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Department of Health and Human Services

MEDICAID 101

Assembly Committee on Health & Human Services

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February 8, 2019

Objectives

- Improve knowledge of Medicaid key features, terminology, and concepts
- Understand Medicaid's eligibility process
- Increase knowledge of Medicaid policy, budgets, and operational components
- Understand the two delivery systems
  - Managed Care
  - Fee-for-Service

What is 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 covers all mandatory groups and some optional groups
  - American Recovery and Reinvestment Act of 2009 (ARRA) stimulus funding and the Affordable Care Act (ACA) limit the state's ability to change eligibility requirements due to Maintenance of Effort (MOE) provisions
- Federal regulations also define mandatory and optional services
  - Nevada covers mandatory services and cost-effective optional services

March 1, 1965

- **Social Security Amendments of 1965**
- Establishing Medicaid to provide health insurance to low-income children, caretaker relatives, the elderly, blind, and individuals with disabilities.

January 23, 1967

- **Early Periodic Screening, Diagnosis, and Treatment (EPSDT)**
- Mandates EPSDT services for children up to age 21.

October 30, 1972

- **Social Security Amendments of 1972**
- Establishes the Supplemental Security Income (SSI) program of cash assistance for elderly and individuals with disabilities and enables states to link SSI and Medicaid eligibility.

August 13, 1982

- **The Omnibus Reconciliation Act of 1981**
- Establishes Section 1915(b) Freedom-of-Choice Waivers and Section 1915(c) Home-and Community-Based Services waivers and allowed states to start making additional payments to hospitals serving a disproportionate share of Medicaid and low-income patients, known as DSH hospitals.

July 18, 1984

- **Deficit Reduction Act of 1984**
- Extends Medicaid coverage to children in the Aid to Families with Dependent Children (AFDC) eligible families up to age five (5), as well as AFDC-eligible first-time pregnant women and pregnant women in two-parent unemployed families

December 22, 1987

- **Omnibus Budget Reconciliation Act of 1987**
- Gives states the option of extending coverage to pregnant women and infants with family income at or below 185% FPL. Imposes quality of care standards for Medicaid-certified nursing homes in response to well-documented problems facing seniors in nursing homes.

December 19, 1989

- **Omnibus Budget Reconciliation Act of 1989**
- Requires states to provide coverage to pregnant women and children up to age six (6) with income below 133% FPL. Expands EPSDT services to include needed diagnostic and treatment services even if not covered by Medicaid. Requires states to cover services provided by federally-qualified health centers (FQHCs).

January 1, 1996

- **Block Grant Veto**
- The U.S. Congress passes and President Bill Clinton vetoes legislation converting Medicaid to a block grant to states.

August 22, 1996

- **Personal Responsibility and Work Opportunity Reconciliation Act of 1996**
- Repeals the AFDC individual entitlement to cash assistance and replaces it with the Temporary Assistance for Needy Families (TANF) block grant to states, removing link between welfare and Medicaid eligibility.

June 22, 1999

- **Olmstead Case**
- The U.S. Supreme Court rules in Olmstead v. L.C. the Americans with Disabilities Act (ADA) can, under certain circumstances, require states to provide community-based services to individuals for whom institutional care is inappropriate.

October 24, 2000

- **Breast and Cervical Cancer Treatment and Prevention Act of 2000**
- Gives states the option to extend Medicaid coverage to uninsured women with breast or cervical cancer, regardless of income or resources.

February 17, 2009

- **American Recovery and Reinvestment Act of 2009**
- Provides for $149 billion in new health spending, including a temporary increase in the federal matching rate for Medicaid, funding for health information technology, and funding for community health centers.

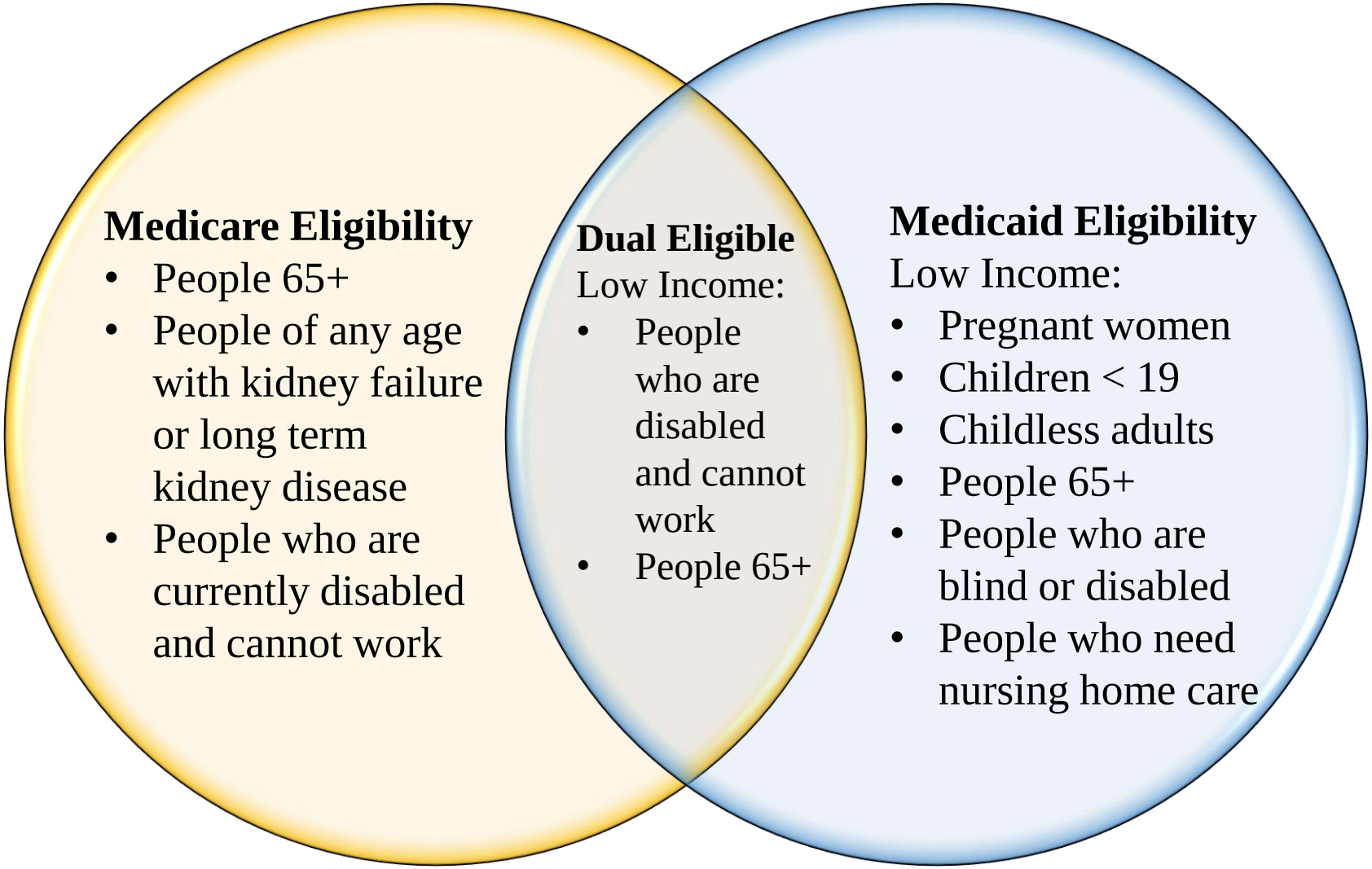
March 23, 2010

- **The Patient Protection and Affordable Care Act of 2010**
- Reforms the health care system and extends health coverage to uninsured individuals across the country, including expansion of coverage, new demonstration projects to control costs, investment in technology and data, and increased CHIP matching through 2019.

June 28, 2012

- **Supreme Court Decision on Constitutionality of the Affordable Care Act**
- Supreme Court upholds the constitutionality of the ACA, but makes the Medicaid expansion effectively a state option.

Medicare and Medicaid



Medicaid's Vital Roles in the National Health Care System

- Health care coverage
  - Children and adults in low-income families
  - Elderly and persons with disabilities
  - Low income childless adults (if the state elected to enroll the expanded population)
- Assistance to Medicare beneficiaries
  - Premiums, co-pays, and deductible coverage
- Long-term care
  - Institutional and community-based services

Medicaid is Unique State to State

If you've seen one Medicaid program, you've seen one Medicaid program.

- Services provided by one state may differ considerably in amount, duration, or scope from services provided in a similar or neighboring state.
- A person eligible in one state may not be eligible in another state.
- Medicaid eligibility, services, and/or reimbursement may change anytime during the year based upon state and federal regulations changes.

CATEGORICALLY NEEDY

MEDICALLY NEEDY

Who is Eligible for Medicaid?

Mandatory Individuals	Optional Individuals
Children	Women with breast or cervical cancer under 200% of the FPL
Pregnant Women	Disabled children who require medical facility care, but can appropriately be cared for at home – Katie Beckett eligibility group
Parent/Caretaker	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)	Home and Community Based Waivers
Certain Qualified Medicare Beneficiaries (QMB)	Childless Adults

How to Apply for Medicaid

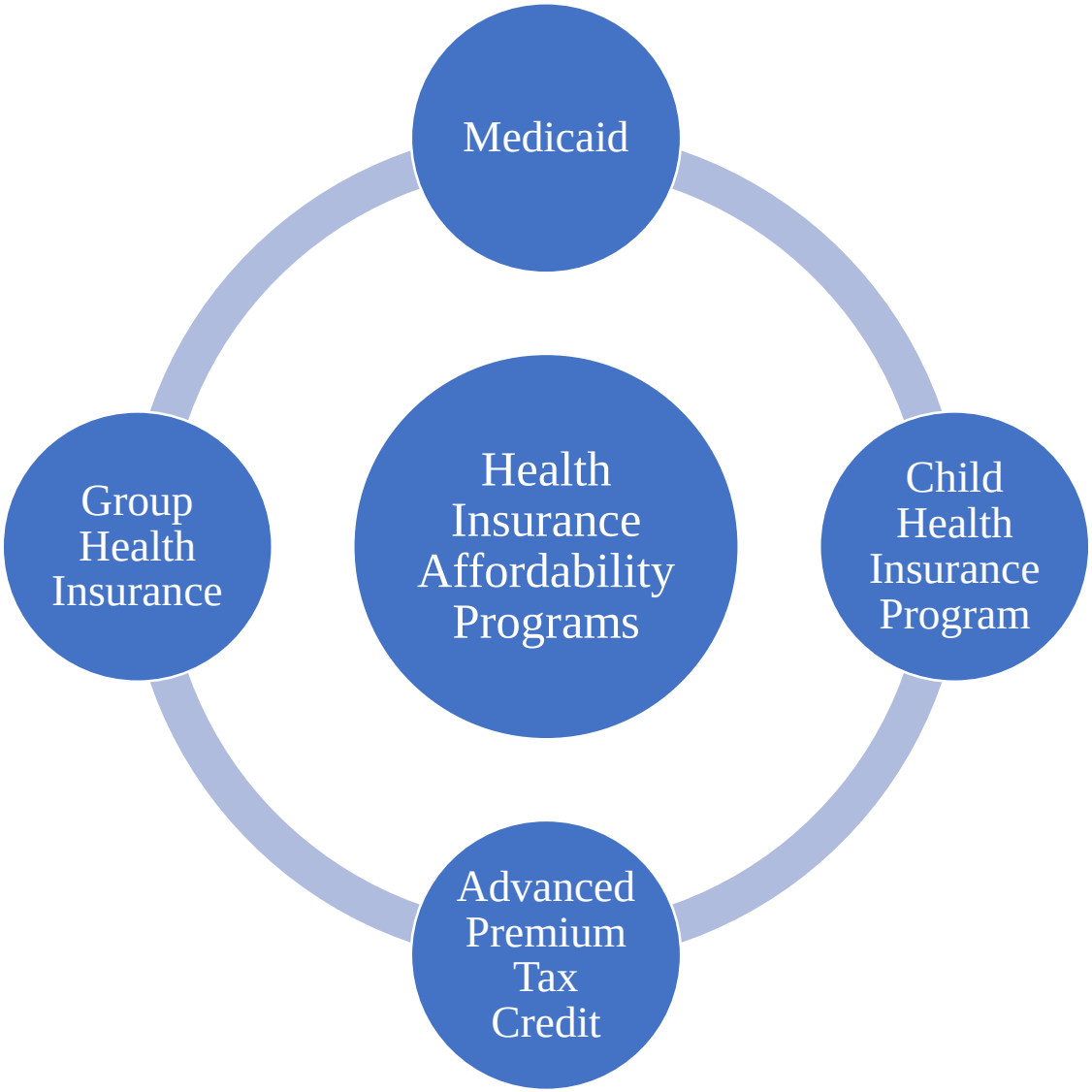
Click in – Come in – Call in

- Individuals applying for assistance are provided service options via
  - Access Nevada – the DWSS online application system
  - Mail/Fax in applications
  - Call Center (CCT) – includes Automated Voice Response system for routine queries
  - Visit one of the local area offices

- SNAP Outreach partners
  - Local food banks and community sites

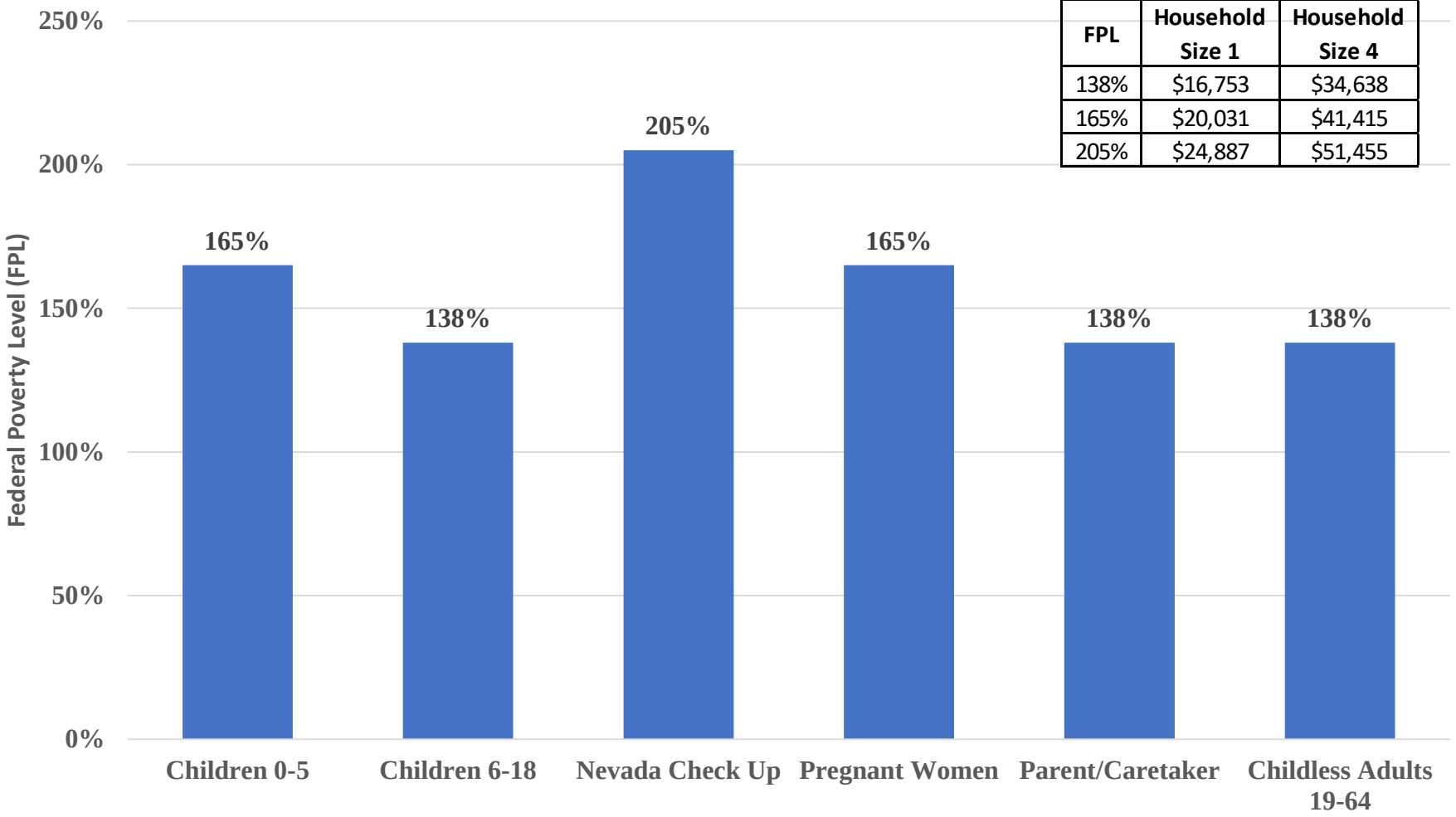
- Targeted DWSS Partnerships
  - Eligibility staff are located onsite in community organizations.

Single Application

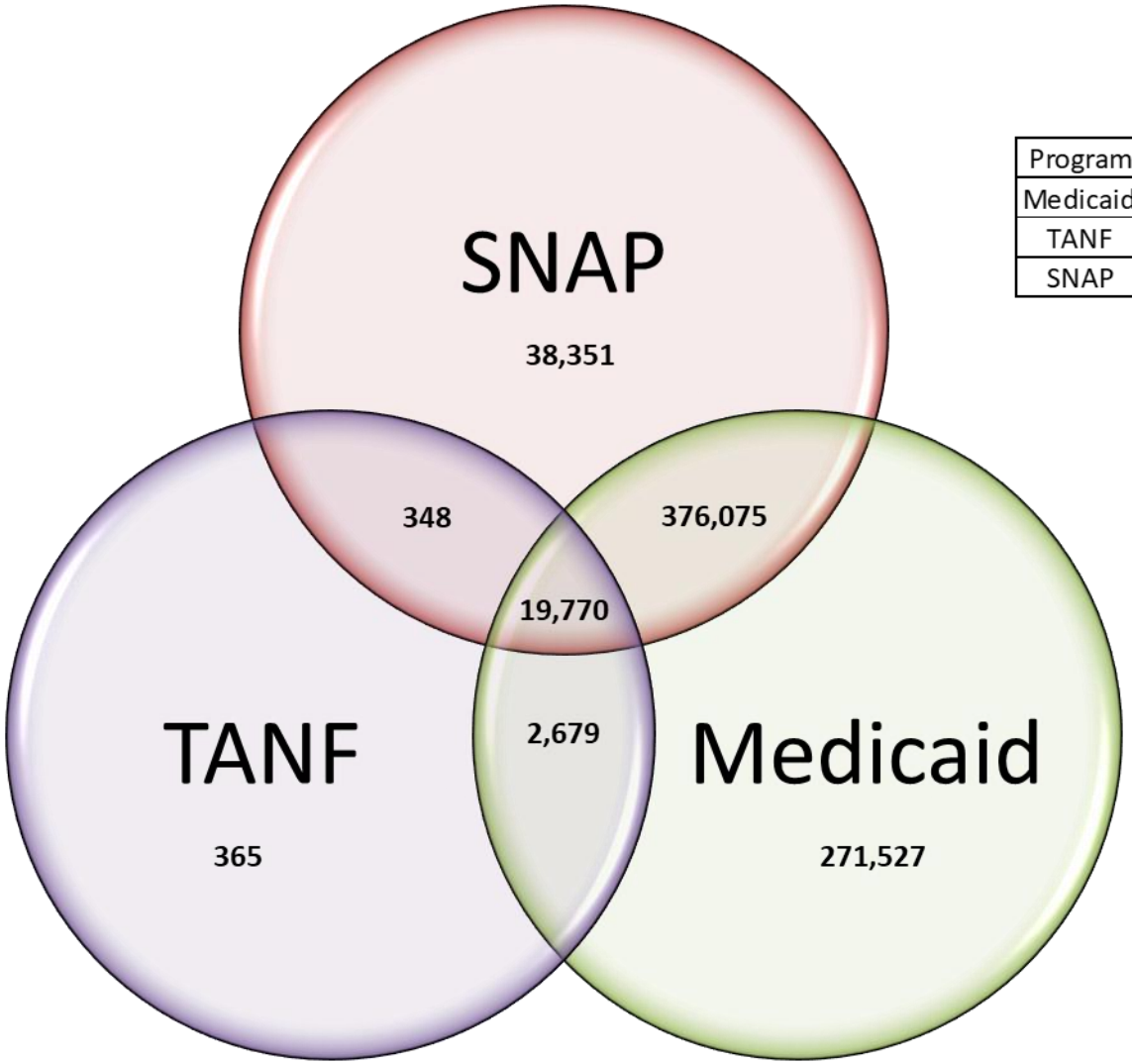


Current Eligibility

2018 Federal Poverty Guidelines		
FPL	Household Size 1	Household Size 4
138%	$16,753	$34,638
165%	$20,031	$41,415
205%	$24,887	$51,455



Recipients by Program



Program	Recipients
Medicaid	670,051
TANF	23,162
SNAP	434,544

Note: October 2018 data is used in the diagram above. 709,115 unique individuals are in at least one of the three programs. Medicaid counts include retroactive cases.

General Rules of Medicaid

- Comparability of Services
- Free Choice of Provider
- Statewide Coverage
- Utilization Control
- Medical Necessity
- Proper & efficient administration
- Payment for services furnished outside the State
- Assurance of Transportation (MTM)
- Early Periodic Screening and Diagnostic Treatment (EPSDT)
  - States are required to provide **all** medically necessary services including services that would otherwise be optional but not part of the Nevada Medicaid State Plan.

10 Essential Health Benefits

Nevada's Mandatory & Optional Services

Mandatory Services:

- Physician Services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- Early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under the age of 21
- Family planning and supplies
- Federally-qualified health center (FQHC) services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Nursing facility (NF) services for individuals 21 or over
- Transportation

Covered Optional Services:

- Prescription drugs
- Medical care or remedial care furnished by licensed practitioners (limited)
- Diagnostic, screening, and preventive services
- Clinic services
- Dental services (only EPSDT), dentures
- Therapy (physical, occupational, speech, audiology)
- Prosthetic devices, eyeglasses
- Primary care case management
- ICF/MR services
- Inpatient/nursing facility services for individuals 65 and over in an institution for mental diseases (IMD)
- Inpatient psychiatric hospital services for individuals under age 21
- Nursing Facility services for individuals under 21
- Home health care services
- Respiratory care services for ventilator-dependent individuals
- Personal care services
- Private duty nursing services
- Hospice services
- Targeted case management (limited)
- Free-standing birthing centers

Service Delivery Models

Medicaid procures most services in the private health care market through purchasing services on a fee-for-service (FFS) basis or through paying premiums to one or more contracted managed care organizations (MCO).

- **Title XIX (Medicaid) MCO in Nevada**
  - In urban Clark and Washoe counties except for the Medicaid Assistance for Aged, Blind, and Disabled or Institutional Categories
  - Disenrollment may occur for individuals that are severely emotionally disturbed (SED), in Child Protective Services (CPS), or severely mentally ill (SMI)
  - Tribal Members may opt-out

- **Title XXI (Nevada Check Up) MCO in Nevada**
  - All children living in urban Clark and Washoe counties
  - No disenrollment option except for tribal members

What is Fee-for-Service (FFS)?

- Individuals may receive services from any provider enrolled with Nevada Medicaid
- Referrals from a primary care physician are not required to see a specialist
- Individuals must coordinate and manage their own care unless they are enrolled in a waiver program
- DXC (formerly Hewlett Packard Enterprise (HPE)) is the State's fiscal agent and responsible for administering the FFS Medicaid program on the State's behalf

What is a Managed Care Organization (MCO)?

- Helps people navigate the health care system
  - Provides care coordination
  - Provides patient education
  - Provides preventative care
  - Connects individuals with primary care and specialty providers
  - Ensures the right service is provided at the right time in the right setting

- Maintains a network of health care providers for their membership

What Services are Currently Provided by Managed Care?

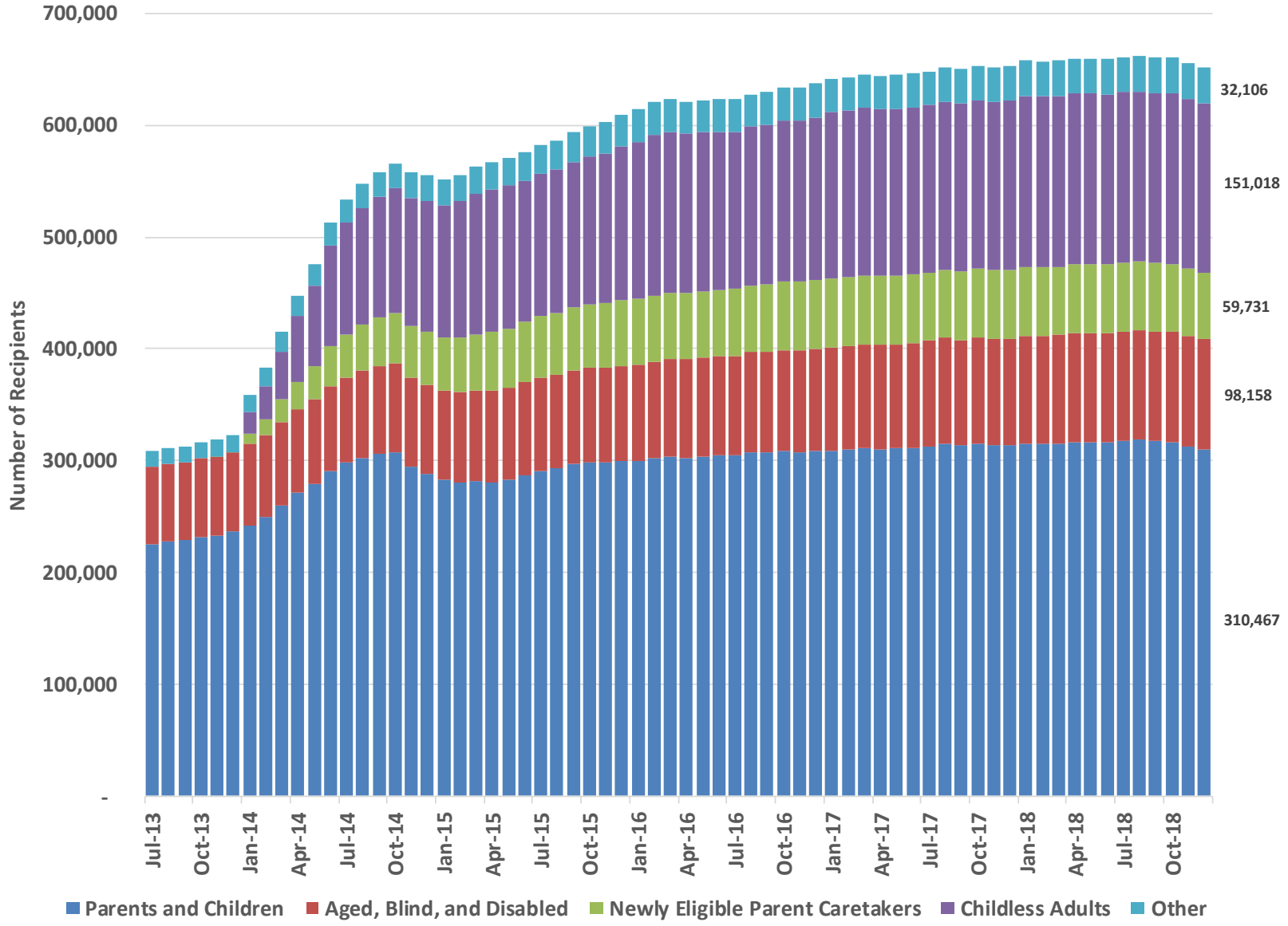
- Managed Care covers most of the services that are in the Medicaid-approved State Plan, such as
    - Physician/Hospital Services
    - Pharmacy
    - Behavioral Health Services
    - Personal Care Services
    - Home Health
    - Therapy Services

- MCOs have the flexibility to offer value-added benefits, known as additional services based on need and the plan selected

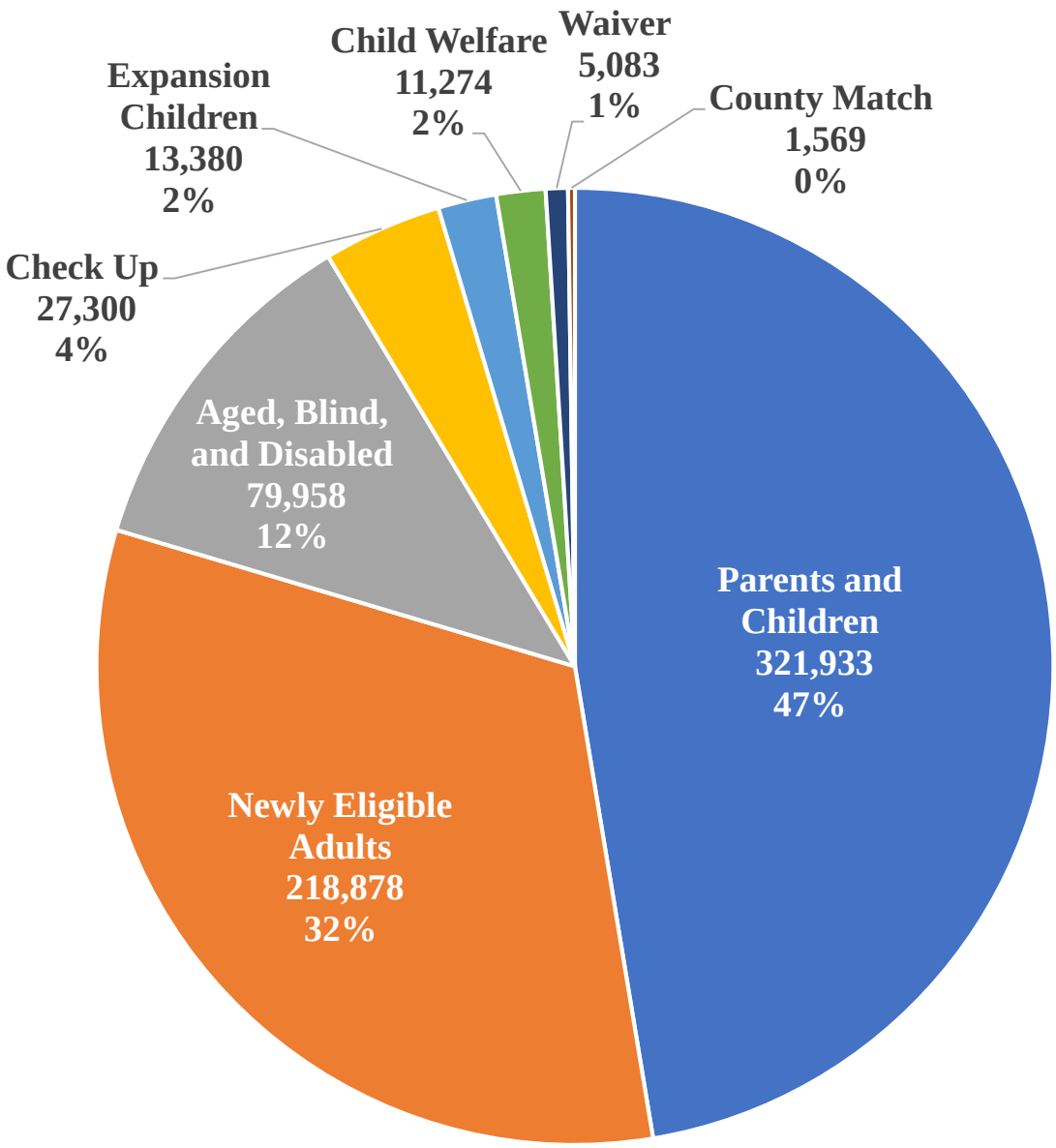
What is Not Currently Provided by Managed Care?

- Hospice
- Adult Day Health Care
- Non-Emergency Transportation
- Targeted Case Management
- Home and Community-Based Waiver Services
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Orthodontia
- Nursing Facility Stays more than 45 days
- Residential Treatment Center stays more than 30 days

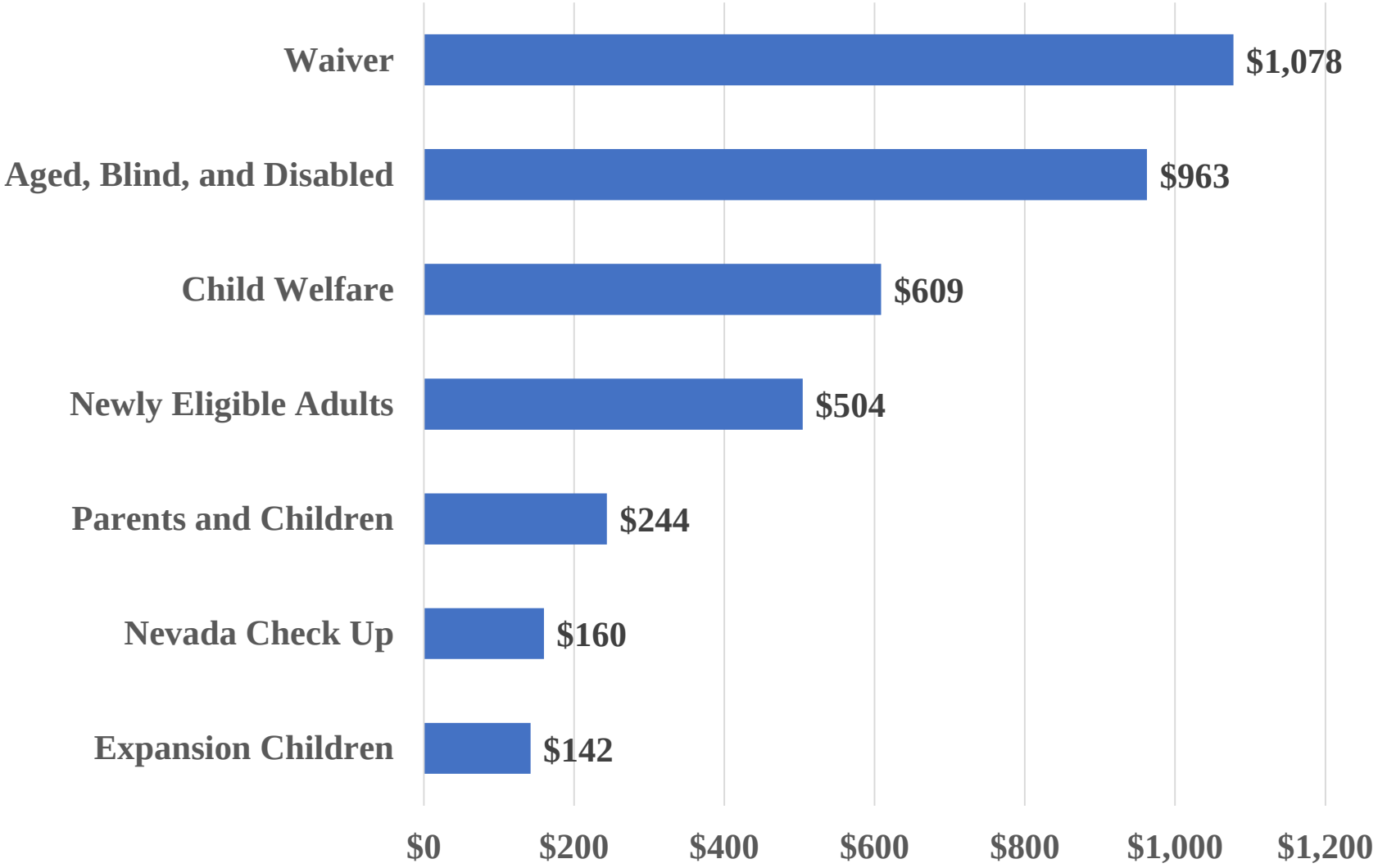
Medicaid Caseload



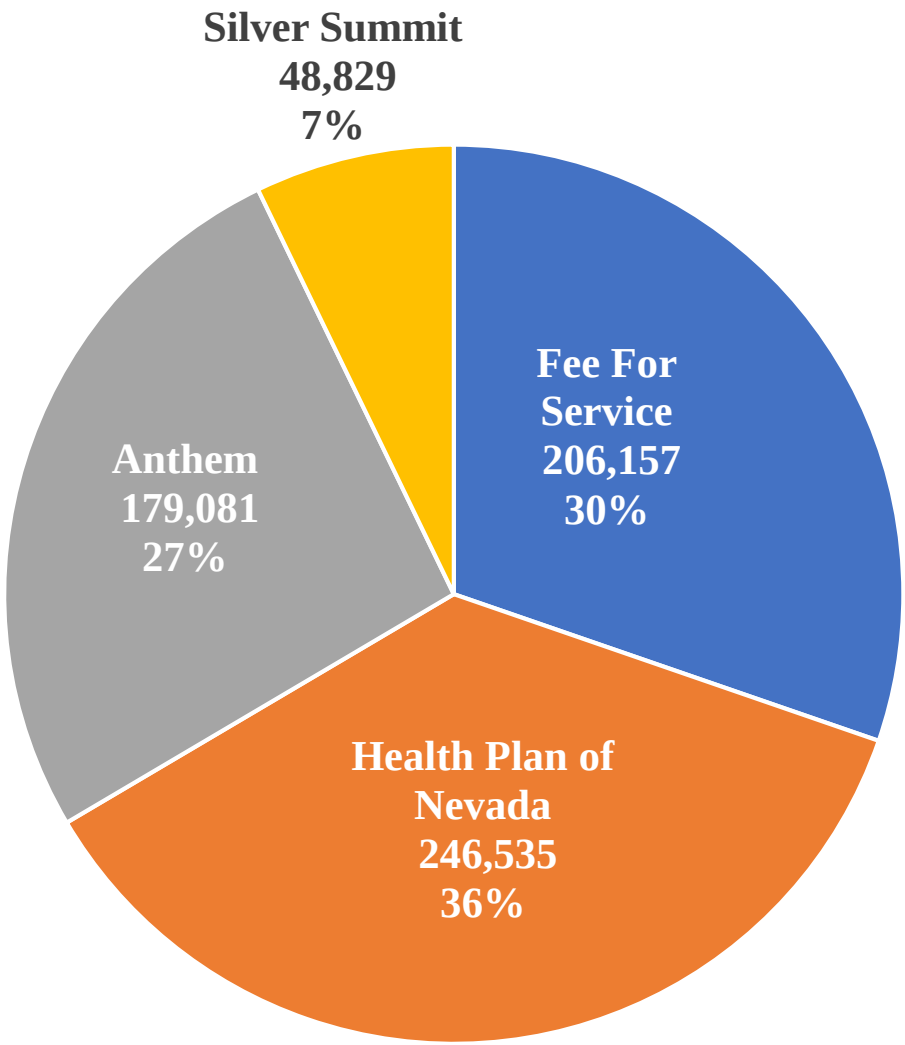
SFY18 Average Caseload by Category



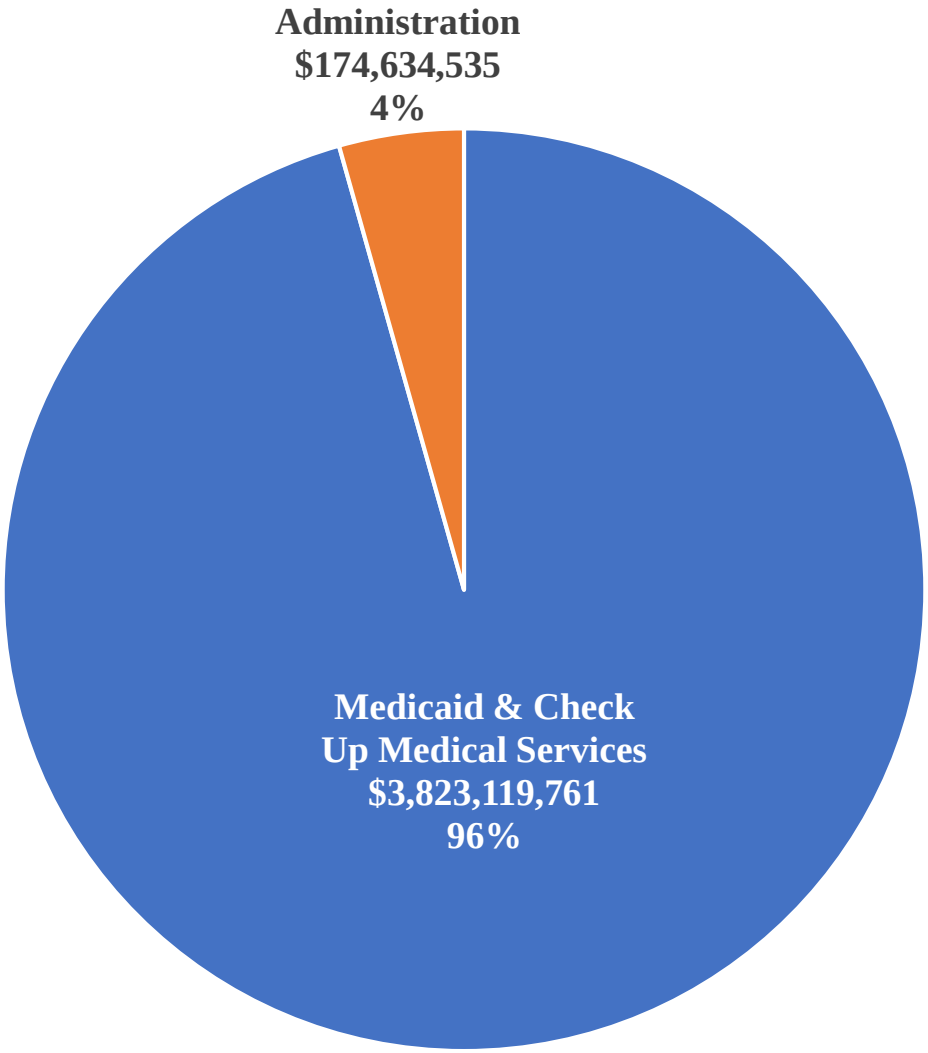
SFY18 Monthly Costs Per Recipient by Caseload Category



Caseload by Fee-for-Service and Managed Care Organization



SFY18 Total Computable Spend by Type



Blended Federal Medical Assistance Percentage (FMAP)

State Fiscal Year	FMAP	Enhanced (CHIP) FMAP	ACA Enhanced (CHIP) FMAP	New Eligibles FMAP
FY12	55.05%	68.54%		
FY13	58.86%	71.20%		
FY14	62.26%	73.58%		100.00%
FY15	64.04%	74.83%		100.00%
FY16	64.79%	75.35%	92.60%	100.00%
FY17	64.74%	75.32%	98.32%	97.50%
FY18	65.48%	75.84%	98.84%	94.50%
FY19	65.09%	75.57%	98.57%	93.50%
FY20	64.17%	74.92%	89.29%	91.50%
FY21	*64.63%*	*75.24%*	*78.11%*	*90.00%*
FY22	*65.24%*	*75.66%*		*90.00%*
FY23	*65.99%*	*76.19%*		*90.00%*

Note: The FMAP values for FY21 through FY23 are projections. The ACA Enhanced (CHIP) FMAP ends in September 2020.

Access to Care

How We've Addressed Access to Care

- Expanded the use of telemedicine/telehealth
- Implemented Community Paramedicine Program
- Continuing to expand the Applied Behavioral Analysis (ABA) Program
- Allowed for the reimbursement of Podiatrists and Registered Dieticians
- Implemented the Certified Community Behavioral Health Clinics (CCBHC) program and requesting to expanding the program
- Increased rates for Inpatient Psychiatric, Skilled Nursing Facilities, Assisted Living, Adult Day Health Care, and Pediatric Surgeons
- Proposing rate increases for Neonatal Intensive Care (NICU) and Pediatric Intensive Care (PICU) services
- Continue meeting with Stakeholders to brainstorm on policy and reimbursement changes
- Eased Administrative Burdens by:
  - Aligning Prior Authorization requirements between FFS and MCO
  - Implementing online provider enrollment
  - Implementing a modernized Medicaid Management Information System (MMIS)

Opportunities

- 1115 Demonstration Waiver for Specialized Foster Care
  - Collaboration with Division of Child and Family Services
- 1115 Demonstration Waiver for CCBHC
  - Collaboration with Division of Public and Behavioral Health
- 1915(i) State Plan Option for Supportive Housing Services
  - Medicaid's piece in the homelessness puzzle
- Establishment of the Hospital Provider Fee
  - Collaboration with the Nevada Hospital Association

Challenges

- Decrease in Federal match
- Lack of Board Certified Behavioral Analyst (BCBA) providers for Applied Behavioral Analysis (ABA) services
- Lack of behavioral health step down facilities in Nevada
- Lack of access to services in rural and frontier areas of the state

Appendix

Acronyms

ACA – The Affordable Care Act

ADA – The Americans with Disabilities Act

ARRA – American Recovery and Reinvestment Act of 2009

APTC – Advanced Premium Tax Credit

CMS – Centers for Medicare and Medicaid Services

EPSDT – Early Periodic Screening, Diagnostic, and Treatment

FMAP – Federal Medical Assistance Percentage

FPL – Federal Poverty Level

HCBS – Home and Community-Based Services

HHS – U.S. Department of Health and Human Services

HPE – Hewlett Packard Enterprise

LTSS – Long-Term Supports and Services

MCO – Managed Care Organization

MLTSS – Managed Long Term Services and Supports

MMIS – Medicaid Management Information System

Modified Adjusted Gross Income (MAGI) Medical Groups

Medical Groups	Income Limits	Exceptions/Rules
Parents & Caretakers	138% of Poverty	Parent/Caretaker must have a dependent minor child in the home.
Children under 19 Poverty Level Children	Children 6-18: < 122% FPL Children under 6: < 165% FPL	
Pregnant Women	< 165% FPL	
Childless Adult Non-Parents 19–64 years old	< 138% FPL	Cannot be pregnant; Cannot be Medicare eligible; Cannot be eligible in another Medical group.
Nevada Check-Up State CHIP program for children under 19	Children under 6: 166%-205% Children 6-18: 139%-205% FPL	Premium payment required; Cannot have other insurance; Cannot be Medicaid eligible.

Specialized Medical Groups

Aged Out of Foster Care	No income or resource determination	Under 26 years of age; were in foster care and enrolled in Medicaid at the time they turned 18 years of age.
Children for Whom a Public Agency has Assumed Financial Responsibility	No income or resource determination	Public agency has assumed responsibility; Child cannot be in DCFS custody
Title IV-E eligible foster children at Rite of Passage	No income or resource determination	Children under 18 years of age residing at Rite of Passage receiving IV-E foster care benefits Applications processed at Yerington D.O.
Breast and Cervical Cancer	No income or resource determination by DWSS. CDC screening includes income determination.	Under age 65; Uninsured or under insured; Not eligible under any other medical assistance program; Screened by CDC and in need of treatment. Applications processed by Elko D.O.

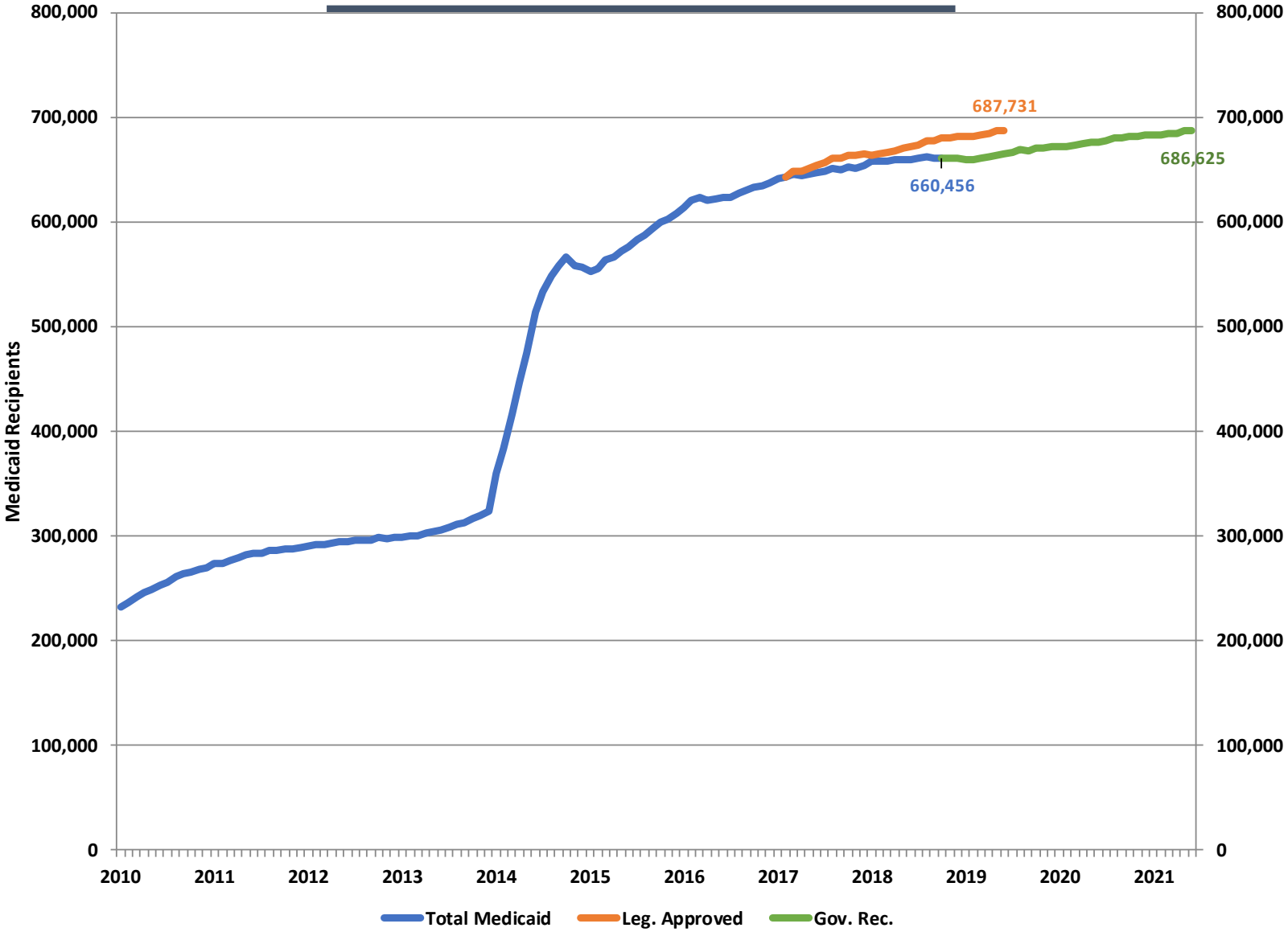
MAABD Medical Groups

Definition	Income Limits	Exceptions/Rules
SSI Recipients	Categorically eligible, income and resource determination made by SSI	Receiving SSI as a Nevada resident
Public Law -Adult Disabled Child -Pickle Amendment -Widow/Widowers -Widow/Widowers and Surviving -Divorced Spouses -Suspension of SSI due to Income		Had SSI, Lost SSI as a result of an event. (usually increase in RSDI)
Institutional	$30 SSI Institutional payment rate	Residing in long term care
HCBW	Frail and Elderly	Over 65 years of age; Meets the level of care assessment;
	Assisted Living Waiver	Over 65 years of age; Residing in approved assisted living facility in Las Vegas only;
	Group Care Waiver for the aged or blind	Over 65 years of age; Residing in approved assisted living facility in Las Vegas only;
	for the mentally impaired	Mentally retarded; Living in a community setting;
	Disabled Waiver	Meet Level of Care as approved by ADSD Living in a community setting

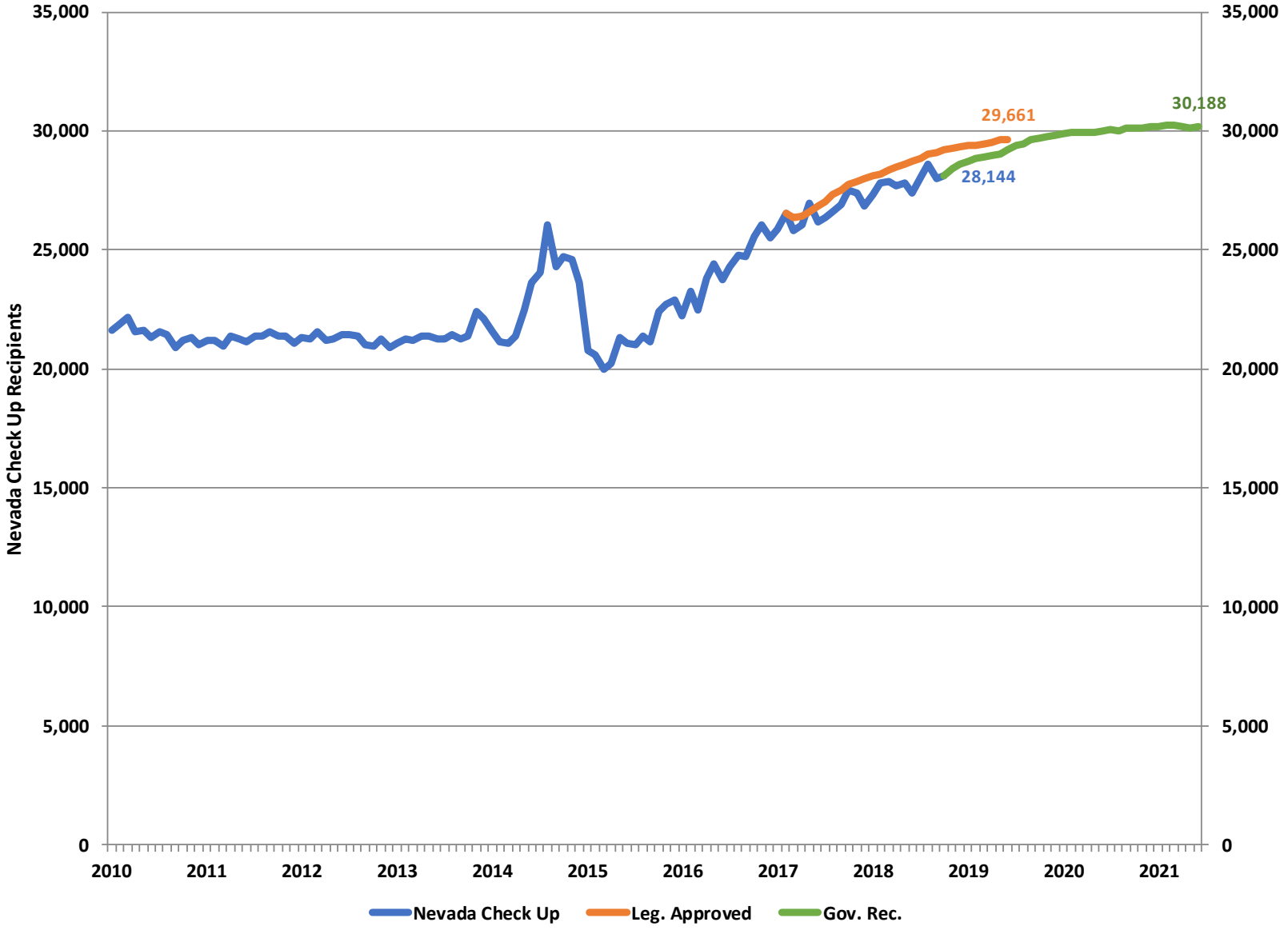
MAABD Medical Groups (Continued)

Definition	Income Limits	Exceptions/Rules
Katie Beckett	Disabled children not eligible for SSI	Child under 19 years of age; Residing at home with parents; Denied SSI for excess income of parents; Meets level of care assessment and can be cared for at home for less cost than institutionalization;
Prior medical for the Aged, Blind or Disabled	Income < SSI payment level;	Disability determination made by DHCFP
Health Insurance for Working Disabled (HIWA)	Gross earned 450% FPL; Unearned $699;	Not eligible for Medicaid under any other category; Between 16-64 years of age; Employment related disregards allowed; Must be disabled or blind.

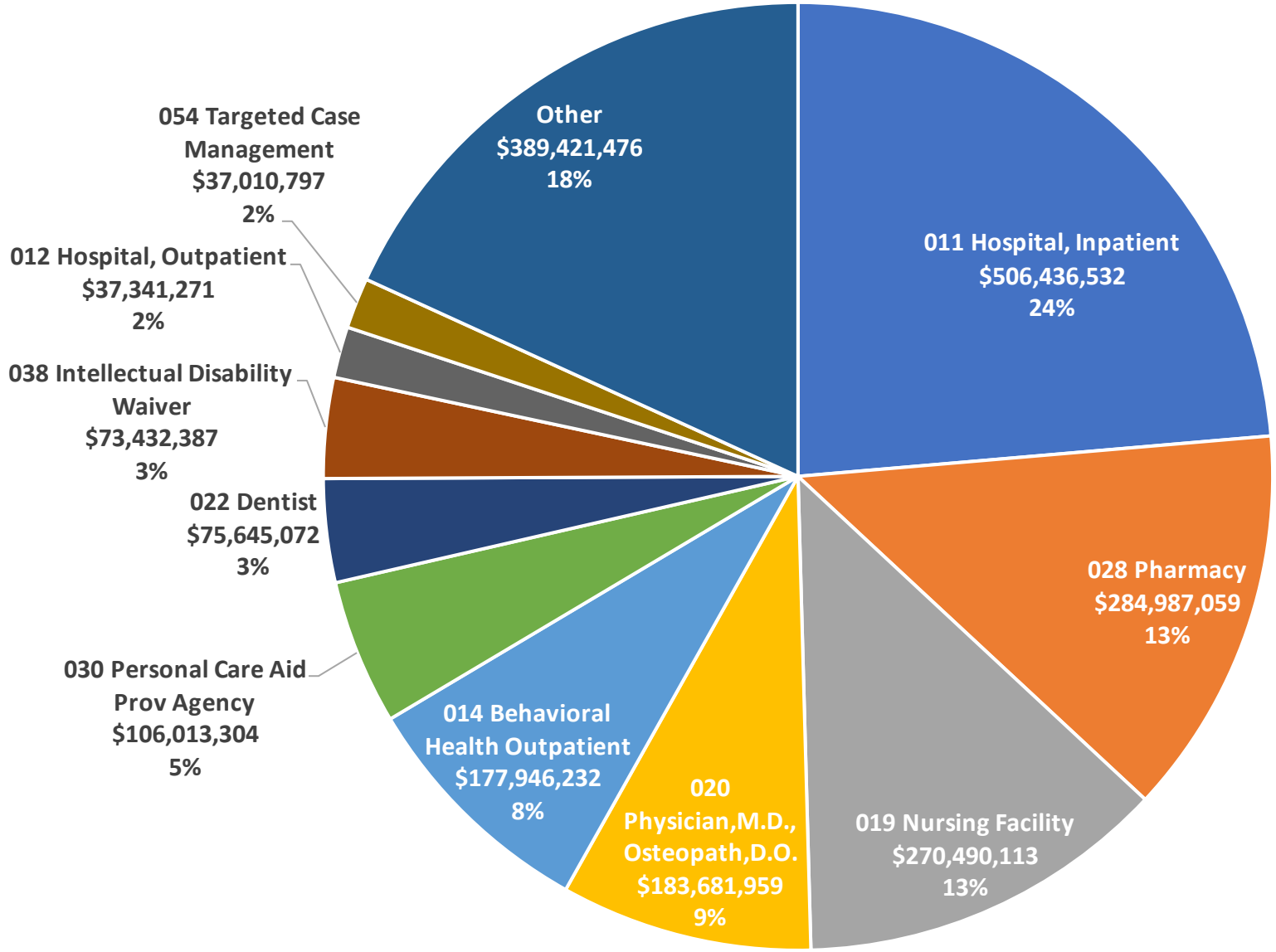
Medicaid Caseload



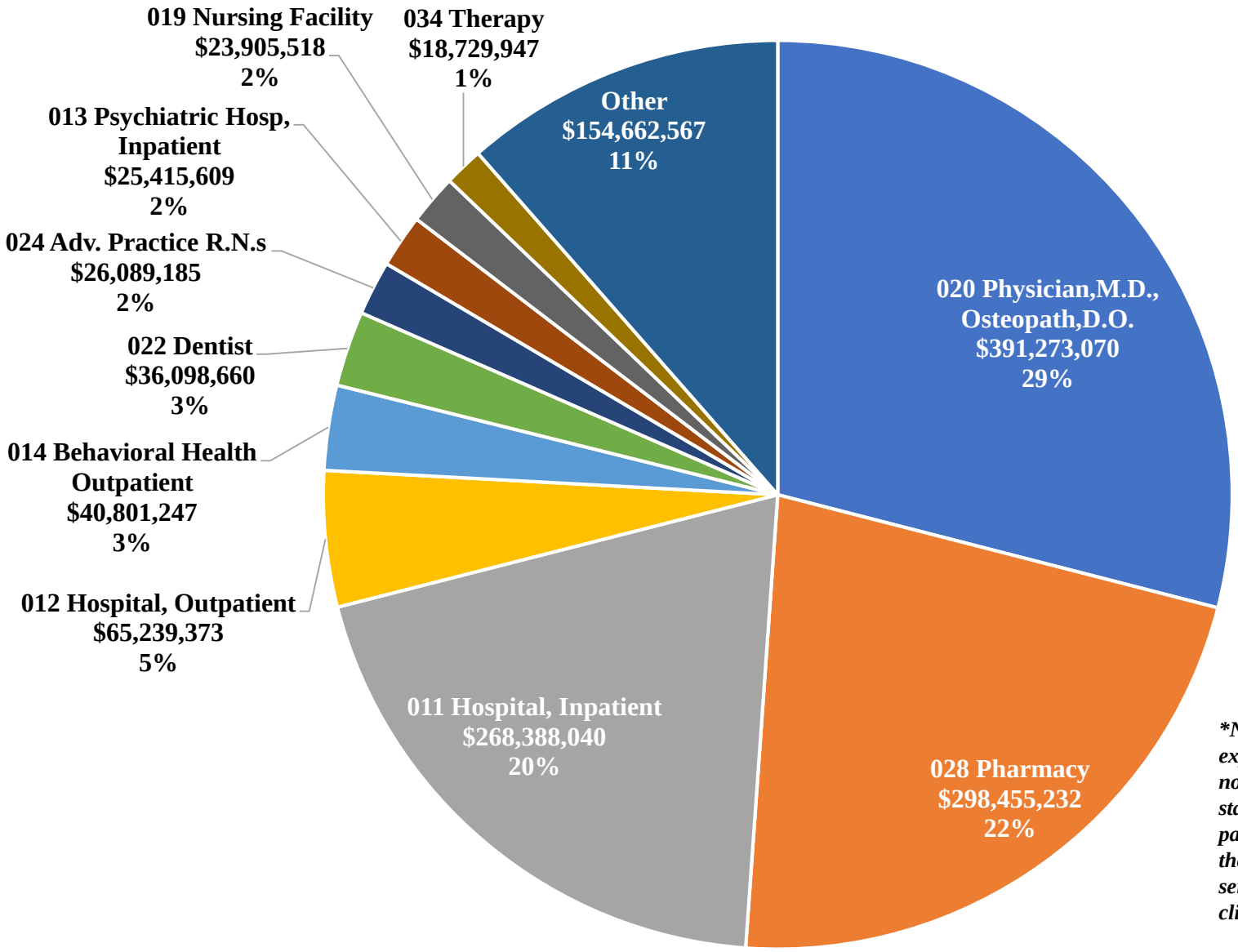
Nevada Check Up Caseload



SFY18 FFS Services



SFY18 MCO Services



Note: The MCO expenditures shown are not direct costs to the state, they are amounts paid by the MCOs to their providers for serving Medicaid clients.