


Medicaid 101: Benefits and Services

Karen E Kimsey, MSW
Speire Healthcare Strategies, LLC

August 28, 2023

speire
HEALTHCARE STRATEGIES

Today's Discussion

- General principles of Medicaid benefits & services
- Overview of mandatory and optional services
- How Medicaid benefits & services are governed – the "State Plan"
- Waiver authority and state flexibility
- Medicaid benefits and Managed Care

speire HEALTHCARE STRATEGIES

General Principles of Medicaid Benefits & Services

- Some benefits & services are federally mandated, while some are optional. In general:
  - Benefits must be equivalent in amount, duration and scope for all enrollees in the state **(comparability rule)**
  - Benefits must be the same throughout the state **(statewideness rule)**
  - Beneficiaries must have choice of which (participating) providers or health plan they receive care though **(freedom of choice rule)**

General Principles of Medicaid Benefits & Services

- States can generally define to what extent a benefit is available by defining medical necessity criteria or the amount, duration, and scope of a benefit.
  - The scope of covered benefits and services is generally defined in the **"State Plan"** – essentially the contract between CMS and the states.
  - States can also seek different types of **"waiver" authority** to gain additional flexibility from these requirements.
  - *One key exception is **Early and Periodic Screening, Diagnostic and Treatment, or EPSDT**, which requires states to cover any medical necessary service (including optional benefits) without limit for children under age 21.*

States are Required to Provide Certain Mandatory Services

- Inpatient Hospital
- Outpatient Hospital
- Physician Services
- Laboratory & X-rays
- Home Health
- Nursing Facility
- EPSDT
- Rural Health Clinics
- Federally Qualified Health Centers (FQHCs)
- Transportation
- Family Planning

States Have Choice to Provide Certain Optional Services

- Prescription Drugs
- Clinic Services
- Physical Therapy
- Occupational Therapy
- Speech, hearing & language disorder
- Podiatry
- Optometry
- Dental
- Chiropractic
- Dentures
- Prosthetics
- Eyeglasses
- Other practitioner services

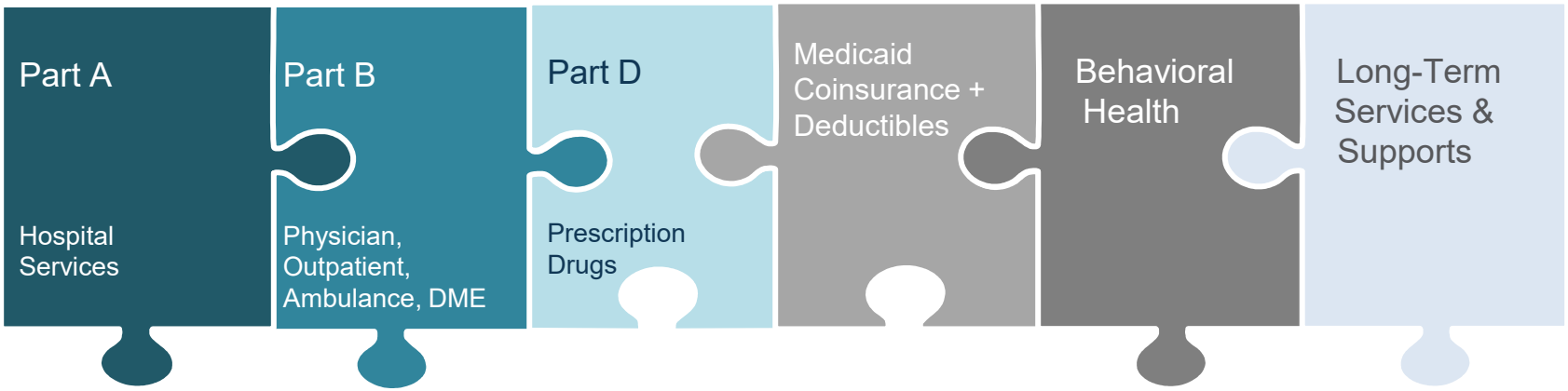
Most Long-Term Services and Supports in the Community are Statutorily Optional

- Personal Care
- Private Duty Nursing
- Hospice
- Case Management
- Home & Community Based Services (using 1915 i, j, k authorities)
- Program of All Inclusive Care for the Elderly (PACE)
- Community Mental Health
- Health Homes for Chronic Conditions
- Institutes for Mental Disease (65+)
- Inpatient psychiatric services (<21 yrs)
- Brain Injury related services

speire HEALTHCARE STRATEGIES

Medicaid Benefits Can Compliment Medicare Coverage for 12.2 Million Dually Eligible Individuals

Medicare | **Medicaid**



*Some dually eligible beneficiaries only qualify for assistance with payment of Medicare premiums and cost sharing, and do not receive full Medicaid benefits.

speire HEALTHCARE STRATEGIES

The Medicaid State Plan

- The Medicaid State Plan is a comprehensive written statement that describes the nature & scope of the Medicaid program, including:
  - Assurances that the program will be operated per federal requirements
  - Which optional groups, services, or programs the state has chosen to cover
  - State-specific eligibility standard methodologies
  - Methodologies for provider reimbursement
  - Other administrative processes
- The State Plan is managed with CMS through the "State Plan Amendment" process:
  - ❑ 90 days initial review process
  - ❑ No cost or budget requirement
  - ❑ Once approved, becomes a permanent change until amended again

Medicaid Waivers and Demonstrations

There are a variety of types of waivers that states can employ to administer their programs with greater flexibility

Waiver Type	Purpose
1115 Demonstration	Demonstration authority to test new eligibility, coverage, or delivery system models that promote the objectives of Medicaid. Must be budget neutral.
1915(b)	Allows states to waive comparability, statewideness, and freedom of choice requirements to operate managed care programs (which can now generally also be implemented through state plan authority.)
1915(c)	"Home and Community-Based Services (HCBS)" Waiver Authority- allows for long term care services outside of institutional settings
Combined 1915(b) and 1915(c)	Allows for managed care for HCBS and other long-term supports and services (LTSS) ("often called Managed LTSS or MLTSS)

speire HEALTHCARE STRATEGIES

1115 Demonstrations

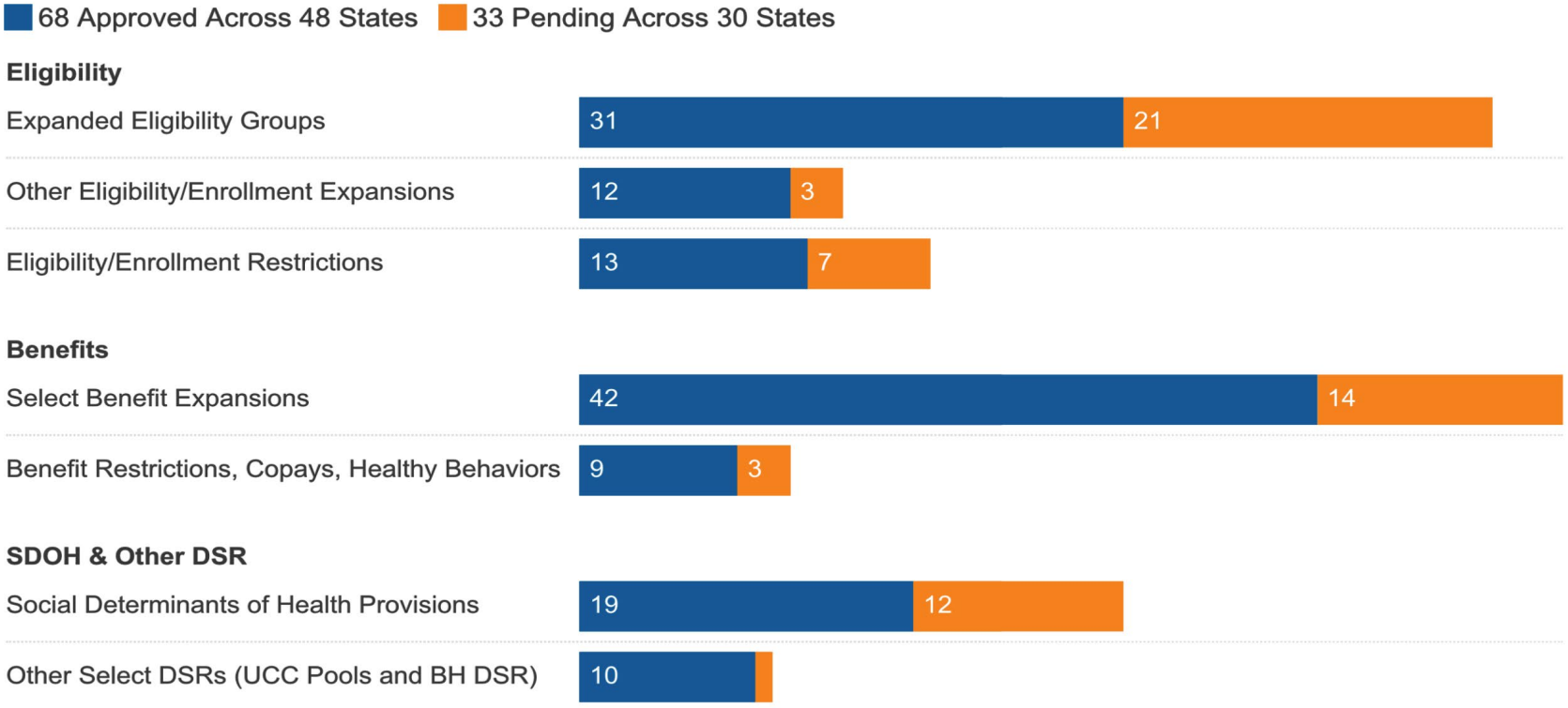
- Demonstration projects are intended to test a new or existing approach to financing or care delivery, subject to federal approval and ongoing evaluation.
- This waiver authority includes two primary mechanisms:
  - 1115(a)(1) allows states to waive various and specific provisions of the Medicaid statute
  - 1115(a)(2) can authorize the state to receive federal matching funds for benefits, services, or populations typically not eligible for federal reimbursement
    - Sometimes called “expenditure authority” or “costs not otherwise matchable (CNOM)”
  - The demonstration as a whole must be budget neutral to the federal government.

1115 Waiver Landscape

Figure 1

Landscape of Approved and Pending Section 1115 Waivers

as of August 11, 2023



NOTE: **For definitions and additional notes, see the** Waiver Tracker Definitions Tab.
SOURCE: KFF Medicaid Waiver Tracker • Get the data • PNG

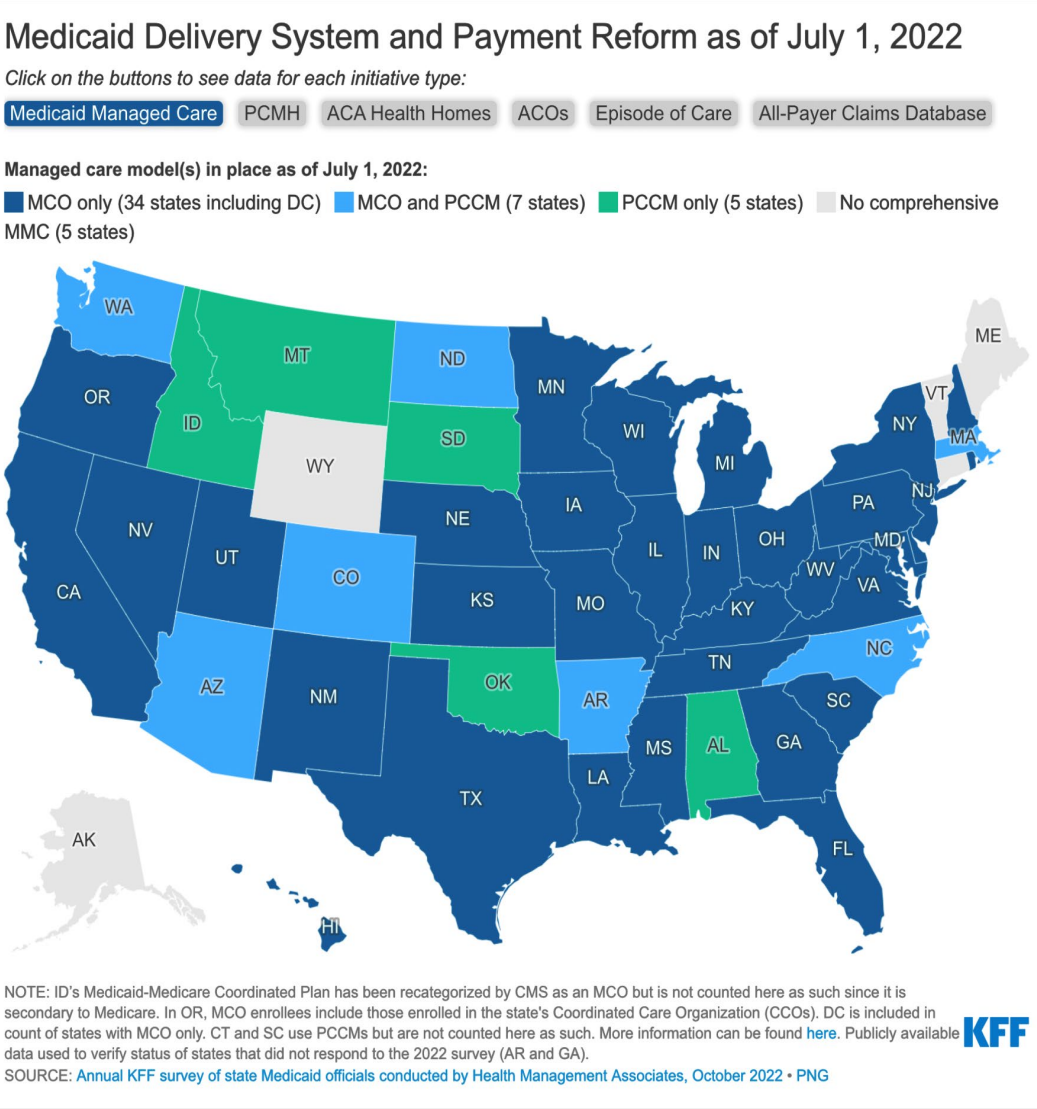
KFF

speire HEALTHCARE STRATEGIES

Most Medicaid Beneficiaries Receive Care through Comprehensive Managed Care

- States may operate managed care through a variety of different authorities, with a majority being through full-risk models

- Most states that contract with MCOs (41) reported that 75% or more of their Medicaid beneficiaries were enrolled in MCOs as of July 1, 2021.



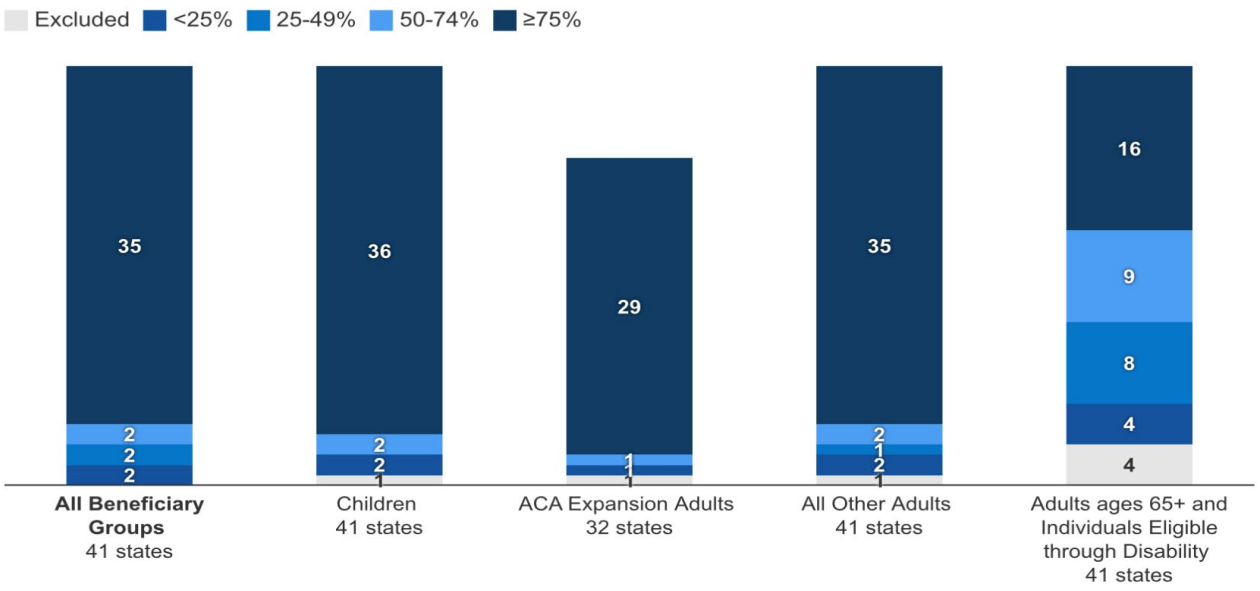
speire HEALTHCARE STRATEGIES

Most Medicaid Beneficiaries Receive Care through Comprehensive Managed Care

- While moms, kids, and expansion adults are predominantly served through MCOs, seniors and people with disabilities were less likely to be enrolled in an MCO:
  - 16 of the 36 MCO states reported covering these enrollees through MCOs.

Figure 3

MCO Managed Care Penetration Rates Have Grown Across Medicaid Eligibility Groups.



NOTE: Limited to 41 states with MCOs in place on July 1, 2022. Of the 39 states that had implemented the ACA Medicaid expansion as of July 1, 2022, 32 had MCOs in operation. 2021 survey data used for states that did not respond to the 2022 survey (AR and GA) and for states that did not provide complete data for this question (NC and VA).

SOURCE: Annual KFF survey of state Medicaid officials conducted by Health Management Associates, October 2022 • PNG

KFF

speire HEALTHCARE STRATEGIES

Medicaid and Managed Care Benefits

- MCOs are generally required to provide benefits consistent with state plan coverage but have flexibility to provide benefits beyond minimum requirements:
  - **"Value-added services"** – could be part of plan's bid & designed to improve outcomes or lower costs (e.g, an adult dental benefit, Weightwatchers membership, non-medical transportation)
  - **"In lieu of services"** – offered in place of other contracted services if such alternative services or settings are medically appropriate, cost-effective, and are offered on an optional basis for both the MCO and its enrollees

- Additional benefits can be designed to support member "social determinants of health (SDOH). In FY 2021, at least 33 states report leveraging MCO contracts to promote strategies to address the SDOH (e.g., behavioral health screening, providing referrals to social services, partnering with community-based organizations (CBOs), and screening enrollees for social needs.
  - States are now pursuing 1115 Waivers to cover some of these services as a Health Related Service Need (HSRN) benefit

- Use of managed care has increased budget predictability for states, but the impact of managed care on access to care and costs has had varying experiences

- Some benefits are "carved out" of managed care and administered through fee-for-service or contracts with other vendors (e.g., ltss services for specific populations, dental, behavioral health, transportation, pharmacy)