



DIVISION OF HEALTH CARE FINANCING & POLICY

**Medicaid and Nevada Check
Up Overview**

Assembly Presentation

February 11, 2013



Medicaid – Who Gets It?

- There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable tests within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.
- Rehabilitation Association of Virginia v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994) (Ervin, Chief Judge)



Medicaid – Unique by State

- If you've seen one Medicaid program, you've seen one Medicaid program.
 - A person eligible in one State may not be eligible in another State.
 - Services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State.
 - State legislatures may change Medicaid eligibility, services, and/or reimbursement during the year.



Medicaid – Publicly Financed but Private Sector Services

- Publicly Financed but not a Government Run Healthcare Delivery System
- Medicaid procures most services in the private health care market through purchasing services on a fee for service basis or through paying premiums to contracted managed care organizations.



Medicaid has many Vital Roles in the National Health Care System

Health Insurance Coverage:

- 31 million children and 16 million adults in low-income families;
16 million elderly and persons with disabilities

Assistance to Medicaid beneficiaries:

- 20% of Medicare beneficiaries

Long-Term Care:

- 1.6 million institutional; 2.8 million community based

Support for Health Care System and Safety-net:

- 16% of national health spending; 40% of long-term care
services



Medicaid Growth

- While Medicaid spending for medical services increased more than the medical care consumer price index, growth in Medicaid per enrollee spending increased more slowly than medical care inflation, national health expenditures per capita and growth in private health insurance premiums.
- Kaiser Commission on Medicaid and the Uninsured. Enrollment-Driven Expenditure Growth: Medicaid Spending during the Economic Downturn, FFY 2007-2010. May 2012



Medicaid Financing

- The current financing system for Medicaid does not adequately account for the “countercyclical” nature of the program; during economic downturns, Medicaid expands and state tax revenues shrink, reducing state capacity to afford increased enrollment.



Medicaid

- Authorized by Congress under Title XIX of the Social Security Act in 1965.
- Medicaid is an optional medical coverage program that states elect to provide to their residents.
- States work in partnership with the federal Centers for Medicare and Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals.
- Federal regulations define mandatory groups to be covered (Nevada generally covers only mandatory groups).
 - In the stimulus funding and health care reform legislation, eligibility groups covered by a State cannot be changed due to Maintenance of Effort (MOE)/eligibility.
- Federal regulations define mandatory and optional services (Nevada generally covers mandatory services, or optional services if cost-effective).



Nevada Health Coverage Programs

- The Division of Health Care Financing and Policy administers two major health coverage programs which provide health care to Nevadans.
 - **Medicaid** provides health care to low-income families, as well as aged, blind and disabled individuals. Services are provided as fee-for-service and through managed care networks.
 - **Nevada Check Up** provides health coverage to low-income, uninsured children who are not eligible for Medicaid. Services are provided as fee-for-service and through managed care networks.



General Medicaid Rules

- Comparability of Services
- Free Choice of Provider
- Statewideness
- Utilization Control
- Medical Necessity
- Proper & efficient administration
- Payment for services furnished outside the State
- Assurance of Transportation (Logisticare)
- EPSDT — States are required to provide all medically necessary services. This includes services that would otherwise be optional services or non state plan.
- Reasonable Promptness
- Fair Hearing



Mandatory vs. Optional Medicaid Services

Mandatory	Optional
Inpatient hospital	Personal Care Services
Clinic services	Prescription drugs
Nursing facility services for individuals 21 and older	Nursing facility care for individuals age 20 and under
EPSDT for children under age 21	
Physician services	Preventive and restorative care for individuals age 21 and older
Family planning services	Home and community based waiver programs
Home health services	Podiatric care
Medically necessary transportation	Hospice
Pregnancy related services	

Note: This is not an all-inclusive list.



Mandatory / Optional Coverage Groups

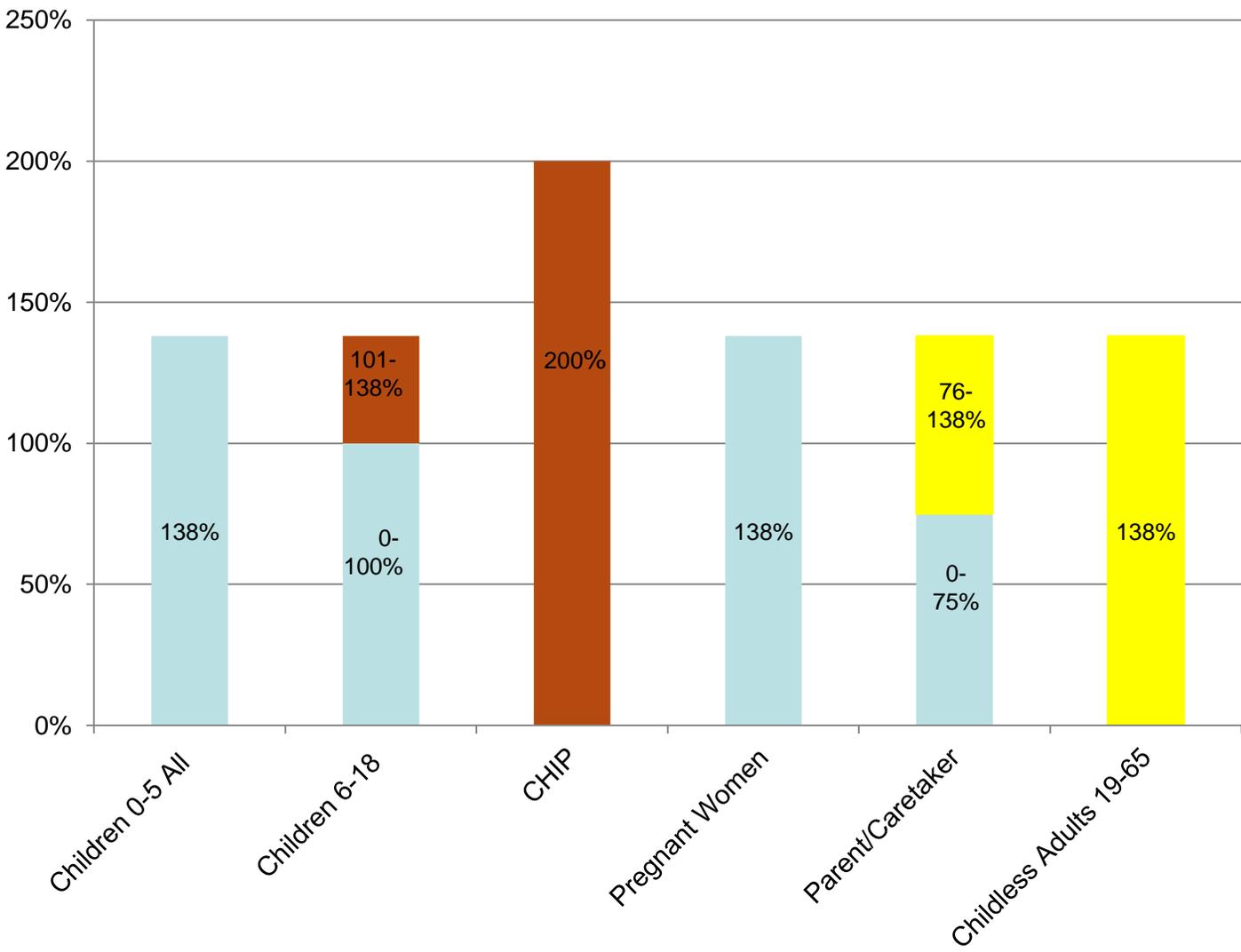
Mandatory	Optional
Families who meet states welfare eligibility standards (AFDC) in effect on July 16, 1996	Women with breast or cervical cancer under 200% of the FPL
Pregnant women and children under age six with incomes at or below 133% of the Federal Poverty Level (FPL)	Disabled children who require medical facility care, but can appropriately be cared for at home – Katie Beckett eligibility group
Children 6 to 19 with family income up to 100% of the FPL	Health Insurance for Work Advancement (HIWA) is for individuals 16 to 64 who are disabled. It allows them to retain essential Medicaid benefits while working and earning income.
SSI recipients (blind or disabled)	
Certain Qualified Medicare Beneficiaries	
Caretakers (relatives or legal guardians who take care of children under age 18)	

* With Health Care Reform, these groups will be simplified.



Medicaid Expansion Eligibility

F
P
L



MED FMAP New ACA 100% FMAP CHIP FMAP



Medicaid Program Flexibility



States choose to:

- Establish their own eligibility standards;
 - MOE;
- Determine the type, amount, duration and scope of services;
- Set the rate of payment for services; and
- Administer their program.



Nevada Categories of Coverage

- Aged (65 and over)
- Blind
- Disabled
- Pregnant women and 0 to 6 year olds
- Children ages 6 to 19 years of age
- Families with blood related and/or adopted dependent children in the home

(Note: Each group must meet specific income and asset standards to qualify)



1915(c) and (i) Waivers

- 1915(c) Nevada Medicaid operates under 4 Secretarial waivers of Section 1902 regulations of the Act
- Eligibility and Service waivers
 - MR/DDRC waiver - MHDS
 - Home and Community Based Waiver(elderly at home and in group care) – ADSD
 - Physical Disabilities – DHCFP
 - Assisted Living – ADSD
- 1915(i) Service waiver
 - Adult Day Health Care
 - Habilitation/brain injury community re-integration
 - Day Treatment or Partial Hospitalization Services for Individuals with Chronic Mental Illness



Medicaid Funding

- Federal Financial Participation (FFP) is provided to pay for medical services authorized by CMS.
- Federal Medical Assistance Percentage (FMAP) defines the level of FFP provided by the federal government for Medicaid benefit costs paid by the state.
- Sources of funds other than State General Fund and Federal Match:
 - Intergovernmental transfers
 - Disproportionate Share Hospital payments
 - Upper Payment Limit payments
 - County Match program
 - Graduate Medical Education
 - Other local government funds
 - School districts
 - Provider fees (Nursing Facilities)
 - Certified Public Expenditures



Increasing Federal Revenue for Nevada



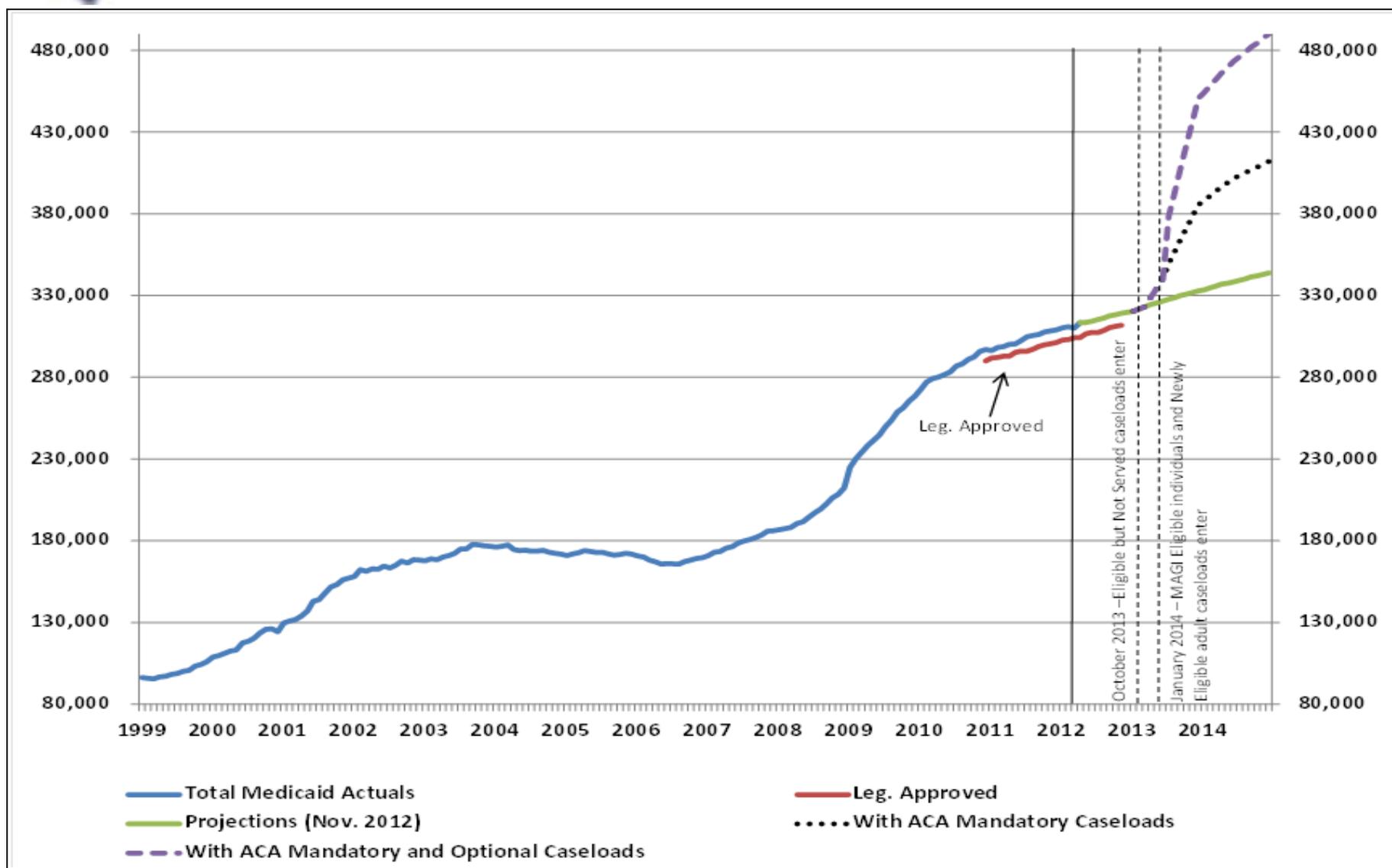
- **County Match Program**

- Effective July 1, 2011, this program supports county care of the medically indigent by providing federal matching funds for individuals in hospitals, nursing facilities, and home/community based services with incomes between 142% and 300% of the SSI level.
- Most other local government agencies providing medical services and having a Medicaid contract provide the non-federal share of the Medicaid costs and the Medicaid program transfers the federal share of allowed costs to these agencies (school districts, county social services).



Division of Health Care Financing and Policy

Total Medicaid





Nevada Check Up

- Authorized by Congress in 1997 as Title XXI of the Social Security Act, Reauthorized in February of 2009 and renamed the Children's Health Insurance Program (CHIP).
- Children uninsured for at least six months, ages birth through 18, who do not qualify for Medicaid, may be eligible for Nevada Check Up.
- Medical coverage follows Medicaid policy (except for non-emergency transportation)
- Families with income levels up to 200% of the Federal Poverty Level (FPL) may qualify (annual household income of less than \$47,100 in 2013 for a family of four).
- Quarterly premiums range between \$25 and \$80, based on family size and income.



Applying for Nevada Check Up

- A child may qualify for Nevada Check Up if:
 - They have income less than 200% FPL;
 - The child is not eligible for Medicaid;
 - The child does not have access to Public Employees Benefit Program (PEBP)
 - The child is a U.S. citizen or legal resident;
- Applying for Nevada Check Up or Medicaid will not affect a family's immigration status.



Nevada Check Up

