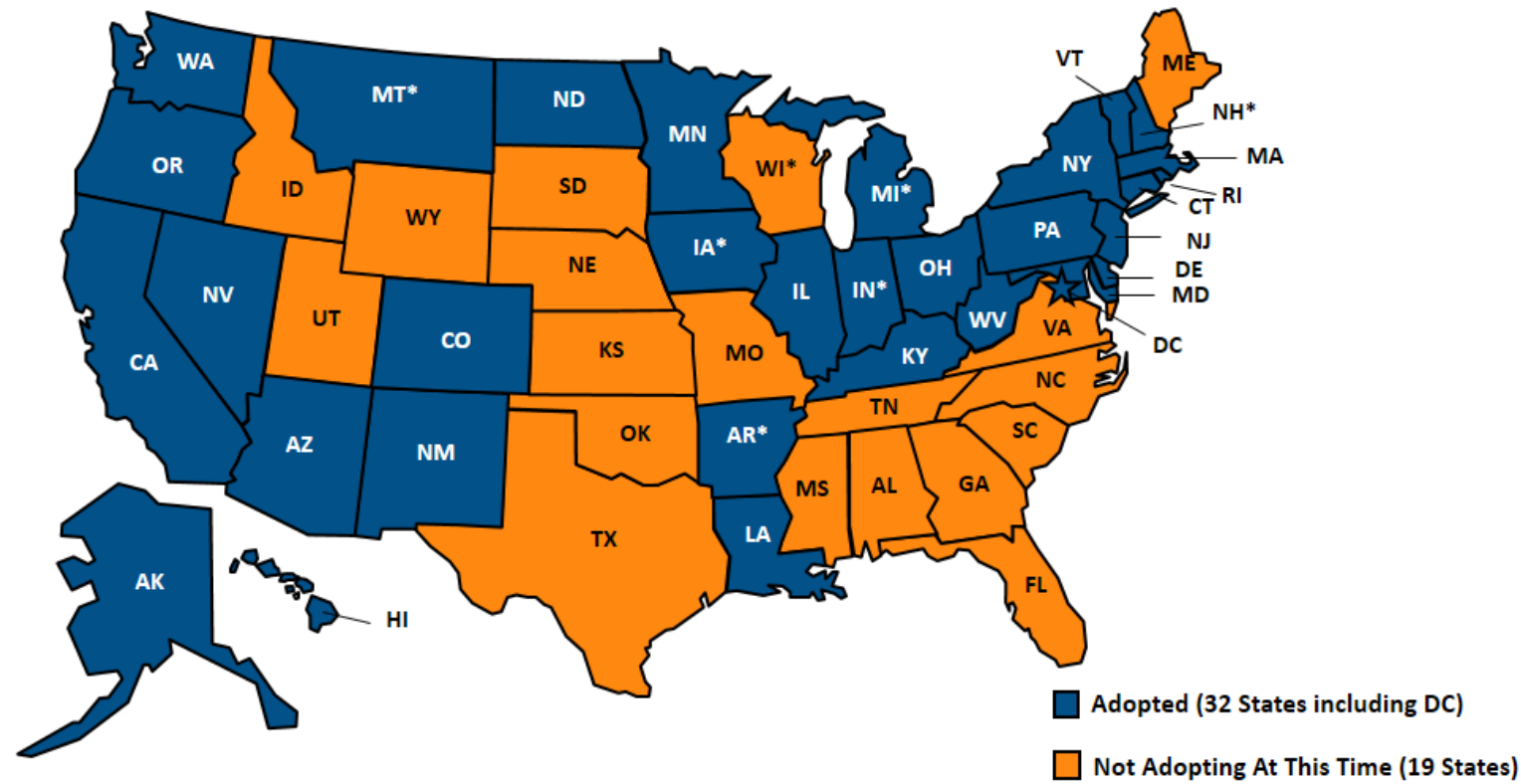
ACA Changes

- ACA expanded Medicaid eligibility to childless adults and raised eligibility to 138% FPL, and eliminated asset tests only for the non-elderly and non-disabled groups
- ACA also changed how income is counted by moving to modified adjusted gross income (MAGI)
 - All States must move to MAGI for non-elderly and non-disabled
- Supreme Court ruled the eligibility expansion could be a 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



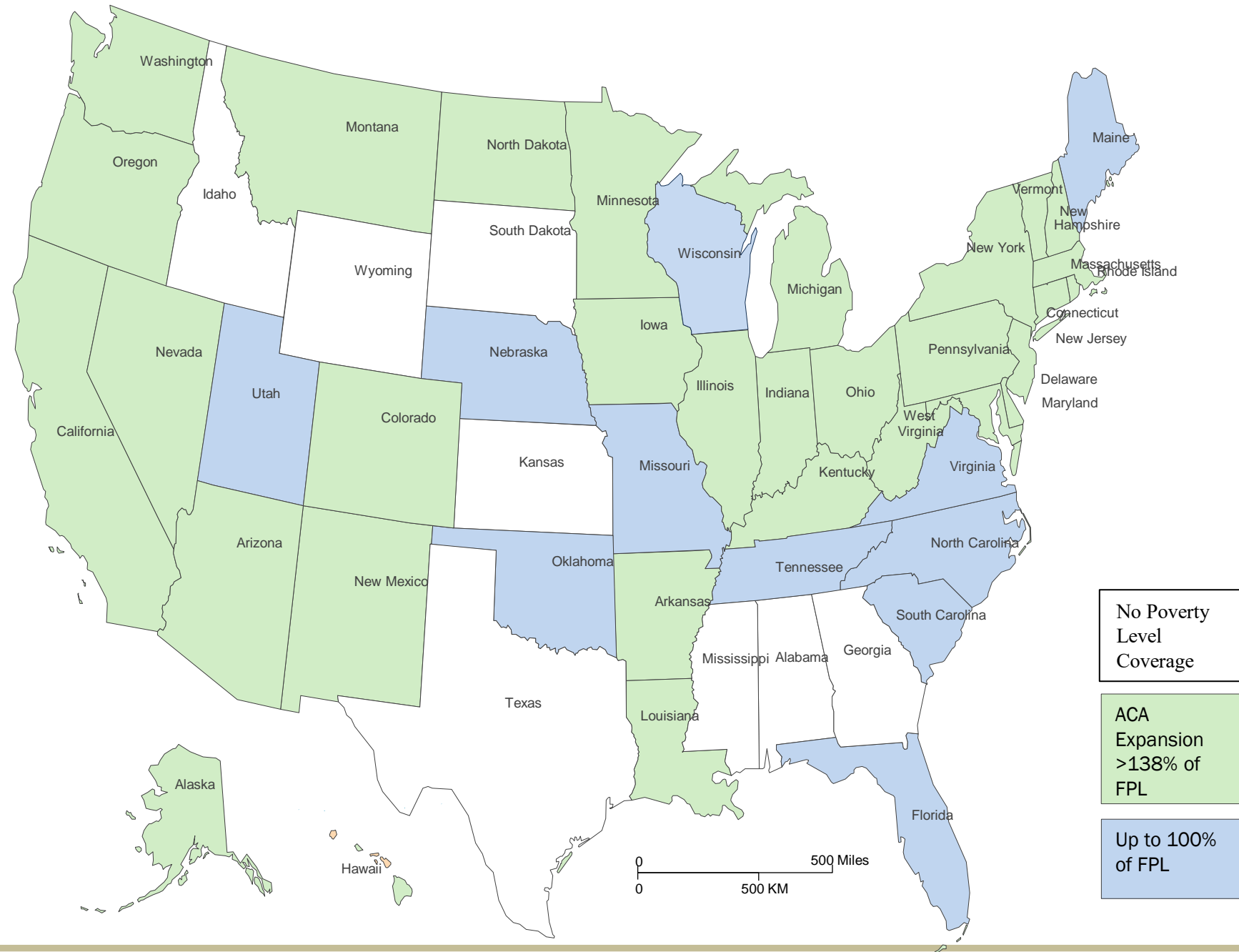
NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated July 7, 2016.

<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



Distribution Of States With Poverty Level Coverage



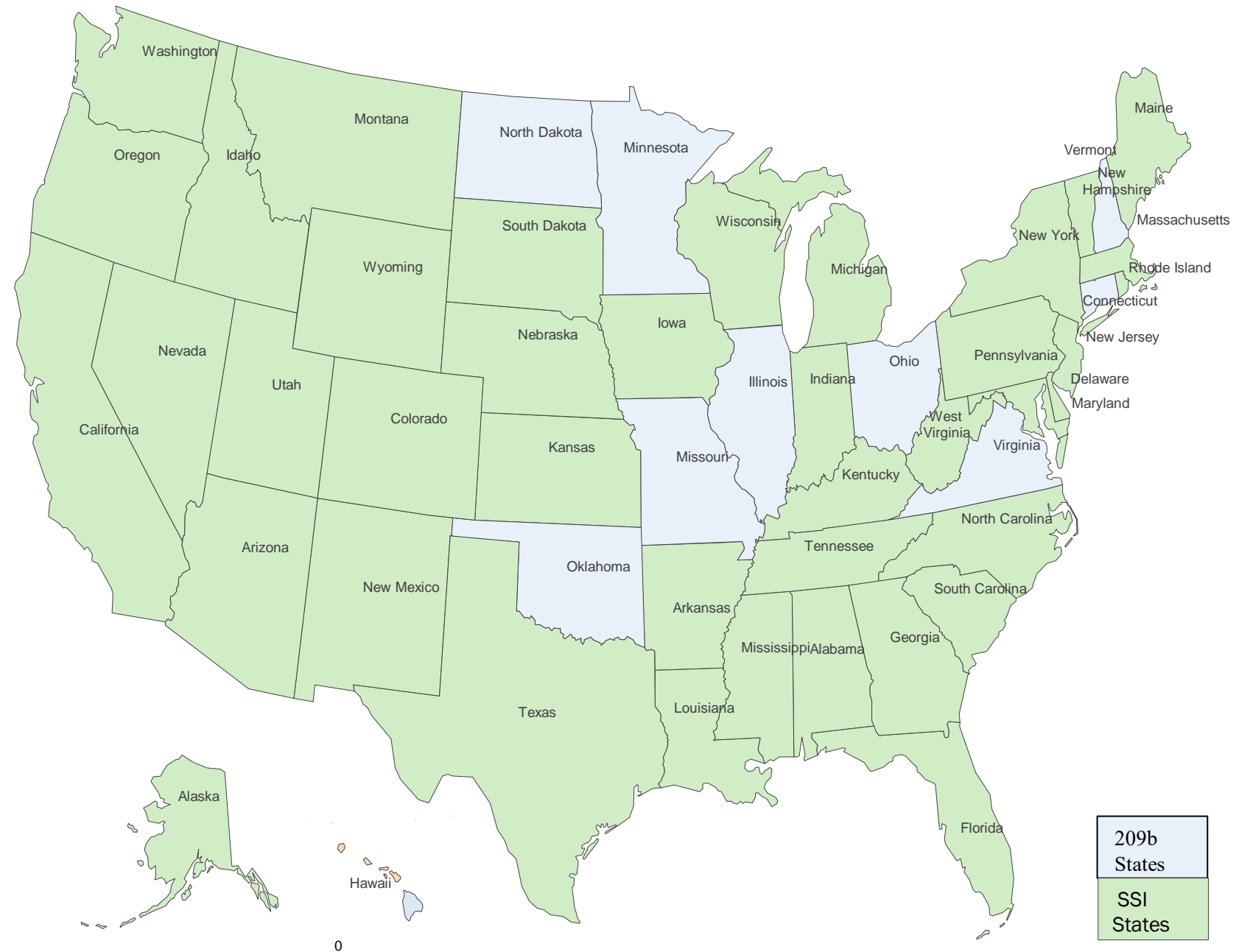
SSI And 209B States

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 that have not expanded Medicaid cover aged and disabled up to the federal poverty level



Distribution Of 209b States

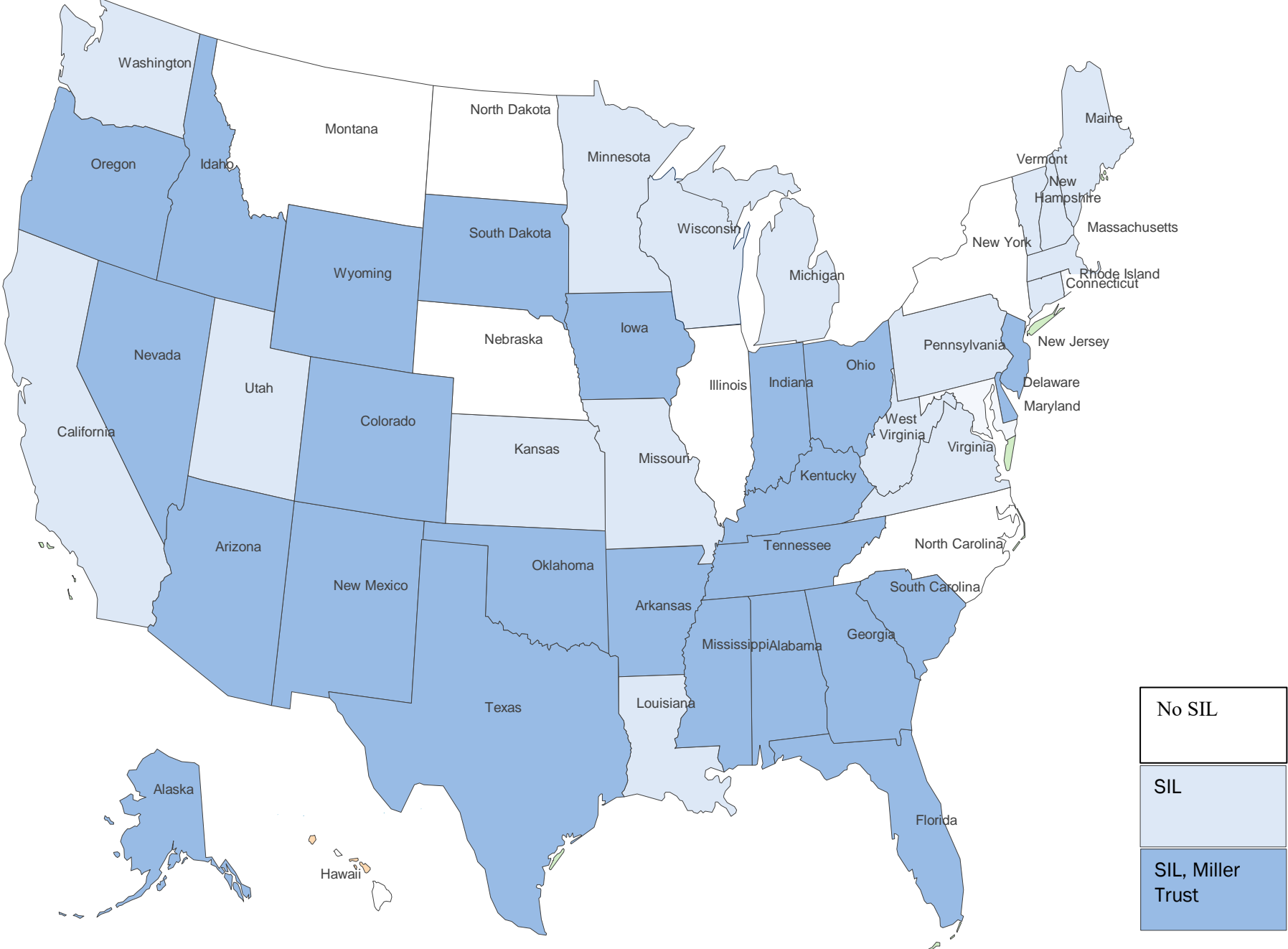


Eligibility Levels for Long Term Care

- **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



Distribution of States That Have Special Income Limits Or Miller Trusts



- **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



Description

Waivers consist of Federal statutory authority given to CMS to exempt states from certain Medicaid requirements, including state-wideness, freedom of choice, comparability, and the definition of a federally “matchable” state health-related expense

Differentiators

Waivers differ from Medicaid state plan amendments in key ways:

- Not an “entitlement” – can have enrollment limits or waiting lists
- Cost-neutrality requirements
- Include evaluation requirements and other “terms and conditions”
- Must be renewed, e.g., every 3-5 years

Most common waivers

- 1115 demonstrations: 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

Examples

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
Scope	<ul style="list-style-type: none"> Medicaid CHIP 	<ul style="list-style-type: none"> Health Insurance Marketplace structure Essential benefits Marketplace subsidies, insurance risk mitigation approaches, benefit design, mandates and penalties <i>Other federal health care laws*</i>
Key Requirements	<ul style="list-style-type: none"> Federal budget neutrality -- <i>within</i> Medicaid and CHIP CMS policy, e.g., beneficiary protections, source of state matching funds, etc. 	<ul style="list-style-type: none"> Federal budget neutrality for all Federal costs, but calculated as if Medicaid policy remained unchanged Budget neutrality must be calculated separately for any associated changes to Medicaid No loss in benefits (services, affordability) for consumers No loss in aggregate number covered in the state, nor for losses among number of vulnerable populations covered HHS and US Treasury Departments will “continue to examine the types of changes that will be considered in assessing State Innovation Waivers.” **
Common Uses	<ul style="list-style-type: none"> Financing alternatives Delivery system transformation 	<ul style="list-style-type: none"> TBD
Effective Date	<ul style="list-style-type: none"> 1965 	<ul style="list-style-type: none"> January 2017

*Coordinated Waiver Process: Section 1332 allows the HHS Secretary to consolidate 1332s, 1115s and “any other Federal law relating to the provision of health care items or services.” The current administration has published regulations enabling coordinated waiver submissions and review, but disallowing consolidation of ACA State Innovation (1332) and non-ACA waivers like Medicaid’s 1115s. See Federal Register 80:241 December 16, 2015 pps. 78133-78134.
 **ibid, p. 78134

Medicaid Rate-Setting Overview

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)) [See next page...]

Fee for service: Traditional approach to payment was to reimburse for each bit or piece of health care used, i.e., a fee for every service.

- For pregnancy that could include multiple prescriptions (and fills), a hospital stay, and physician’s services for delivery, prenatal and post-natal visits
- Fee-for-service now also means “not managed care”

Prescription Drugs: “Rate-setting” for prescription drugs entails setting reimbursement formulas for local pharmacies, federally-mandated manufacturer rebates and sometimes a state-negotiated rebate as well

- All approved drugs must be covered (so long as manufacturer participates in federal drug rebate program) but NOT all drugs must be “preferred” nor covered without guidelines or conditions, such as prior authorization
- The potential for establishing preferred or unconditional prescribing helps leverage state-negotiated rebates

Institutions: Some hospitals and nursing homes receive lump-sum “supplemental” payments not directly tied to individual services

Reform: Revisiting the “fee for service” approach has risen to the top of State Medicaid program agendas....

Medicaid Rate-Setting

Medicaid's Minimum Access Requirements

Statutory Requirement

*“SEC. 1902. [42 U.S.C. 1396a] (a) A State plan for medical assistance must—
...(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section [1903\(i\)\(4\)](#)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that 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;”*

(emphasis added)

New Federal Regulations*

Requirements: Federal law requires rates to be sufficient to generate access on a par with general population (SSA Section 1902(a)(30)(A))

- That same federal law also requires that “payment” secure quality services and provoke efficient use
- Supreme Court recently determined that providers do NOT have legal standing to challenge state payment rates against this federal standard
- Following the Supreme Court decision, CMS published regulations establishing the process states must go through to assure sufficient access
- Medicaid services covered under the new regulations include:
 - Primary care and physician services
 - Behavioral health services
 - Obstetric services
 - Home health
 - Other services for which the state or CMS has received unusually high number of complaints, or which is experiencing a change in payment that could diminish access
- Beginning July 2016 States are to create and maintain “access monitoring plans” for each service
 - Stakeholder input and public notice
 - Comparison of Medicaid rates to other payers
 - Measurement of access versus established metrics such as time and distance to participating providers

*Source: 42 CFR 447.203, as amended November 2, 2015 (see Federal Register 80:211 p. 67611 and following)

Value-Based Purchasing

Overview

Overarching objective

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

Basic approach

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

These collections of services vary, and each could be thought of as a health-related **product**.

Initial steps

Defining these collections of related services entails answering a number of questions:

- Which services should be grouped together?
- Which providers should be included in the “team”?
- What time frame should be included in each package of services?
- How is quality factored into payment?

Core idea

VBP pays for (or incents) end-to-end or comprehensive care that *should be* managed together, e.g., by a coordinated team

Value-Based Purchasing

Terminology

“New Payment Models” v. “Delivery System Redesign”

- Payments go to those who deliver a service – or, increasingly, packages of services
- Payment innovations that redefine a package of services often directly entail a new model of service delivery
- Health care provider markets and delivery systems sometimes reorganize themselves in response to (consolidated) payment for these new packages of service
- These innovations are known *both* as new delivery models *and* new payment models

Value-Based Purchasing

Examples of New Payment Models and Delivery System Redesigns

Managed care organizations

- Service package: comprehensive care for each enrollee
- New payment model: single monthly payment for all services for each enrollee
- Scale: encompasses geographic regions or full states

Accountable care organizations

- Service package: comprehensive care for each enrollee
- New payment model: single monthly payment for all medical services for each assigned patient
- Scale: encompasses patients of a particular health system

Patient-centered medical homes

- Service package: comprehensive care for each enrollee
- New payment model: monthly supplemental payment **and/or** periodic incentive payment
- Scale: incentives encompass total medical spend for all of a doctor's patients

Health homes

- Service package: variable, but might include all specialized services (e.g., behavioral health care) or both specialized and physical health services
- New payment model: monthly supplemental payment to a provider or care coordinator
- Scale: encompasses some combination of care for all of a provider's patients

Episode-based payments

- Service package: all services associated with an episode of sinusitis, pregnancy and delivery, etc.
- New payment model: bundled/combined payment or retrospective incentives
- Scale: encompasses all condition-related care for all of a provider's patients

General requirements for a proper Medicaid payment

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

Core concepts (not formal definitions)

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

*Under proposed federal regulations published June 23, 2016, PERM would supercede/encompass statewide eligibility accuracy measurement previously conducted by state Medicaid Eligibility Quality Control (MEQC) units, and MEQC would be reshaped to compliment PERM as an off-year state-driven analytic pilot program

Medicaid Payment Integrity

Tools and Activities

Resources and Requirements

- Accountability for all payments accrues to the single state Medicaid agency
- Agency investigators, auditors, compliance and program staff all contribute
- CMS efforts are now consolidated in the Payment Error Rate Measurement (PERM)* program
- All states implement MMIS-related Surveillance and Utilization Review Systems (SURS)

External review and audit authorities

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

Core activities

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

Medicaid Long Term Supports and Services

David Parrella, Last Best Hope Consulting
August 29, 2016

Section 8



Topics

- Overview of Medicaid Long Term Supports
- LTSS Authority Options
- Deinstitutionalization
- The mystery of “The Duals”

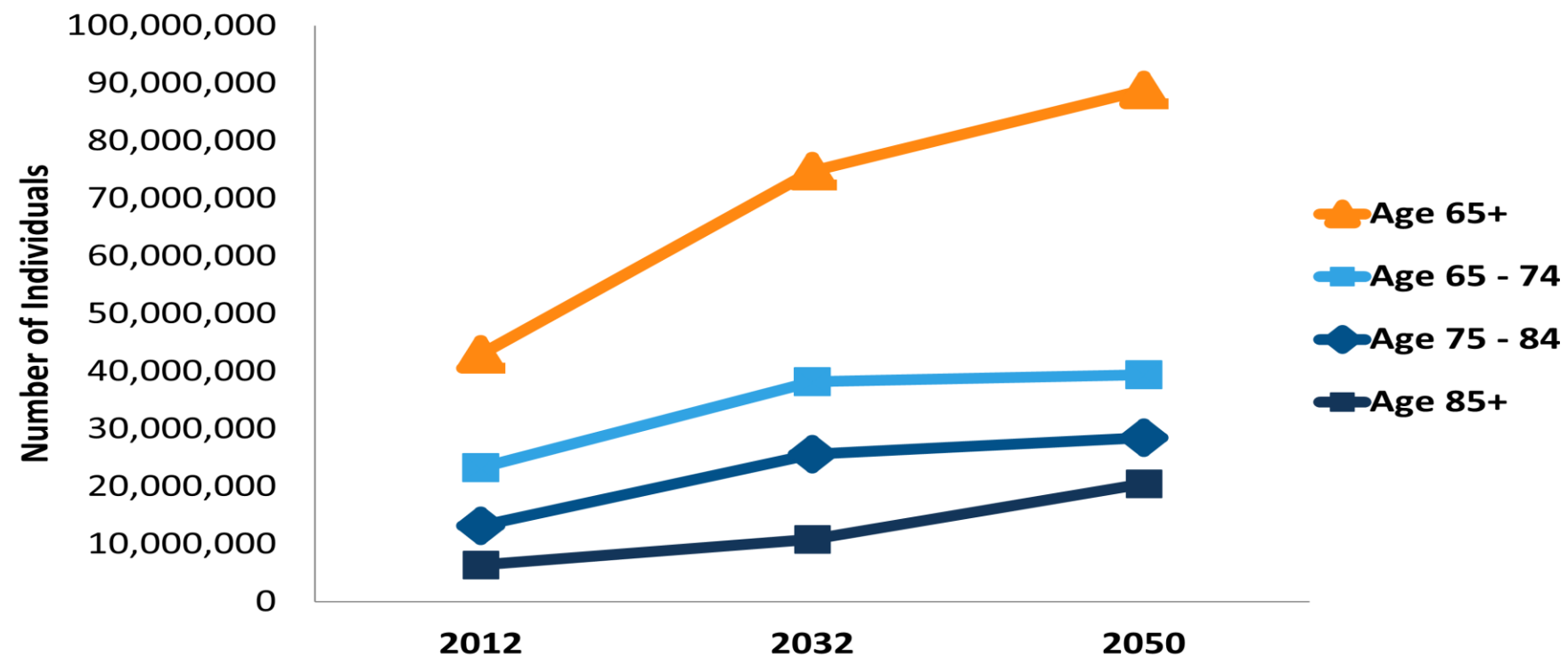
SOME FUNDAMENTAL QUESTIONS

- Is demography destiny? Will the needs of an aging population overwhelm the public financing systems (Medicaid and Medicare)
- Are we headed for a long term care financing crisis?
 - Maybe not??

IMPLICATIONS OF AN AGING POPULATION

Figure 1

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



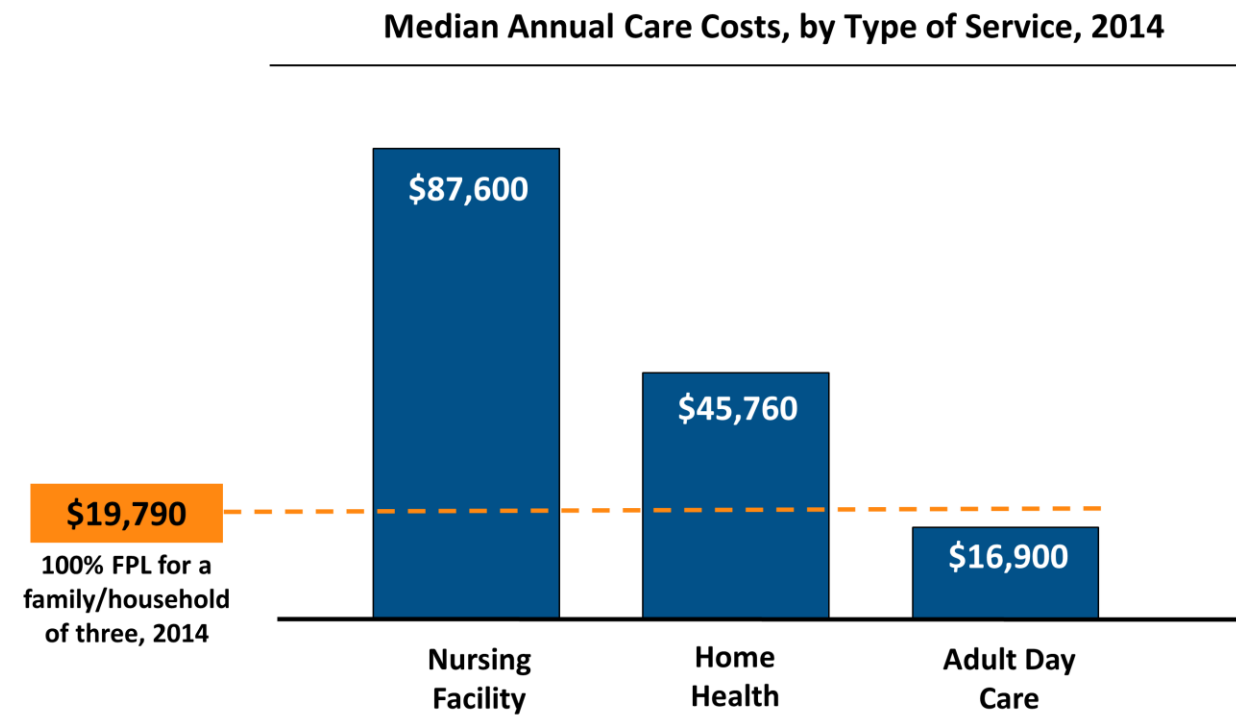
SOURCE: A. Houser, W. Fox-Grage, and K. Ujvari. *Across the States 2013: Profiles of Long-Term Services and Supports* (Washington, DC: AARP Public Policy Institute, September 2012), http://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2012/across-the-states-2012-full-report-AARP-ppi-ltc.pdf.



LONG TERM CARE IS EXPENSIVE!!

Figure 2

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



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; U.S. Department of Health and Human Services, 2014 Poverty Guidelines, <http://aspe.hhs.gov/poverty/14poverty.cfm>.



OVERVIEW of MEDICAID LTSS

- Includes *Institutional Care* and *Home and Community Based* Long Term Services and Supports
- Services may be defined through a state plan authority, waiver authority, or a combination
- Medicaid is the primary payer of LTSS
 - Not Medicare
 - Not Private Insurance

MEDICAID LTSS EXPENDITURES

INCLUDES STATE AND FEDERAL SHARE

- 2014 National Medicaid LTSS Expenditures = \$118.7 Billion
 - Nursing Facilities = \$ 49.8 Billion
 - ICF-ID = \$ 10.5 Billion
 - Mental Health Facilities = \$ 2.6 Billion
 - Home and Personal Care = \$ 55.8 Billion

Source: Kaiser Family Foundation 2016-kff.org/Medicaid/state-indicator/spending-on-long-term-care

WHAT'S THE HEADLINE HERE?

- Medicaid spending on Home Health and Personal Care services exceeds spending on Nursing Facility services (\$55.8 billion vs. \$49.8billion)
- If client choice and state policy have shifted in favor of community care, can we escape the long term care financing crisis?
- Will we have the labor force to sustain the momentum for community care?

LTSS AUTHORITY OPTIONS

- Waivers
 - 1115 - Research and Demonstration
 - 1915(b) - Waiver of Freedom of Choice (Managed Care)
 - 1915(c) - Waiver of Comparability and Statewidedness (Home and Community Based Services)
- State Plan
 - Operational agreement/contract between state and federal government regarding how each State Medicaid program will be structured and administered
 - The “Partnership”

1915(c) Waivers

- Introduced by the Omnibus Reconciliation Act of 1981
- What does “waive” mean?
 - “Waive” means that CMS agrees not to abide by certain statutory requirements
- May waive
 - Statewide (service can be provided in limited geographic areas)
 - Comparability (service can be provided to limited populations)
 - Income and Resource Rules (client eligibility can be determined outside of standard rules for categorically or medically needy populations)
- Provide services in a home and 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 (comparing the cost of the intervention against “do nothing” over a period of time, 3-5 years)
 - States can use “waiver math” – “If I don’t get this waiver I’ll have build x number of nursing home beds over the next 5 years which would cost me \$\$\$ million...”
 - Protect people’s health and welfare (through a quality assurance plan)
 - Provide adequate and reasonable provider standards to meet the needs of the target population (spelled out in the waiver application and state regulations)
 - Ensure that services follow an individualized and person-centered plan of care

1915 (c) Waiver

- Can be combined with a 1915(b) waiver – Freedom of Choice – to implement managed care
- Historically, 1915 (c) waivers were required to be unique for each condition/population to be served
 - Often administered by different state agencies outside of the Medicaid agency
 - However, Medicaid retains the federal accountability
 - Resulted in service silos

Impact of the CMS Regulation on HCBS

- Published in the Federal Register 1/16/14, effective 3/17/14
- Applies to all HCBS programs
 - 1915 (c) waivers and 1915 (i) and 1915 (k) State Plan Amendments
- Sets forth rules for where HCBS services can be provided
 - Must be in a setting that provided greater integration with the wider community (i.e. non-institutional)
 - Must be selected by the individual
 - Ensures privacy and dignity (a door that can be locked, access to food at all hours, protections of a lease or rental agreement)
 - Optimizes autonomy
 - Facilitates individual choice
 - Not any of the following: Nursing Facility, IMD, ICF-ID, Hospital

Sources of Further Information

- Link to CMS HCBS guidance:
- <http://www.medicaid.gov/MedicaidCHIP-Program-Information/By-Topics/Long-Term-Services-andSupports/Home-and-Community-Based-Services/Home-andCommunity-Based-Services.html>
- including: • Federal Regulations: 1915(c) waiver: 42 CFR§441.301(c)(4); 1915(i) State Plan option: 42 CFR§441.710(a)(1); 1915(k) State Plan option: 42 CFR §441.530(a)(1)

Other Federal 1915 (c) Waiver Changes

- You are now allowed to combine multiple conditions and populations under a single 1915 (c) waiver
- Reduces the administrative burden in terms of federal reporting
- States/Advocates may still resist combining populations because of the state appropriation process
 - May want to preserve line item funding for unique populations and needs

And Now for Something Completely Different.. The 1915 (i) State Plan Option!!

- Provides HCBS services under a State Plan Amendment, not a waiver
- Does not require that members be at an institutional level of care (LOC)
- Targets one or more specific populations
- Allows for self-direction
- Originally restricted to individuals with incomes below 150% FPL, now expanded to 300% of SSI under the ACA
- **However**, the ACA also removed the ability to cap enrollment or maintain a waiting list, as you can do under a waiver

1915(j) Self-Directed Personal Care Attendant Services

- Allows for self-directed personal care attendant services under the State Plan
- Can target a population that is already under a 1915 (c) waiver
- State may still limit self-direction to certain geographic areas and limit to number of individuals who are allowed to self-direct
- States can permit
 - Hiring of relatives
 - Purchasing of good and supplies that increase personal independence

1915(k) Community First Choice Option

- Established under the ACA
- States can provide certain HCBS services and supports through a State Plan option, like 1915(i)
 - Personal Care Attendant Services
 - Services to acquire, enhance, or maintain skills to perform Activities of Daily Living (ADLs)
 - Backup systems to ensure continuity of care (respite)
 - States can offer clients voluntary training on the hiring, managing, and firing of attendants

1915(k) Community First Choice (cont.)

- \$\$ Optional Community First Choice Services \$\$
 - Can cover transition costs associated with moving from an institutional to a community setting
 - Other services to increase independence
 - No waiting list is allowed, but...
 - There is a 6% increase in FMAP for these optional services

Potential Problem Areas for States Contemplating Community First Choice..

- Client income is capped at 150% FPL
- Clients must meet the institutional level of care (LOC)
- Must comply with statutory statewidedness, comparability and freedom of choice requirements
- Cannot limit amount, duration, and scope
- Must demonstrate maintenance of effort in state outlays
- That means
 - No targeting by population or condition
 - No mandated enrollment in managed care
 - No geographic limitations
 - Must maintain current level of the State financial investment

LTSS within 1115 Waivers

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

Medicaid Health Home

- State Plan option under Section 2703 of the ACA
- My target services to a certain group
- Cannot exclude the dual eligibles (Medicare/Medicaid)
- Health Home providers are expected to integrate and coordinate acute, primary, behavioral, and LTSS for individuals with:
 - Two or more chronic conditions, or
 - One chronic condition and the risk of developing a second
 - Severe Persistent Mental Illness
 - Represents an important step for many states to integrate medical and behavioral health care

Medicaid Health Home (continued)

- Health Home services receive a **90%** federal match for the first 8 calendar quarters
- Health Home Services include:
 - Comprehensive care management
 - Care coordination
 - Health promotion
 - Comprehensive transitional care/follow-up
 - Patient and family support
 - Referrals to community and social support services

DEINSTITUTIONALIZATION

Not for the Faint of Heart

Deinstitutionalization can be tough!

- Older bricks and mortar nursing facilities may be forced to close
- While that is part of the long term goal, in the short term closings can cause disruptions for clients and their families
- Job losses can be significant issues for workers, collective bargaining, and state legislators
- As you implement the new community LTSS, you will be forced to double-fund some portion of your LTC system (nursing home and HCB) as you wind one system down in favor of the other
 - It's hard to shut down the facilities on the day that funding begins for the new alternatives

Preadmission Screening and Resident Review (PASRR)

- Mandatory administrative activity created under OBRA 1987
- Level I PASARR
 - Screen for evidence of mental illness, intellectual disability, or a related condition
- Level II PASARR
 - If the screen is *positive* in Level I PASARR
 - Determines the appropriateness (or not) of Nursing Home placement
 - Determines patient needs
 - Informs the Plan of Care

Why is PASARR Important?

- For the States
 - It provides a mechanism identify potential individuals with mental illness where placement in a nursing facility could cause that facility to be classified as an *Institution for the Treatment of Mental Disease (IMD)*
 - Applies if more than 50% of the residents have a diagnosis of mental illness or substance abuse
 - Could result in the loss of \$\$ FFP \$\$ for the *entire* facility
- For the clients
 - It provides a check on inappropriate placement of persons with mental illness or intellectual disabilities in a nursing home environment which may not be suitable for their needs

Americans with Disabilities Act (ADA)

- Integration mandate in the 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
- Un justified institutionalization of people with disabilities is illegal and discriminatory
- Requires states to serve individuals in the least restrictive and integrated setting when:
 - Appropriate for the individual
 - Not opposed by the affected person
 - Can be reasonably accommodated

Olmstead (continued)

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

Money Follows the Person

- From CMS

“...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.”

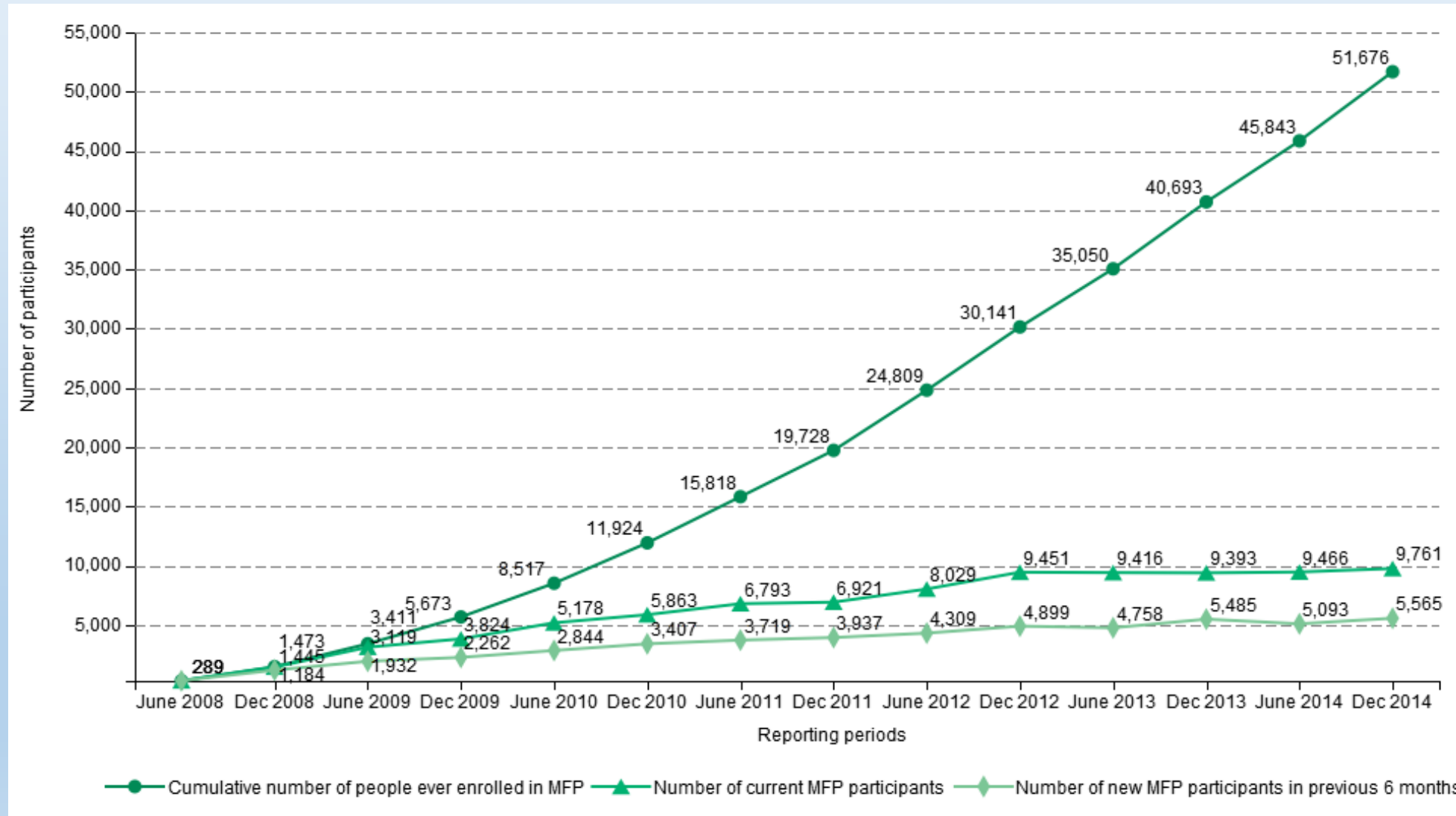
Money Follows the Person (cont.)

- 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 the authority through 2016 and reduced the time that an individual must first be in an institution from 6 months to 90 days

Money Follows the Person (cont.)

- 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
 - Rental Assistance Program (RAP) certificates – security deposit, first and last month rent assistance
 - Furniture
 - Funds transition coordination services

MFP Transitions (June 2008 Through December 2014)



MFP and Medically Needy Eligibility: A Conundrum

- What if your Medicaid eligibility is determined based on the cost of your care in nursing home?
 - Your income and/or your assets are too high for you to be categorically eligible.
- The **good** news is that you may be eligible to transition from the nursing home to the community.
- The **bad** news is that without the high cost of care in the nursing home that helped you in the spend down calculation of your Medicaid eligibility...
 - **You may no longer be eligible for Medicaid!**

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 Incentives Payment Program (cont.)

- 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 Incentives Payment Program (cont.)

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

- Further Expansion of Medicaid LTSS
- Changing marketplace for boomers planning for different alternatives in LTC
- Increasing movement of Medicaid LTSS to Managed Care
- Improved 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
- Work force issues to support HCB services

Rulemaking: Application of FLSA to Domestic Service (RIN1235-AA05), September, 2013

- Removed the exemption of “companionship” services from the FLSA if the individual spends more than 20% of his/her time providing “care”
- Care means:
 - Assistance with Activities of Daily Living (ADLs)
 - Dressing, Grooming, Feeding, bathing, Toileting and Transferring
 - Instrumental Activities of Daily Living (IADLs)
 - Tasks that enable a person to live independently
 - Meal preparation, Driving, Arranging Medical Care, Assistance with Medications, etc.

What Are the Consequences?

- **NAMD** Letter to OMB April 8, 2013
 - Rule is “incompatible” with the CMS objectives to promote independence
 - Rule will “chill state initiatives to develop and implement person-centered care programs”
 - States have limited budgets. Higher personnel costs for “care” will potentially result in fewer waiver slots.
 - Individuals who have been able to “self-direct” their care may be forced to accept institutional placement if the costs of their person-centered care plan exceed their state-approved budgets

Are We Facing a New Reality?

- If we have made the choice to increasingly rely on companion services for long term care services and supports:
 - Can we reduce our reliance on institutional LTC quickly enough so that community-based care can continue to expand?
 - There is a period where you have to “double-fund” both systems
 - Do we owe the people who will care for us a better standard of living?
 - Where will this workforce come from?
 - Within the U.S.? What will be the contribution of continued immigration?
 - Is there an opportunity here to provide training and employment with a living wage to displaced workers from other sectors of the economy?

The Duals

- How to integrate financing – Medicaid-Medicare
- Shared savings, but...
 - CMS is looking for a 3% (MSR) Minimum Savings Ratio
 - Hard to achieve in fee-or-service when the expansion of community options will initially cost the states money and save on Medicare costs (inpatient, SNF)
 - Is the answer to be found in Managed Long Services and Supports (MLTSS)?
 - DSNPS and SNPs
 - Medicaid and Medicare pay their separate actuarially sound rates for their covered services
 - What about grievances and appeals?
 - Does the final appeal default to Medicaid rules?

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Not to Worry, Managed Care will solve Mr. Parrella's Problems

2016 HCBS Conference

August 29, 2016

Section 9

Topics We Will Cover

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

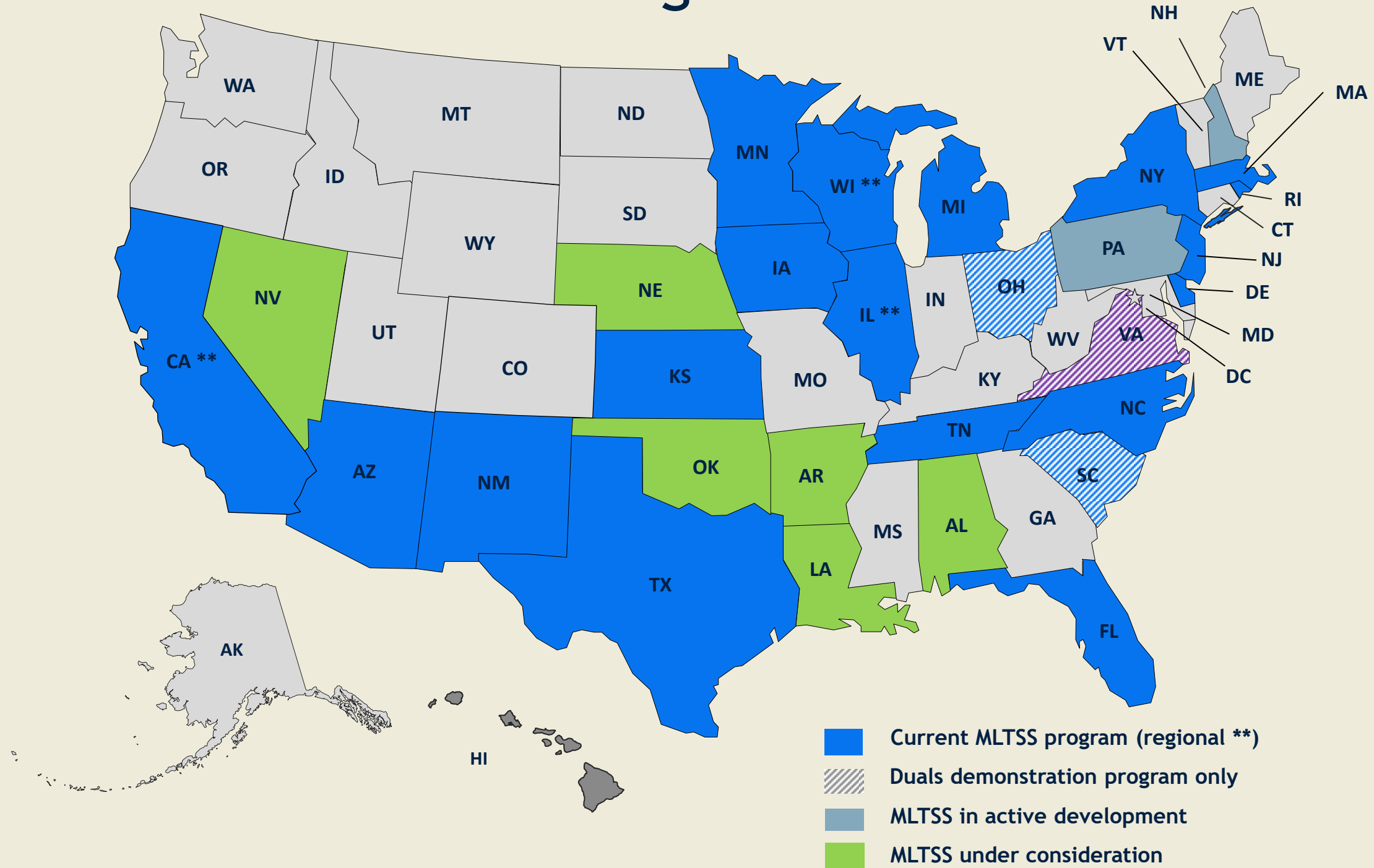
Movement to Managed Long Term Services and Supports

- Currently 22 states have implemented MLTSS and 10 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

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 - 2016



Source: NASUAD survey; 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

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
- Electronic care management systems
- Value based purchasing
- Diversion, transition and relocations
- Person centered service plans that offer increased options

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

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

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

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

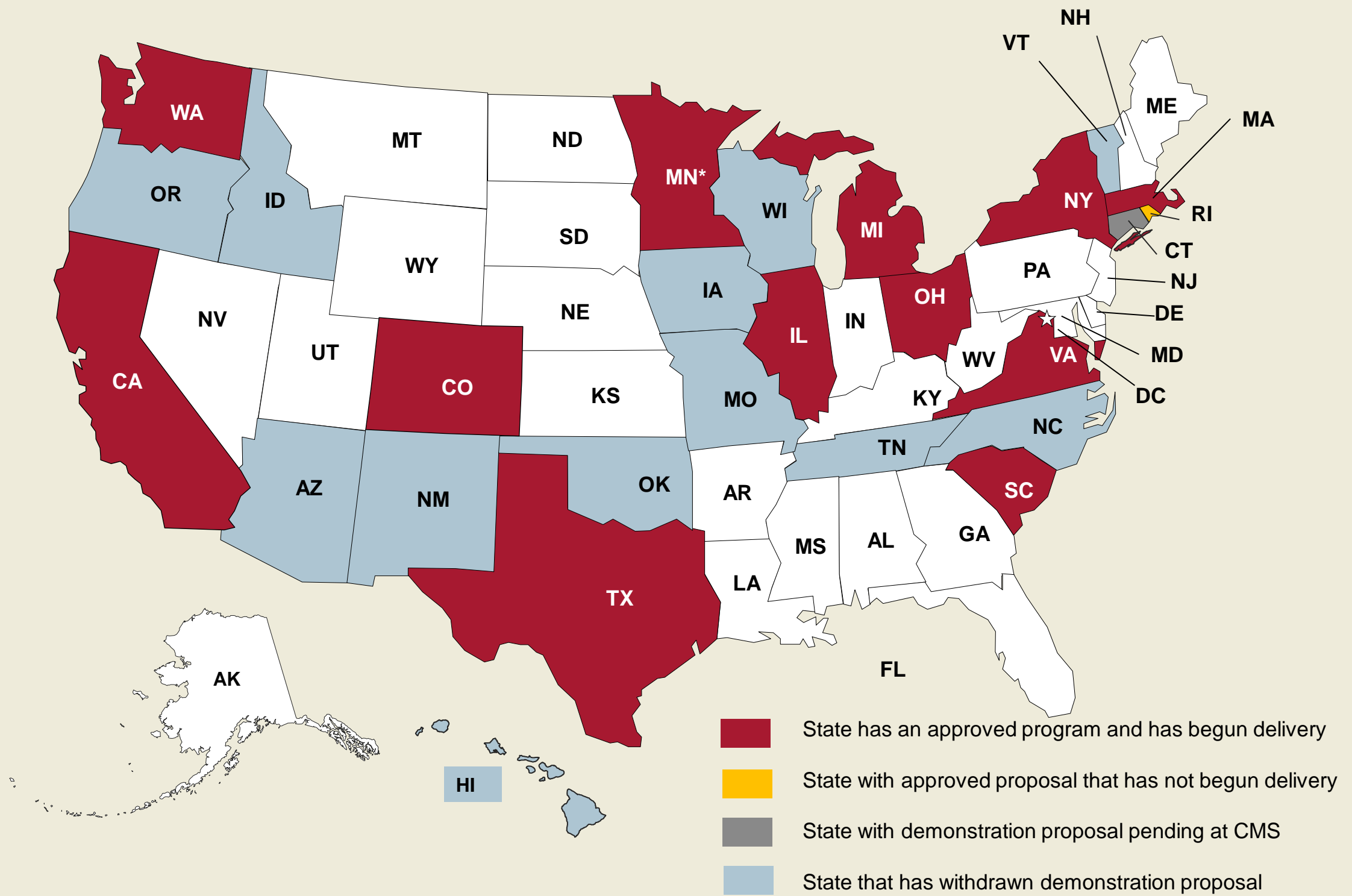
➤ **State Specific Waivers/MOUs**

- ✓ 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.

Dual Eligible Managed Care Demonstrations



*The Minnesota demonstration involves administrative alignment but does not include payment or service delivery innovations

Federal Programmatic Requirements

- MLTSS-specific provisions are based on May 2013 published guidance for States implementing Medicaid-only MLTSS and are weaved throughout rule in sections dealing with care coordination, stakeholder engagement, and beneficiary supports
- The regulations address these elements:

1. Adequate planning and transition strategies	6. Support for beneficiaries
2. Stakeholder engagement	7. Person-centered processes
3. Enhanced provision of HCBS	8. Qualified providers
4. Alignment of payment structures with MLTSS programmatic goals	9. Participant protections
5. Comprehensive and integrated service package	10. Quality

Federal Programmatic Requirements

- Application of HCBS regulations to all managed care programs
 - ✓ Settings (with appropriate transition period)
 - ✓ Conflict of interest
- Allow MCO change if NF/residential/employment provider leaves network



eff. 7/4/16



eff. 7/1/17

Federal Programmatic Requirements

Person-Centered Processes

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



eff. 7/1/17



eff. 7/1/18

The Future of MLTSS

- 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
- CMS will focus more sharply on areas of risk in managed care (e.g. DME, personal care, lack of access) leading to...
- 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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