Medicaid Waiver Project
MACDDS

June 26, 2008

Identify Objectives

- Cover more persons with developmental disabilities
- Close benefit gaps - underinsurance
- Pay for additional services
- Build capacity

MO HealthNet Eligibility

- Children (regardless of insurance status) are eligible if monthly net family income does not exceed the following:

- 185% FPL for children under age 1
- 133% FPL for ages 1-5
- 100% FPL for ages 6-18
- Uninsured children whose income is over the above limits, and whose monthly gross family income is under 150% FPL, are also eligible.

SCHIP Eligibility in Missouri

- Children's Health Insurance Program – 1997 for uninsured children
- family gross income over 150% FPL up to 300% FPL;
- uninsured for 6 months;
- family assets with a net worth of less than $250,000;
- children in families with gross income over 150% FPL cannot have access to affordable health insurance and must pay a monthly premium (no more than 5% of income - range from a minimum of $12 to a maximum of $294 per month)

Other States SCHIP Programs

- Louisiana – Expanded eligibility for those with income between 200 – 250% FPL; estimated to cover an additional 6,500 children
- Monthly premium of $50 with 10% copay on most services
- Service package modeled after state employee plan

Expanded Eligibility

- TEFRA- Optional eligibility program allows for disregard of family income for child with disability under 21 with institutional LOC needs – creates entitlement
- SSI – Child who is SSI eligible has portion of family income deemed as available to child in Missouri
- In PA, family income disregarded for all SSI eligible children through state plan option qualifying 32,000 kids otherwise ineligible due to income
- In NH, disregard family income in child is SSI eligible and meets institutional LOC

Medicaid Buy-In Programs

- Allows those whose income is too high to qualify for Medicaid to purchase Medicaid coverage
- No institutional LOC requirement
- Some states had buy-in programs that predated option under DRA - Vermont

Vermont – 1115 Waiver

- Waiver predated DRA option but not SCHIP
- To prevent families from dropping private insurance to obtain SCHIP coverage created buy-in program under 1115 for those who were income eligible for SCHIP but had private insurance
- Difference from FOA is no disability criteria – any family could utilize

DRA – Family Opportunity Act

- Buy-in program for SSI-eligible children if family income less than 300% FPL (uninsured and underinsured – SCHIP only serves uninsured)
- Creates incentives for families to keep private insurance if premiums are reasonable
- If child has private insurance, cost to state is relatively low
- Expands Medicaid coverage

Pennsylvania – Infant, Toddlers and Families Medicaid Waiver

Authority of 1915(c)

- Financial Eligibility:
  - Income limit 300 percent Federal Benefit Rate (must be enrolled in Medicaid)
  - Disregard parental income

- Functional Eligibility:
  - Age 0 - 3 (Birth until the 3rd birthday)
  - Need for early intervention services
  - ICF/MR level of care or Other Related Conditions (ICF/MR-ORC)
    - 50% delay in 1 or 33% delay in 2 or more developmental

- Services:
  - Habilitation services includes as therapies, nutrition, developmentalists

- Source: Pennsylvania Code§ 4226. Early Intervention Services.

Nebraska – Early Intervention Medicaid Home and Community-Based Waiver

- Authority of 1915 (c)
- Financial Eligibility – based on child's income-Medicaid eligible; not receiving services under another waiver
- Functional Eligibility – meet institutional LOC; participant of EI services
- Services – respite of up to $100/month; family negotiates rate with provider; service coordination; services added to IFSP
- Source: Nebraska DSS Manual Title 480

North Carolina

- 1915 (c) waiver for children under 18 yrs
- SSI eligible
- Open to all children regardless of income
- 3 levels of care with $ limit on each
- If child meets LOC requirements and budget limits, admitted to waiver and receives all Medicaid services
- If no longer meets LOC requirements, lose Medicaid eligibility if not income eligible

Alternative Approaches

- New Jersey – FamilyCare Advantage
- For families with income too high to qualify for SCHIP (>350% FPL) – children <19 only
- Must be uninsured for at least 6 months
- Must cover all eligible children in household
- Same benefits as SCHIP at significantly lower cost than private market with small copays
- $137/mo 1 child; $274/mo 2 children; $411/mo 3 or more children
- Serve approximately 15,000 children
- Sole contract with Horizon BC/BS of NJ

Mandated Benefits

- MA – Mandated private insurers to cover EI services up to certain $ limit
- RI – Mandated coverage of EI services up to $5,000
- KY – Mandated autism benefit of $500/yr

Build Capacity

- DE – health based/risk adjusted rates to MCOs
- FL – Title V operates Medicaid MCO for CYSHCN; currently PCCM but transitioning to rate adjusted capitation
- IA – SPA to enhance EPSDT benefits including specialty dental care
- NM & OH – required screening for CYSHCN in Medicaid managed care
- Use of telemedicine to provide access to specialty care

Waivers

- http://170.107.184.126/CMS/faces/portal.jsp

Case Management Federal Regulation

- FR Volume 72 No 232 December 4, 2007
- www.cms.hhs.gov/DeficitReductionAct/Downloads/CM_IFC.pdf
- Effective March 3, 2008; moratorium
- Incorporates changes of Section 6052 of the DRA and earlier legislation
- Redefine CM services “assist individual eligible under state plan in gaining access to needed medical, social, educational, and other services”

Case Management

- Assessment
- Development of specific care plan
- Referral and related activities
- Monitoring and follow up
- Does not include direct delivery of underlying medical, educational, social or other service to which the individual has been referred

Targeted Case Management

- Added definition – Case management services furnished without regard to requirement of statewide availability and comparability of service

Case Management

- Added clarification that when case manager contacts individual who is not XIX eligible or not in target population, may qualify as case management if directly related to eligible individual's care
- FFP only available if no other third party liable to pay for cost of service

Case Management

- Freedom of Choice requirements apply -if target group is developmentally disabled or chronic mental illness, state may limit choice to providers qualified to provide case management to the target population based on criteria state establishes for qualified providers

Case Management

- Transitioning from Institution to Community – transitioning during last 60 consecutive days of covered long term institutional stay of 180 consecutive days or longer; if less than 180 days, only transition during last 14 days

Case Management

- Assessment – must be comprehensive and address all needs
- Individual may decline to receive services in plan
- If individual eligible under more than one TCM plan, must determine appropriate target group and that case manager responsible for ensuring plan addresses all needs and must coordinate with providers in both systems of care
- Case Management is one-on-one activity and restricted to one Case Manager
- State option on minimum educational or professional qualifications of case manager

Case Management

- Receipt of CM is optional – cannot compel receipt of service and cannot condition receipt of CM on receipt of other services and cannot use CM to restrict access
- Documentation requirements – added need for and occurrences of coordination with case managers of other programs
- Up to one year after end of next legislative session to comply

State Plan Amendment

- Whether CM will be targeted and if so define group
- Describe services to be furnished including types of monitoring
- Frequency of assessments and monitoring and justification for frequency
- Qualifications of providers
- Methodology for payments and rate
- Cannot bundle rates
- If state limits qualified providers for targeted group, state limitations and how they enable providers to ensure that individual within targeted group will received needed services

Case Management

- FFP not available for activities that are integral component of another covered XIX service
- Health assessment not case management but separate form of billable medical assistance
- Case management is integral part of managed care but purpose is to manage medical services and not assist with access so person in managed care may also receive case management

Case Management

- IEP – identifies special education and related services needed by child
- IFSP – identifies early intervention and other services needed
- One distinction of IEP and IFSP is IFSP requires a service coordinator, some of whose activities may be Medicaid funded including taking history, identifying service needs, gathering information to form comprehensive assessment but not administrative functions (writing plan, conducting plan meeting)
- “To facilitate coordinated care, case management is a covered Medicaid service only when a single case manager comprehensively addresses all of the individual’s service needs.”

Case Management Rate Setting

- “Payment rates and their corresponding methodologies tend to over-allocate cost to the Medicaid program.”
- Allowable costs – salary and fringe benefits; indirect costs; transportation; adjustment for nonproductive time
- Payments must be consistent with efficiency, economy and quality of care

Allowable Costs

- Direct practitioners – not supervisors or support staff, by FTE and adjusted for other funding sources
- Fringe benefits – employer cost of health insurance, Medicare and Soc Sec contributions
- Cost must be demonstrated to be included
- Indirect cost of 10% acceptable
- Transportation – must be actual

Rate Setting

- Rate may recognize general and administrative or nonproductive time – holidays, training, breaks
- Use of CMS approved, statistically valid time study to identify percent of time on G & A activities OR specific documentation to justify time allocated, example - state statute specifying number of required hours of training, state paid holidays
- State assurance that billed time does not exceed available productive time and must identify billing limits in state plan amendment
- If using CPE, must reimburse governmental provider at cost based on cost accounting system to identify expenditures for Medicaid clients for TCM services

TCM Rate

- Total allowed cost/2,080 hours - G&A time = TCM Rate
- Allowable cost example - $48,000/provider + indirect cost + allowable G & A = reasonable and economic payment
- “Sniff Test” example: $17/15 min unit

$17 x 4 units/hr x 2080 hours/yr = $141,440
“appears on its face to exceed reasonable cost of providing TCM”

MO: $7.78/5 min =$93.36/hr x 2080 = $194,188