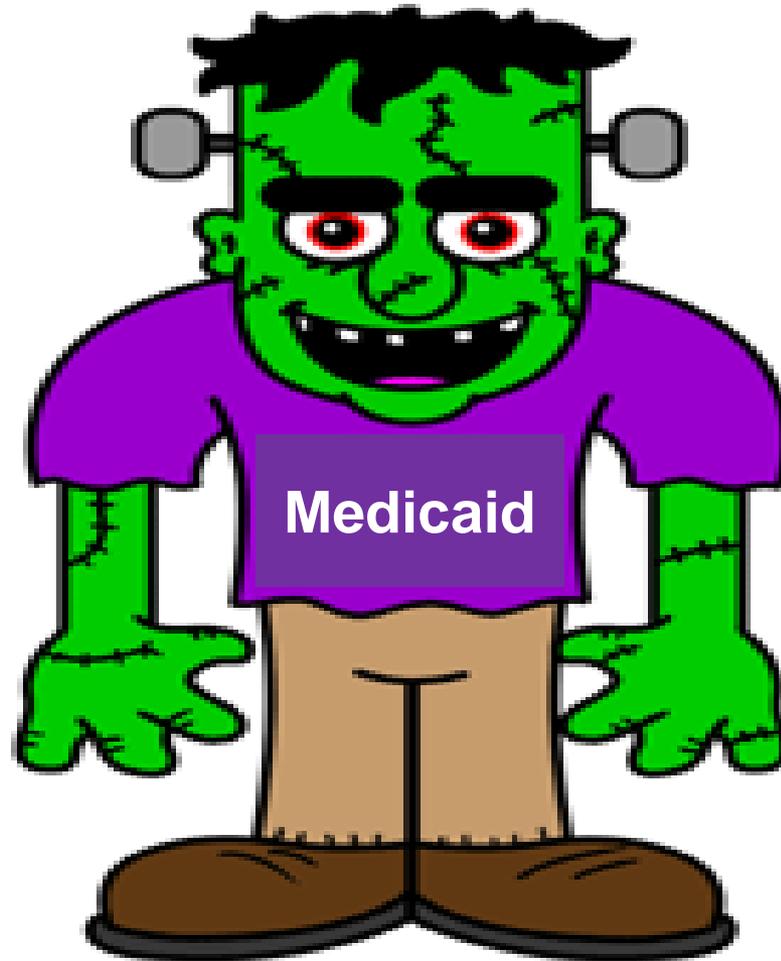


MEDICAID OVERVIEW



The Frankenstein Monster



History and Background

- Medicare and Medicaid legislation passed in 1965
 1. Part of the Social Security Act (passed in 1935)
 2. Title 18 – Medicare
 3. Title 19 – Medicaid

What's the difference?

- **Medicare** – national health insurance for people \geq 65 and some people who have disabilities
 1. If you've performed paid work, you've paid into it
 2. Part A – hospital insurance
 3. Part B – medical insurance (e.g. doctor visits)
 4. Part C – managed care plan for hospital and medical coverage (Medicare Advantage)
 5. Part D – prescription drug coverage

What's the difference?

- **Medicaid** – Health care program for people with very low incomes who also meet some other eligibility criteria:
 1. Age (child or elder)
 2. Condition (pregnancy)
 3. Disability
- States don't have to participate, but all states now do

Medicaid

- State-run program jointly financed by federal and state governments
 1. Federal money in the form of the matching of state money
 2. Each state has a different match rate each year based on a variety of economic factors (FMAP)
- Certain people can be covered by both Medicare and Medicaid

Medicaid's Three Big Rules

- Services must be offered statewide
- Services must be comparable, i.e. the same for everyone
- Beneficiaries must be offered freedom of choice among qualified providers

Who Is Covered By Medicaid?

- Low income and age
- Low income and disability
- Low income and pregnant/caretaker
- Optional populations (e.g. medically needy)

What Flexibility Do States Have?

- Optional eligibility requirements
- Optional benefits
- Limited or alternative benefits
(more on this later)
- Service delivery mechanisms
 - Fee for service (FFS)
 - Primary Care Case Management (PCCM)
 - Capitated managed care

Medicaid State Plan

- Specifies the eligibility groups served, benefits provided, and how the program is operated
- Provides the basis for a state's claim for Federal financial participation (FFP)
- All state plans and subsequent amendments must be reviewed and approved by the federal government

What Is Covered By Medicaid?

- Mandatory Services
 - Inpatient Hospital
 - Outpatient Hospital
 - Rural Health Clinic Services
 - Federally Qualified Health Center (FQHC) Services
 - Lab and X-Ray Services
 - Transportation to medical care
 - Home Health
 - EPSDT “Kan Be Healthy”
 - Physician Services
 - Dental Services (for children)
 - Tobacco cessation counseling for pregnant women
 - Nursing Facilities
 - Family Planning
 - Pregnancy Care
 - Some Other Practitioner Services

What Is Covered By Medicaid?

- Optional Services

- Prescribed Drugs
- Clinic Services
- Physical Therapy
- Occupational Therapy
- Speech, Hearing and Language
- Prosthetic Devices
- Optometric Services
- Eyeglasses
- Rehabilitation Services
- Health Homes
- Respiratory Care Services
- Other diagnostic/screening services
- Mental Health
- Hospice
- Targeted Case Management
- Podiatry
- Chiropractic
- HCBS, ICF-MR (ICF/IDD)

Working Healthy

Working Healthy incentivizes employment for people with disabilities

Working Healthy benefits include:

- Full Medicaid coverage
- Elimination of spend down or client obligation
- Ability to earn more income without loss of medical coverage
- Affordable premiums
- Allowance of higher savings than traditional Medicaid
- Help with Medicare expenses
- Personal assistance services under *WORK*
- Benefits planning and assistance
- Long term supports via *WORK*

WORK

- Individuals eligible for *Working Healthy* receive personal assistance and other services through *WORK*
- State Plan “Alternative Benefit Plan” consisting of services approved by CMS in September 2014
 - > Personal Assistance Services (PAS)
 - > Assistive Services
 - > Independent Living Counseling (ILC)

How Does Medicaid Work In Kansas?

- Single State Medicaid Agency (SSMA) – KDHE – responsibilities:
 1. Maintains State Plan
 2. Sets eligibility policy, within federal guidelines, to allow people to apply for Medicaid
 3. Contracts for Medicaid Management Information System (MMIS)
 4. Contracts with three managed care organizations (MCOs)

Kansas Department of Health & Environment

- Primary contact with Centers for Medicare and Medicaid Services (CMS) at the federal level for:
 1. Drawing down federal funds
 2. Maintaining program integrity and combating fraud and abuse
 3. Submitting federal reports

Defining Medicaid Policy: Federal Level

- Federal Laws
- CMS
 - Regulations (general Medicaid as well as specific managed care regulations)
 - Medicaid Manual
 - Informal Guidance
 - Waivers

Defining Medicaid Policy: State Level

- State Laws
- State Regulations
- Single State Agency
 - State Plan
 - 1115 Demonstration Waiver

What questions do you have so far?



What is KanCare?

- Medicaid + Children's Health Insurance Program (CHIP) = KanCare
 1. CHIP (Title 21 of Social Security Act) covers children in families with incomes too high to qualify for Medicaid)
 2. Covers children up to age 19
 3. Benefits almost identical to Medicaid

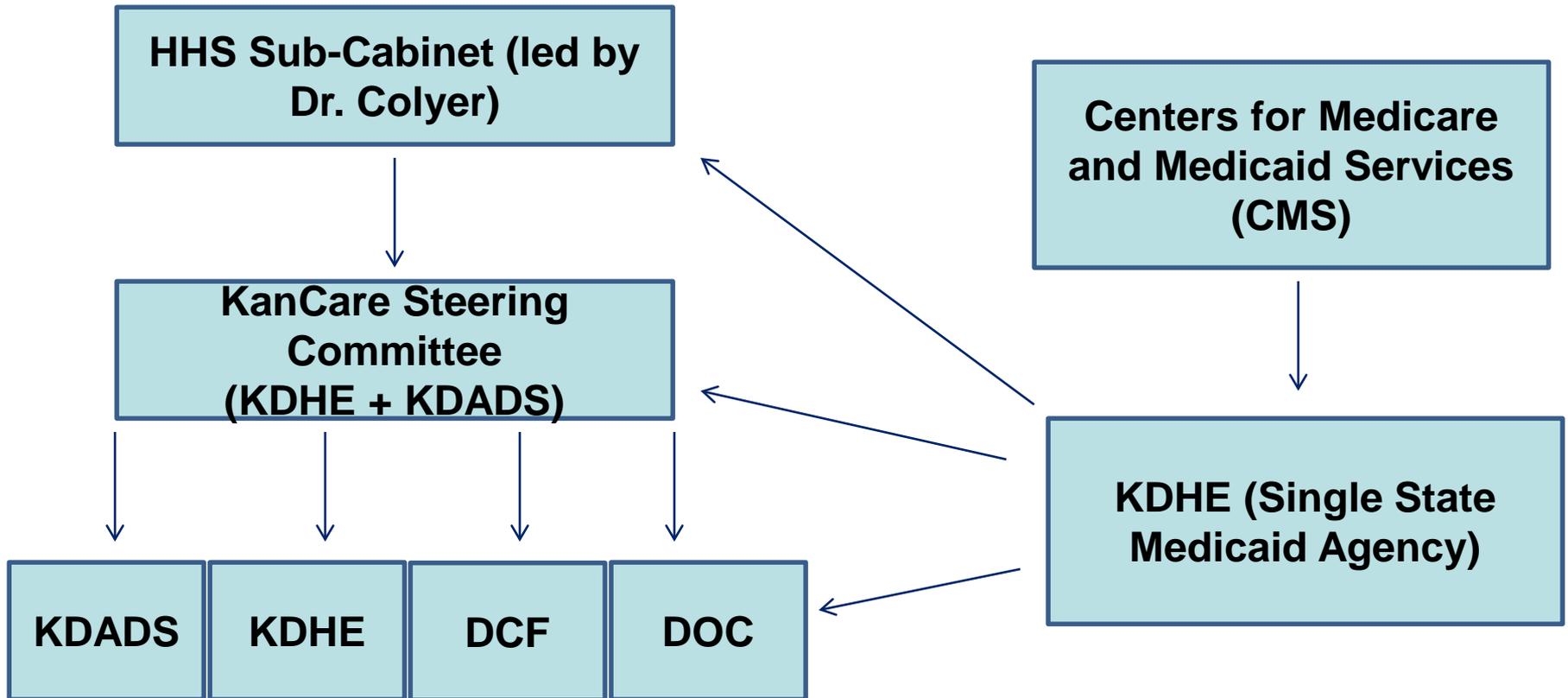
Managed Care

- KDHE contracts with three managed care organizations (MCOs) who:
 1. Enroll providers
 2. Pay for services
 3. Receive a monthly payment for each person in KanCare
 4. Are at financial risk for almost all the costs of care for KanCare members

Payment for KanCare Services

- Capitated per member per month (PMPM) payment made to KanCare MCOs for each KanCare member – 56 rate cells
- Federal government matches those payments (approximately 60 cents for every dollar) – CHIP and some specific services matched at a higher rate
- Providers bill the MCOs for services and are paid, generally, on a fee for service basis

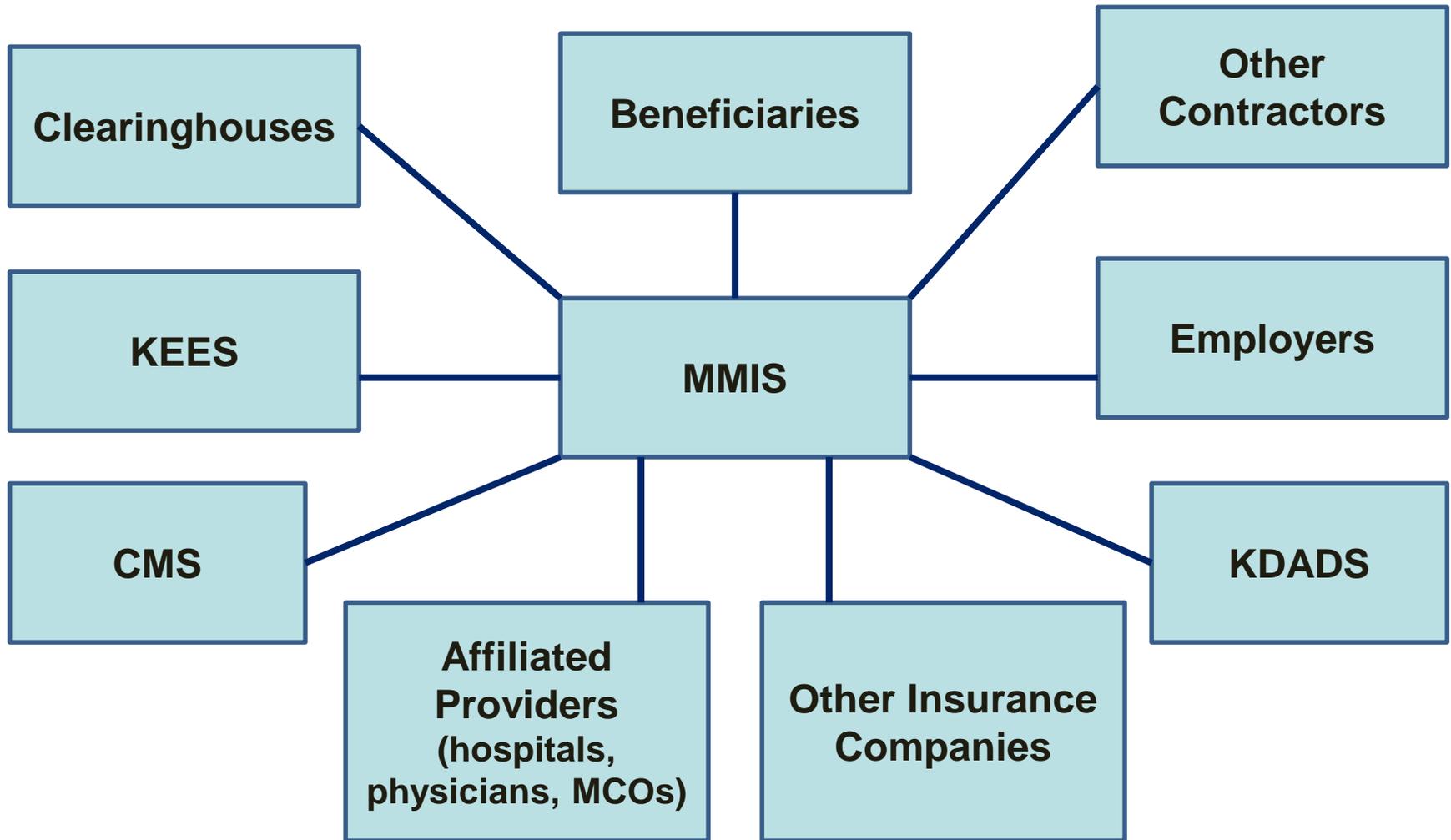
KanCare Policy Development



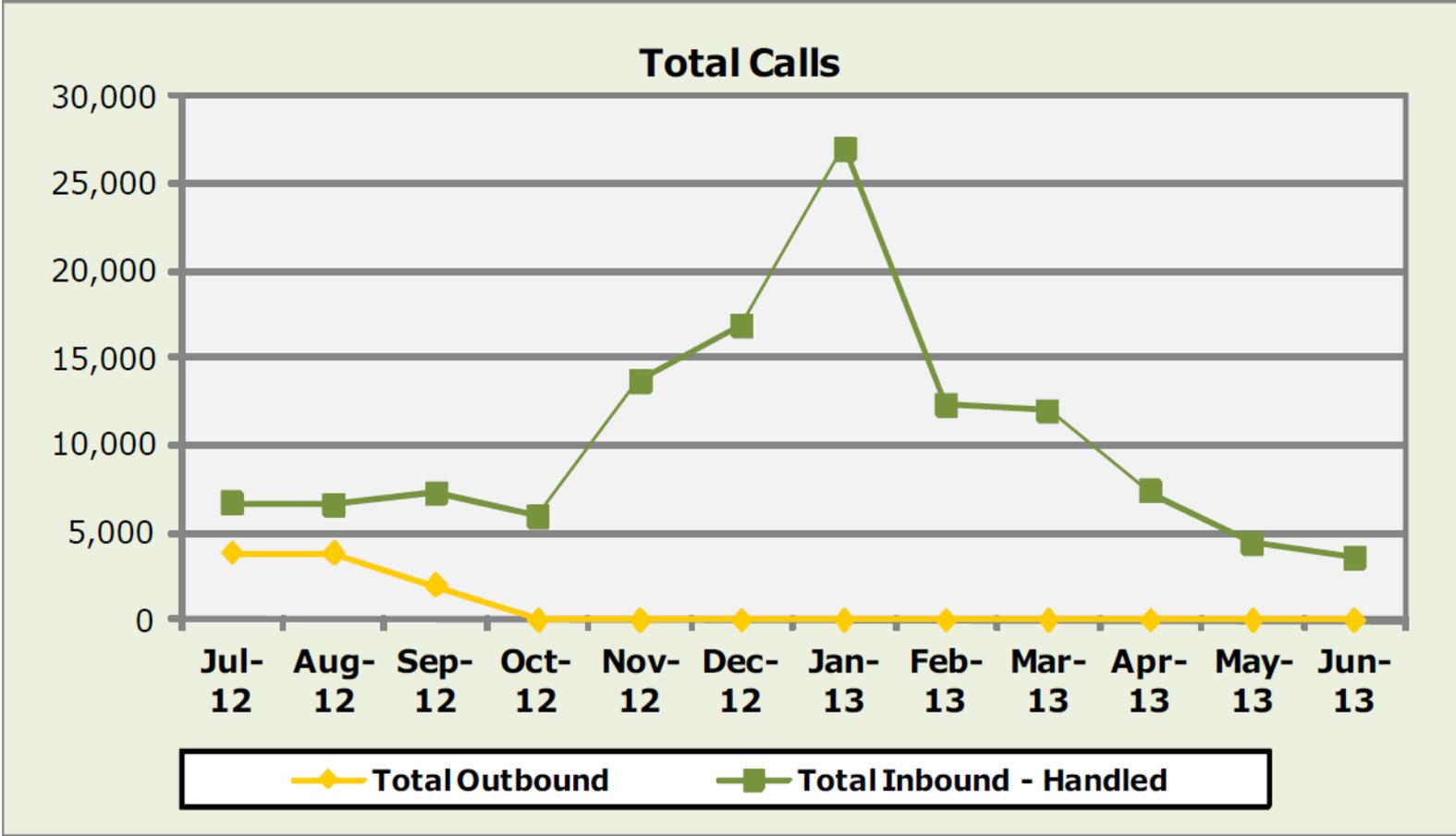
Agency Roles

- **KDHE**
 - Responsible for:
 - Physical health care services
 - 1115 Medicaid Demonstration Waiver
 - Medicaid Management Information System (MMIS)
 - Medicaid Program Integrity
 - Eligibility policy
 - Managing KanCare Eligibility Clearinghouse
 - KanCare MCO contract management and compliance
- **KDADS**
 - Oversight of:
 - Behavioral health care services
 - HCBS (1915(c)) waivers
 - Nursing Facilities
 - State MH and I/DD Hospitals
- **DCF**
 - Implementation of eligibility policy

MMIS: A Complex System



Managed Care Enrollment Calls



Medicaid As An Insurer

- Medicaid is the 3rd largest provider of health benefits coverage in Kansas after Blue Cross/Blue Shield and Medicare
- Single largest insurer of children
- Medicaid pays for about 40% of births in Kansas
- Medicaid pays for most mental health services, both nationally and in Kansas

Who Uses Medicaid in Kansas?

Average Monthly Members in Kansas Medical Assistance Programs: FY 10-14

Population	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
Families	190,681	210,120	227,033	231,463	240,378
Disabled	60,586	62,858	62,837	62,531	62,871
CHIP	40,825	43,226	47,240	51,332	56,758
Aged	36,482	39,178	40,731	42,116	43,885
Foster Care and Adoption	13,845	14,244	14,491	14,972	15,282
Other Populations	1,533	1,569	1,541	1,606	1,687
MediKan	1,482	1,325	900	654	660

How Does Someone Apply for KanCare?

- Through Department of Family and Children (until January 2016)
 1. Disabled adults
 2. Elderly
- Through KanCare Eligibility Clearinghouse (in Topeka)
 1. Children (including CHIP)
 2. Pregnant women
 3. Caretakers

What Is A Waiver?

- States can ask the federal government to waive one or more Medicaid rules
- Usually ask to waive one of the big three rules
- Home and Community Based Services (HCBS) waivers are the most common (also referred to as 1915(c) waivers)

1915(c) (HCBS) Waivers

- Targeted population (waive the comparability rule)
- Special package of services (waive the comparability rule)
- Can be limited to a certain number of people (waive the comparability rule)
- Designed to bring someone out of nursing facility or other institution
- Seven HCBS waivers in Kansas

Kansas 1915(c) (HCBS) Waivers

- Autism (children only, begins before age 6)
- Frail Elderly – FE (65+)
- Intellectual/Developmental Disability - IDD (age 5+)
- Physical Disability – PD (ages 16-64)
- Seriously Emotionally Disturbed - SED (children only, age
- Technology Assisted – TA (children only, 0-21)
- Traumatic Brain Injury – TBI (ages 16-64)

Kansas 1915(c) (HCBS) Waivers

- Each has an institutional equivalent
- Each requires a functional eligibility assessment in addition to a financial eligibility determination
- Functional assessments completed by a third party – not state or MCOs
- Waiver beneficiaries usually reassessed on a regular basis
- Those who receive HCBS can also receive any medically necessary State Plan services

1115 Research & Demonstration Waiver

- How Kansas operates both its State Plan and HCBS waivers
- Authority to require most beneficiaries to receive all their services through managed care plans
- Authority for MCOs to manage HCBS waiver services along with physical and behavioral health services
- Over 100 special terms and conditions (STC)
 - KanCare Ombudsman
 - Quarterly reporting

Medicaid Waiver Costs

- 1915(c) or HCBS waivers must be cost effective – per capita costs do not exceed average cost of institutional settings
- 1115 waivers must demonstrate budget neutrality – federal spending cannot exceed what would have been spent in the absence of the waiver

Making Changes to Medicaid

- State Plan – once submitted, never has to be amended unless eligibility groups or services are changed or a new SSMA is designated
- 1915(c) waivers must be amended to change eligibility or services and must be renewed every 5 years after initial 3-year period
- 1115 waivers are approved for 5 years and then must be renewed or will expire; they can also be amended any time

Questions?



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