

# HIV Health Improvement Affinity Group

## State Medicaid Programs: An In-Depth Look

February 16, 3:00pm-4:30pm ET



# Moderator

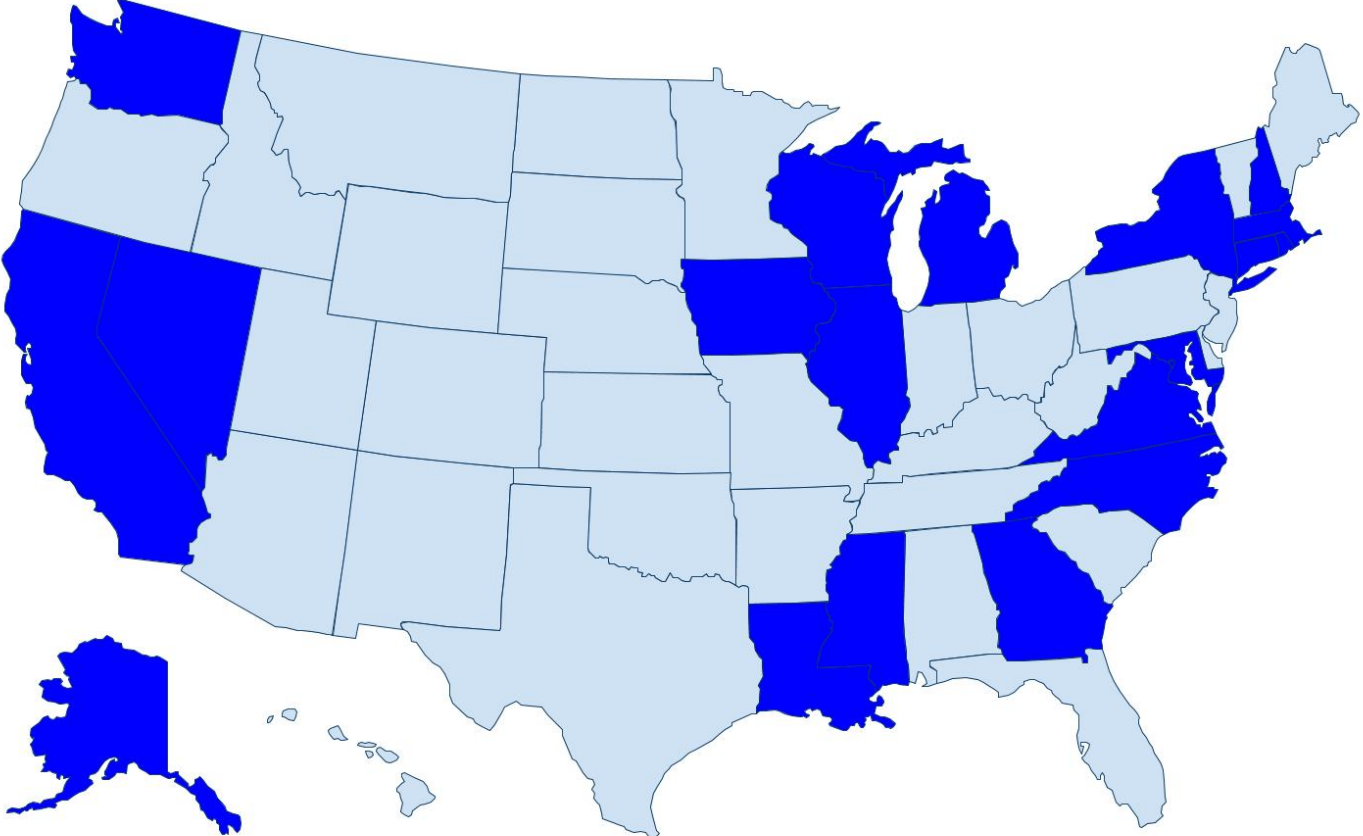
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# Logistics for the Webinar

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# Welcome HIV Affinity Group Teams!



# Presenter



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# State Medicaid Programs: An In-Depth Look



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# Session Objectives



- This webinar should help you:
  - Describe eligibility, benefits, and administration of Medicaid including state assistance for Medicare-Medicaid enrollees
  - Describe eligibility, benefits, and administration of the Children's Health Insurance Program (CHIP)

# Medicaid Overview



- What is Medicaid?
- Medicaid Administration
- Eligibility
- Medicaid Expansion
- Enrollment
- Modified Adjusted Gross Income (MAGI)
- Coverage
- Waivers
- Medicare and Medicaid Dual Eligibility



# What is Medicaid?



- Created in 1965 under Title XIX of the Social Security Act
- Federal and state entitlement program\*
- Medical assistance for people with limited income and resources
- Covers more than 70 million adults and children
- Supplements Medicare for more than 10 million people who are aged and/or disabled
- Largest state expenditure

\*Entitlement program—a government program that guarantees certain benefits to a particular group or segment of the population.

# Medicaid Administration



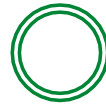
- Federal/state partnership
- Jointly financed entitlement program
- Federally established national guidelines
- States receive federal matching funds
  - Known as the Federal Medical Assistance Percentage (FMAP)
    - Used to calculate amount of federal share of state expenditures
  - Varies from state-to-state
  - Based on state per capita income
  - Certain eligibility groups and administrative costs receive a higher match.

# State Medicaid Administration



- Within federal guidelines, each state develops a State Plan:
  - Develops its own programs
  - Develops and operates its own plan
  - Establishes its own eligibility standards
  - Determines the type, amount, duration, and scope of services
  - Sets the rate of payment for services
  - Partners with CMS to administer its program. State Plan must be approved by CMS.
- States may change eligibility, services, and reimbursement during the year by submitting “State Plan Amendment” or “SPA”

# Paying For Services Provided



- Numerous payment methodologies. Most well-known are:
  - Fee For Service (FFS)
  - Managed Care
    - ✦ Per Member Per Month (PMPM)
- States experimenting with different methodologies (“Value Based Purchasing”)
- All states have to operate and maintain an adequate provider network, access to benefits (geographic and time requirements), MMIS for claims payments, and maintain adequate provider rates.

# The Single Medicaid State Agency



- Administers the Medicaid State Plan
- May delegate some administrative functions
- Local office names may vary, e.g.:
  - Social Services
  - Public Assistance
  - Human Services

# Medicaid Eligibility



- Eligibility tied to groups specified under the federal Medicaid law
  - Pregnant women
  - Children
  - People with disabilities
  - Seniors
  - Adult Group in states with Affordable Care Act expansion
  - States must cover certain groups, such as children and pregnant women, and have the option to cover other groups
- Financial and non-financial (Medical Eligibility) requirements for certain populations.

# Who can determine Medicaid Eligibility?



- State determines what entities authorized to determine eligibility for Medicaid.
  - Ultimately responsible for all determinations
- Partnerships with Marketplace
- Outstation Eligibility Workers
- Presumptive Eligibility

# State Options for Coordinated Eligibility Determinations With the Marketplace



- Determination Model
  - Marketplace makes Medicaid/Children's Health Insurance Program (CHIP) Modified Adjusted Gross Income eligibility determinations using state Medicaid/CHIP eligibility rules and standards
  - Must be a governmental entity
- Assessment Model
  - Marketplace makes initial assessment of Medicaid/CHIP eligibility; state Medicaid and CHIP agencies make the final eligibility determination



# Application and Enrollment Process



- Application process
  - Relies primarily on electronic data
  - Reduces need for paper documentation
  - 12-month eligibility period for most:
    - ✦ Adults
    - ✦ Parents
    - ✦ Children

# Eligibility – Streamlined Application



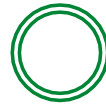
- One application for Marketplace health plans, Medicaid, and the Children’s Health Insurance Program (CHIP)
- Advance premium tax credits and cost-sharing reductions
- Online, by phone, by mail, or in person
- May be able to enroll immediately once eligibility determination is complete
- Depending on the program for which the applicant is eligible
- Can apply for Medicaid and CHIP at any time at [HealthCare.gov](https://www.healthcare.gov), or through the state agency

# Financial Eligibility: Modified Adjusted Gross Income (MAGI)



- MAGI is a methodology for how income is counted and how household composition and family size are determined
- MAGI is not a number on a tax return
- MAGI-based rules are used to determine Medicaid and Children's Health Insurance Program (CHIP) eligibility for most individuals

# MAGI – Based Income Methodology



- Tied to taxable income
- Income disregards replaced by a single 5% disregard
- Household composition based on tax filer and tax-dependent relationships
- Child support and other assistance not counted because they're not taxable income
- Family size adjusted for pregnancy

# Medical Eligibility for Medicaid



- Non-financial eligibility requirements for:
  - Disabled Adults and Children
    - ✦ Variety of programs such as:
      - Aid to the Permanently and Totally Disabled
      - Aid to the Needy Blind
      - Katie Beckett Eligibility (Children with Severe Disabilities)
    - Nursing Facility Care

# Verification of Income and Residency



- Primary reliance on electronic data sources
- Supported by Federal Data Services Hub
- Social Security
- Internal Revenue Service
- U.S. Department of Homeland Security
- Decreased reliance on documentation
- Increased reliance on self-attestation

# Documentation Required for Proof of Eligibility



- U.S. Citizens
- Must provide satisfactory documentary evidence
- Tribal membership and enrollment documents satisfy requirements
- Lawfully residing immigrant children and pregnant women otherwise eligible
- States may choose to lift 5-year ban
  - Legal immigration documentation requirements apply
- Individuals enrolled as of 2010 may use Social Security data match

# Medicaid – Eligibility Expansion

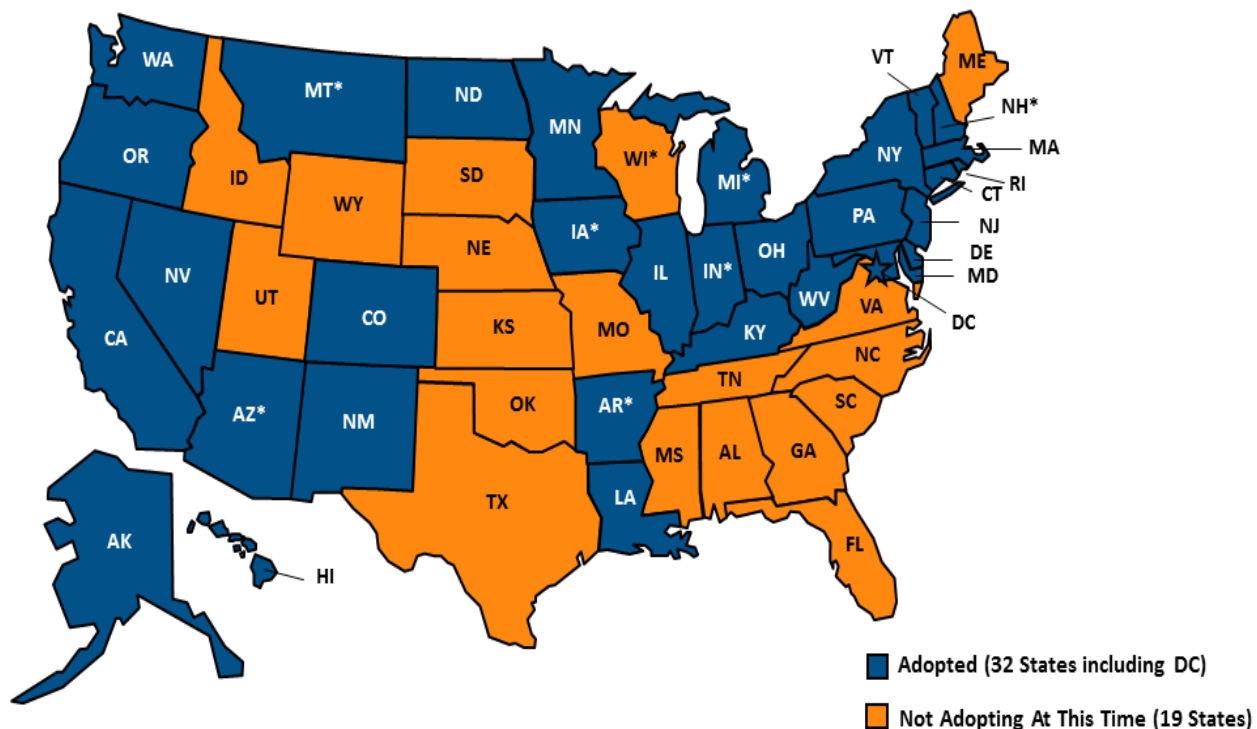


- Affordable Care Act's Eligibility Groups (effective 1/1/2014):
  - Adult group
    - ✦ 19–64 with income below 133% of Federal Poverty Level (FPL)
  - Former foster care group
    - ✦ Under 26 and enrolled in Medicaid while in foster care at 18 or “aged out” of foster care
  - Optional eligibility group for individuals with income above 133% of FPL
  - Under 65



# Medicaid Expansion under the ACA

## Current Status of State Medicaid Expansion Decisions



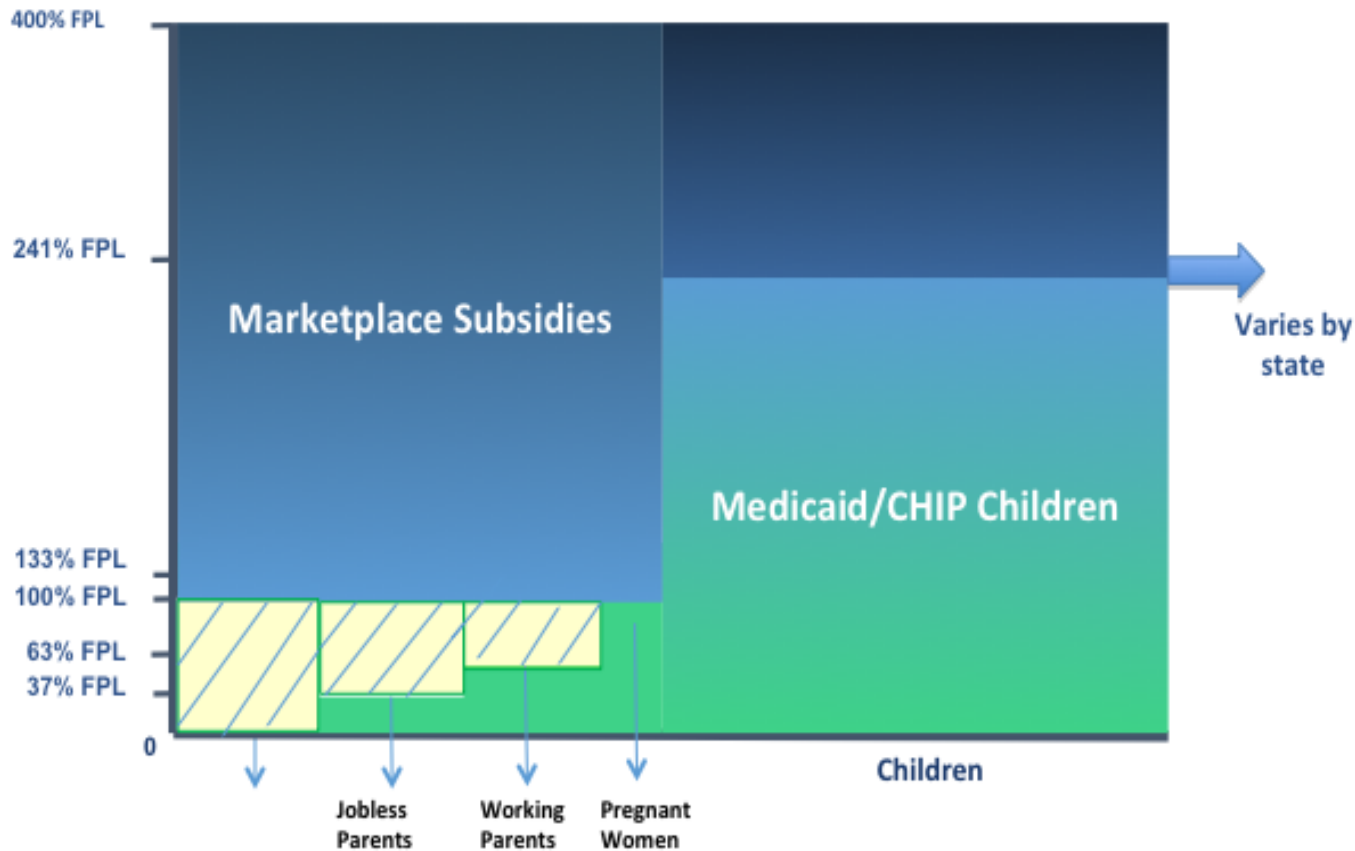
NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. \*AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated January 1, 2017.  
<http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

# Insurance Coverage without Expansion



For non-elderly, non-disabled individuals, based on current median state eligibility

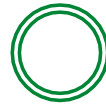


# States not expanding Medicaid



- If you live in a state that's NOT expanding Medicaid, you may:
  - Have fewer coverage options
  - Not qualify for either Medicaid or reduced costs on a private insurance plan in the Marketplace
  - Be able to get a hardship exemption and won't have to pay a fee if you don't have minimum essential health coverage

# Mandatory Medicaid Benefits



- Inpatient hospital services
- Outpatient hospital services
- Early and Periodic Screening, Diagnostic, and Treatment services (for children under 21 years of age)
- Nursing facility services (except for Medically Needy)
- Home health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center services
- Laboratory and X-ray services

# Mandatory Medicaid Benefits – Continued



- 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
- Tobacco cessation

# What's the difference between State Plan, LTC and LTSS Benefits?



- State Plan Benefits
  - Often referred to as Medical Services
- Long Term Care or LTC
  - Nursing Home Care and Home and Community-Based Care
- Long Term Services and Supports or LTSS
  - Home and Community-Based Care to avoid institutional settings
- Beneficiaries eligible for LTC and LTSS services also receive State Plan Benefits but not necessarily the other way around.

# Benefits Management



- State Fee for Service and Medicaid Management Care
  - Utilization Management, for example:
    - ✦ Limits on amount and scope of services
    - ✦ Requirement for Prior Authorization
    - ✦ Requirements for Pharmacy Step Therapy
    - ✦ Requirements for Pharmacy Preferred Drug Lists and Formularies

# Medicaid Waivers



- Allow states to test alternative delivery of care
- Certain federal requirements “waived” for example:
  - Statewide-ness
  - Comparability of benefits
  - Limits placed on provider choice
- Types of waivers include but are not limited to:
  - Section 1915(b) Managed Care Waiver
  - Section 1915(c) Home and Community-Based Services Waiver
  - Section 1115 Research and Demonstration Waiver
  - Concurrent Section 1915(b) and 1915(c) Waivers



# ACA Medicaid Funding Improvements & Expansion of Waivers



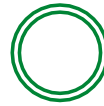
- ACA created new opportunities
  - Health Homes for Individuals with Chronic Conditions
  - Community First Choice State Plan Option
  - Balancing Incentive Program
- ACA expanded and increased flexibility of current Medicaid programs
  - Money Follows the Person (MFP)
  - 1915(i) State Plan Option
  - Home and Community Based Services

# Medicare and Medicaid



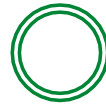
## **JUST THE BASICS**

# Differences between Medicare and Medicaid



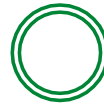
Medicare	Medicaid
National program that is consistent across the country	Statewide programs that vary among states
Administered by the federal government	Administered by state governments within federal rules (federal/state partnership)
Health insurance for people 65 or over, with certain disabilities, or diagnosed with End-Stage Renal Disease (ESRD)	Health coverage for people who meet financial and non-financial requirements
Nation's primary payer of inpatient hospital services for the elderly and people with ESRD	Nation's primary public payer of mental health and long-term care services; 40% of all births

# Medicare – Medicaid Eligibles



- Referred to as “dual eligibles”:
- Over 10 million nationally
  - Medicaid may provide full benefits and/or partial assistance with Medicare costs
  - The Medicare Savings Programs are partial Medicaid benefits that help pay Medicare premiums and sometimes cost-sharing
  - You can qualify for full Medicaid only, full Medicaid with a Medicare Savings Program, or just a Medicare Savings Program
  - For those with full Medicaid, Medicare pays first and Medicaid pays second for services

# Eligibility Criteria for Duals



Medicare Savings Program	Individual Monthly Income Limit (2016)	Married Couple Monthly Income Limit (2016)	Helps Pay Your
<b>Qualified Medicare Beneficiary (QMB)</b>	\$1,010	\$1,355	Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments)
<b>Specified Low-Income Medicare Beneficiary (SLMB)</b>	\$1,208	\$1,622	Part B premiums only
<b>Qualifying Individual (QI)</b>	\$1,357	\$1,823	Part B premiums only
<b>Qualified Disabled &amp; Working Individuals (QDWI)</b>	\$4,045	\$5,425	Part A premiums only

# The Children's Health Insurance Program



## **CHIP** **TITLE XXI OF THE SOCIAL** **SECURITY ACT (SSA)**

# CHIP Overview



- Explains the following:
  - What is CHIP?
  - State Options for CHIP
  - CHIP Eligibility

# What is CHIP?



- State-federal partnership
- CMS establishes broad guidelines
- Federal government provides matching funds
- States receive annual allotment determined by statute



# State Options for CHIP



- All 50 states, the District of Columbia, and U.S. territories have approved CHIP programs
- States can design their CHIP program in 1 of 3 ways
  - Medicaid expansion (8 states, the District of Columbia, and 5 territories)
  - Separate Child Health Insurance Program (2 states)
  - Combination of the 2 approaches (40 states)

# CHIP Eligibility



- To be eligible for CHIP you must:
  - Be under 19
  - Have income up to 200% of the federal poverty level (FPL) or income 50 percentage points higher than Medicaid as of June 1, 1997
    - ✦ Many states have higher limits
    - ✦ 46 states and DC cover children up to and above 200% FPL
    - ✦ 24 of these cover children at 250% FPL or higher
- States may add eligibility criteria such as waiting period to reapply due to failure to pay premium or prior insurance coverage that was purposefully dropped

# CHIP Eligibility Limitations



- Children of public employees
- Inmates of public institutions
- Some non-citizens
- Must be uninsured unlike Medicaid where child can have another form of coverage such as commercial insurance.

# CHIP Authorization and Funding



- Maintenance of Effort requirement through 2019
- Increase in CHIP federal matching rate by 23 percentage points in October 2015
- Funding for outreach efforts
- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  - Extended CHIP funding through September 30, 2017

# Why is this important to Public Health/HIV/ Ryan White Programs?



- Integration of Medicaid and Public Health
  - Important to understand purpose and limitations
  - Opportunity to apply the art and science of public health practice to the Medicaid beneficiary population to improve quality of care and life
    - ✦ Alignment via policy, providers, finance, client services, pharmacy benefit management, benefits including home and community based services to support a continuum of care
    - ✦ Improve timely access to care
      - Leverage eligibility screening opportunities and policies
    - ✦ Coordinate “care coordination” to avoid duplication of efforts and confusion
    - ✦ Align quality improvement initiatives via sharing of data and of data analytic capacity
    - ✦ Collaborate on leveraging available CMS authorities
      - Leverage subject matter expertise and clinical staff
  - Impacts of Medicaid Expansion on people living with HIV (<http://content.healthaffairs.org/content/34/12/2061.full>)

# Thank You!



If you have questions or would like more information, please contact Katie Dunn  
([kdunn@nashp.org](mailto:kdunn@nashp.org))

# Questions



# Upcoming Activities and Next Steps

## Activity

**New Funding Opportunity through HRSA**

**Upcoming Webinar: Data Privacy & Confidentiality**

**Technical Assistance - [HIVtechnicalassistance@nashp.org](mailto:HIVtechnicalassistance@nashp.org)**



# HIV Health Improvement Affinity Group

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