While I can explain the meaning of life, I don't dare try to explain how the Medicaid system works.
Medicaid is an Optional Program

- Federal Law passed in 1965 (Title XIX of Soc. Security Act)
- Federal matching funds available Jan. 1966
- 26 states “opted in” within the first year
  - 41 within 3 years
- Alaska joined in 1972
- Arizona joined in 1982, through a waiver

Large financial incentive

Medicaid: Why Should You Care?

- Nearly 24% of total state expenditures (FY 2013, both federal and state funds)
- Largest financing source for low-income (44% of federal funds to states)
- Pays for >60% of nursing home residents
- Funds about 46% of U.S. births (2013)
- Covers 37% of children 0-18 (2013)
- Subsidizes care for the uninsured
- Subsidizes graduate medical education

“Traditional” Medicaid at a Glance

Three programs in one:
- A health insurance program for low-income parents (mostly mothers) and children
- A funding source to provide services to people with significant disabilities (nation’s “high-risk” pool)
- A long-term care program for the elderly

“Medicaid makes Medicare work.”
- Virtually no one else without expansion options (volunters or ACA)

People & Services (“Entitlement”)

<table>
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<tr>
<th>Mandatory Services</th>
<th>Optional Services</th>
<th>Mandatory People</th>
<th>Optional People</th>
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<td>Hospital</td>
<td>Prescription drugs</td>
<td>Children &amp; pregnant women</td>
<td>Adult children &amp; pregnant women</td>
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<td>Nursing facility</td>
<td>Hospice care</td>
<td>“Wellness” population</td>
<td>“Medically needy”</td>
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<td>Physician</td>
<td>Home care</td>
<td>SSI</td>
<td>Other “waiver” populations</td>
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<td>Rural health clinics</td>
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<td>Everyone with income &gt;133% poverty</td>
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<td>Labs &amp; x-ray</td>
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<td>Kids’ care</td>
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<tr>
<td>Others</td>
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<td>Others</td>
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</tbody>
</table>

Medicaid makes Medicare work.
- Virtually no one else without expansion options (volunteers or ACA).
NOTE: Medicaid income eligibility for most, including non-elderly adults with disabilities is based on the income guidelines of Supplemental Security Income (SSI).

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2009.

Federal Medicaid share in FY 2016:
- Alaska: $840 million
- Colorado: $3.4 billion
- Idaho: $1.5 billion
- Nevada: $1.6 billion
- Wyoming: $280 million

ACAs Medicaid Expansion

(Estimated to add 17 million Americans)

Established a minimum eligibility level at 133% of Federal Poverty Guidelines, with no asset or resource test.

New mandatory categories of eligibility:
- Childless adults
- Parents
- Former Foster Care Children to age 26

Law, as passed, allowed the DHHS Secretary to "punish" states by withholding regular federal match.

Decision Factors

- Political philosophy/role of gov't
- Costs/benefits
- Fiscal climate/national debt
- Pragmatism
- Federal flexibility or lack thereof
- Interested parties within the state (e.g., hospitals)

Court Ruling on Medicaid

The Medicaid expansion is a "gun to the head" because the "threatened loss of over 10 percent of a State's overall budget ... is economic dragooning that leaves the States with no real option but to acquiesce."

[Table and chart showing Medicaid/SCHIP income eligibility thresholds, 2009, with bars for different groups: Children, Pregnant Women, Elderly and Individuals with Disabilities, Working Parents, Non-Working Parents, Childless Adults, and Federally Poverty Line.]

[Chart showing ACA's Medicaid Expansion: Estimated to add 17 million Americans, established a minimum eligibility level at 133% of Federal Poverty Guidelines, with no asset or resource test. New mandatory categories of eligibility: Childless adults, Parents, Former Foster Care Children to age 26. Law, as passed, allowed the DHHS Secretary to "punish" states by withholding regular federal match.]

[Chart showing Decision Factors: Political philosophy/role of gov't, Costs/benefits, Fiscal climate/national debt, Pragmatism, Federal flexibility or lack thereof, Interested parties within the state (e.g., hospitals).]

Median Medicaid/SCHIP Income Eligibility Thresholds, 2015

Federal Poverty Line
(For a family of four is $24,250 per year in 2015)

Source: Kaiser Family Foundation

Medicaid Enrollees and Expenditures, FY 2011

Source: Kaiser Family Foundation
What are Long Term Services and Supports?

Long Term Services and Supports

- Home-based care: personal care aide, home health aide, caregiver
- Community-based care: assisted living facility, adult day care, respite care, senior centers, meal programs
- Facility-based care: nursing home, intermediate care facilities/IDDs, adult foster care, i.e., 24 hr care

What are Long Term Services and Supports?

- Personal care aide, home health aide, caregiver
- Assisted living facility, adult day care, respite care, senior centers, meal programs
- Nursing home, intermediate care facilities/IDDs, adult foster care, i.e., 24 hr care
What percentage of all long-term services and supports in the U.S. are paid for by Medicaid?

A) 15 percent  
B) 33 percent  
C) 43 percent  
D) 51 percent

Bonus question! How much is spent nationally on long-term services and supports?

Medicaid is the primary payer of long term services and supports

$310 Billion- Total National LTSS Spending

Source: Kaiser Family Foundation

Long Term Services and Supports and the Aging Population

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

Source: Kaiser Family Foundation

Home and Community Based Services

Median Annual Care Costs, by Type of Service, 2014

Source: Kaiser Family Foundation
Home and Community Based Services (HCBS)

HCBS accounted for 51.6% of long term services and supports spending in 2013

State options:
- 1915(c) waiver
- 1915(i) state plan option
- 1915(k): Community First Choice option

Community First Choice

HCBS through State Plan Option (October 2015)

Medicaid Managed Long Term Services and Supports
22 States Had MLTSS Programs as of October 2015

Source: Truven Health Analytics
Managed care is a set of tools and principles that can help improve coordination, quality, and cost-effectiveness of care for the most complex populations. It is up to us to implement these tools in the right way to achieve the desired objectives and preserve core system values.

Implementing managed care “well” and achieving program objectives requires a significant investment in the State's capacity to manage managed care.

It takes time to design and implement managed care. Moving too quickly will undermine the success of your program.

While managed care has significant potential for cost containment and even savings, assuming too much too soon will result in unintended negative consequences, and will undermine quality and cost-effectiveness goals.

Be careful not to confuse the success of the model with the success of the implementation.

Dual Eligibles
9 Million Dual Eligible Beneficiaries are Covered by Both Medicare and Medicaid

Takeaways and Advice - TennCare: CHOICES

Dual Eligible Demonstration Proposals - July 2015
Delivery System and Payment Reform

- Waivers
- State Innovation Models Initiative
- Managed Care

Medicaid Waivers

Medicaid Waivers
Section 1115
Section 1332
Section 1915(b)
Section 1915(c)
1915(b)&(c)
Concurrent

In 2017
1016
Waivers
Section 1115 Research & Demonstration Waivers

- Broad waivers that can expand coverage with limited benefits, change delivery systems, alter benefits and cost-sharing, restructure federal financing, modify provider payments and quickly extend coverage during an emergency, for the most part.
- There also are more narrowly drawn Section 1115 waivers that focus on specific services and populations (family planning.)
- Currently, 30 states and the District of Columbia operate one or more Section 1115 Medicaid waivers, for a total of 36 approved waivers.

State Innovation Waivers: Section 1332

States may request 1332 waivers from HHS and the Treasury Department of certain requirements of the Affordable Care Act (ACA).

<table>
<thead>
<tr>
<th>Waivers must preserve coverage and the fiscal parameters of ACA and are a vehicle for diverse system-wide changes. They must not increase the federal debt.</th>
<th>Cannot take effect before January 1, 2017, but states will need to prepare early in order to implement in 2017.</th>
<th>States are entitled to the subsidies their residents would have received through exchange if state proposes to waive subsidies and use funds for other purposes.</th>
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</thead>
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ACA Expansion Waivers

<table>
<thead>
<tr>
<th>Agreement Waivers</th>
<th>Provider Access</th>
<th>Provider/Healthcare Collaboration</th>
<th>Healthy Behavior Incentives</th>
<th>Benefits</th>
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*Cost-sharing waivers were approved in Indiana and are proposed in Tennessee and Idaho through Section 1332 via state waiver authority.
CMS State Innovation Model (SIM) Grants

- CMS Priorities for SIM Grants
  - Achieve triple aim: improve care, health, reduce costs
  - Multiple payers - Medicare, Medicaid, CHIP, State Employee Plans and private payer plans
  - Organized health care networks that provide integrated, seamless patient/person-centered care
  - Accelerate broad health system transformation
    - To move the delivery system away from fee-for-service, to value and performance, outcome-based reimbursement.

“...to transform health care systems through development and testing of state-based, multi-payer models of care delivery and payment transformation.”

SIMs Strategies

- Medical/Health Homes (at least 13 states)
- Accountable Care Organizations (at least 12 states)
- Bundled & Episodic Payment (at least 5 states)
- Integrating Care (at least 17 states)

These strategies are not limited to the SIMs models...
Summary of Successes, Challenges & Lessons Learned

1. New payment model ≠ system reform
2. New payment models = new provider expectations = workforce development to meet new delivery system demands
3. Data, data infrastructure, health information technology are fundamental
4. Payment models should drive focus on population health outcomes
5. Multi-payer collaboration can accelerate reform efforts
6. Stakeholder engagement strengthens the process

Super-Utilizer Programs

- Five percent of Medicaid beneficiaries account for 54 percent of total Medicaid expenditures and 1 percent account for 25 percent of total Medicaid expenditures.
- Among this top 1 percent, 83 percent have at least three chronic conditions.
- Robust “super-utilizer” programs that provide intensive outpatient care management to high-need, high-cost patients are being implemented.
- The term “super-utilizer” describes individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission or institutionalization—all costly, chaotic, and ineffective ways to provide care and improve patient outcomes.

MANAGED CARE

Many states are expanding their Medicaid managed care programs.
NOTES: ID’s MMCP program, which is secondary to Medicare, has been reclassified by CMS from a PAHP to an MCO by CMS but is not counted here as such. CA has a small PCCM program operating in LA county for those with HIV.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.

Comprehensive Medicaid Managed Care Models in the States, 2014

Missouri’s HealthNet Oversight Committee is a multidisciplinary committee created by the legislature to provide Medicaid oversight. There are 4 legislative committee members. The Committee is charged with evaluating the MO HealthNet program and its implementation.

Indiana created the Select Joint Commission on Medicaid Oversight to provide legislative branch oversight of Medicaid due to the size of the Medicaid program in the state budget and the number of recipients.

Kentucky’s Medicaid Oversight and Advisory Committee is required to meet at least four times annually and provide oversight on the implementation of Medicaid including access to services, utilization of services, quality of services, and cost containment.

Ohio’s Joint Medicaid Oversight Committee (JMOC) is a bicameral, bipartisan legislative committee that was created to review and recommend policies and strategies to improve how the Medicaid program in Ohio relates to the public and private provision of health care coverage.

Colorado Regional Care Collaborative Organizations

- PCPs are signed up with one of 7 RCCOs to serve the Medicaid population
- RCCOs receive $11.53 PMPM for PCMP support and care coordination, PCMP paid a $3 PMPM for medical home services
- Incentive payments are also available if the RCCO provider reduces ER utilization, 30 day hospital readmissions & use of high-cost imaging services
- Shared savings paid on top of FFS
- State net savings totaled between $29,330,495 to $32,997,329 (gross savings minus administrative expenses)
- ER visits decreased 21% and readmits 33% for adults

Oregon Care Coordination Organizations

- CCOs are local health entities governed by a partnership among health care providers, community members, and stakeholders in the health systems that share financial responsibility and risk in caring for the Medicaid population
- Emergency department visits have decreased 21% since 2011 baseline data.
- 30 day readmissions have dropped 6.5%
- Decrease in potentially avoidable hospitalizations
- Inpatient PMPM costs have decreased 5.7%
- Outpatient costs have also decreased 4%