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Medicaid Fundamentals

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Medicaid Fundamentals

- Provides medical benefits to groups of low-income people with no medical insurance or inadequate medical insurance.
- Federally defined, State administered—each state sets its own guidelines regarding eligibility and services.
- Federal Financial Participation (FFP) is conditional on federal approval of state plan
- Entitlement—if you qualify you must receive any medically necessary services

Medicaid Fundamentals

- Within broad national guidelines established by Federal statutes, regulations, and policies, each State
  - establishes its own eligibility standards
  - determines the type, amount, duration, and scope of services;
  - sets the rate of payment for services; and
  - administers its own program.

Medicaid Fundamentals

- Social Security Act of 1965
- Titles XVIII, XIX
- Health Insurance Portability and Accountability Act of 1996
- Balanced Budget Act of 1997, Refinement Act of 1999.
- Annual Omnibus Budget Act
- Deficit Reduction Act
- ARRA

Medicaid Facts

- Medicaid now serves more than Medicare—over 40 million Americans
- Cover 1 in 5 children; 1 in 3 live births; 48% of nursing home costs, over ½ enrolled are children
- In 1987, Medicaid was 26% of total Federal aide to States; in 1999, it had grown to 44%.
- Orientation is medical-remedial, not social or educational
- Most states (except Alaska, New Hampshire and Wyoming) employ a managed care model for containing costs and utilization

Coverage—Eligibility

- States are required to include certain types of individuals or eligibility groups under their Medicaid plans
- States' eligibility groups will be considered one of the following:
  - categorically needy,
  - medically needy,
  - or special groups

Categorically Needy

- States are required to include certain types of individuals or eligibility groups under their Medicaid plans—this is referred to as categorically needy individuals

Categorically Needy

- Families who meet states' Aid to Families with Dependent Children (AFDC) eligibility requirements in effect on July 16, 1996.
- Pregnant women and children under age 6 whose family income is at or below 133 % of the Federal poverty level.
- Children ages 6 to 19 with family income up to 100% of the Federal poverty level.
- Caretakers (relatives or legal guardians who take care of children under age 18 (or 19 if still in high school)).
- Supplemental Security Income (SSI) recipients (or, in certain states, aged, blind, and disabled people who meet requirements that are more restrictive than those of the SSI program).
- Individuals and couples who are living in medical institutions and who have monthly income up to 300% of the SSI income standard (Federal benefit rate).

Medically Needy

- The medically needy have too much money (and in some cases resources like savings) to be eligible as categorically needy.
- If a state has a medically needy program, it must include
  - pregnant women through a 60-day postpartum period,
  - children under age 18,
  - certain newborns for one year, and
  - certain protected blind persons.

Medically Needy

- Children under age 21, 20, 19, or under age 19 who are full-time students.
- Caretaker relatives (relatives or legal guardians who live with and take care of children).
- Aged persons (age 65 and older).
- Blind persons (blindness is determined using the SSI program standards or state standards).
- Disabled persons (disability is determined using the SSI program standards or state standards).
- Persons who would be eligible if not enrolled in a health maintenance organization.

Other Groups

- Medicare Beneficiaries—Medicaid pays Medicare premiums, deductibles and coinsurance for Qualified Medicare Beneficiaries (QMB)—individuals whose income is at or below 100% of the Federal poverty level and whose resources are at or below twice the standard allowed under SSI.
- Qualified Working Disabled Individuals—Medicaid can pay Medicare Part A premiums for certain disabled individuals who lose Medicare coverage because of work. These individuals have income below 200% of the Federal poverty level and resources that are no more than twice the standard allowed under SSI.
- States may also improve access to employment, training, and placement of people with disabilities who want to work through expanded Medicaid eligibility.

Coverage—Services

- Inpatient hospital (excluding inpatient services in institutions for mental disease).
- Outpatient hospital including Federally Qualified Health Centers (FQHCs)
- Other laboratory and x-ray.
- Certified pediatric and family nurse practitioners (when licensed to practice under state law).
- Nursing facility services for beneficiaries age 21 and older.
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under age 21.
- Family planning services and supplies.
- Physicians' services.
- Medical and surgical services of a dentist.
- Home health services for beneficiaries who are entitled to nursing facility services under the state's Medicaid plan.
- Nurse mid-wife services.
- Pregnancy related services and service for other conditions that might complicate pregnancy.
- 60 days postpartum pregnancy related services.

Coverage—Services

- States must provide at least the following services when the medically needy are included under the Medicaid plans:
  - Prenatal and delivery services.
  - Post partum pregnancy related services for beneficiaries under age 18
  - Home health services to beneficiaries who are entitled to receive nursing facility services under the state's Medicaid plan.

Coverage—Optional Services

- Prescription Drugs
- Clinic Services
- Inpatient psychiatric services for individuals under 21
- Other practitioners
- Targeted case management
- Diagnostic, screening, prevention and rehabilitation:
- Transportation
- Dental, eyeglasses, podiatry

Important Federal Requirements

- Statewideness—Services contained in the Medicaid state plan are to be available regardless of geography
- Freedom of Choice of Qualified Providers—States may not limit the number of providers that can render a service if they meet enrollment criteria
- Amount, Duration and Scope of Benefits—states can limit the amount of benefits an enrollee receives based on medical necessity criteria

Important Federal Requirements

- Comparability--States are required to provide comparable amounts, duration, and scope of services to all categorically needy and categorically related eligible persons.
- Reasonable Promptness—state Medicaid agencies are required to pay providers for services rendered within established timeframes

Additional Requirements on Providers

- Accept Medicaid reimbursement as payment in full, except where co-pay is included in the State Plan
- Document medical necessity/service provision

Financing

- The Federal Government pays a share of the medical assistance expenditures under each State's Medicaid program.
- This share is determined annually by a formula that compares the State's average per capita income level with the national income average
- States with a higher per capita income level are reimbursed a smaller share of their costs.
- By law, federal contribution cannot be lower than 50 percent or higher than 83 percent.

Vehicles for Coverage
State Plan

- Describe Services
- Describe Agency/practitioner qualification for each service
- Define any limits on scope amount or duration
- Defines reimbursement methodology

Vehicles for Coverage
1915b Waiver

- General Purpose—state use this "waiver" for:
  - Mandatory managed care enrollment
  - Creating a carve out of specialty health care (e.g. mental health and addictions)
  - Create benefits that do not have to be available statewide
  - Use savings from managed care to purchase services not covered under the state plan
- 1915 b waives the following requirements:
  - Statewideness
  - Comparability of services
  - Freedom of choice of providers

Vehicles for Coverage
1915c Waiver

- 1915c or Home and Community Based Waiver are used to provide home and community services to individuals as an alternative to long term care
- 1915c waives the following provisions:
  - Comparability of services
  - Statewideness
  - Community income and resource rules for the medically needy

Vehicles for Coverage
1115 Waivers

- 1115 Waivers: allows states to develop innovative approaches to delivering a variety of health care services to Medicaid recipients. Also allows states to expand eligibility
- General provisions Waived:
  - Most provisions (statewideness, etc.)
  - Income and eligibility standards
  - IMDs (no longer allowed)

Vehicles for Coverage
1915 i and j

- 2005 Deficit Reduction Act developed two new programs
  - 1915i—home and community based program—less restrictive than a 1915i
  - 1915j—extension of the cash and counseling program

What Does Medicaid Cover for Addiction Treatment?

- Generally covered
  - Inpatient Services (medical detoxification)
  - Emergency Department
  - Outpatient Services (clinic or individual practitioner)
    - Individual
    - Group
    - Family/Multi-family
  - Accredited Residential Treatment Facilities (youth)
- Infrequently covered
  - Intensive Outpatient Services
  - Skill building
  - Case management
  - Limited medication assisted treatment

Where Are They Covered?

- State Plan Services
  - Targeted Case Management
  - Rehabilitation Services
  - Clinic Services
  - Practitioner Services
  - Pharmacy
  - Inpatient Services
  - IMD for Children Under the Age of 21

Targeted Case Management

- State Plan Service
- Allows states to offer case management to specific populations
- Allows states to be very prescriptive re: agencies/practitioners that can offer the service
- Under intense scrutiny from CMS—draft regulations clarify intent and activities

Medicaid Rehabilitation Option

- Federal Definition Re: Rehabilitation Option
  - "Maximum reduction of disability & restoration of recipient to best possible functioning level"
- Goal of services – move beyond stabilization to restoration & recovery
- Flexible benefits
- Non-clinic based services
- Allowed to be provided by non-licensed individuals (with licensed supervision)
- Was under intense scrutiny in the mid 2000s
- New regulation is being considered

Clinic and Practitioner Services

- Clinic—must generally be provided in a licensed clinic and provided by a licensed professional
- Practitioner services—licensed professionals can provide medication administration, assessment and counseling—guided by state practice acts

Inpatient Services

- Inpatient Services—mandatory services—states cover medical detoxification
- Inpatient and other services provided in a Institution for Mental Diseases (IMD) not covered. IMD:
  - Institution with more than 16 beds
  - Providing treatment to persons with “mental diseases” including SA
  - More than 50% of individuals have a mental disorder or significant amount of staff have behavioral health credentials

Early Periodic Screening, Diagnosis & Treatment (EPSDT)

- Not a service—but a requirement
- EPSDT added in 1969, but expanded in 1989 to explicitly include
  - Any medically necessary treatment needed even if not in a State plan but covered by Medicaid
  - Mental illnesses (include SUD) and developmental delays
- States do not take advantage of this program for SA
- Most states have poor or no screening for SA
- Recent litigation under EPSDT to cover services—mostly mental health

Questions

- Does your state Medicaid program cover addition treatment?
- What services are covered?
- What vehicle do they use?
- What is your best guess on Medicaid spending for your site?
- What is your state match?
- What plans does your site have to change coverage?