

Administration of Medicaid Eligibility, Benefits, Payment and Service Delivery

The Pieces Make a Whole

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Medicaid Program

“Federal/State Partnership”

- Medicaid is a mandatory entitlement program (enacted 1965)
- Federal Role:
 - The Law: Title XIX Social Security Act
 - The Regulation: 42 CFR and other regulations
 - Policy Clarifications through “State Medicaid Director” letters
- State Role:
 - Eligibility Standards
 - Type, Amount, Duration, and Scope of Services
 - Rate of Payment for Services
 - Administration of Program

Medicaid: Largest Health Insurance Program in U.S.

- Medicaid Expenditures: \$304 billion (2006)
- Per Capita Cost for Children: about \$1,600 compared to \$2,100 per adult, \$13,500 per disabled enrollee and \$11,800 per elderly enrollee (2005)
- Medicaid covers:
 - 45% of poor Americans -- those with income below the federal poverty level (FPL), which was \$21,203 for a family of four in 2007
 - About one-quarter of near-poor Americans, those between 100% and 200% FPL
 - More than 29 million children as some point during the year 2005 – more than one-quarter of all children and just over half of low-income children
 - More than 8 million non-elderly people with disabilities, including 1.3 million children
 - Pregnant women up to 185% FPL (20 states) and at higher income levels (about 20 states)

Medicaid: Second Largest Budget Item in Most States

- States General Funds: About 17% on Medicaid
- Highest-Cost 5%: Accounted for 57% of Program Spending (2004)
- Almost 60%: Acute Care, including Payments to MCOs.
 - From 2000 to 2006, the increase in acute care spending per Medicaid enrollee averaged 4% per year. During the same period, health spending per person with private coverage grew 8% per year and growth
- Long-Term Care: Over a third (36%)
 - About 70% of Medicaid spending is attributable to seniors and people with disabilities.
 - Covers more than 6 of 10 nursing home residents
 - Finances 43% of nursing home spending.
- Largest single source of federal funding in state budget
 - FMAP: 50% to 83%

Waivers

- Section 1115 Research & Demonstration Projects:
 - Test policy innovations likely to further the objectives of the Medicaid Program.
 - Provides FFP for “Costs Not Otherwise Matchable”
 - Limited in Duration
 - Requires: Budget Neutrality (MCO savings, redirecting DSH payments, cost-sharing savings) and Evaluation
- Section 1915(b) Managed Care/Freedom of Choice Waivers:
 - Allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.
- Section 1915(c) Home and Community-Based Services Waivers:
 - Allow long-term care services to be delivered in community settings.
 - Allows waiver of:
 - Section 1902(a)(1), regarding *statewideness*.
 - Section 1902(a)(10)(B), regarding *comparability* of services.
 - Section 1902(a)(10)(C)(i)(III), regarding income and resource rules applicable in the community.

Variables of Medicaid

- Eligible: Who is Health Care Purchased For?
- Benefits: What Services Provided and Rules for Providing Them?
- Delivery System: Who can Provide the Services and Under What Circumstances?
- Payment: How much is Paid the Provider for Delivering the Care?
- Financial and Quality Oversight: Did the Eligible Person get “the appropriate service at the appropriate time from the appropriate provider in the appropriate setting for an appropriate price”?

Eligible: Categorically Needy

- Mandatory Categorically Eligible Groups
 - Eligible if would have been eligible under rules in effect 1996
 - Under Age 19 up to 100% of Federal Poverty Limit (FPL)
 - Under Age 6 and Pregnant Women below 133% of FPL
 - SSI and certain Medicare
 - Title IV Foster Care and Adoption Assistance
 - Transitional Medicaid: Up to 12 Months for Incomes up to 185%
- Optional Categorically Eligible Groups: 2/3 of Medicaid spending for optional groups)
 - Infants and pregnant women up to 185% of FPL
 - Children under 21
 - Institutionalized Individuals up to 300 percent of SSI
 - HCBWS Individuals who would be eligible if Institutionalized
 - ABD with incomes above mandatory coverage, but below FPL
 - Recipients of State Supplementary Income Payments
 - Certain Working-and-Disabled Persons below 250 percent of FPL
 - TB-infected persons at SSI Income: Coverage Limited
 - Women who are screened for breast or cervical cancer
 - Optional targeted low-income children" included within SCHIP

Eligible: Medically Needy (MN)

- Persons eligible for Medicaid under one of the mandatory or optional groups and assets within requirements but income “spend-down”
- Persons may "spend down" by incurring medical expenses that reduce their income to or below their State's MN income level.
 - One-month spenddown
 - Six-month spenddown
- If a State elects to have a MN program, there are Federal requirements that certain groups and certain services must be included:
 - Children under age 19 and pregnant women who are medically needy,
 - Prenatal and delivery care for pregnant women
 - Ambulatory care for children
- 39 States

Eligible: Medicare-Medicaid “Duals”

- Medicare premium and Cost-sharing Payments
- Qualified Medicare Beneficiaries (QMBs) :
 - Resources at or below twice SSI standard and incomes at or below 100 percent of the FPL.
 - Medicaid pays the Hospital Insurance (HI, or Part A) and Supplementary Medical Insurance (SMI) Part B premiums and Medicare coinsurance and deductibles, subject to Stated payment limits.
- Specified Low-Income Medicare Beneficiaries (SLMBs)
 - Resources like QMBs, but incomes less than 120 percent of FPL.
 - Medicaid pays only the Part B premiums.
- Qualified Disabled-and-Working Individuals (QDWIs)
 - Previously qualified for Medicare because of disability, but lost entitlement because of return to work and incomes below 200 percent of the FPL
 - Part A premiums

Benefits: Mandatory

- Services Required for all Mandatory Eligibility Groups subject to Medical Necessity
 - Inpatient and Outpatient Hospital Services
 - Physician Services
 - Nursing Facility Services for age 21 or older,
 - Health Clinic Services
 - Laboratory and X-ray Services
 - Pediatric/Family Nurse Practitioner Services
 - Nurse-Midwife Services
 - Family Planning Services and Supplies
 - Early and Periodic Screening, Diagnosis and Treatment Services for under age 21
 - Transportation Services
 - Federally-Qualified Health Center and Rural Health Clinic Services

Benefits: Optional

- Optional Benefits to Mandatory and Optional Eligibility Groups
 - Prescription Drugs
 - Clinic Services
 - Care furnished by Other Licensed Practitioners
 - Nursing Facility Services for under age 21
 - Services in an Intermediate Care Facility for Individuals with Mental Retardation
 - Optometrist Services and Eye Glasses
 - Dental Services and Dentures
 - Prosthetic Devices and Durable Medical Equipment (DME)
 - Rehabilitation and Other Therapies
 - Case Management
 - Inpatient Psychiatric Services for Individuals under age 21
 - Respiratory Care Services for Ventilator-Dependent Individuals
 - Personal Care Services
 - Hospice Services
 - Home and Community Based Services, including Case Management, Personal Care Services, Adult Day Health Services, etc.

Benefits: Requirements

- Amount, Duration and Scope: “Sufficient in amount, duration and scope to reasonably achieve its purpose”
- Comparability “Across the eligible population” and may not limit services based on diagnosis, type of illness or condition
- Statewideness: “Available to all eligible individuals, regardless of where in the state they live”
- Medicaid “Out of State”
- Cost Sharing “Traditional Medicaid”:
 - No Cost Sharing for Children and Pregnant Women
 - “Nominal” Co-Payments for Adults
 - Premiums Permitted for Optional Populations
 - DRA: Provided Additional Cost Sharing Options based on Income Level and Types of Services

Service Delivery

- Traditional Medicaid: Individual Providers – “Non-network”
- Managed Care: Most Common Health Care Delivery System in Medicaid
 - Nearly two-thirds are enrolled in some form of managed care
 - Managed Care Organizations, including traditional health maintenance organizations (HMO) and Medicaid only
 - Prepaid Health Plans – often mental health carve-outs
 - Primary Care Case Management (PCCM) arrangements.
- Administrative Contracts
 - Nurse Lines – Case Management
 - Fiscal Agent – MMIS (HIT Infrastructure)
- Service Contracts
 - Transportation – Non-emergency Contracts
 - Volume Purchasing (Durable Medical Equipment)

Quality & Financial Oversight: HIT As A Tool

- MITA: Medicaid Information Technology Architecture Initiative
- MMIS: Medicaid Management Information System
 - Single State Medicaid Agency: Direct Control of Funds
 - Advance Planning Document (APD): CMS Prior Approved
 - Benefit Medicaid Enrollees and Providers
 - Statewide: Medicaid Transformation Grants allow for lesser regions
- FFP
 - 90-10 Design, Development and Implementation
 - 76-25 Operations
 - Cost Allocation Principles apply
- Authority
 - Social Security Act, Section 1903
 - State Medicaid Manual, Part 11
 - 45 CFR, Part 95.605 and 42 CFR 433, Sup-part C