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Medicaid

- Single State Agency – administer or supervise administration of program
- Cooperative agreements for administration
- State Plan
  - Amount, duration and scope of services
  - Recipients
  - Rate setting methodologies
  - Quality control

Medicaid Financing

- Federal match rate or federal financial participation
- State financial participation
- Nonfederal share of expenditures

Medicaid State Plan Process

- Review process
- Public notice requirements

Basic Tenets of Federal Medicaid Policy

- Comparability -Services “sufficient in amount, duration and scope to reasonably achieve their purpose”
- Utilization Review Requirements - Methods and procedures relating to the utilization of and payment for care and services consistent with efficiency, economy, and quality of care & sufficient to enlist enough providers
- Reasonable promptness
- Statewideness, with certain exceptions
- Freedom of Choice of Provider, with some exceptions

Medicaid Services

- Mandatory
- Optional
- EPSDT - medically necessary care and treatment to correct or ameliorate defects and physical and mental illness and conditions
- If mandatory service, states may require medical necessity and may limit utilization
- If optional benefit, service must be equally available to all who meet criteria established

Medicaid Eligibility

- SSI
- SCHIP
- TEFRA
- Buy-In

Medicaid Waivers

- Institutional Bias
- Provisions that may be waived
  - Comparability
  - Statewideness
  - Income and resource rules

Research & Demonstration Waivers (Section 1115)

- Research and demonstration – adopted primarily to implement managed care; test new reimbursement methodologies
- May cover non Medicaid services
- Offer different services in different parts of state
- Budget neutral

Section 1915 Waivers

- 1915(a)
  - Used to authorize voluntary managed care statewide or limited geographic area
- 1915(b)
  - Freedom of choice waiver
  - Mandatory enrollment of beneficiaries in managed care programs

Section 1915 Waivers cont'd

- 1915(c)
  - Home and community based services as an alternative to institutionalization
- 1915(b)/(c)
  - Mandatory managed care program that includes home and community based services with targeted eligibility

Home and Community-Based Services (HCBS) Waivers

- HCBS – only available as an alternative to institutional care
- Must meet LOC as defined by state and approved by CMS
- May target areas of state and eligibles
- Range of cost containment strategies

HCBS Waivers continued

- Services: case management; homemaker; home health aide; personal care; adult day health; habilitation-residential and day; expanded habilitation services – prevocational, supported employment, education; respite
- "Such other services requested by the states as the Secretary may approve" – so long as necessary to avoid institutionalization and cost effective
- Extended State Plan Services

Services under HCBS Waiver

- Standard application format with suggested definitions of services – states may modify or propose new services
- Options in waiver format:
- 1. Case Management
- 2. Personal care/assistant – homemaker; home health aide; personal care; chore; attendant care
- 3. Services usually furnished outside the home – residential habilitation; adult foster care; assisted living
- 4. Specialized disability-related services – day habilitation; adult day health

HCBS Waiver Services Cont’d

- 5. Services for persons with mental illness – clinic, day treatment; psych rehabilitation
- 6. Health Related Services – skilled nursing; private duty nursing
- 7. Assistive devices, aids and equipment and modifications and specialized medical equipment
- 8. Family training and respite

Other Services not in Standard Format

- Home delivered meals and nutrition services (Ohio, Maryland, Oregon)
- Family counseling to deal with behavioral problems and substance abuse services for persons with acquired brain disorders
- Training in child and infant care for parent with a disability (Colorado)
- Wellness monitoring (Kansas)
- Adult foster care (Ohio)
- Adult day care services
- Latch key supports

Financial Considerations

- Budget neutrality test – compare total spending for LTC services with and without offering HCBS
- Cost effectiveness – compare overall per recipient spending on institutional services to overall per recipient spending on HCBS, including costs of other Medicaid services;

Financial Considerations Cont'd

- Spending affected by: limitations on services; cap on number served; expenditure limits
- State are required to specify the # of unduplicated recipients of wavier services (42 CFR 441.303(f)(6)
- State may impose absolute limit of maximum dollar value of waiver services authorized for any beneficiary or it may meet a target average cost per beneficiary **which may exceed institutional cost**
- If absolute dollar limit, state may exempt certain services from counting against cap to lessen impact (Ex: home adaptations)

Informal Caregiving

- Medicaid requires the service address the recipients' needs – can't primarily benefit the family unit
- No federal requirement that family provide some minimum level of care but states may take into account amount of informal care available; states can match services to needs of recipient and circumstances of informal caregivers
- Federal law permits family members to be paid unless member is legally responsible for care (spouses and parents/guardians of minors)
- States may establish different provider qualifications for family members –ex. Exempt from criminal background check; may allow only if residence is so remote that service would be otherwise unavailable

Support Waivers

- Developed limited benefit packages as result of CMS policy against “waiver within a waiver”
- Clarification allowed caps on services or package of services within waiver

Managed Care Arrangements

- Being used on limited basis for HCBS
- May now mandate enrollment in managed care (previously required waiver) except dual eligibles and LTC services
- 1915 (b) (c) combination waivers – allows coverage of HCBS not in state plan through managed care approach
- PACE – capitated; XIX and XVIII funding; integrates acute and LTC services; > 55 yrs

Recommendations of Medicaid Waiver Work Group

- Revenue Maximization
- Enhanced Funding
- Improved Access
- Expanded Eligibility

Allocation of Waiver Capacity to Local Entities

- Issues currently facing local entities: unfilled capacity; inability to obtain waiver slots; inability to use local funds as match to serve local residents in need; limitations of existing UR system; crisis management
- Allocate waiver capacity to local entities based on formula recognizing population, services, local availability of funds, unfilled slots

Program Issues

- New Waiver with Lower Cap
- Variable funding limits within waivers
- Sheltered workshop services included within waiver
- Additional covered services in waivers
- County Boards role in health improvement plans
- Opportunities of Deficit Reduction Act
- HCBS as an entitlement through managed care initiative
- Allocation of waiver capacity to local entities

Children’s Issues

- Waivers to cover services provided to young children covered by First Steps
- Developmental surveillance tool
- Family Opportunity Act

Administrative Issues

- QMRP
- Post Medicaid Waivers and Proposed Amendments on Website
- Standardized Process of Communication