Medicaid 101

mahp
Michigan Association of Health Plans

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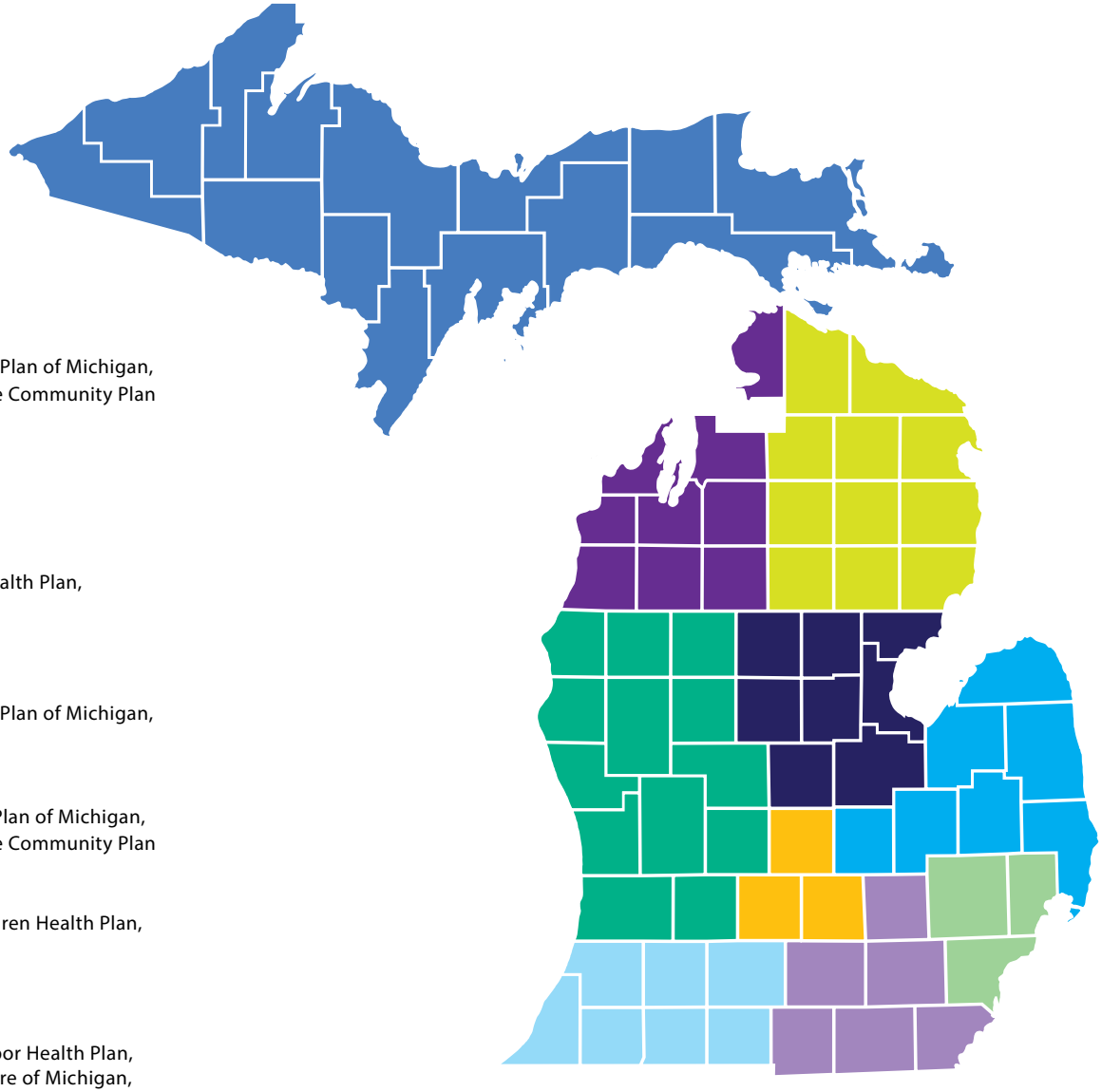


The History of Medicaid

- In 1965, Title XIX of the Social Security Act (Medicaid) and Title XVIII (Medicare) were enacted
- Titles XVIII and XIX were passed in response to the widely perceived inadequacy of public assistance for the health care of low-income persons.
- Michigan first introduced Medicaid Managed Care in 1996 and later added beneficiary groups such as foster care, Children Special Health Care Services and dual eligible.
- Medicaid is jointly funded by the federal and state governments.
- On average, the federal government pays 57 percent of Medicaid national costs.
- The federal government matches funds contributed by state governments. Michigan's Match Rate for 2018 is 64.45 percent. A decrease of 0.7 percent from the year before.
- Medicaid is the nation's primary form of health coverage for individuals and families with limited incomes and resources.
- Medicaid is an insurance affordability program to aid low-income popula tions including children, pregnant women, parents with dependents, the aged, blind and disabled (ABD), foster children and dual eligible adults.
- The elderly and the disabled account for the largest portion of Medicaid spending; 24 percent of enrollment totaling 63 percent of expenditures nationally.
- The federal government establishes broad national guidelines for eligibility, services covered and payment schedules. Within those guidelines, states establish their own standards and administer their own programs.
- Eligibility, scope of services, and payment rates vary among states.

State Management of Medicaid

Primary Care Case Management (PCCM)

- Primary care physicians (PCP) provide care coordination in a patient-centered medical home environment.
- The PCP and the patient make decisions together about needed services and who will provide those services.
- State is billed on a fee-for-service (FFS) rate.

Managed Care with Capitation

- Managed care organizations (MCO's) are paid a per member/per month fee to cover services.
- Incentive is for MCOs to manage care in a way that results in fewer unnecessary procedures per patient.
- Risk is shifted to the MCO.

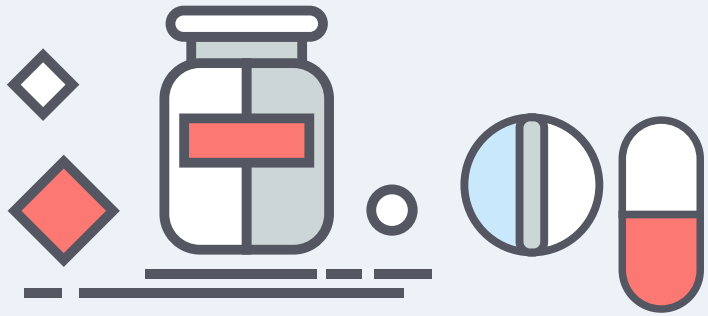
Fee-for-Service (FFS)

- This traditional model pays a provider each time a service is provided.
- Providers have a financial incentive to do more procedures because they are reimbursed more.
- This undermines care coordination as there is no risk.

Medicaid Benefits

Mandatory

- 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.
- Mild to moderate outpatient health services.



Optional

- 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
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (MD)
- Services in an intermediate care facility for the mentally retarded
- State Plan Home and Community Based Services – 1915(i)
- Self-Directed Personal Assistance Services – 1915(j)
- Community First Choice Option – 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Health Homes for Enrollees with Chronic Conditions – Section 1945

Integration of Behavioral Health

Managed care is the predominant financing model for state Medicaid programs, with nearly 40 states contracting with managed care organizations (MCOs) to provide all or some physical health benefits for beneficiaries. Although the Medicaid population has a complex array of behavioral and physical needs and high associated costs, in Michigan many are served in fragmented systems of care with little to no coordination across providers, often resulting in poor health care quality and high costs. Increasingly states are seeking ways to better coordinate physical and behavioral health services with the goal of improving outcomes and reducing unnecessary utilization. One strategy gaining traction is the move to integrate behavioral health services within a comprehensive Medicaid managed care environment that traditionally covered physical health services only.

More states in recent years have adopted integrated payment and delivery models that cover all or some combination of physical, behavioral health, long-term services and supports (LTSS), and other social supports needs. A rapidly growing number of states are adopting managed care models in which a single entity is responsible for both behavioral and physical health services, thus "carving-in" behavioral health services. Michigan began moving in this direction as part of the FY 17 state budget.

Michigan is poised to modernize its Medicaid program through the creation of a fully integrated MHP-led delivery system that reduces costs, streamlines administration, improves the experiences of beneficiaries and providers and delivers better outcomes. The transition to this system must be structured thoughtfully to consider its impact on Michigan's ongoing Medicaid innovations, multiple waivers and programs that currently operate within the system.

For example, a patient with a physical condition coupled with schizophrenia will likely have trouble managing the physical condition if the schizophrenia is not well controlled.

Beneficiaries with behavioral health conditions are more likely to suffer from physical health conditions.

- Health care costs for Medicaid beneficiaries with major depression and a chronic medical condition are twice as high as those for beneficiaries without depression.
- Opportunity exists to reduce physical health related costs by focusing services on people with behavioral health conditions.
- A managed care model with capitated payments incents providers to keep patients healthy. For individuals with behavioral health issues, managed care can provide better access to treatment before a crisis or hospitalization.
- States are moving toward including behavioral health in their Medicaid managed care programs to decrease costs associated with co-morbid physical and behavioral health conditions.

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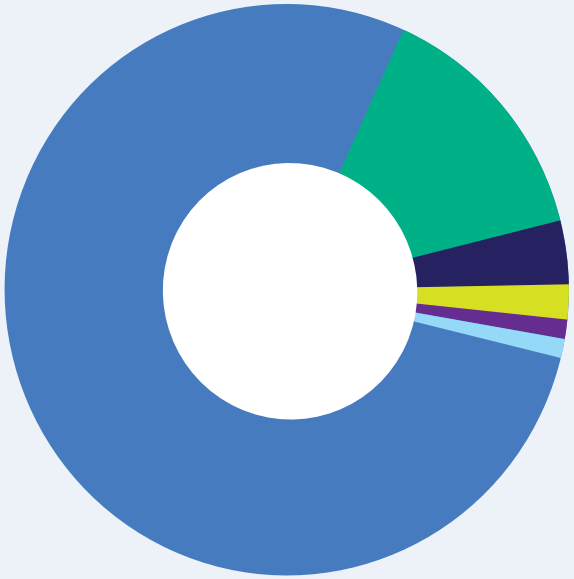
MDHHS Medicaid Expenditures



- 74% Medicaid
- 18% Medicaid & Non-Medicaid Behavioral Health Services
- 4% Public Health / Maternal and Child Health Services
- 2% Administration & Information Technology
- 1% Children's Special Health Care Services
- 1% Aging / Crime Victim Services

TOTAL: $17.4 BILLION

FEDERAL POVERTY LEVEL (FPL) 2018

FAMILY SIZE	100% FPL	138% FPL
1	$12,140	$16,753
2	$16,460	$22,715
3	$20,780	$28,676
4	$25,100	$34,638

Waivers

Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP).

- Used when states want to change a policy that is inconsistent with one or more federal requirements for state Medicaid plans.
- Used when state request flexibility in how federal funds are used.
- Must be budget neutral.
- Can be used to add or cut certain aspects of Medicaid plans such as behavioral health services.

Section 1115: Research and Demonstration

- Allows states to apply for flexibility in programs to test new or existing approaches to cost cutting and delivery of Medicaid and CHIP.
- Approved for a five-year period.
- Can be renewed for an additional three years.

Section 1115 waivers allow states to add populations or to cover specific services to their Medicaid managed care that are not typically covered.

- Flint water crisis, expanded Medicaid services to pregnant women and children with income up to 400% FPL.
- Health Michigan Program Covers non-pregnant, non-disabled adults ages 21-64 with incomes up to 138% of federal poverty level.

Section 1915(b): Managed care waivers Commonly known as the Freedom of Choice waiver:

- Mandates enrollees be placed in a managed care program; although some states have the option to enroll beneficiaries into managed care through a state plan amendment.
- Creates programs that may only be available in particular counties/regions.
- Allows the state to provide additional health programs to Medicaid beneficiaries that may not be available through managed care.

Waivers, Waivers, Waivers…

- A waiver for states to provide services through managed care delivery systems and limit the choice of providers.
    - 1915(b)(1): Implements a managed care delivery system that restricts the type of providers available for Medicaid benefits.
    - 1915(b)(2): Allows a country or local government to act as a choice counselor or enrollment broker to help citizens pick a managed care plan.
    - 1915(b)(3): Uses savings from a managed care delivery system that the state obtains to provide additional resources.
    - 1915(b)(4): Restricts the number or type of providers who can provide specific Medicaid services.
- Approved for two-year-periods.
- Waivers are renewable, if the state applies.
- Once CMS receives the application for a 1915(b) waiver, the program will be deemed approved unless it is acted on within 90 days.
- Within 90 days, CMS can approve disapprove or stop the 90-day clock if additional information is needed.

Examples of state with 1915(b) waivers for their mandatory Medicaid managed care programs are Michigan, Missouri, New Mexico, Pennsylvania, Virginia, and West Virginia.

Section 1915(b)(c): Concurrent

Provides a continuum of services to the elderly and those with disabilities as long as all federal regulations and requirements are met.

Section 1915 (c): Home and Community-Based Services Waivers

- The Home and Community-Based Services waivers allow states to provide community support services to individuals that would normally require institutionalization. This enhanced service allows for more independent living.
- Other HCBS resources include Physical Disabilities, Aged and Disabled, AIDS, and Children with Developmental Disabilities waivers, among others.

Michigan's Waivers:

1. 1115- Healthy Michigan
2. 1915(c)- MI Choice Renewal
3. 1915(c)- MI Waiver for Children with Serious Emotional Disturbances
4. 1915(c)- MI Children's Waiver Program
5. 1915(c)- MI Habilitation Supports
6. 1915(b4)- Children's Waiver Program
7. 1915(b1), 1915(b3), 1915(b4)- Managed Specialty Services and Supports Program
8. 1915(b1), 1915(b4)- Healthy Kids Dental Waiver
9. 1915(b4)- Children with Serious Emotional Disturbances
10. 1915(b1), 1915(b2), 1915(b4)- Michigan Comprehensive Health Care Program 1915(b)
11. 1915(b1), 1915(b4)- MI Choice
12. 1915(b1), 1915(b2), 1915(b4)- MI Health Link
13. 1915(c)- MI Health Link HCBS
14. 1115- Flint Section 1115 Demonstration

Block Grants

A block grant is a large sum of money the federal government grants to states with only general provisions as to how they are to spend the funds. The federal government is currently considering block grants for Medicaid.

- Funding for block grants is often based on past individual state expenditures.
- State government can use block grant money without restrictions and may be able to use the money they collected from the block grant through their own tax system.
- Michigan's current Federal allocation is 12.9 billion

Advantages

- The State can experiment with different ways of spending the money with the same goal in mind.
- A Medicaid block grant may decrease costs and be more effective, by removing duplicative administration.

Disadvantages

- It is difficult to compare results.
- Under a Medicaid block grant, Medicaid has the potential to no longer be an entitlement program and certain populations may not have to be covered.

Care Coordination

According to the National Coalition on Care Coordination, care coordination is a person-centered, assessment-based, and interdisciplinary approach to integrating health care and social support services.

- Goals of care coordination include assessing each individual's needs and preferences, developing an individualized, comprehensive care plan, and managing and monitoring all steps of care with an evidence-based assessment process.
- Care coordination involves placing individuals who are enrolled in insurance affordability programs into Patient Centered Medical Homes (PCMHs). By placing patients into medical homes, doctors and other health professionals can work in teams to better coordinate care.
- The ACA sets up opportunities for states to participate in accountable care organization (ACO) Pilot programs to determine which methods of care coordination are most effective.
- ACOs create incentives for providers to work together when treating individual patients across all types of health care settings, from doctors' offices to long-term care facilities.

Health Plans Value-Based Purchasing

The ACA establishes the Hospital Value-Based Purchasing Program, under which the Centers for Medicare and Medicaid Services (CMS) will make incentive payments to hospitals based on how well they perform on certain quality measures and how much their performance improves.

- The higher the hospital scores on quality and improvement measures, the higher the incentive payment.
- Quality measures for determining incentive payments include patient satisfaction and use of efficient clinical processes of care.
- Payment for value-based purchasing will be reallocated from the amount originally designated for Medicare and Medicaid spending.
- The amount allotted for value-based purchasing will gradually increase over time, which will lead to a shift from payment based on volume of services to payment based on quality of services.

Electronic Health Records

- Section 1561 of the ACA states that the Department of Health and Human Services (HHS) along with the Health Information Technology (HIT) Policy Committee and HIT Standards Committee must develop standards and protocols for electronic enrollment of individuals into state and federal insurance affordability programs. The product of this electronic enrollment system is the electronic health record (EHR).
- EHRs are electronic versions of a patient's medical history maintained by the patient's providers.
- Information in an EHR can include demographics, progress notes, complications, medications, immunizations, laboratory results and other information the provider thinks could be helpful to the care and treatment of the individual patient.
- As of 2015, eligible professionals who do not successfully demonstrate meaningful use will be subject to a payment adjustment. The payment reduction starts at 1% and increases each year that an eligible professional does not demonstrate meaningful use, to a maximum of 5%.

Major Goals of EHRs:

- Ensure the secure and confidential exchange of health information
- Reduce administrative burdens and costs
- Reduce medical errors
- Improve the quality and efficiency of care
- Support evidence-based decision-making for providers, health care quality management initiatives and health outcome reporting.

In order to qualify for the ACA's EHR incentive payments, hospitals, physicians, and other health providers must comply with the CMS' criteria and objectives for "meaningful use" of EHRs. "Meaningful use" can include using EHRs to engage patients and their families, and reporting clinical quality measures and public health information to appropriate governing boards.

Glossary

- **Behavioral Health Care**- assessment and treatment of mental and/or psycho-active substance abuse disorders.
- **Capitation** – a stipulated dollar amount established to cover the cost of health care delivery for a person. The term usually refers to a negotiated per capita rate to be paid periodically to a health care provider. The provider is then responsible for delivery of all health services required by the covered person.
- **Carve-Out** – a transfer of particular services and responsibilities designed to reduce costs.
- **Categorically Needy** – people who fall into certain eligible groups based on demographic criteria.
- **Claim** – submission to MCO that contains detailed information about the patient, insurance coverage, diagnosis and procedures performed.
- **Co-Morbidity** – the presence of one or more diseases or disorders in addition to the primary disease or disorder. The disease or disorder can exist simultaneously with another condition or can be a medical condition that is caused by or related to another condition.
- **Continuum of Care** – a range of clinical services provided to an individual or group which may reflect treatment received during a single inpatient hospitalization, or care for many conditions over a lifetime. The continuum provides a basis on which to analyze quality, cost, and utilization over the long term.
- **Enrollee** – a person designated by an insuring organization as eligible to receive insurance benefits.
- **Disability** – any condition which results in functional limitations that can interfere with a person's ability to perform his/her customary work and results in substantial limitations in one or more major life activities.
- **Dual Eligible** – people who are eligible for both Medicare and Medicaid.
- **Federal Poverty Level (FPL)** – identifies poverty level based on yearly income and household size, calculated by the federal government.
- **Federally Qualified Health Center (FQHC)** – health centers funded by the Health Center Consolidation Act of 1996 (also called Section 330), which brings together various funding mechanisms for community health facilities.
- **Federal Match Assistance Percentage (FMAP)** – used in determining federal matching funds in regard to state expenditures.
- **Health Benefit Exchange** – state regulated and standardized health plan marketplace from which individuals can purchase health insurance. Eligible for federal subsidies.
- **Integrated Behavioral Health** – a carve-out benefit plan which combines independent managed care services into a delivery system for behavioral health concerns. Components may include assistance services, telephone counseling triage, utilization management, behavioral health treatment networks, claims payment and data management.
- **Managed Care** – a health care delivery system that influences utilization and cost of services and measures performance. The goal is a system that delivers value through access, quality, and cost-effective health care.
- **Mental Health Provider** – a psychiatrist, licensed consulting psychologist, social worker, or hospital or licensed family qualified to provide mental health services under the law or jurisdiction in which treatment is provided.
- **Medically Needy** – Medicaid category that describes people who have too much income or resources to be eligible as categorically needy.
- **Participating Provider** – a provider who has contracted with the health plan to provide medical services to those covered. The provider can be a physician, facility or pharmacy, or hospital that has accepted under contract the terms and conditions set by the health plan.
- **Payer** – a public or private organization that pays for or underwrites coverage for health care expenses.
- **Preventative Care** – comprehensive care emphasizing the priority for prevention, early detection and early treatment of symptoms, and immunizations.
- **Primary Care Physician (PCP)** – a physician whose practice is devoted toward internal, family/general, or pediatric medicine.
- **Provider** – a physician, hospital, group practice, nursing home, pharmacy or any individual(s) that provide a health care service.
- **State Children's Health Insurance Program (SCHIP/CHIP)** – federally funded health insurance program for students.
- **Supplemental Security Income (SSI)** – a monthly cash assistance payment for those who are 65+, blind or disabled who are legal U.S. residents, and have applied for assistance.
- **Temporary Assistance for Needy Families (TANF)** – cash benefits given to low-income families.

Acronym Alley

- ACA Affordable Care Act
- ACAP Association for Community Affiliated plans
- ACO Accountable Care Organization
- ADL Activities of Daily Living
- AHCA Agency for Health Care Administration
- AHIP America's Health Insurance Plans
- AHRQ Agency for Healthcare Research and Quality within the HHS
- ALJ Administrative Law Judge
- CBO Congressional Budget Office
- CDC Centers for Disease Control and Prevention
- CHIP Children's Health Insurance Program
- CMI Center for Medicare and Medicaid Innovation
- CMS Centers for Medicare and Medicaid Services
- CMHC Community Mental Health Centers
- DSH Disproportionate Share Hospital
- EHB Essential Health Benefits
- EMEVS Electronic Medicaid Eligibility Verification System
- ERA Electronic Remittance Advice
- EQRO External Quality Review Organization
- FQHC Federally Qualified Health Centers
- HHS Department of Health and Human Services
- HIT Health Information Technology
- ICO Integrated Care Organization
- IGA Interested Government Agency
- LTSS Long Term Services and Supports
- MAC Medicare Administrative Contractors
- MHPA Medicaid Health Plans of America
- MOE Maintenance of Effort
- MQC Medicaid Quality Control
- NACHC National Association of Community Health Centers
- NAIC National Association of Insurance Commissioners
- NAMD National Association of Medicaid Directors
- NCQA National Committee for Quality Assurance
- NCSL National Conference of State Legislatures
- NGA National Governors Association
- RAC Recovery Audit Contractor
- RBHA Regional Behavioral Health Authority
- SMI Serious Mental Illness
- SNP Special Needs Plan
- URAC Utilization Review Accreditation Commission

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