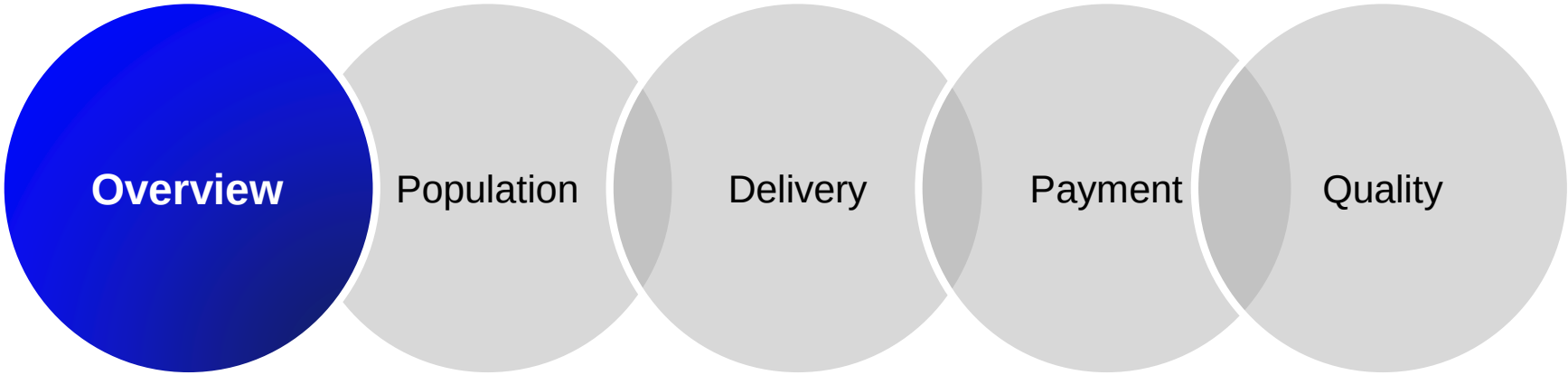
Overview of the Medicaid Program

North Carolina Medical Care Commission
February 11, 2015

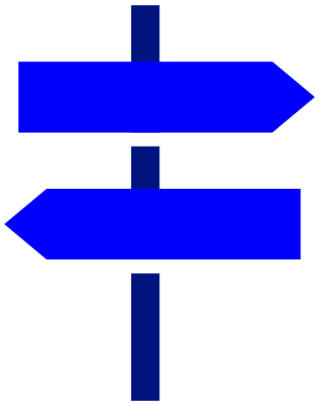
Overview of the Medicaid Program



Medicaid Basics

- Medicaid was established in 1965 as a companion program to Medicare
- Medicaid is an entitlement program, the cost is determined by the number of beneficiaries enrolled
- Medicaid is a joint federal state program
  - The Centers for Medicare & Medicaid Services (CMS) regulates, oversees and partially funds Medicaid
  - The states administer and fund the program
- Traditional Medicaid provides benefits for dependent children (up to age 19) and their mothers, pregnant women, older adults and individuals with disabilities
- Children's Health Insurance Program (CHIP) provides health coverage to children in families with incomes too high to qualify for Medicaid, that can not afford private coverage
  - Under CHIP, each state is allotted a capped amount of federal funds each year
  - Once the allocation is spent, the state cannot get additional federal funds as with Medicaid
- Health coverage is provided to eligible individuals at very little or no charge
- The Affordable Care Act (ACA) was the first major Medicaid reform since the program's establishment, giving states the option to expand Medicaid coverage for individuals up to 138% of the federal poverty level

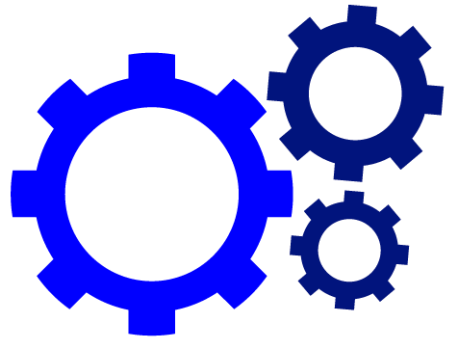
The Intersection of Medicaid and Medicare



- Medicare is a federal health insurance program that provides coverage for individuals over 65 or those with certain disabilities
- Medicare has four major parts that cover services:
  - **Part A Hospitalization Insurance**: Most people do not pay a premium because they or a spouse have already paid for it through their payroll taxes while working
  - **Part B Medical Insurance**: Most people pay a monthly premium
  - **Part C Medicare Advantage Plans**: Medicare parts A and B are provided by Medicare approved private companies, out of pocket costs vary by company
  - **Part D Prescription Drug Coverage:** Beneficiaries choose a drug plan and pay a monthly premium
- Medicare and Medicaid intersect when individuals are deemed eligible for both programs; they are termed “dual eligibles”

Medicaid Program Administration

- CMS grants states flexibility in program design and administration
- Some states administer the program through a designated Medicaid agency and others incorporate it into a larger health and human services agency
- Each state develops and publishes its own state plan outlining the program and its funding
- Federal Medicaid matching rates are state specific and are based on a formula that results in the state's Federal Medicaid Assistance Percentage (FMAP)



State Plan Requirements

- Each state determines their own unique programs and documents them in its state plan. The state plan covers the following:
  - eligibility groups and services for Medicaid beneficiaries
  - reimbursement methodologies for Medicaid providers
- Reimbursement methodologies must include methods/procedures to ensure payments are consistent with economy, efficiency, and quality of care principles
- A state plan is the basis for a state's claim for federal matching funds
- The federal government must review and approve all state plans and plan amendments before the state receives federal matching funds.
- States must comply with applicable federal rules and regulations

State Responsibilities in Medicaid Administration

States have 63 unique responsibilities in administering Medicaid programs, including

- Setting rates for covered services
- Conducting outreach and enrollment activities for beneficiaries
- Enrolling providers
- Defining the scope of benefits
- Making payments to providers and health plans
- Processing appeals
- Monitoring service quality
- Ensuring program integrity
- Collecting and reporting information

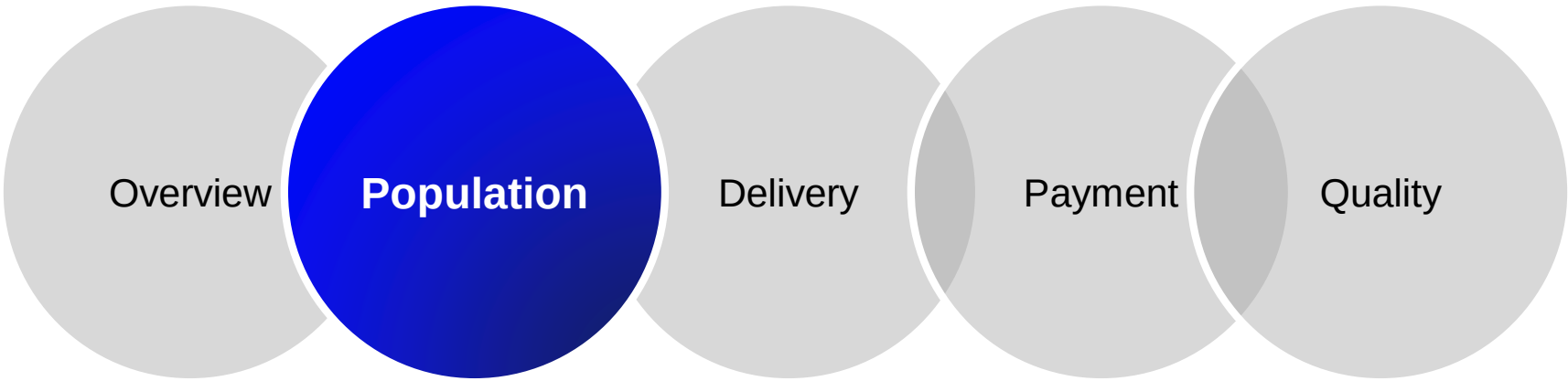
Federal Responsibilities in Medicaid Administration

- Administering matching payments
- Approving state plan amendments and waivers
- Monitoring and enforcing state compliance
- Interpreting federal statutory requirements for states and providers
- Ensuring efficient administration by state Medicaid agencies
- Ensuring the quality of institutional care (state survey agencies)
- Ensuring program integrity
- Ensuring compliance with federal anti-discrimination laws
- Collecting accurate data on the expenditure of federal funds

Determining the Medicaid Matching Rate

- CMS provides federal matching funds to states based on the calculated Federal Medical Assistance Percentages (FMAP)
- The FMAP, which is adjusted and published every three years, is based on the state's per capita income
  - The US average FMAP is 57%
  - The national range is from 50% to 83%
- States that elected to expand their Medicaid programs receive an initial FMAP of 100% for the expansion population
  - The increased FMAP amount will decrease to 90% over several years
- The Federal matching rate for state CHIP programs is typically about 15 percentage points higher than the Medicaid matching rate for that state

Overview of the Medicaid Program



The Categorically Needy

Mandatory Coverage Requirements

- **Pregnant women** and **children** whose family income is at or below 133% of the Federal poverty level (FPL)
- **Individuals** and **couples** who are living in medical institutions and have a monthly income up to 300% of the SSI income standard
- Supplemental Security Income **(SSI) recipients**
- **Caretakers** (relatives or legal guardians) who care for children under age 18

The Medically Needy

Optional Coverage Requirements

States can extend Medicaid coverage to individuals with high medical expenses, who would otherwise be ineligible for Medicaid because their incomes exceed eligibility limits. If a state has a medically needy program, it must cover:

- Pregnant women through a 60 day postpartum period
- Children under age 18
- Certain newborns for one year
- Certain protected blind persons
- Caretaker relatives (relatives or legal guardians who live with and take care of children)
- Aged, blind, disabled individuals

Dual Eligible Beneficiaries

Special Populations

Include individuals who receive full Medicaid benefits as well as those who only receive assistance with Medicare premiums or cost sharing. They must meet certain income and resource requirements and be entitled to Medicare Part A and/or Part B and one of the following Medicaid Programs:

- **Full Medicaid**
- **Medicare Savings Programs, which include the following four programs:**
  - Qualified Medicare Beneficiary (QMB) Program
  - Specified Low-Income Medicare Beneficiary (SLMB) Program
  - Qualifying Individual (QI) Program
  - Qualified Disabled Working Individual (QDWI) Program

Dual Eligible Beneficiaries

Beneficiary Type	Eligibility Standard	Medicaid Coverage
Qualified Medicare Beneficiaries (QMBs)	Resources at/below twice the standard allowed under the SSI program and income at or below 100% FPL	Medicaid pays their monthly Medicare premiums, deductibles, and coinsurance
Specified Low-Income Medicare Beneficiaries (SLMBs)	Resources at/below twice the standard allowed under the SSI program and income exceeding the QMB level, but less than 120% FPL	Medicaid pays their monthly Medicare Part B premiums
Qualifying Individuals (QIs)	Resources at/below twice the standard allowed under the SSI program, if their income exceeds the SLMB level, but is less than 135% FPL	Medicaid pays their monthly Medicare Part B premiums
Qualified Disabled and Working Individuals (QDWIs)	Receiving Medicare due to disability, but have lost entitlement to Medicare because they returned to work, and are not eligible for Medicaid. Income below 200% FPL and resources at/below twice the standard allowed under the SSI program.	Medicaid pays their monthly Medicare Part A premiums

American Indian and Alaska Natives

Medicaid-eligible patients in Indian Health Service (IHS) or tribal facilities can receive services that are reimbursed at 100% FMAP, instead of a State's regular FMAP

- CMS reimburses 100%, thus services reimbursed at 100% FMAP cost the State nothing
- This is a significantly higher Medicaid reimbursement for tribally provided services than for other State Medicaid services

Medicaid Eligibility

- **Historically, Medicaid eligibility has been set by states within federal minimum standards**
  - States determined an individual's (or family's) gross income using a combination of state and federal rules on household or family composition and then deducted income amounts not considered countable, such as childcare expenses
  - These income deductions varied by state, type of income, and by eligibility group
  - The resulting net income was then compared to an income eligibility threshold to determine whether the individual was income eligible for Medicaid or CHIP
- **Effective January 1, 2014 states began using the modified adjusted gross income (MAGI) based methodology for determining the income of an individual and the individual's household**
  - By using one uniform set of income eligibility rules and one application across all insurance affordability programs, the ACA simplified the application and enrollment process
  - MAGI-based income methodologies do not apply to determinations of Medicaid eligibility for elderly and disabled populations

Modified Adjusted Gross Income

MAGI is based on federal tax rules for determining adjusted gross income, which include:

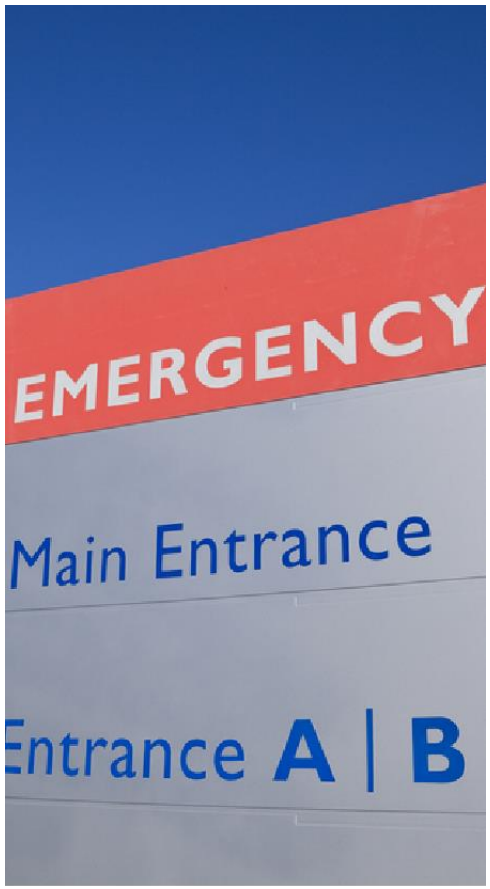
- Earned income *(e.g., wages, salary, or any compensation for work)* minus any pre- tax contributions *(i.e., dependent care, retirement)*
- Net profit from self-employment income
- Certain Social Security income, including Social Security Disability Insurance (SSDI) and retirement benefits, but not SSI
- Unemployment benefits
- Investment income, including interest, dividends, and capital gains

Presumptive Eligibility

- **Presumptive eligibility** allows children to get access to Medicaid or CHIP services without having to wait for their application to be fully processed

- **Qualified entities** are state-authorized health care providers, community-based organizations, and schools, among others -- can also help families gather the documents needed to complete the full application process, thereby reducing the administrative burden on States to obtain missing information

Emergency Medicaid

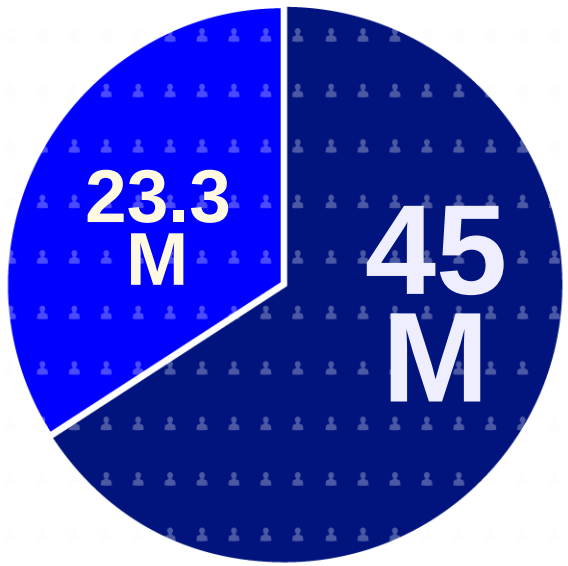


- **Immigrants** who belong to one of the covered groups and meet the income requirements may qualify for limited Medicaid, i.e. coverage is limited to care and services necessary for treatment of an emergency medical condition
- **An emergency medical condition** is a condition that presents acute symptoms of sufficient severity, like severe pain, such that without immediate medical attention, could reasonably be expected to result in:
  - Placing the patient's health in serious jeopardy
  - Causing serious impairment to bodily functions
  - Causing serious dysfunction of any bodily organ or part

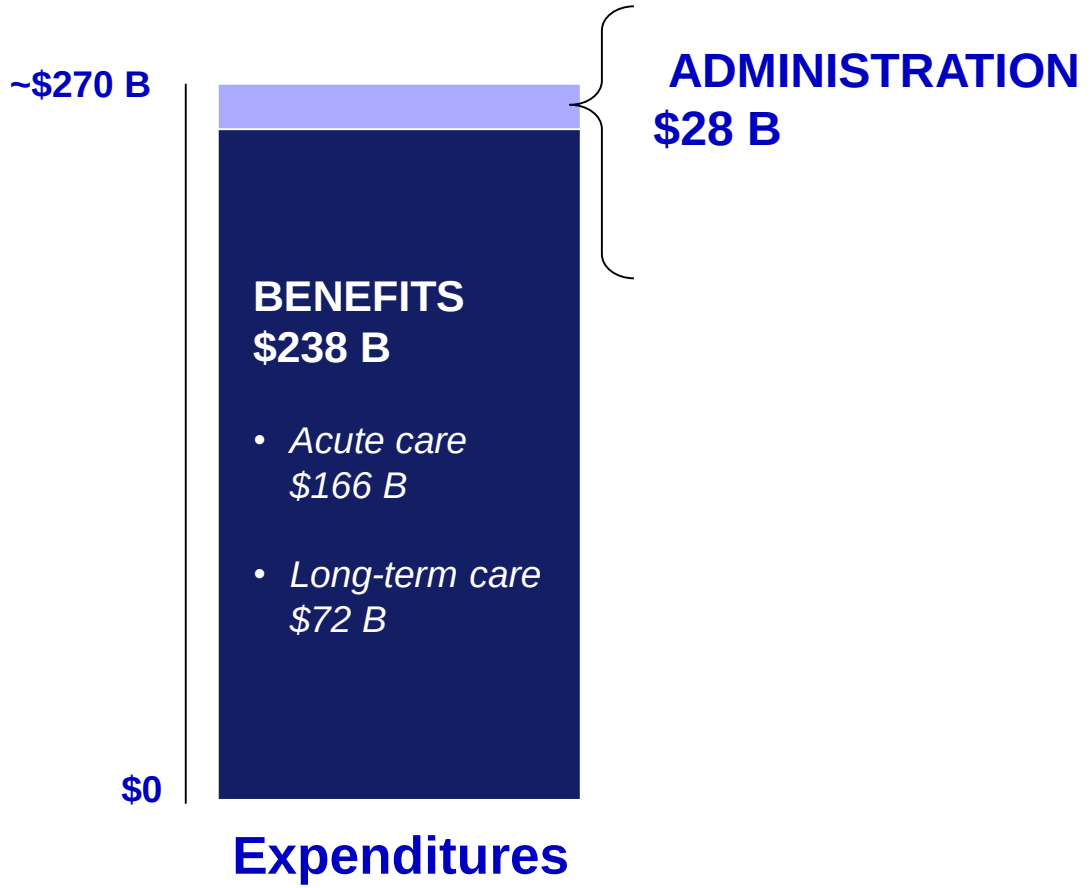
Medicaid and CHIP Enrollment at a Glance*

45 M people enrolled in states that expanded Medicaid

23.3 M people in states that did not expand Medicaid



(approximately 68 M beneficiaries)



*Note: Enrollment and expenditures are as of 2014

Source: Centers for Medicaid and Medicaid and Congressional Budget Office

Overview of the Medicaid Program

Delivery Models

Fee for Service (FFS) – unrestricted choice of providers; state sets rates within federal parameters

Managed Care – restricted choice of providers; plans take risk; providers paid FFS or partial capitation

Primary Care Case Management (PCCM) – beneficiaries choose or assigned to PCP to coordinate care; providers paid case management fee

Accountable Care Organizations (ACOs) – new model of provider networks, various forms of risk-sharing

Medicaid Coverage: Overview

Covered services vary from state to state

States must specify the services to be covered and the "amount, duration, and scope" of each covered service

States may not place limits on services or deny/reduce coverage due to a particular illness or condition

Services must be medically necessary

Medicaid Benefits

Mandatory Services

- Physicians' services
- Lab and X-ray
- Inpatient hospital
- Outpatient hospital
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for children under 21
- Family planning services and supplies
- Federally Qualified Health Centers (FQHC) and Rural Health Clinic services
- Nurse midwife services
- Certified Nurse Practitioner services
- Nursing facility (NF) services for adults 21 and older
- Home health services for individuals entitled to NF care

Optional Services

- Medical or remedial care furnished by licensed practitioners
- Prescription drugs
- Diagnostic, preventive, screening, and rehabilitative services
- Clinic services
- Primary care case management (CM)
- Inpatient and NF services for individuals over 65 in an institution for mental diseases
- Intermediate Care Facilities for Individuals with Mental Retardation
- Inpatient psychiatric services for children under 21
- Home health care
- CM services
- Dental services and dentures
- Physical therapy and related services
- Prosthetic devices and eyeglasses
- TB-related services
- Other medical or remedial care
- Personal care services
- Private duty nursing
- Hospice care
- Services furnished under Program of All-inclusive Care for the Elderly
- Home and Community Based Services (waiver is required)
- Respiratory services for ventilator-dependent individuals

Early and Periodic Screening, Diagnostic and Treatment Services

- Preventive and comprehensive health services are provided for Medicaid individuals under the age of 21
- Health care must be made available for treatment or other measures to correct or improve illnesses or conditions discovered by the screening service
- The State Medicaid agency determines medical necessity

Medicaid Waivers

- **Home and Community-Based Services Waivers (1915c):** permit a state to provide community-based long-term care services to individuals who would otherwise require and be eligible for services in a nursing facility
- **Managed Care Waivers (1915b):** permit a state to allow the use of managed care in the Medicaid program
- **Research and Demonstration Waivers (1115):** permit a state to waive virtually any part of the federal Medicaid Act regarding mandatory eligibility, benefits or managed care and other delivery systems

Home and Community Based Services Waivers

- Designed to target certain categories of beneficiaries, such as elderly or traumatic brain injury
- Enrollment in the waiver is limited, once the enrollment is at capacity, states form waiting lists
- Services can be provided on a less than statewide basis
- Must be “cost neutral” as compared to institutional services, on average for the individuals enrolled in the waiver
- Applies to Medicaid eligible individuals, who meet an institutional level of care, and are in the target population(s) chosen/defined by the state
- Services must be provided in accordance with an individualized assessment and person-centered service plan

Section 1115 Research and Demonstration Waivers

- Must assist in promoting the objectives of the Medicaid or CHIP statute, as determined by the Secretary
- Provides waivers from statutory and regulatory requirements not available under SPAs or 1915(b) waivers
- Allows States to receive Federal match for activities not otherwise considered medical assistance
- States must submit a demonstration application to CMS
- State must show that demonstration is “budget neutral” over the demonstration period

Additional Medicaid Waivers

- **Section 1915(i) State Plan HCBS:** gives States the option to amend the State Plan to offer HCBS as a state plan benefit instead of under a waiver

- **Section 1915(j) Self Directed Personal Assistance Services State Plan Option:** allows beneficiaries receiving state plan personal care and/or HCBS under a waiver to have employer and budget authority—meaning, the beneficiary can hire, fire, supervise and manage workers

- **Section 1915(k) Community First Choice (CFC):** gives States the option to provide person-centered home and community based attendant services and supports

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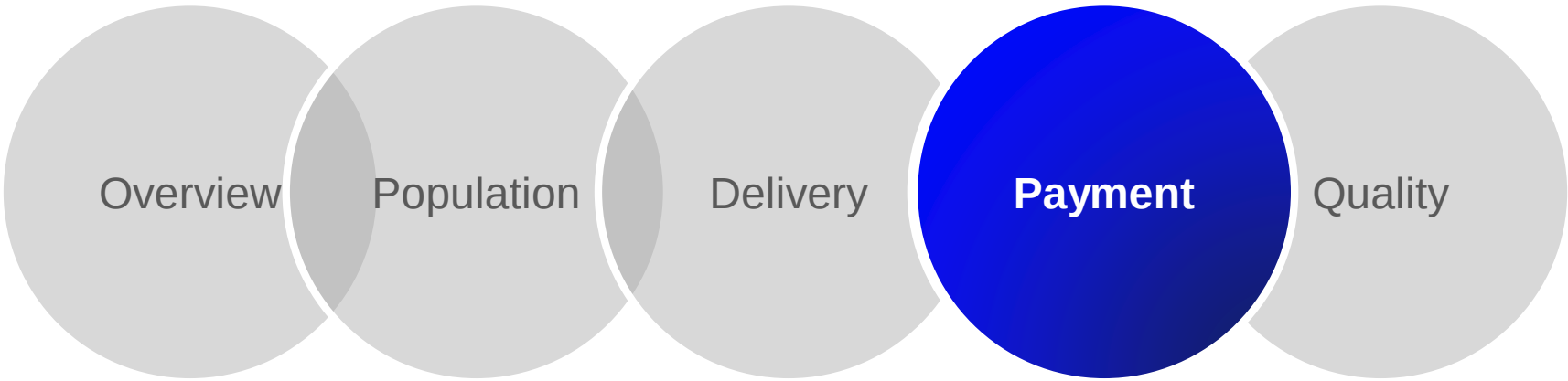
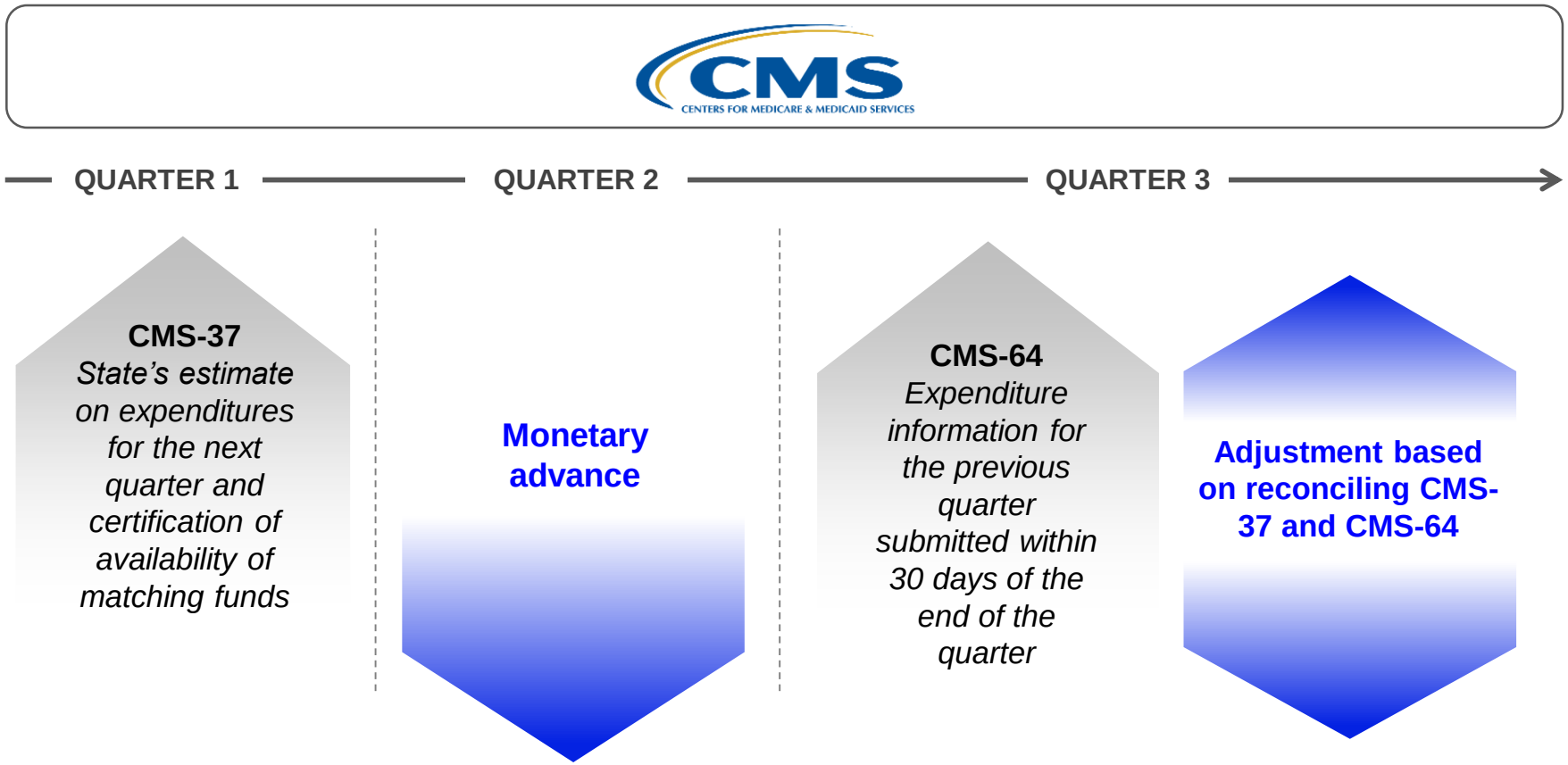


Medicaid Financial Relationships

Two types of financial relationships in Medicaid:

- Relationship between the federal government and state to administer the Medicaid program
- Relationship between states and providers (MCOs or actual providers) to provide care to Medicaid beneficiaries

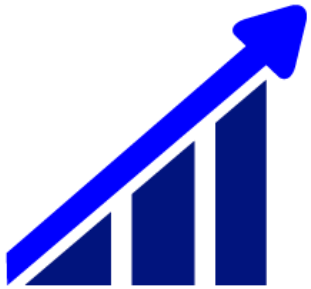
Federal-State Government Payment Process



Methods States Use to Maximize FMAP

Provider Taxes

- "Hold harmless" provision
- States can comply with the hold harmless provision by limiting the taxes to a federally defined safe harbor amount of 5.5 percent of a provider's revenues
- Provider taxes cannot exceed 25 percent of a state's share of Medicaid funding

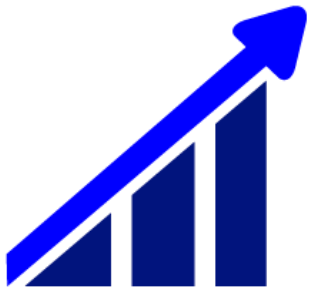


Upper Payment Limit (UPL)

- Establish an upper limit on Medicaid payments for which states can receive FMAP
- States are able to make large supplemental payments to a few government health facilities, receive federal matching funds, and still be under the aggregate UPL

Methods States Use to Maximize FMAP (continued)

Intergovernmental Transfers (IGT)



- States can collect up to 60% of its Medicaid share from local governments for purposes of receiving FMAP
- Example: (i) states make large payments to providers operated by local governments, (ii) claim FMAP on the payments, and (iii) require the local government-operated provider to return all or much of the payment back to the state via an IGT, effectively increasing FMAP

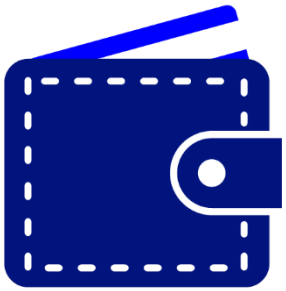
Disproportionate Share Hospital Program (DSH)

- Ensures that state Medicaid programs provide adequate payments to hospitals whose patient populations are disproportionately composed of low-income and uninsured patients

Medicaid Program Expenditures

Factors Driving Medicaid Spending

- The number of eligible individuals that enroll
- The price of medical and long term care (LTC) services that Medicaid buys (rates)
- Utilization of covered services by enrollees
- State decisions regarding coverage of optional benefits or optional eligibility groups
- Effectiveness of managed care (MC) in achieving savings



Notable Spending Trends

- Vary greatly from state-to-state
- Most of Medicaid payments are made on behalf of elderly and disabled
- Spending for those eligibility groups is driven by the cost of LTC
- About 65% of Medicaid spending is for optional services (i.e. prescription drugs)

Cost-Sharing

- Prior to the Deficit Reduction Act (DRA) states could charge nominal cost sharing to certain Medicaid beneficiaries but not premiums, cost sharing had to be uniform across the state
- States may impose higher or new cost sharing and premiums
  - Maintains cost sharing exemption for mandatory children (infants with incomes up to 185% FPL, children up to age 6 up to 133% FPL, and older children under 100% FPL), and pregnant women
  - States can make cost sharing “enforceable”
- Allows variation in benefits and cost sharing across groups and geographic areas

Cost-Sharing (continued)

Exempt categories of beneficiaries

- Children under 18
- Pregnant women for pregnancy-related services
- Terminally ill in hospice
- Inpatient hospital, NF, ICFMR patients in “spend-down” mode

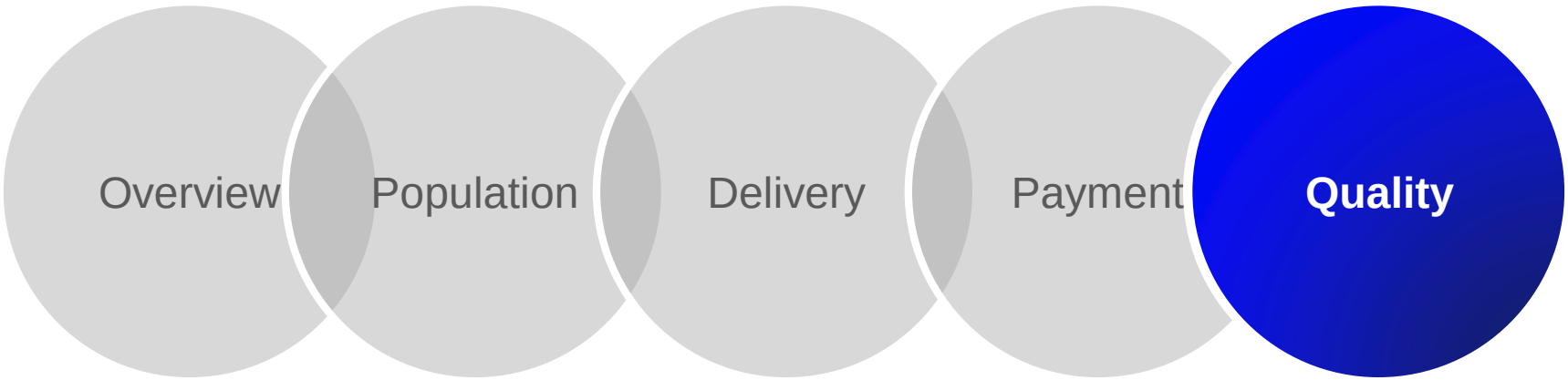
Exempt categories of services

- Emergency services
- Family planning

Provider obligations

- To treat patients

Overview of the Medicaid Program



Quality and the Medicaid Program

Key elements in Medicaid quality strategy

Aligned with broader national and CMS quality strategies

- Reduce harm
- Strengthen patient engagement
- Promote effective communication
- Improve chronic disease prevention and treatment
- Support healthy communities
- Improve access to care

Three cornerstones

- **Population focus** – identify and address specific quality issues for segments of Medicaid population
- **Regulatory focus** – structure and process requirements for providers and health plans
- **Improvement focus** – provide technical assistance and incentives to measure and improve quality

Quality and the Medicaid Program (continued)

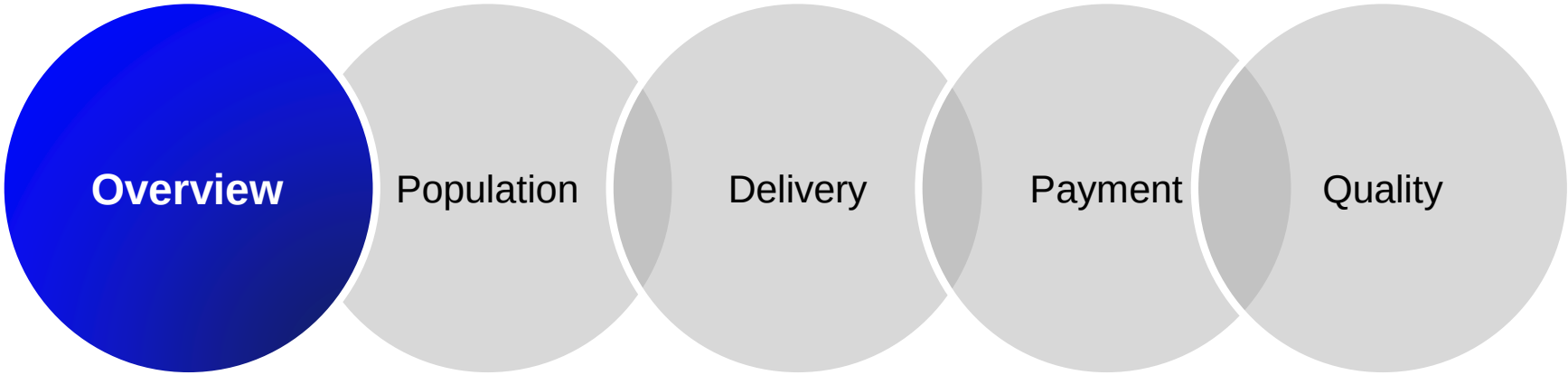
Selected Areas of Focus

- **EPSDT initiatives**– improve screening, treatment, data collection and reporting; state resource page on children and adolescents
- **Oral health initiatives** – primary focus on state action plans for prevention, access, treatment
- **Maternal and infant health** – reduce mortality and morbidity relating to adverse birth outcomes; Center for Medicare and Medicaid Innovation grants
- **Managed care quality** – standardized measures, quality assurance and improvement activities
- **Chronic disease treatment and prevention** – obesity, smoking cessation, heart attacks and strokes (e.g., Million Hearts campaign)

Medicaid Moving Forward

North Carolina Medical Care Commission
February 11, 2015

Medicaid Moving Forward



Medicaid Program Initiatives in the Affordable Care Act (ACA)

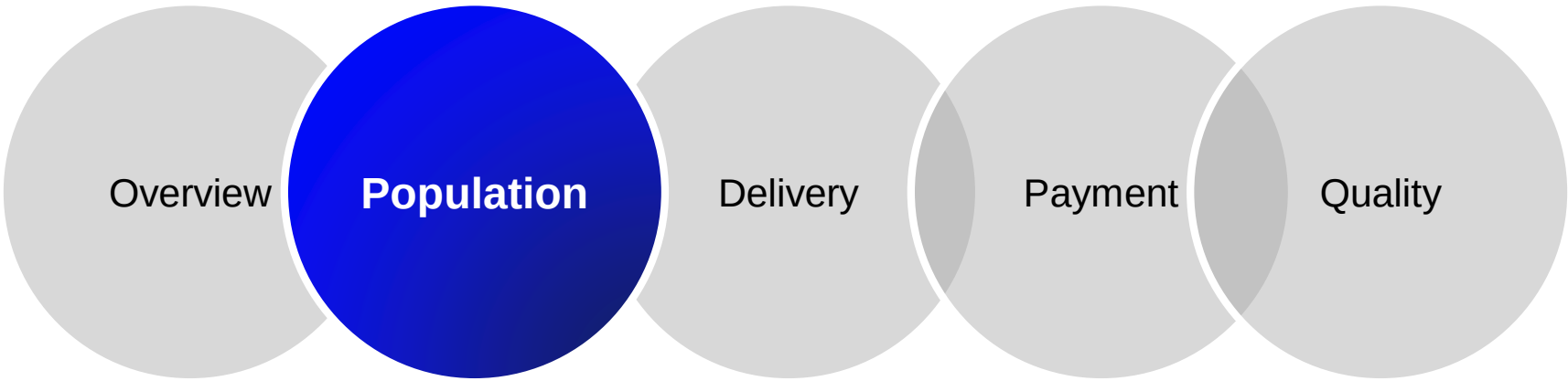
- **Medicaid eligibility expansion**
  Expands Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 138% FPL based on modified adjusted gross income (as under current law undocumented immigrants are not eligible for Medicaid)

- **Increasing payments for primary care services to equal Medicare Part B payments**
  States receive 100 percent federal matching funds for the increase in payments (effective January 1, 2014)

- **Medicaid Emergency Psychiatric Demonstration Project**
  Establishing a three-year demonstration project under which states may provide payment to non-publicly owned and operated institutions for mental disease (IMDs) that are subject to EMTALA requirements for purposes of treating Medicaid beneficiaries ages 21-64 who are experiencing a mental health emergency

- **Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)**
  Providing federal funding for and expands the role of the congressionally-created, independent commission tasked with reviewing state and federal Medicaid and CHIP access and payment policies and making recommendations to Congress, the Secretary of Health and Human Services (HHS), and the states

Medicaid Moving Forward



Medicaid Eligibility Expansion Overview

- **The Supreme Court ruling on the constitutionality of the ACA upheld the Medicaid expansion**
  - Limited the ability of HHS to enforce expansion
  - Made the decision to expand Medicaid optional for states.
- **Newly eligible**
  - Not previously eligible for at least benchmark equivalent coverage
  - Eligible for a capped program but were not enrolled
  - Enrolled in state-funded programs
- **All newly eligible adults** will be guaranteed a benchmark benefit package that meets the essential health benefits available through the Marketplaces
- **FMAP for the "newly eligible"**
  - 100% federal funding for 2014 through 2016
  - 95% federal financing in 2017
  - 94% federal financing in 2018
  - 93% federal financing in 2019
  - 90% federal financing for 2020 and subsequent years

Medicaid Eligibility Before and After the ACA

Prior to the ACA

- States used 1115 waivers to expand Medicaid coverage to non-traditional populations, such as low-income childless adults, who could not get covered under the actual Medicaid rules
- Medicaid coverage was limited to individuals who met income and other eligibility requirements and fell into one of several specified groups, including children, pregnant women, parents, seniors and people with disabilities

After the implementation of the ACA

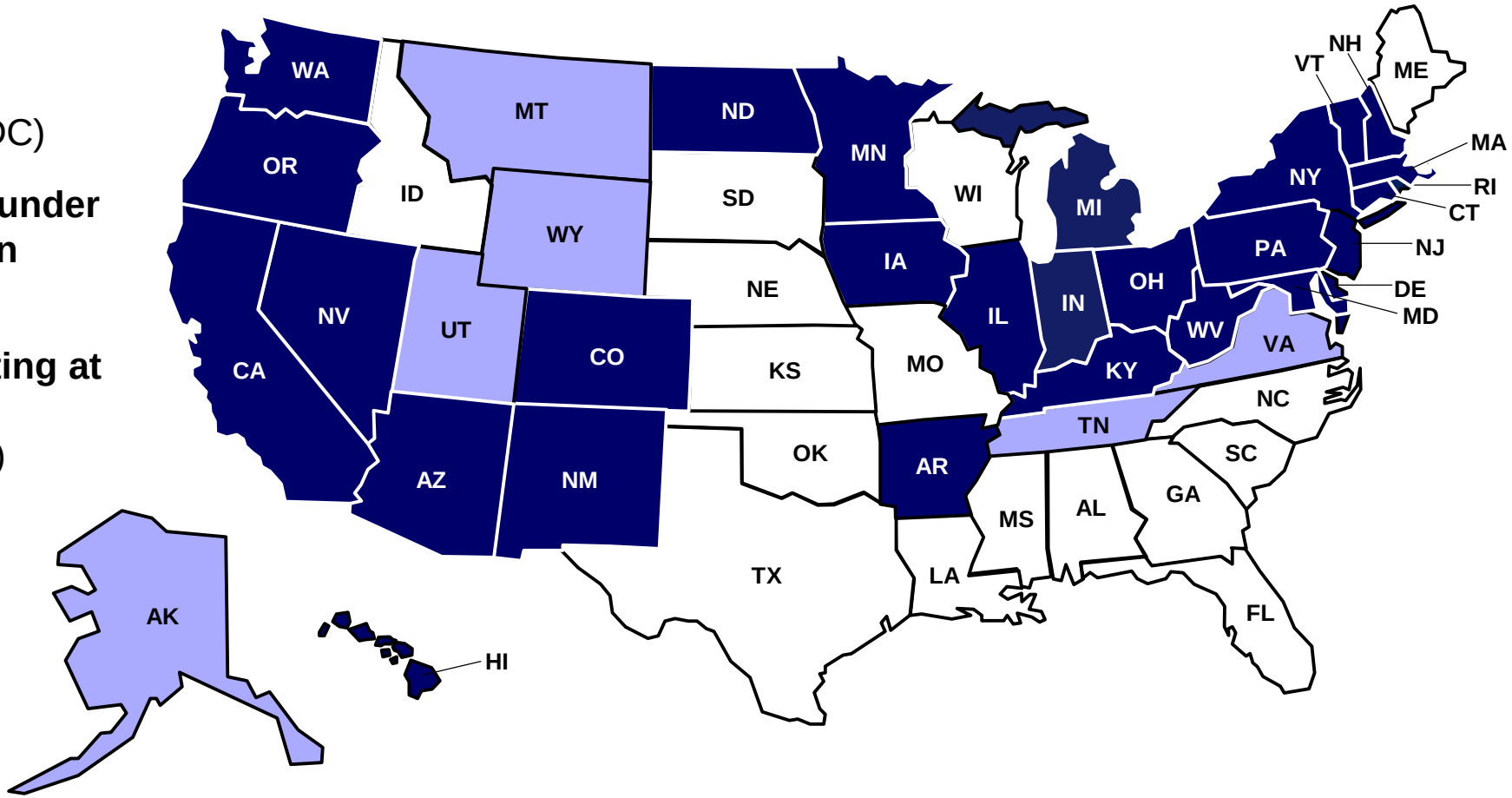
- By way of a State Plan Amendment, Medicaid can been expanded to all low income individuals below 138% of the poverty level
- An 1115 waiver is no longer necessary for expanding coverage to low-income childless adults; however states continue to use waivers to expand coverage in creative ways that are not mentioned in the ACA

Medicaid Eligibility Expansion Landscape at a Glance

Adopted
(29 States including DC)

Adoption under discussion
(6 States)

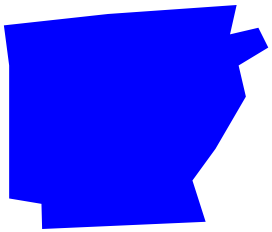
Not Adopting at This Time
(16 States)



Medicaid Eligibility Expansion Landscape

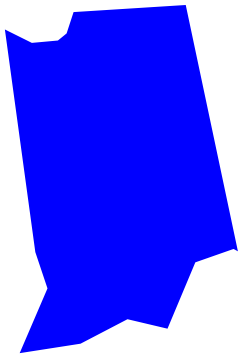
- States are implementing the expansion differently across the nation through avenues provided through state plans and Section 1115 waivers:
  - Twenty-two states plus the District of Columbia expanded coverage through state plan option
  - Six states (i.e. Arkansas, Iowa, etc.) through 1115 waiver
- Under the ACA, the Medicaid expansion was intended to occur nationwide
  - The Supreme Court's ruling on the ACA effectively made the expansion a state option
- As of February 2015, a total of 29 states (including the District of Columbia) have implemented the Medicaid expansion
- In states expanding Medicaid, most individuals with incomes above 138% up to 400% FPL (above Medicaid levels) are eligible for tax credits to purchase coverage through the Marketplaces

Arkansas: State Highlights



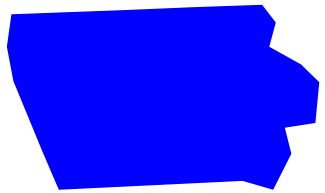
- Residents earning **up to 138%** of the FPL receive premium assistance to buy private plans on the insurance Marketplace
- Recipients may be required to make monthly contributions ranging **from $5-$25**, depending on income levels
- Providers are not allowed to refuse medical services to patients who are **below the poverty level** and don't pay—but they can refuse patients in the **100%-138%** income range

Indiana: State Highlights



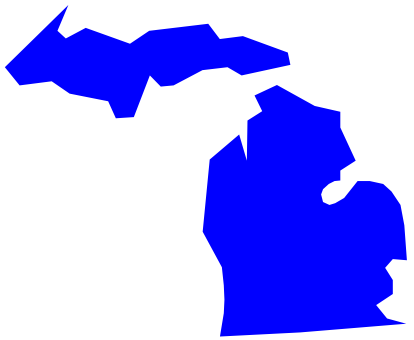
- Expands coverage for individuals with incomes of **up to 138%** of FPL
- Creates premiums of **2%** of household income for those under the poverty level, individuals who do not pay premiums will have coverage downgraded to exclude dental and vision
- Implements co-pays including **$4** for a doctor's visit and $75 for a hospitalization
- Allows **six month** lockout periods for people who do not pay premiums (exception for those under FPL or medically fragile).

Iowa: State Highlights



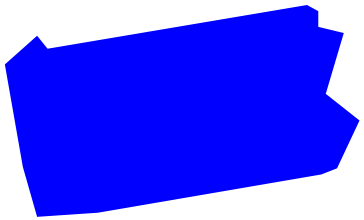
- Residents earning **up to 138%** of the FPL receive premium assistance to buy private plans on the insurance exchange
- Recipients are charged monthly premiums ranging from **$5 to $10**, depending on income levels
- Recipients **may reduce or eliminate** monthly premiums by completing a wellness exam or health risk assessment
- Those with exceptionally low incomes **may not have coverage revoked** for failing to pay monthly premiums

Michigan: State Highlights



- **Implements 2% cost-sharing** for residents with incomes between 100%-133% of FPL, not to exceed 5% of annual household income for the first 2 years
- **Requires co-pays** between $1-$3 for most health care services
- **Offers an option** for residents to reduce cost-sharing amount by completing an annual health risk assessment

Pennsylvania: State Highlights



- Requires premiums on a sliding scale for non-disabled, childless adults, not to exceed 2 percent of household income
- Allows termination of coverage for those who fail to pay their premiums
- Offers incentives of reduced premiums if a person completes activities such as getting an annual physical, and participates in job training or a work-search program
- Expected to expand Medicaid under a State Plan Amendment

Alternatives to Full Medicaid Expansion

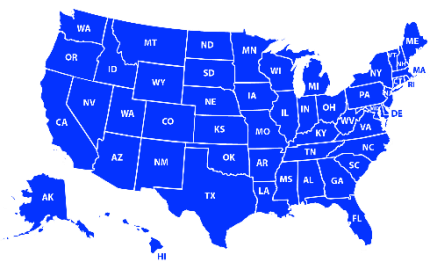
A small number of states are using waivers to maintain pre-ACA coverage expansions without adopting the full Medicaid expansion

- **Oklahoma and Utah** have used waivers to provide coverage to otherwise ineligible adults prior to the ACA
- CMS granted temporary extensions for these waivers, but the coverage is limited to residents with incomes below 100% FPL

Alternatives to Full Medicaid Expansion (continued)

- **Minnesota** currently provides Medicaid to adults with incomes between 138 and 200% FPL who would likely be eligible for Marketplace subsidies
  - State receives 95% of what the federal government would have spent on premium and cost-sharing subsidies in the Marketplace for the eligible population
  - State provides coverage through a state-managed basic health plan which is not part of Medicaid
- **Massachusetts, New York and Vermont** have eliminated Medicaid coverage for adults with incomes above 138% FPL, but have waivers in place to use Medicaid funds to provide premium assistance that further subsidizes Marketplace coverage

States That Did Not Expand Medicaid Under the ACA



As of February, 2015, 16 states are not expanding Medicaid eligibility

- 6 states are considering expansion avenues (AK, MT, TN, UT, VA, WY)
- Use of waivers to cover non-traditional Medicaid populations in non-expansion states varies widely
- Individuals in a “coverage gap” are not eligible for financial assistance to purchase coverage through the Marketplaces

Medicaid Moving Forward

Overview of Delivery Reforms

- States use a variety of innovative practices to engage in delivery system reform
- **These initiatives vary by state, some examples include**
  - ✓ Shared Savings Methodologies
  - ✓ Payments to Primary Care Physicians
  - ✓ Health Homes
  - ✓ Care Coordination for Super Utilizers
  - ✓ Demonstration Waivers
  - ✓ Accountable Care Organization Model
  - ✓ Medicaid Managed Care

Shared Savings Methodologies

Shared Savings Methodologies are used to facilitate coordination and cooperation among providers to improve the quality of care and reduce unnecessary costs

Key features

- Incentivizing states, health plans, and providers to invest in delivery system reform by sharing the savings generated from reform
- Improving health outcomes
- Increasing overall quality of care
- Lowering program costs

Arkansas, Louisiana and Minnesota received approval to implement these payment models

Payments to Primary Care Physicians

- To help promote access to primary care, the ACA included a provision to temporarily increase reimbursement for primary care payments for certain primary care services to equal Medicare Part B payments in 2013 and 2014
- States receive 100% federal matching funds for the increase in payments
- States may extend the primary care rate increase beyond 2014 at regular FMAP rates

Fifteen states plan to continue the primary care fee increase in 2015 fully or partially

Health Homes

- System of care offered under the ACA as a method to treat eligible Medicaid enrollees with chronic conditions
- Eligible for temporarily increased federal matching funds

The main goals for the health home

- Improve health outcomes that will result in lower rates of emergency room use
- Reduce hospital admissions, readmissions, and health care costs
- Create less reliance on long term care facilities
- Improve experience of care for Medicaid individuals with chronic conditions

Missouri and New York report reduction in utilization and spending for inpatient services for beneficiaries continuously enrolled in health homes

Care Coordination for "Super Utilizers"

- One percent of Medicaid beneficiaries represent 25% of spending
- Super utilizers are beneficiaries with complex, unaddressed health issues and a history of frequent encounters with health care providers who drive acute care utilization in the Medicaid program
- The CMS Innovation Center has approved multiple Health Care Innovation Award grants for super utilizer programs

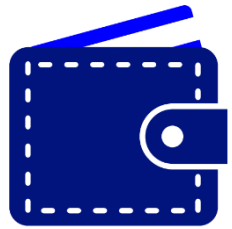
NC transitional care initiative that is designed to address the care of high need beneficiaries reduced hospital readmissions by 20%

Demonstration Waivers

- 1115 waiver initiatives vary by state, but in general, CMS has worked with states to design transformation efforts that address state's specific issues and needs
- The goal is to align such initiatives with broader Medicare and commercial market activities to encourage system-wide reforms
- CMS continues to work with states to improve the measurement and evaluation of 1115 demonstration projects to support shared learning

Oregon used 1115 waiver to establish Coordinated Care Organizations to deliver community-driver, coordinated care to Medicaid beneficiaries

Accountable Care Organization Model



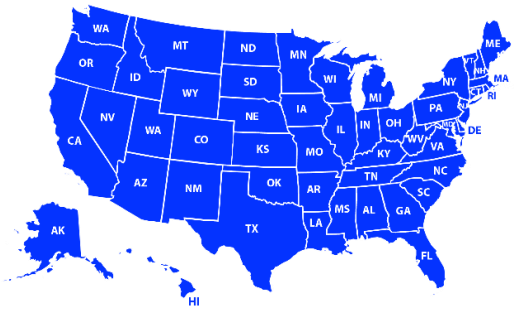
ACO Basics

- A comprehensive network of providers
- A shared savings payment model
- Experimentation with value based payment models at the provider level
- Performance measures that include quality and total cost of care

Trends in ACO Development

- Rapid development due in part to new Medicare payment options
- Many large commercial payers, hospital systems, and physician groups have created ACOs to participate in Medicare or in the commercial market
- State Medicaid programs have adopted ACO care delivery models as an alternative to a traditional managed care organization (MCO) model

Accountable Care Organizations: State Highlights



- **Alabama** Medicaid created Regional Care Organizations to provide Medicaid services. RCOs are paid on a capitated basis for a defined population
- **Colorado** established the Medicaid Accountable Care Collaborative, which is based on regional ACOs
- **Iowa** partnered with a commercial payer sponsored ACO to administer the Health and Wellness Plan for Medicaid beneficiaries
- **Minnesota** and **Washington** established Accountable Communities for Health to bring community services and prevention efforts into their ACO model
- **Minnesota** and **Maine** developed shared savings and partial risk payment models for their Medicaid ACOs
- **Vermont** leveraged their existing Medicaid SSP ACOs to create common standards for commercial and Medicaid payers

Transition to Managed Care Delivery Model

States can use one (or a combination) of three options to implement a mandatory Managed Care program

1915(b) Freedom of Choice Waiver

- Does not cover nontraditional Medicaid populations
- Cannot modify benefits, cost sharing, or some payment rates

1115 Research and Demonstration Waiver

- Allows states flexibility in programmatic aspects
- Imposes a budget neutrality requirement
- States may use waiver while simultaneously implementing other types of Medicaid reform types

1932(a) State Plan Amendment Process

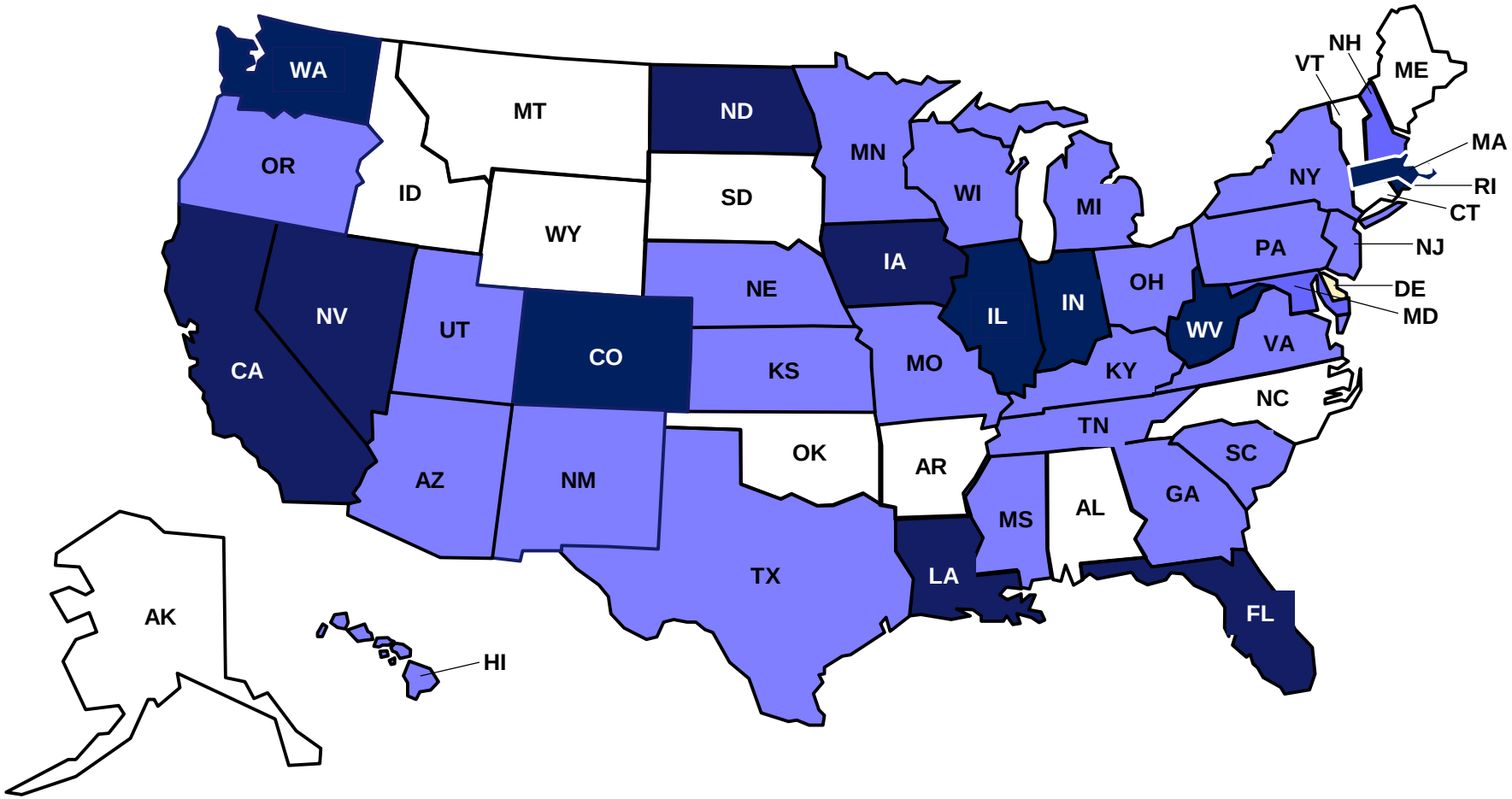
- Preferred route due to simple application and approval process
- Does not require periodic review and re-approval
- Does not apply to certain population groups

39 States with Comprehensive Medicaid Managed Care Models, 2014

MCO (26 including DC)

MCO and Primary Care Case Management (PCCM) (13 states)

PCCM only or no MCO (12 states)



Overview of the Medicaid Managed Care Landscape

39 states operate comprehensive Medicaid managed care (MC)

- 26 operate a MCO-only program
- 13 operate both MCO and PCCM programs
- 15 operate a pre-paid health plan program
- 12 operate a managed long-term care services and supports (MLTSS) program

Since 2011, many states have expanded their Medicaid MC program

- 15 states have expanded the geographic reach of their Medicaid MC program
- 27 states have added eligibility groups or new populations to their MC program

Florida: Statewide Managed Care Using a Regional Approach

Program Highlights

- Began MC transition with a 5 county pilot
- Statewide implementation for the general population and consumers with long term care (LTC) needs by 2014
- CMS-required 85% Medical Loss Ratio (MLR) Requirement – this is the first time CMS included an MLR requirement in a waiver agreement

Contracting

- 6 Health Maintenance Organizations (HMOs) and 4 Provider Service Networks (PSNs) serve the general population
- Contracts were awarded to MCOs serving special needs populations
- MCOs serve selected regions
- Each of the selected MCOs had prior Medicaid experience

Louisiana: Market-Driven Solution Without a Medicaid Expansion

Bayou Health runs two MC programs

- **Pre-paid full risk plans** have a 85% MLR requirement and are responsible for care management, claims processing, enrollment, etc.
- **Shared savings partial risk plans** (PCCM-like model) only provide a primary care network, and at-risk for care management, but providers are paid on a fee-for-service arrangement

Challenges of running both programs in the same geographic area

- Provider steerage and adverse selection favoring PCCM-like model
- Benefit of greater budget predictability is not realized
- Administrative burden of the complicated claims payment process
- Initial savings are less because PCCM-like plans do not have the flexibility to rebalance spending

Illinois: Focus on Local Providers

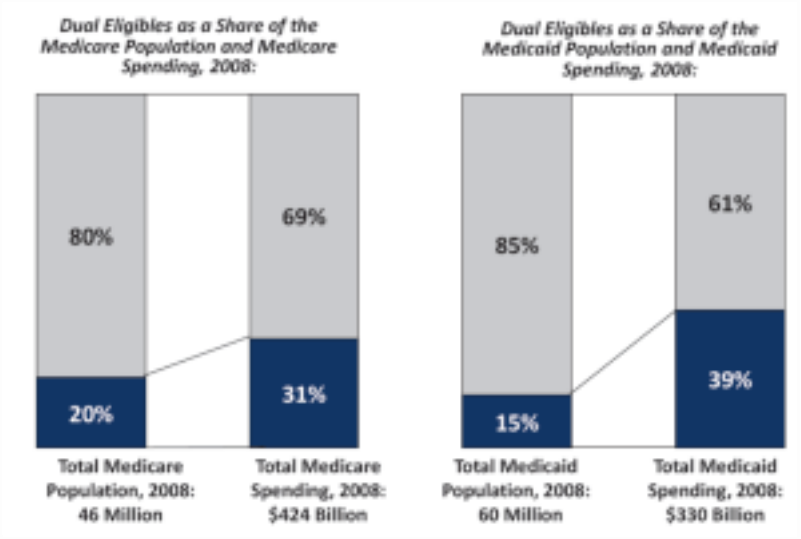
- 50% of Medicaid beneficiaries are transitioning to risk-based MC over 2 years in 5 regions
- Each beneficiary will have a choice of managed care entities (MCE):
  - Full-risk capitated MCO
  - Managed Care Community Networks (MCCN): Provider-organized entities, full-risk capitated payments
  - Care Coordination Entities (CCE): Provider-organized networks providing care coordination for risk- and performance-based fees, but with medical and other services paid FFS
  - Accountable Care Entities (ACE): Provider-organized entities on a 3-year path to full-risk capitated payments
- All Medicaid transition initiatives include MLTSS
- Department of Insurance regulates only MCOs; MCCNs are certified by the Medicaid Department
- Opportunity for providers to develop integrated delivery systems to manage Medicaid populations
- Providers had 5 months after the release of the RFP to organize and apply

New Jersey: Transition to Statewide Managed Care

- In 2012, statewide health reform expanded existing MC programs to include MLTSS and Home and Community Based Services (HCBS) to some populations through an 1115 waiver
- The state preserved the existing care delivery model by awarding contracts to 3 statewide MCOs
- Phased approach to transitioning special needs population into MC:
  - **Phase 1:** Enrolled all adults age 65 and over and individuals with physical disabilities in MCOs for primary and acute care (shift from voluntary to mandatory enrollment)
  - **Phase 2:** Added LTSS to the MCO benefit package and enrolled all individuals receiving nursing facility services into MCOs
- MLTSS transition is guided by a Steering Committee that is comprised of members of the Medicaid Long Term Care Funding Advisory Council, consumers, providers, and representatives of the state Medicaid MCOs and PACE

Reforms in Care Delivery for Dual Eligibles

- 9 million beneficiaries, 2/3 receive full benefits from Medicaid and Medicare
- Population accounts for about 15% of each program's total enrollment but 27% of Medicare expenditures and 39% of Medicaid expenditures
- CMS created the Financial Alignment Initiative for states to implement integrated care management and financing models for dual eligible beneficiaries
- Programs serving this population
  - Special Needs Plans (SNP)
  - Programs of All Inclusive Care for the Elderly (PACE)
  - Managed Long Term Services and Supports (MLTSS)



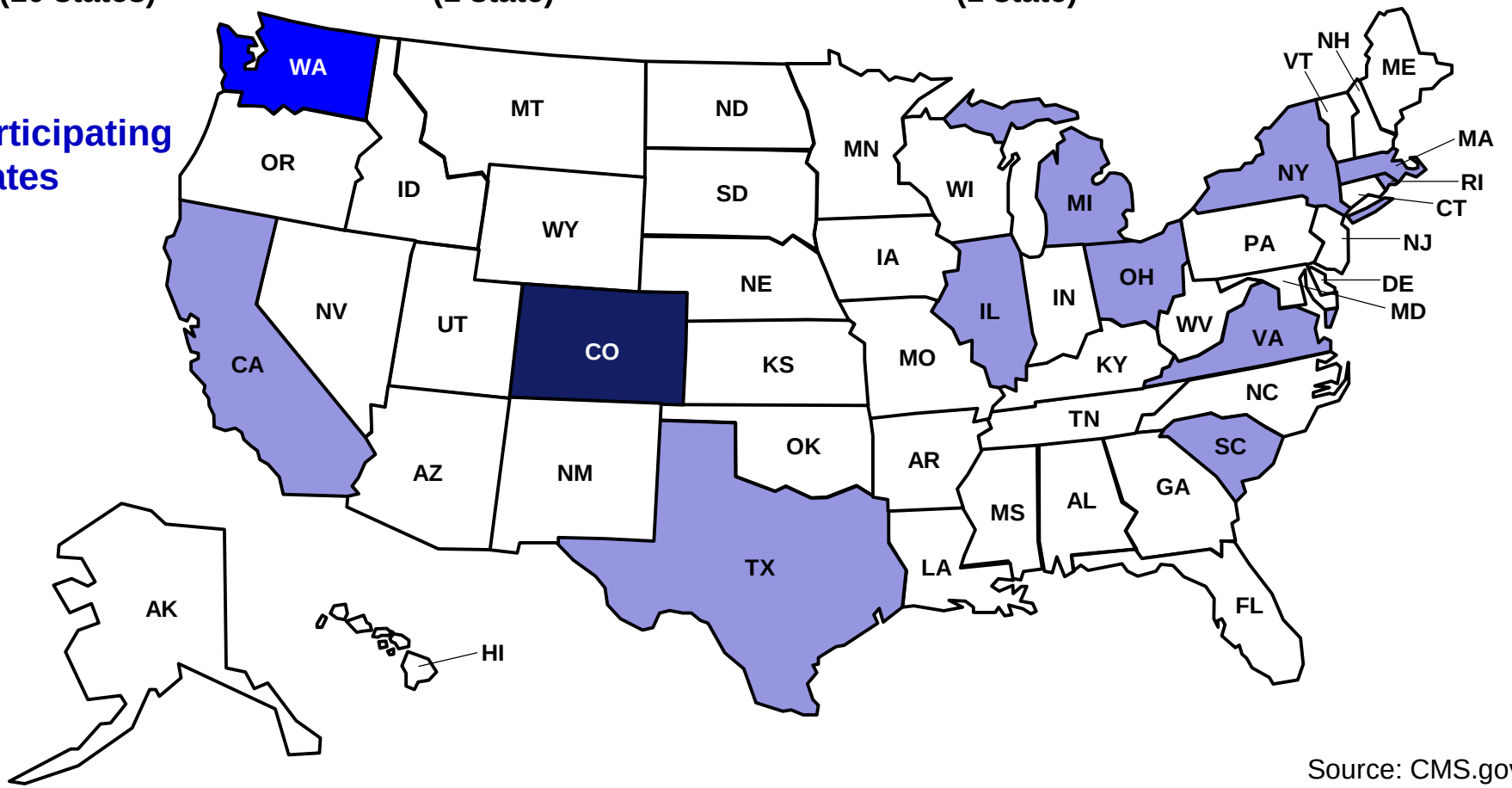
Financial Alignment Initiative Delivery Models at a Glance

Capitated Models
(10 states)

Managed FFS Models
(1 state)

Hybrid Models
(1 state)

Participating States



Source: CMS.gov

Special Needs Plans

- Some dual eligible beneficiaries receive services from Medicare Advantage care coordinated plans also known as Specialized MA plans for Special Needs Individuals or SNPs
- **Special Needs Individuals**
  - institutionalized beneficiaries
  - dual eligible beneficiaries
  - individuals with severe or disabling chronic conditions as specified by CMS
- SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care
- SNPs may be organized as a health maintenance organization (HMO) or a local or regional preferred provider organization (PPO) plan

Programs of All-Inclusive Care for the Elderly (PACE)

The Programs of All-Inclusive Care for the Elderly (PACE) provides comprehensive medical and social services to certain frail, community-dwelling elderly individuals, most of whom are dually eligible

- ✓ An interdisciplinary team of health professionals provides PACE participants with coordinated care
- ✓ PACE offers a comprehensive service package enables them to remain in the community rather than receive care in a nursing home
- ✓ Financing for the program is capitated allowing providers to deliver all services participants need rather than only those reimbursable under Medicare and Medicaid fee-for-service plans
- ✓ PACE is a program under Medicare, and states can elect to provide PACE services to Medicaid beneficiaries as an optional Medicaid benefit

Managed Long Term Services and Supports

Managed Long Term Services and Supports (MLTSS) refers to the delivery of long term services and supports through capitated Medicaid managed care programs

- Increasing numbers of States are using MLTSS as a strategy for expanding home and community based services (HCBS)
- The use of HCBS promotes community inclusion, ensuring quality and increasing efficiency
- There are a variety of programs designed to increase home and community based services:
  - ✓ Balancing Incentive Program
  - ✓ Community First Choice
  - ✓ Money Follows the Person

Tennessee:
Implementation of MLTSS Program

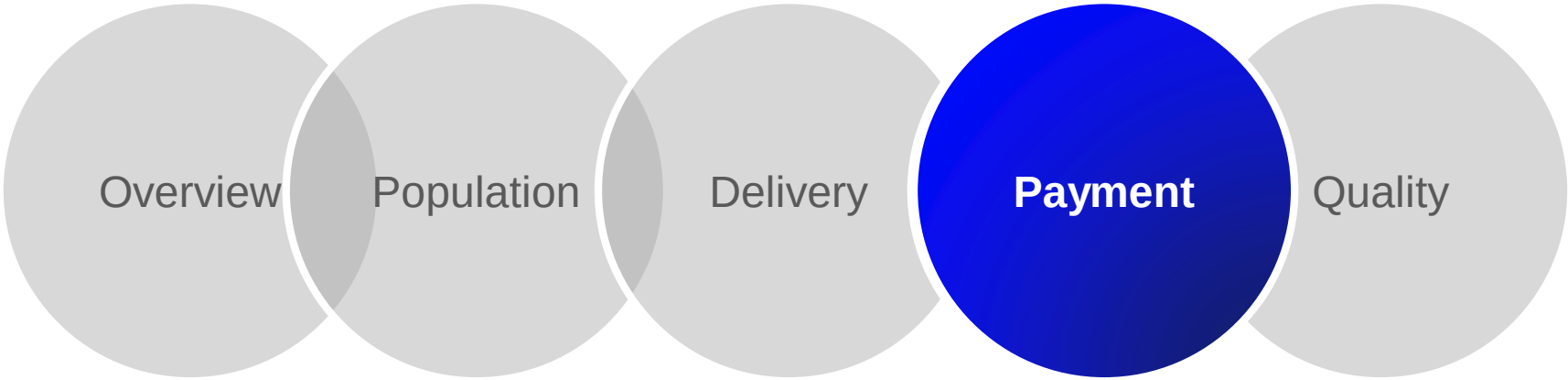
100% of Medicaid population is in MC

- Medical, behavioral, and LTSS are administered by 2 regional MCOs
- Statewide back-up plan manages care for certain special populations (e.g., children receiving SSI, children in state custody, persons enrolled in ID waiver programs) via a risk-modified arrangement
- Prescription drugs administered by statewide Pharmacy Benefits Manager
- MCOs in the MLTSS are at full risk for all services, including nursing facilities

Outcomes and Lessons Learned:

- Integration of benefits results in improved coordination of care and reduces potential for duplicative services and cost shifting
- Effective contracting is essential with a true partnership between MCOs and state
- MCOs need multiple tools and options to manage benefits and costs

Medicaid Moving Forward



Payment Reforms

- **Pharmacy Survey:** increase transparency in drug pricing and help states determine appropriate payments to pharmacies through survey of invoice pricing information on covered outpatient drugs purchased by retail pharmacies
- **Increased Federal Payment for Preventive Services:** provide one percentage point increase in the FMAP effective January 1, 2013, applied to expenditures for specified preventive services
- **Additional Accountability for Medicaid Expenditures:** implement safeguards and ensure proper and appropriate use of Medicaid dollars through new efforts to analyze program and expenditure data at the federal level and a requirement that states submit annual UPL demonstrations for many state plan Medicaid services

Fraud Prevention Efforts

- Combatting fraud and abuse is a major priority for CMS and other federal agencies
- In recent years CMS has focused additional activities and resources to strengthen federal and state activities
- The government accounting office has designated Medicaid as a “high risk” program from a program integrity perspective since it accounts for $400 billion in spending today coupled with projected increases in enrollment and spending

Program Integrity Landscape

Oversight organizations include

- CMS Center for Program Integrity
- State Medicaid Programs
- Medicaid Fraud Control Units (MFCUs)
- HHS Office of Inspector General
- Government Accounting Office
- US Department of Justice

Oversight functions include

- Surveillance and utilization review
- Payment error detection
- Provider enrollment
- Data analysis techniques such as predictive modeling
- Education and training
- Public information

Comprehensive Medicaid Integrity Plan (CMIP)

The current priorities are reflected in the CMIP, which is updated on a five-year federal cycle – the current plan covers FFY 2014-2018

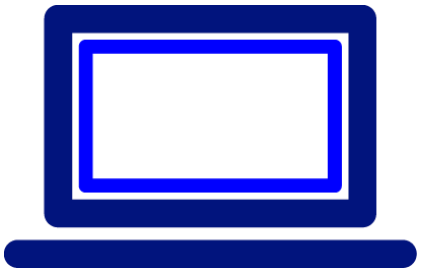
- Shift from “pay and chase” to prevention
- Improve quality and consistency of enrollment and payment data
- Increase State access to Medicare program integrity data
- Increase State capacity for surveillance and enforcement
- Increase CMS capacity for program and financial management
- Develop strategies to monitor new delivery and payment models

Predictive Analytics Technologies

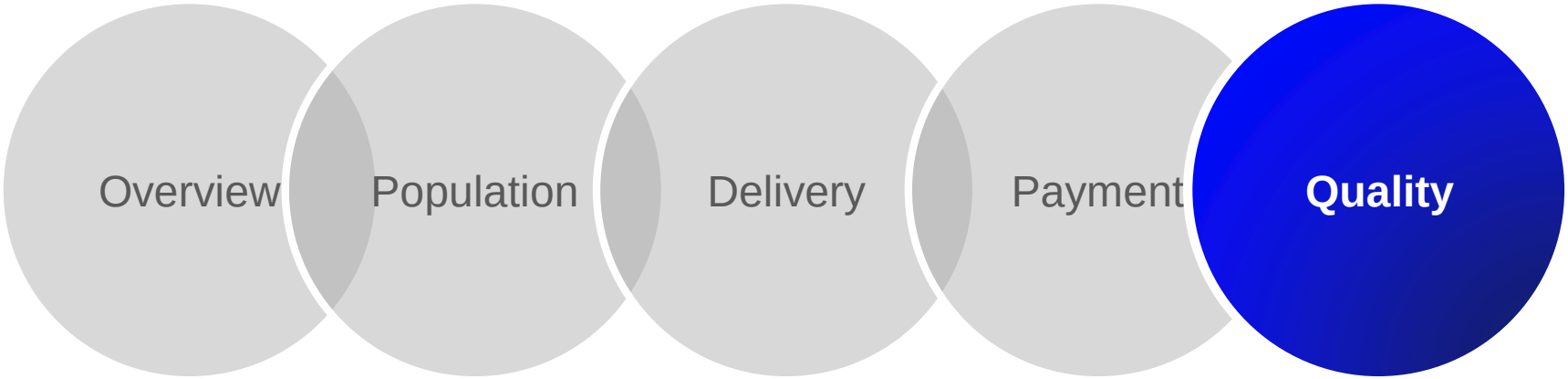
- CMS operates a Fraud Prevention System to implement predictive analytics technologies to identify and prevent the payment of improper claims in the Medicare fee-for-service program

- CMS is congressionally mandated to analyze the feasibility and cost-effectiveness of expanding the use of predictive analytics technologies to Medicaid and CHIP

- Several states are already in the process of implementing predictive analytics technology as part of their program integrity efforts



Medicaid Moving Forward



Improving Quality of Care

- **Efforts to promote quality improvement across the Medicaid program**
  - Promoting Updated and Aligned Core Quality Measures
  - Updating Child and Adult Medicaid Core Set 2014
  - Developing Health Home Core Set of Quality Measures
- **Tackling Specific Care Challenges**
  - Covering behavioral health services for individuals with significant mental health conditions
  - Integrating trauma care
  - Improving oral health
  - Reducing emergency department utilization
  - Improving infant and maternal health
  - Promoting smoking cessation

Improving Quality of Care (continued)

- **Quality Improvement Grants to States** assist states in collecting and reporting the Medicaid Adult Core Set, CMS launched the Medicaid Adult Quality Measurement Program in December 2012
- **The CHIPRA Quality Demonstration Grants** support two states (Florida and Illinois) in working to reduce early elective deliveries to improve maternal and infant outcomes
- **Medicaid Managed Care Improvement** provide comprehensive information and guidance on Medicaid managed care program operations

CONCLUSION

- Medicaid programs are evolving across states
- States are looking for innovative and creative approaches to reduce expenditures through
  - Eligibility reforms
  - Streamlining operations
  - Improving health outcomes
  - Reducing fraud, waste, and abuse
  - Improving accountability
- Federal government is offering technical assistance to states in effort to support innovative initiatives