Medicaid Basics and Home and Community Based Services

Jeanine Zlockie,
NASDDDS Director of Technical Assistance & Special Projects
4.26.22

Of Medicaid it has been said. . .

"It's not rocket science.....it's far more complicated."

But, not once you know the basics and the tools!

Webinar Agenda

- Medicaid Facts and data
- Historical Perspectives: Origins of Medicaid
- Medicaid: The Basics
- HCBS Regulations
- Resources
- Open Discussion/Questions

Medicaid & CHIP
SCORECARD

Medicaid Facts

- Medicaid and Medicare are, respectively, the first- and second-largest public payers, accounting for 60.4% of all LTSS spending nationwide in 2021. (Congressional Research Report, June 2022)
- Medicaid and the Children's Health Insurance Program (CHIP) provide health and long-term care coverage to more than ***82.3 million** low-income children, pregnant women, adults, seniors, and people with disabilities
- For individuals with I/DD, Medicaid is the primary source of both health care and LTSS
- Medicaid finances 40% of all long-term care spending
- More than a quarter of all Medicaid LTSS spending is overseen by State I/DD agencies – and most services in those systems are provided in HCBS.

Medicaid and CHIP Scorecard 2021 | Medicaid

Medicaid Data

- National Medicaid LTSS expenditures totaled $**162.1 billion in FY 2019**, with HCBS accounting for **$95.0 billion**
- The U.S. total surpassed the long-standing benchmark of 50 percent of LTSS expenditures in FFY 2013 and has remained **higher than 50 percent since then**, reaching **58.6** percent. This was an all-time high and represented a 2.5 percentage point increase from FY 2018.
- **Nursing facilities** represented the greatest share of institutional LTSS expenditures, accounting for **80 percent of expenditures**
- **Section 1915(c)** waiver programs represented the majority of HCBS expenditures, accounting for **51 percent of expenditures**.
- Total Medicaid LTSS spending grew by 26 percent over FY 2018, but the increase was largely due to more complete data for several states in FY 2019

Data retrieved from: Medicaid LTSS Annual Expenditures Report for Federal Fiscal Years (FFY) 2019 Medicaid Long Term Services and Supports Annual Expenditures Report

Historical Perspectives: Origins of Medicaid

Medicaid's Early Days

1965—The Medicaid Program, authorized under Title XIX of the Social Security Act, is enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities.

1967—EPSDT comprehensive health services benefit for all Medicaid children under age 21 is established.

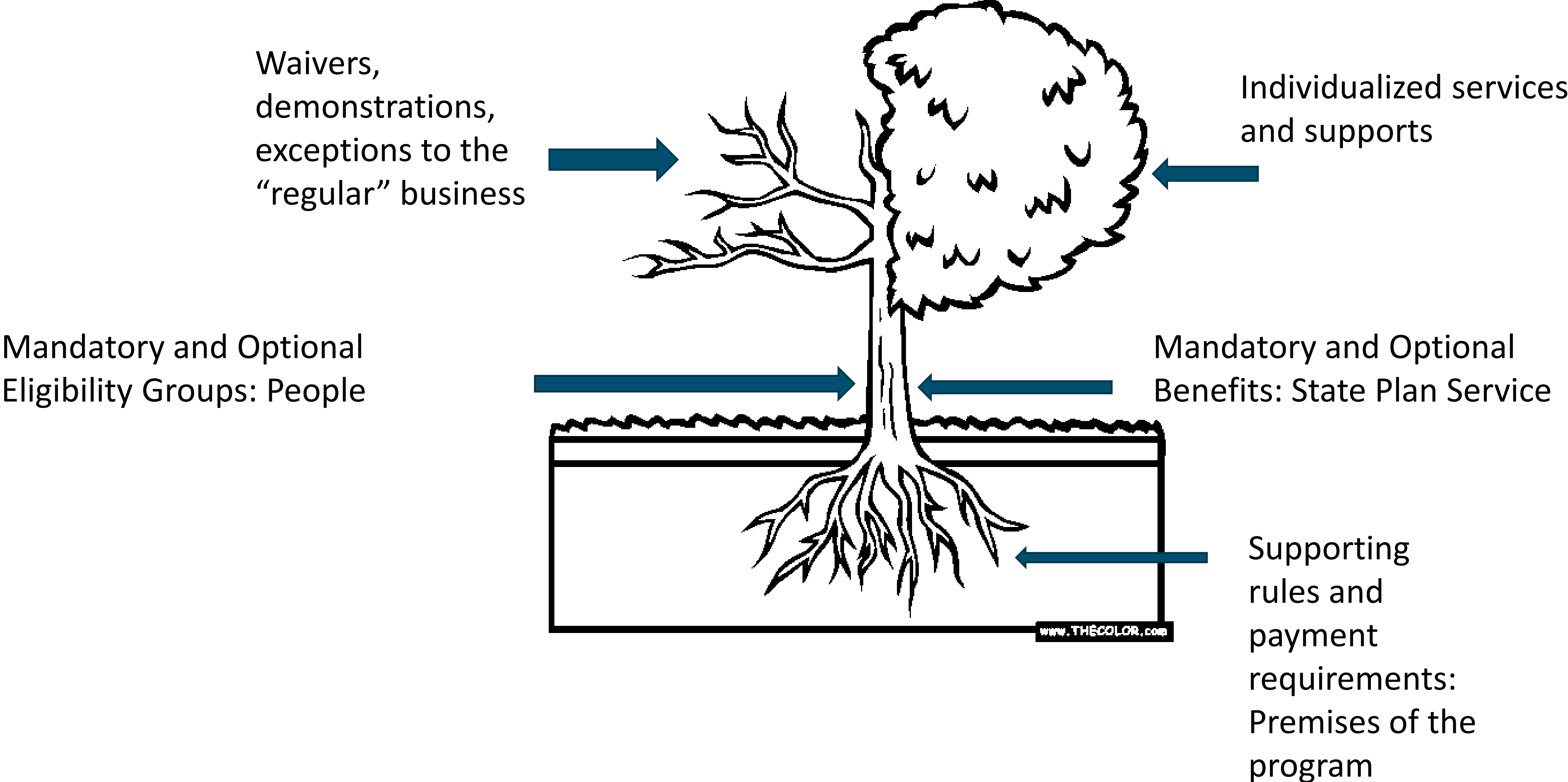
1971 - Congressional authorization for ICF/IID services as a state plan option under Medicaid allowed states to receive Federal matching funds for institutional services that had been funded with state or local government money.

1972—Medicaid eligibility for elderly, blind, and disabled residents of a State can be linked to eligibility for the newly enacted Federal SSI program if a State chooses.

1981—Freedom of choice waivers (1915(b)) and home and community-based care waivers (1915(c)) are established;

Medicaid: The Basics

Structure of Medicaid

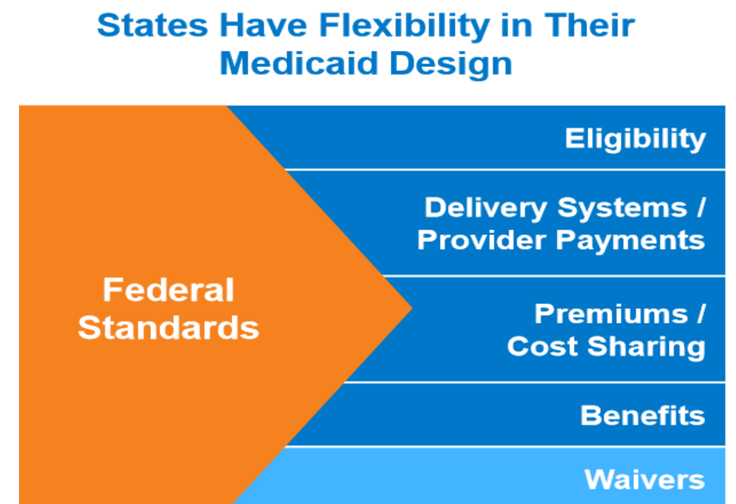


Medicaid Single State Agency

Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency will often contract with other public or private entities to perform various program functions.

Medicaid Is A State/Federal Partnership

- Feds "match" state contribution on an annually determined formula called the matching rate based on the state's economic picture
- The Federal share is called Federal Financial Participation (FFP)
- The state share is called state match



Medicaid: Overarching Coverage and Payment Requirements

Section 1902 of the Social Security Act – Rules of the Road

- Some key examples:
  - State-wideness
  - Due process
  - Single State Medicaid Agency
  - Anyone can make an application and services must be furnished with reasonable promptness
  - Free choice of all willing and qualified providers
  - Comparability
  - Medicaid is the payer of last resort – almost always

Medicaid: Overarching Coverage and Payment Requirements, Continued

Section 1903 of the Social Security Act

- Sets forth rules for payment including Federal Medical Assistance Percentage (by reference to 1905(b)
- Provides requirements for administrative claiming for the “proper and efficient administration of the State plan”
  - Most administrative claiming is at 50%
  - Some special categories of activity are eligible for variable higher rates (PASRR, Design and Development of certain information systems, etc)
  - Claiming and authorization for administrative activities is a different process than claiming for services.

Direct Bill

- Regulations at §1902(a)(32) require that , “no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service…”.

- §1902(a)(32) also is often referred to as the “anti-factoring” statute. The intended purpose of the provision was to prohibit the practice of “factors” purchasing Medicaid claims (accounts receivable) from vendors at a discount in order to turn a profit as a result of their successful collection of payments from the Medicaid program.

Medicaid Eligibility

In order to participate in Medicaid, federal law requires states to cover certain groups of individuals. Low income families, qualified pregnant women and children, and individuals receiving Supplemental Security Income (SSI) are examples of mandatory eligibility groups. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community based services and children in foster care who are not otherwise eligible.

Medicaid Eligibility Groups: Mandatory

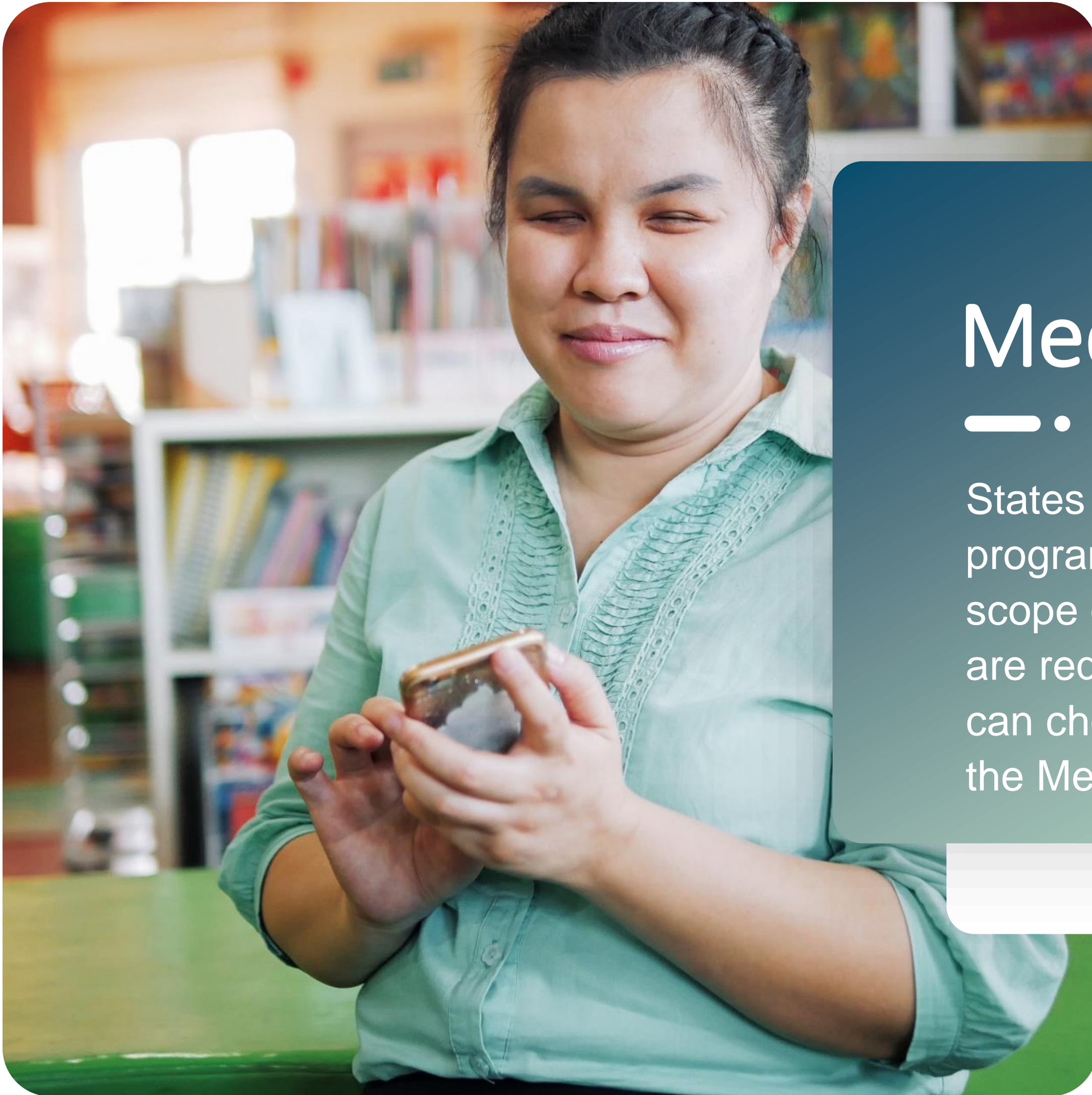
- Low Income Families
- Transitional Medical Assistance
- Extended Medicaid due to Child or Spousal Support Collections
- Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care
- Qualified Pregnant Women and Children
- Mandatory Poverty Level Related Pregnant Women
- Mandatory Poverty Level Related Infants
- Mandatory Poverty Level Related Children Aged 1-5
- Mandatory Poverty Level Related Children Aged 6-18
- Deemed Newborns
- Individuals Receiving SSI
- Aged, Blind and Disabled Individuals in 209(b) States
- Individuals Receiving Mandatory State Supplements
- Individuals Who Are Essential Spouses
- Institutionalized Individuals Continuously Eligible Since 1973
- Blind or Disabled Individuals Eligible in 1973
- Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972
- Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977
- Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI
- Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security
- Working Disabled under 1619(b)
- Disabled Adult Children
- Qualified Medicare Beneficiaries
- Qualified Disabled and Working Individuals
- Specified Low Income Medicare Beneficiaries
- Qualifying Individuals

Medicaid Eligibility Groups: Optional

- Children with Non-IV-E Adoption Assistance
- Independent Foster Care Adolescents
- Optional Targeted Low Income Children (M-CHIP)
- Children under 21 Not Receiving Cash
- Families Who Would Qualify for Cash if Requirements Were More Broad
- Individuals Eligible for Cash except for Child Care Subsidy
- Optional Poverty Level Related Pregnant Women and Infants
- Presumptively Eligible Pregnant Women
- Presumptively Eligible Children
- Individuals Electing COBRA Continuation Coverage
- Individuals Eligible for but not Receiving Cash
- Individuals Eligible for Cash except for Institutionalization
- Individuals in HMOs Guaranteed Eligibility
- Individuals Receiving Home and Community Based Services under Institutional Rules
- Individuals Participating in a PACE Program under Institutional Rules
- Individuals Receiving Hospice Care

Medicaid Eligibility Groups: Optional, Continued

- Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements
- Optional State Supplement Recipients - 209(b) States, and SSI Criteria States without 1616 Agreements
- Qualified Disabled Children under 19
- Institutionalized Individuals Eligible under a Special Income Level
- Poverty Level Aged or Disabled
- Individuals with Tuberculosis
- Certain Women Needing Treatment for Breast or Cervical Cancer
- Presumptively Eligible Women with Breast or Cervical Cancer
- Work Incentives Eligibility Group
- Ticket to Work Basic Group
- Ticket to Work Medical Improvements Group
- Family Opportunity Act Children with Disabilities
- Individuals Eligible for Family Planning Services
- Individuals Eligible for Home and Community-Based Services
- Individuals Eligible for Home and Community-Based Services - Special Income Level
- Individuals at or below 133% FPL Age 19 through 64



Medicaid Benefits

States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain "mandatory benefits," and can choose to provide other "optional benefits" through the Medicaid program.

Medicaid Services: Mandatory Benefits

- 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

Medicaid Services: Optional Benefits*

- 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
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- TB related services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary*
- Health Homes for Enrollees with Chronic Conditions – Section 1945

*this list does not include optional HCBS benefits discussed later

Medicaid: Early Periodic Screening, Diagnosis and Treatment (EPSDT)

(Includes All Mandatory and Optional Benefits)

- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.
- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

Medicaid: Pre-Admission Screening and Resident Review (PASRR)

Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care.

PASRR requires that

1) all applicants **to a Medicaid-certified nursing facility** be evaluated for serious mental illness (SMI) and/or intellectual disability;
2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and
3) receive the services they need in those settings.

This is a very important function for State I/DD agencies!

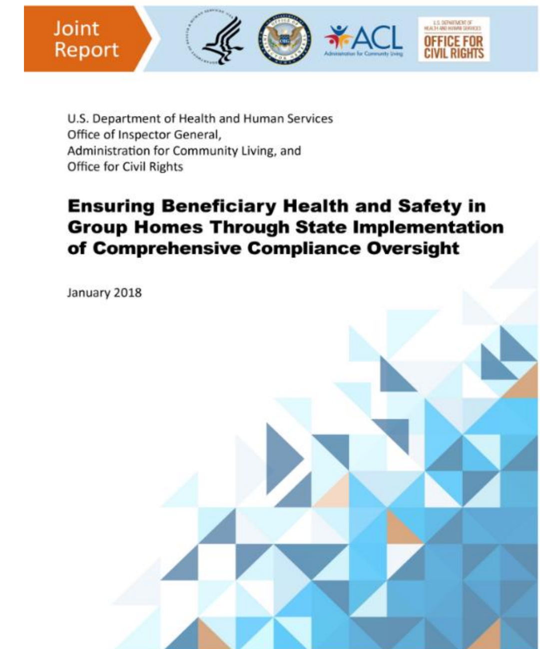
Medicaid: Interaction with Medicare

- Many individuals with I/DD served by State agencies also have Medicare
- Individuals receive acute, primary and pharmacy coverage from Medicare (Medicaid is payer of last resort)
- Many individuals on Medicare may need supplemental Medicaid services, or help paying for co-pays
- Medicare does not cover (much) HCBS or LTSS to date

Medicaid: Program Integrity Expectations (growing!)

- CMS, OIG, and the GAO are all keenly interested (and concerned) with program integrity within HCBS.
- These entities are concerned with:
  - Financial Integrity of the program: Combatting fraud, waste and abuse

  Ensuring that individuals are free from abuse, neglect and exploitation


Joint Report

OFFICE FOR CIVIL RIGHTS

U.S. Department of Health and Human Services
Office of Inspector General,
Administration for Community Living, and
Office for Civil Rights

Ensuring Beneficiary Health and Safety in Group Homes Through State Implementation of Comprehensive Compliance Oversight

January 2018

https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf

Program Integrity Efforts

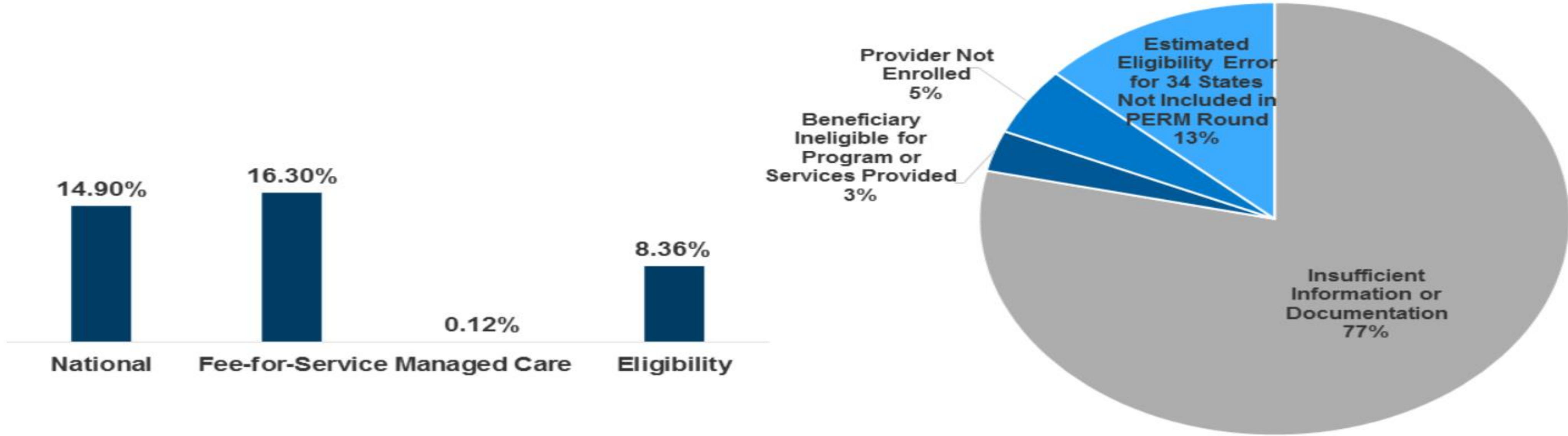
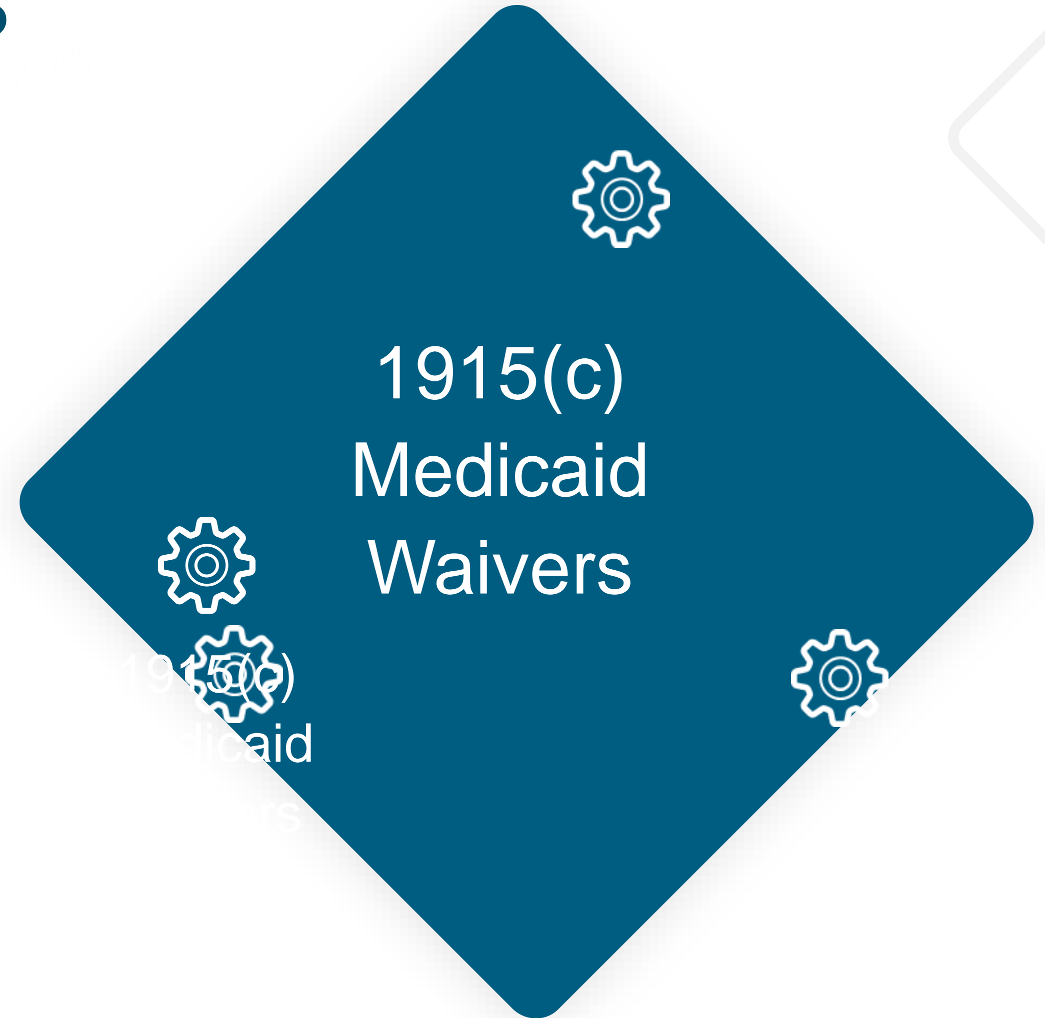


Figure 1: National Estimates of Medicaid Improper Payments, FY2019

Medicaid 1915 C Medicaid Waivers

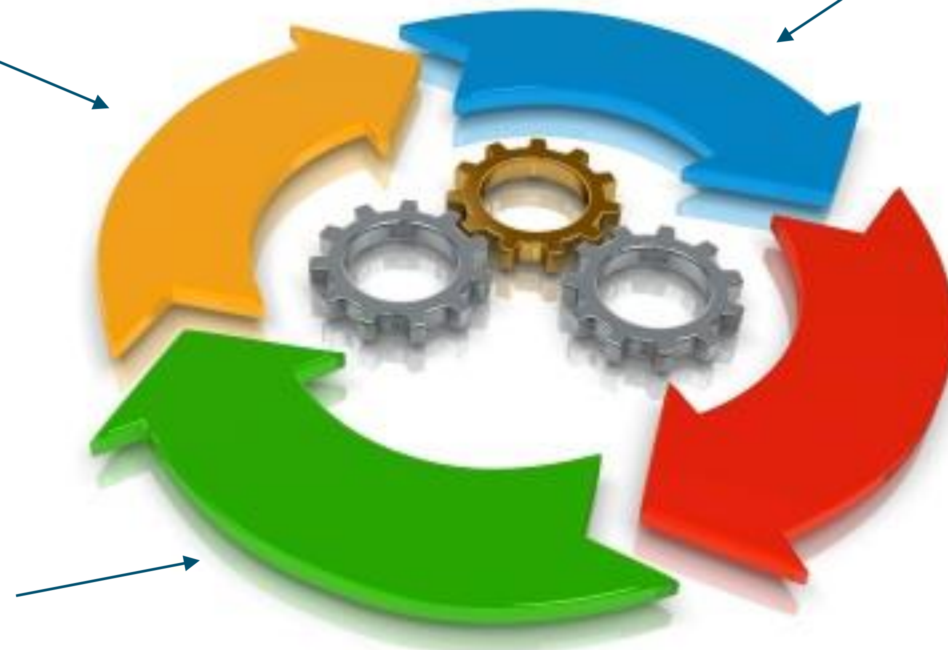


Medicaid: 1915(c) HCBS Waivers

- The HCBS waiver began in 1981 as a means to correct the "institutional bias" of Medicaid funding
- A waiver means that the regular rules are "waived", that is not applied
- Section 1915 (c) of the Social Security Act allows states to ask for waivers of existing Medicaid rules related to state wideness, comparability and income and resources for medically needy

Initial Waiver Application

CMS Review; Approval



24 months before expiration: CMS Evidence Based Review

Public Input

Renewal Submission

CMS Review

Preparation for Renewal

Each Year: 372 Submissions

Life Cycle of a Waiver

CMS Review Process

- When a state wants to develop a new waiver, the state submits the waiver application to CMS after a comprehensive stakeholder engagement/public input process
- States submit waiver applications using a web-based application and as soon as the state hits submit, a 90-day clock begins for CMS review
- CMS assigns analysts to review the waiver simultaneously
- They will use the instructions and technical guide, and a related review tool, to determine whether the state has met all of the criteria

Life Cycle of a Waiver Cont'd.

CMS Review Process

- 15-day call will be scheduled with state.
- The review team compares notes and develops a set of *informal* questions for the state. This is often called the *informal request for additional information (IRAI).*
- These questions are sent to the state – usually by day 30 on the clock– but the clock is still ticking.
- The state typically submits responses to these informal questions within two to three weeks, and CMS reviews those responses to see if they answered all of the questions in a satisfactory manner
- If CMS feels there is an issue that remains that prevents approval, they will issue a *formal request for additional information (RAI).*
- This stops the clock.

HCBS Regulations

Published
January 16, 2014

Effective date (for most provisions of the rule): March 17, 2014

New Compliance Date for settings provisions of the rule for programs in existence before 2014: March 17, 2023

[Home & Community Based Services Final Regulation | Medicaid]

HCBS Regulations, Continued

- The final rules included provisions related to:
  - Conflict of interest requirements
  - Person centered planning
  - Settings in which HCBS can be delivered, and
  - Miscellaneous other provisions of importance for HCBS operations

HCBS Setting Requirements

A setting in which HCBS is delivered:

- Is integrated in **and** supports access to the greater community
- Provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services
- The setting is selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting

HCBS Setting Requirements

- Ensures an individual's rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimizes individual initiative, autonomy, and independence in making life choices
- Facilitates individual choice regarding services and supports, and who provides them

Person-Centered Planning

EFFECTIVE AS OF 3/17/2014

- Conducted to reflect what is important to the individual to ensure delivery of services in a manner reflecting personal preferences and ensuring health and welfare
- Identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual
- May include whether and what services are self-directed

Case Management and Conflict of Interest

- **EFFECTIVE 3/17/2014**
- "Providers of HCBS for the individual, or those who have an interest in or are employed by a provider of HCBS for the individual must not provide case management or develop the person-centered service plan,
- [Providers may be allowed if] the State demonstrates that the only willing and qualified entity to provide case management and/or develop person- centered service plans in a geographic area also provides HCBS.
- In these cases, the State must devise conflict of interest protections …which must be approved by CMS. Individuals must be provided with a clear and accessible alternative dispute resolution process."

42 CFR §441.301

HCBS Settings Rule Implementation – Moving Forward Toward March 2023 & Beyond

Expectation: All states and settings will be fully compliant with the following regulatory settings criteria that are not impacted by the COVID-19 PHE, including its exacerbation of the workforce shortage, by the end of the transition period.

- Privacy, dignity, respect, and freedom from coercion and restraint; and
- Control of personal resources.

Expectation: All states and provider-owned and controlled residential settings will be fully compliant with the following regulatory settings criteria that are not impacted by the COVID-19 PHE, including its exacerbation of the workforce shortage, by the end of the transition period.

- A lease or other legally enforceable agreement providing similar protections;
- Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit;
- Access to food at any time;
- Access to visitors at any time;
- Physical accessibility; and
- Person-centered service plan documentation of modifications to relevant regulatory criteria

Information obtained from CMS presentation found here: Heightened Scrutiny: Facts, Process and Content (medicaid.gov)

HCBS Settings Rule Implementation – Moving Forward Toward March 2023 & Beyond

CMS Multi-faceted approach contains the following components, in order to continue federal reimbursement of HCBS beyond the transition period:

- States must receive final Statewide Transition Plan approval
- States and providers must be in compliance with all settings criteria NOT directly impacted by PHE disruptions, including PHE-related workforce challenges
- Time-limited corrective action plans (CAPs) are available to states to authorize additional time to achieve full compliance with settings criteria that ARE directly impacted by PHE disruptions, when states document the efforts to meet these requirements to the fullest extent possible and are in compliance with all other settings criteria.

Information obtained from CMS presentation found here: Heightened Scrutiny: Facts, Process and Content (medicaid.gov)

Implementation of Regulatory Settings Criteria Not Impacted by the PHE

States were to ensure the following information was submitted to CMS by January 1, 2023, to document state and provider compliance with these regulatory criteria.

– Description of how the state's oversight systems (licensure and certification standards, provider manuals, person-centered plan monitoring by case managers, etc.) have been modified to embed the regulatory criteria into ongoing operations;

– Description of how the state assesses providers for initial compliance and conducts ongoing monitoring for continued compliance; and

– Description of a beneficiary's recourse to notify the state of provider non-Compliance (grievance process, notification of case manager, etc.) and how the state will address beneficiary feedback.

- Information should already be contained in the state's STP

Information obtained from CMS presentation found here: Heightened Scrutiny: Facts, Process and Content (medicaid.gov)

Corrective Action Plans (CAPs)

States can request a CAP to continue implementation of regulatory criteria impacted by the PHE's effect on workforce stability beyond the end of the transition period. CMS has indicated that CAPs will not be allowed for requirements related to privacy, dignity, respect, freedom from coercion and restraint, and control of personal resources, or for the following requirements related to provider-owned or controlled residential settings:

- A lease or other legally enforceable agreement providing similar protections;
- Privacy in their unit, including lockable doors, and freedom to furnish or decorate the unit;
- Access to food at any time;
- Access to visitors at any time;
- Physical accessibility; and
- Person-centered service plan documentation of modifications to relevant regulatory criteria

Information obtained from CMS presentation found here: [Heightened Scrutiny: Facts, Process and Content (medicaid.gov)]

HCBS Corrective Action Plan Updates

As of 4/26/23

- 34 states have submitted Corrective Action Plan (CAPs)
- 13 states will not be requesting a CAP
- CMS Reports the following information was missing from some of the CAPs that were submitted:
    - Timelines with milestones necessary to remediate any outstanding issues
    - The specific waivers the CAP(s) apply to
    - The specific strategies that the state will use to fix the identified problems

https://www.medicaid.gov/medicaid/home-community-based-services/statewide-transition-plans/index.html

Medicaid: Tools of the Trade – Key Resources

Statute

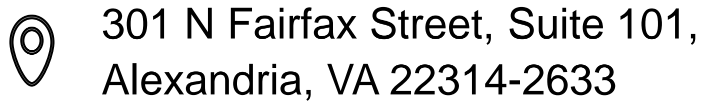
Regulations

State Medicaid Director Letters

CMS Informational Bulletins

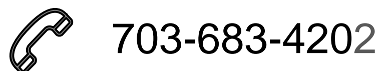
www.Medicaid.gov

NASDDDS



301 N Fairfax Street, Suite 101,
Alexandria, VA 22314-2633

www.nasddds.org | @NasdddsUS



703-683-4202