MEDICAID: OVERVIEW AND INNOVATIONS

NCSL HEALTH SEMINAR FOR NEWER LEGISLATORS

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MEDICAID: OVERVIEW AND INNOVATIONS

- Medicaid overview
  - Emily Blanford, NCSL

- Federal policy updates
  - Haley Nicholson, NCSL

- Medicaid waivers: a mechanism for state-level innovation
  - Emily Blanford, NCSL

- Table exercise: reviewing your own state’s Medicaid data
MEDICAID: WHY SO IMPORTANT?

- 29.7% of total state spending from all sources in Fiscal Year 2018
  - (includes both federal and state funds)
- Total expenditures of $603.2 Billion in FY 2018
- Primary payer of long-term services and supports (LTSS)
  - Covers 3 out of 4 nursing home residents
- Funds about 50% of U.S. births on average
- Covers about 39% of children
COMPOSITION OF TOTAL STATE EXPENDITURES BY FUNCTION
FISCAL YEARS 1987 TO 2018

Source: National Association of State Budget Officers
<table>
<thead>
<tr>
<th>Program</th>
<th>Population served</th>
<th>Funding source</th>
<th>Source of control</th>
<th>Pays for long-term care?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>Eligibility by <strong>income</strong>: Children, pregnant women, parents, people with disabilities</td>
<td>Federal match of state funds</td>
<td>State government with federal guidelines</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicare</td>
<td>Eligibility by <strong>age</strong>: Adults ages 65 and older; also people with certain permanent disabilities</td>
<td>Social Security payroll tax, premiums, general revenue</td>
<td>Federal government</td>
<td>No</td>
</tr>
<tr>
<td>CHIP: Children’s Health Insurance Program</td>
<td>Uninsured children up to age 19 in families with incomes too high to qualify for Medicaid</td>
<td>Federal match of states funds</td>
<td>State government with federal guidelines</td>
<td>No</td>
</tr>
</tbody>
</table>
THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP) AND MEDICAID: OPTIONS FOR STATES

- State flexibility - benefit coverage, premium levels and cost sharing
- Program design - Expansion of Medicaid, separate program or combination of both
- Benefits - Requirements differ based on the program selected by the state
Medicaid is an optional program

Federal oversight agency is the Centers for Medicare & Medicaid Services (CMS)

States are required to delegate a Single State Agency to oversee administration of the program

Do you know your state’s Medicaid agency?
Federal Medical Assistance Percentage (FMAP) is used to determine the amount of federal matching funds provided to states.

- Each state receives the same percentage for administrative activities.
- Rate for direct services varies by state, based on average income.
- Different FMAP established for Medicaid expansion through the Affordable Care Act.
The Medicaid State Plan is an agreement between a state and the Federal government describing how that state administers its Medicaid program.

- Changes to the State Plan are called State Plan Amendments (SPAs).

The state plan defines:

- groups of individuals to be covered
- services to be provided
- provider reimbursement methodologies
Services in the State Plan must meet certain requirements:

- Service comparability
- Offered statewide
- Freedom of provider choice
States seeking additional flexibility to design their Medicaid programs (influence “policy levers”) may apply for formal waivers of some statutory requirements.

- 1915 (b) Managed Care Waivers
- 1915 (c) Home and Community Based Services (HCBS) Waivers
- 1115 Demonstration Waivers
MEDICAID POLICY OPTIONS – “LEVERS”

- Eligibility levels
- Mandatory and optional benefits
- Delivery systems
- Provider reimbursement
- Long term services and supports (LTSS)
MEDICAID ELIGIBILITY LEVELS

Median eligibility levels as a percent of the Federal Poverty Level (FPL), as of January 2017

Source: Kaiser Family Foundation
Established a new eligibility level at 138% of the federal poverty level (FPL):

- Childless adults
- Parents
- Former foster care children to age 26
MEDICAID BENEFITS

Mandatory Benefits

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing facility services
- Home health services
- Physician services
- Rural health clinic services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse midwife services
- Certified pediatric and family nurse practitioner services
- Freestanding birth center services (when licensed or otherwise recognized by the state)
- Transportation to medical care
- Tobacco cessation counseling for pregnant women
Optional Benefits

- Prescription drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental services
- Dentures
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal care
- Hospice
- Case management
- Services for individuals age 65 or older in an Institution for Mental Disease (IMD)
- Intermediate care facility for individuals with intellectual disability
- State Plan Home and Community Based Services- 1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- Tuberculosis related services
- Inpatient psychiatric services for individuals under age 21
- Health Homes for Enrollees with Chronic Conditions – Section 1945
- Other services approved by the Secretary
Managed care is the primary service delivery system in most states

- 33 states report 75% or more of Medicaid beneficiaries are enrolled in managed care

- Managed Long Term Services and Supports (MLTSS)

- Primary Care Case Management (PCCM) – primary care provider coordinates services

- Historically, most states paid for services on a fee-for-service basis

Source: Kaiser Family Foundation
DELIVERY SYSTEMS

- **Patient Centered Medical Homes (PCMH)**
  - Similar to Primary Care Case Management Model

- **Health Home**
  - Builds on the PCMH model and targets individuals with multiple chronic conditions

- **Accountable Care Organization**
  - Similar to PCCM model, but an organization takes responsibility for coordinating care. Generally includes primary and specialty care and one hospital
Fee-For-Service

- Medicaid agency establishes the fee levels for covered services and pays participating providers directly for each service they deliver to Medicaid beneficiaries.
- Providers do not bear financial risk

Capitation Payments

- Fixed per-member-per-month (PMPM) amount that a state Medicaid agency pays a managed care organization (MCO)
- Providers bear full financial risk

Pay for performance

Episode of care payment
LONG TERM SERVICES AND SUPPORTS

Long term services and supports provides a variety of services including:

- Nursing facility care
- Adult day programs
- Home health aide services
- Personal care services
- Transportation (including non-medical)
- Supported employment
- Family caregiver services
LONG TERM SERVICES AND SUPPORTS
MEDICAID SPENDING

**Medicaid Spending by Enrollment Group**

- **Disabled** (15%)
  - Elderly (9%)
  - Adults (27%)
  - Children (48%)

- **Expenditures** Total: $397.6 billion

**Medicaid Spending by Population**

- **Adults**
  - Average Spending Per Person: $3,247

- **Children**
  - Average Spending Per Person: $2,463

- **Disabled**
  - Average Spending Per Person: $16,443

- **Elderly**
  - Average Spending Per Person: $15,249

*Source: Kaiser Family Foundation, 2011*
Dually eligible individuals are eligible for Medicaid and Medicare

All beneficiaries receive the full Medicare benefit package

Most (72%) are also eligible to receive full Medicaid benefits

Some (28%) receive Medicare premium assistance funded by Medicaid

On average, 35% of total Medicaid spending for dually eligible individuals

Source: Kaiser Family Foundation
NCSL MEDICAID FEDERAL UPDATE

HALEY NICHOLSON-POLICY DIRECTOR, HEALTH
NCSL, WASHINGTON D.C.
Over 100 bills and resolutions related to Medicaid have been introduced so far.

Continued discussions on budget levels for 2021-2024, caps for defense and non-defense accounts.
Ways to avoid losing Medicaid and CHIP enrollees due to administrative burdens.

Addressing Medicaid fraud and abuse.

Increased flexibility in Medicaid for children with complex medical problems.
CONGRESSIONAL UPDATE:

- Coordination of Medicaid programs for public health pandemics.
- Medicaid Buy-In.
- Medicare for All.
- Role of Medicaid in behavior health and substance use disorder treatment.
H.R. 1839 - the Medicaid Services Investment and Accountability Act of 2019:

- Bi-partisan legislation passed and sent to the President.
- Extends Medicaid eligibility criteria by protecting against spousal impoverishment for those patients receiving home-and community-based services (HCBS).
- Provides medical assistance for coordinated care through health home for children with medically complex conditions.
- Additional money for the Money Follows the Person demonstration.
- Addresses prescription drug manufacturers participating in Medicaid rebate agreements to give drug product information, and compensate for rebates that were underpaid due to misclassification of a drug.
FEDERAL AGENCY UPDATES:

- Nursing Home Compare and the Five-Star Quality Rating System.
- Guidance on State Implementation of Home and Community Based Services Regulation.
- 2020 Budget Inclusion of Medicaid Block Grant Proposal.
- 1115 Waivers.
- Work and Community Engagement Requirements.
NURSING HOME COMPARE:
NURSING HOME COMPARE:

- Ongoing updates worked on past several years.
- In addition to updated rating systems now will include quality measures for nursing homes.
- Health Inspections, Staffing Levels and Quality Measures.
HOME AND COMMUNITY BASED SERVICES:
CMS released updated guidance to states on previous implementation of 2014 Home and Community Based Services (HCBS) regulation.

Previous guidance required HCBS be provided in settings ensuring enrollees have access to benefits of community living and have services in integrated settings.

2014 guidance also required states to transition to new integrated, noninstitutional settings for HCBS within three years.
HOME AND COMMUNITY BASED SERVICES:

- Met with stakeholders to address guidance from 2014 as well as its inclusion of “heightened scrutiny” reviews.

- Feedback received it was difficult to define settings under new guidance, and not enough transition time.

- CMS granted an transition extension for states in 2017, allowing states to fully comply by 2022.

- Guidance released FAQs to help providers and community stakeholders with transition period and streamlined administrative requirements.
As of April-2019, 47-1115 waivers have been approved across 39 states, and 18 are pending across 17 states.

Before the passage of the ACA and its Medicaid expansion, states primarily used 1115 waivers to provide coverage to childless adults who didn’t qualify for Medicaid.
CURRENT 1115 WAIVERS:

Landscape of Approved vs. Pending Section 1115 Medicaid Demonstration Waivers, April 1, 2019

- Approved (47 across 30 states)
- Pending (18 across 17 states)
- Set Aside by Court (2 across 2 states)

Eligibility and Enrollment Restrictions: 11
Work Requirements: 7
Benefit Restrictions, Copays, Healthy Behaviors: 7
Behavioral Health: 28
Delivery System Reform: 16
MLTSS: 13
Other Targeted Waivers: 15

NOTES: Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive and may fall into a few different areas. Therefore, the total number of pending or approved waivers across states cannot be calculated by summing counts of waivers in each category. Pending waiver applications are not included here until they are officially accepted by CMS and posted on Medicaid.gov. For more detailed information on each Section 1115 waiver, download the detailed approved and pending waiver tables posted on the tracker page. "MLTSS" = Managed long-term services and supports.
WORK & COMMUNITY REQUIREMENTS:
WORK & COMMUNITY REQUIREMENT WAIVERS:

- Program created to incentivize work and community engagement among non-elderly, nonpregnant, adult Medicaid enrollees.
- Activities that qualify under these requirements: work or community engagement, skills training, education, job searches, caregiving and volunteer service.
- States can also make modifications for eligible individuals with substance use disorders (SUD).
- CMS released new guidance for 1115 waivers including those with work and community engagement requirements.
WORK & COMMUNITY REQUIREMENT WAIVERS:

- As of March 1, 2019, the following states have been approved for these waivers: Arkansas, Arizona, Indiana, Kentucky, Michigan, Ohio, New Hampshire, Utah and Wisconsin.
- The following are pending approval: Alabama, Mississippi, Oklahoma, South Dakota, Tennessee, and Virginia.
- Indiana and New Hampshire are the only states of this list that have implemented their programs.
- Kentucky and Arkansas’ programs have been set aside by Court.
- Judicial action around work and community requirements.
MEDICAID WAIVERS: A MECHANISM FOR STATE-LEVEL INNOVATION

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HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS

- Authorized under Section 1915(c) of the Social Security Act
- Option for individuals with disabilities who meet institutional level of care
  - Hospital, nursing facility, intermediate care facility
- Allows states to waive certain provisions in order to:
  - Target populations
  - Target geographic areas
  - Place limits on enrollment
HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS

- HCBS waivers allow states to provide services in less costly community settings rather than more expensive institutional settings
- 1915 (c) HCBS programs provide a combination of medical and non-medical services, including: home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care
- 47 states offer services through this waiver, with the other three (Arizona, Rhode Island and Vermont) offering HCBS through an 1115 demonstration waiver
1115 DEMONSTRATION WAIVERS

- 1115 waivers provide an option for experimental, pilot, or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program
- Like 1915 waivers, allows states to waive certain provisions but has more flexibility
- Requires more time to implement than other “traditional” options
Elements of Medicaid expansion waivers include:

- Premium assistance
- Premiums/monthly contributions
- Healthy behavior incentives
- Waiving required benefits (transportation)
- Waiving retroactive eligibility
ELIGIBILITY AND ENROLLMENT RESTRICTION WAIVERS

- Largely includes options for premiums/monthly contributions
  - Coverage loss and lock-out due to non-payment
- Tobacco premium surcharge – Indiana example
Several states require 80 hours of work/community engagement per month
- Arizona, Kentucky, Michigan, Oklahoma, South Dakota, Wisconsin

Other states require 20 hours of work/community engagement per month
- Alaska (parents and caretakers), Mississippi, Ohio

One state, New Hampshire, requires 100 hours of work/community engagement per month

Indiana and Virginia requirements vary based on amount of time enrolled in the program
Waive required transportation benefits
Waive Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) for 19 and 20 year olds
Restriction on free choice of family planning provider
Coverage of services in Institutions for Mental Disease (IMD) – residential treatment option for substance use and mental health

Community based benefit expansions

Eligibility expansion

Delivery systems
States are looking to integrate physical and behavioral health to create efficiencies and improve health outcomes.
Nearly half of all states provide long term services and supports (LTSS) through a managed care option

- Increase access to HCBS by expanding Medicaid financial eligibility criteria
- Allow beneficiaries to employ spouses as paid caregivers
- Require reporting on LTSS rebalancing measures (from institutional care to community based)
- Require monitoring of service decreases by health plans
FUTURE WAIVER DISCUSSIONS – MEDICAID FINANCING

Current Model

- Federal financing formula for Medicaid range from 50-75%
- States with higher per capita income (a measure of state fiscal capacity) have lower Federal Medical Assistance Percentage (FMAP)
- Federal funding un-capped; as health costs increase, Feds pay a share

Block Grants

- Set Federal allotment provided to states
- Likely not sensitive to cost, enrollment and economic downturn

Per Capita Cap

- Per beneficiary amounts provided to states
- Would provide some sensitivity to enrollment and economic downturn
GROUP DISCUSSION
STATE-LEVEL MEDICAID INFORMATION
NATIONAL SPENDING TRENDS
AVERAGE ANNUAL GROWTH RATE OF SPENDING PER PERSON

Source: Kaiser Family Foundation Analysis of National Health Expenditure Data
ANNUAL GROWTH RATES IN MEDICAID ENROLLMENT AND SPENDING FY 1975 – 2014

Source: Medicaid and CHIP Payment and Access Commission
Total State Expenditures By Function FY 2018
Includes State and Federal Funds

Federal Fund Expenditures By Function FY 2018

Source: National Association of State Budget Officers, 2018 State expenditures Report
Objectives

- Increase knowledge about Medicaid data and information in your state
- Learn about strategies and policy options from other states
- Share your concerns, interests and health policy successes in your own state
60.9% of beneficiaries in IL are in managed care.

50.14% is the Federal Medical Assistance Percentage (FMAP) for Medicaid in IL.
POLICY LEVER 1: GUIDING QUESTIONS

What jumps out or surprises you about this information?

What questions does this raise for you?

What are you hearing from your constituents on this topic?

What are you hearing from your Medicaid agency on this topic?

Are there any actions you might take based on this information?
In 2017, 20% of individuals in IL were covered by Medicaid/CHIP

Medicaid spending per full-benefit enrollee in IL is $5,301

The national average Medicaid spending per full-benefit enrollee is $6,396
POLICY LEVER 2: GUIDING QUESTIONS

What jumps out or surprises you about this information?

What questions does this raise for you?

What are you hearing from your constituents on this topic?

What are you hearing from your Medicaid agency on this topic?

Are there any actions you might take based on this information?
POLICY LEVER 3: LONG TERM SERVICES AND SUPPORT

388,600
Medicare beneficiaries in IL rely on Medicaid assistance with Medicare premiums and cost-sharing, and services not covered by Medicare, particularly long-term care.

34%
of Medicaid spending in IL is for Medicare beneficiaries.

42.7%
of long-term care spending in IL is for home and community-based care.
POLICY LEVER 3: GUIDING QUESTIONS

What jumps out or surprises you about this information?

What questions does this raise for you?

What are you hearing from your constituents on this topic?

What are you hearing from your Medicaid agency on this topic?

Are there any actions you might take based on this information?
RESOURCES:

- Understanding Medicaid: A Primer for State Legislators
- Medicaid Services Investment and Accountability Act of 2019
- Nursing Home Compare and the Five-Star Quality Rating System
- CMS Updated Guidance for 1115 Waivers
- FAQs on State Implementation of HCBS
- CMS Implementation of New Medicare Advantage Policies
RESOURCES:

- Looking at a State’s Role in Medicaid Work/Community Engagement Requirements
- About Section 1115 Waivers
- Kaiser Family Foundation Medicaid Waiver Tracker
- White House 2020 Budget
- 1115 Waiver Primer
- Medicaid Waivers in the States: Seven FAQs
Thank you!

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