DIVISION OF HEALTH CARE FINANCING & POLICY

Legislative Committee on Health Care

Presentation on Medicaid and Nevada Check Up

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Contents

- Medicaid and SCHIP Overview
- Expansion Options
  - Medically Needy Option
  - “210” Option
  - Presumptive Eligibility for Children and Pregnant Women
- Deficit Reduction Act – Impacts and Options
- Update on Nevada’s HIFA Waiver

Medicaid – Who Gets It?

- There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable tests within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

Rehabilitation Association of Virginia v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994) (Ervin, Chief Judge)

Medicaid and SCHIP Overview

- The Division of Health Care Financing and Policy administers two major health coverage programs which provide health care to Nevadan's.
  - ***Medicaid*** provides health care to low-income families, as well as aged, blind and disabled individuals. Services are provided as fee-for-service and through managed care networks.
  - ***Nevada Check Up*** provides health coverage to low-income, uninsured children who are not eligible for Medicaid. Services are provided as fee-for-service and through managed care networks.

Medicaid Overview

- Medicaid is used by states to achieve health policy goals
- Medicaid is used to fill gaps in health coverage by providing:
  - Health insurance for very low-income families with children, many in working households
  - Catastrophic coverage for the disabled
  - Long-term care coverage
  - Supplemental coverage for low-income seniors on Medicare
- Medicaid is used to maximize return of federal tax dollars to the states
- “If you’ve seen one state Medicaid program, you have seen one state Medicaid program.”
  - A person eligible in one State may not be eligible in another State.
  - Services provided by one State may differ considerably in amount, duration, or scope from services provided in a similar or neighboring State.
  - States may change Medicaid eligibility, services, and/or reimbursement during the year.

Medicaid Overview (continued)

- Authorized by Congress under Title XIX of the Social Security Act in 1965.
- Medicaid is an optional medical coverage program that states elect to provide to their residents.
- States work in partnership with the federal Centers for Medicare and Medicaid Services (CMS) to assist in providing quality medical care for eligible individuals.
- Federal regulations define mandatory groups to be covered (Nevada generally covers only mandatory groups).
- Federal regulations define mandatory and optional services (Nevada generally covers mandatory services, or optional services if cost-effective).
- Current avg. caseload (2/1/06): 171,047 Nevadans.

Medicaid Overview (continued)

- State Plan - The Medicaid State Plan defines how each state will operate its Medicaid program. It includes eligibility and service options elected by the State.
- States Choose an eligibility State Plan
  - Medically Needy

  ➔Categorically Needy

  - Special Groups

Medicaid Overview (continued)

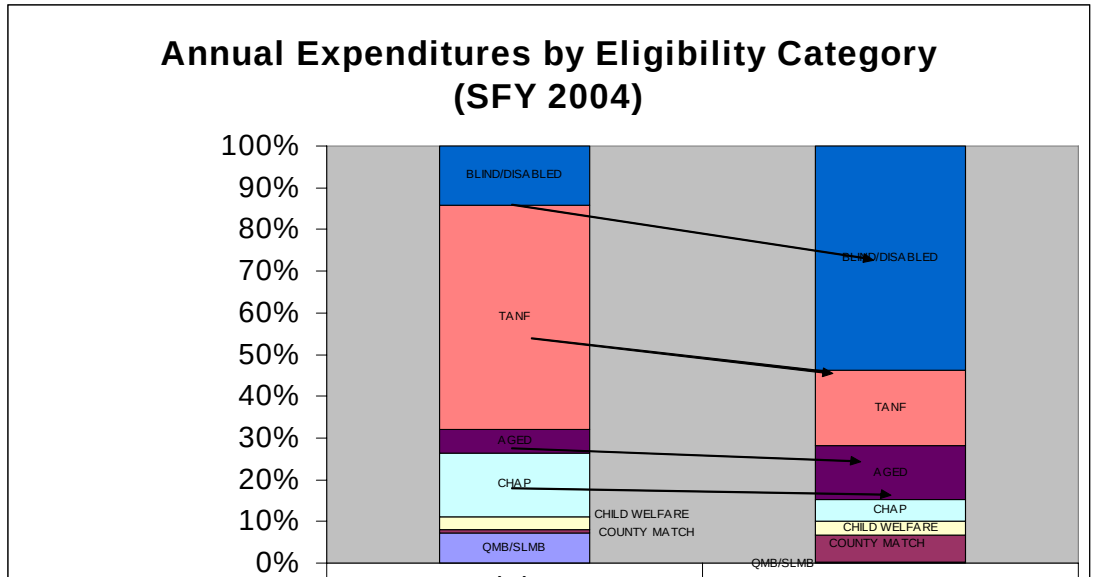
- Mandatory eligibility groups including:
  - Families who meet states welfare eligibility standards (AFDC) in effect on July 16, 1996;
  - Pregnant women and children under age six with incomes at or below 133% of the Federal Poverty Level (FPL);
  - Children 6 to 19 with family income up to 100% of the FPL;
  - SSI recipients (blind or disabled);
  - Certain Qualified Medicare Beneficiaries; and
  - Caretakers (relatives or legal guardians who take care of children under age 18)
- Optional groups including:
  - Women with breast or cervical cancer under 200% of the FPL;
  - Disabled children who require medical facility care, but can appropriately be cared for at home – Katie Beckett eligibility group.
  - Health Insurance for Work Advancement (HIWA) is for individuals 16 to 64 who are disabled. It allows them to retain essential Medicaid benefits while working and earning income.
- 1115 Medicaid Waivers:
  - Some states have expanded eligibility under Medicaid waivers.
  - HIFA – must include small employer insurance option

Medicaid Overview (continued)

- Mandatory services include:
  - Inpatient hospital
  - Clinic services
  - Nursing facility services for individuals 21 and older
  - Early and Periodic Screening, Diagnosis, and Treatment for children under age 21
  - Physician services
  - Family planning services
  - Home health services
  - Pregnancy related services
- Optional services include:
  - Prescription drugs
  - Nursing facility care for individuals age 20 and under
  - Podiatric care
  - Preventive and restorative care for individuals age 21 and older
  - Home and community based waiver programs
- Transportation

Medicaid Overview (continued)

- Aged and Disabled represent 30% of the caseload and use 70% of budget dollars



	Recipients	
BLIND/DISABLED	24,522	$494,968,346
TANF	92,885	$167,197,418
AGED	9,841	$119,688,063
CHAP	26,627	$46,991,152
CHILD WELFARE	5,139	$32,122,127
COUNTY MATCH	1,346	$58,225,510
QMB/SLMB	12,531	$2,908,703

Nevada Check Up Overview

- Authorized by Congress in 1997 as Title XXI of the Social Security Act, called the State Children's Health Insurance Program (SCHIP).
- Children uninsured for six months or more, ages birth through 18, whose family income is too high for Medicaid may be eligible for Nevada Check Up.
- Medical coverage follows Medicaid policy, including coverage of dental services.
- Family income levels up to 200% of the federal poverty level may qualify (Annual household income of less than $36,800 for family of four).
- Quarterly premiums between $15 and $70, based on income.
- FMAP for SFY 2006 = 68.53%; FMAP for SFY 2007 = 67.90%
- Current avg. caseload (April 2006): 27,664 children

Expansion Options

- Medically Needy
  - Currently 36 states offer this option
  - Allows an individual or family with excess income or resources to reduce countable income (or resources) by the amount of incurred medical expenses to establish financial eligibility.
  - This group MUST include:
    - Pregnant women who, except for income or resources, would be eligible. These individuals would also continue to be eligible for 60 days after the pregnancy ends;
    - Individuals under 18 year of age who, except for income and resources, would be eligible;
    - All newborns born on or after Oct. 1, 1984 born to a medically needy mother;
    - Protected blind persons; and
    - Individuals required to enroll in their employer's health plan, if cost-effective.

Expansion Options

- Medically Needy (continued)
  - In addition, the following groups MAY be covered:
    - Children under age 21;
    - Caretaker relatives who are not eligible as categorically needy;
    - Aged, blind and disabled individuals who are ineligible as categorically needy; and
    - Individuals who would be eligible if not enrolled in an HMO.
  - Cost estimate
    - In 2004, the Division projected the enrollment associated with establishing a “basic” medically program. Using current cost per eligible figures, the estimated cost, including administration, is approximately $40 million.

Expansion Options

- 210 Option
  - 42 CFR 435.210: The agency may provide Medicaid to any group or groups of individuals specified in Sec. 435.201 (a)(1) through (a)(3) and (a)(5) and (a)(6) who are not mandatory categorically needy, who meet the income and resource requirements of the appropriate cash assistance program for their status (that is, the State's approved AFDC plan or SSI, or optional State supplements in States that provide Medicaid to optional State supplement recipients).
  - The State can perform presumptive SSI eligibility determinations based on federal guidelines, thus avoiding unnecessary delays in disability adjudication.

Expansion Options

- 210 Option (continued)
  - Faster SSI determinations will afford prompt Medicaid coverage and access to needed health care services, including targeted case management services.
  - Individuals who are Seriously Mentally Ill (SMI) could benefit for early access to community based services and reduce dependence on state funded services while SSI eligibility is pending.
  - SSA is implementing a new disability determination process
    - Focus on customer service by shortening decision time for individuals who are obviously disabled.
    - Providing more accurate initial decisions and reducing the need for subsequent appeals.
  - Estimated administrative costs: $7.6 million when fully operational

Expansion Options

- Presumptive Eligibility for Children and Pregnant Women
  - States have the option of allowing certain qualified health care providers and community based organizations to "presumptively" enroll children and pregnant women in Medicaid who appear eligible based on age and family income.
  - "Qualified entities" make the presumptive eligibility determination based on self-declaration of income that is below the state's eligibility guidelines. The pregnant woman or parent/guardian must submit a full Medicaid application by the end of the following month. The child or pregnant woman is provisionally enrolled until a full eligibility determination is done by the agency.

Expansion Options

- Presumptive Eligibility for Children and Pregnant Women (continued)
  - As of 2005, the following states used presumptive eligibility in their Medicaid and/or SCHIP programs:
    - Separate SCHIP only – New York
    - Medicaid and separate SCHIP – California, Illinois, Michigan, and Massachusetts
    - Medicaid – New Mexico, Nebraska, Missouri, New Hampshire, and Connecticut (Note: Missouri, Nebraska, and New Mexico do not have separate Medicaid and SCHIP programs.)
  - In 2001, administrative and medical costs were estimated at $31 million per year.
  - In July 2004, the asset test was eliminated for the CHAP program, reducing Medicaid verification requirements for pregnant women and children applying for the program.

Deficit Reduction Act

- DRA Overview
  - Pres. Bush signed the DRA of 2005 on Feb. 8, 2006.
  - Expected to generate $39B in federal entitlement reductions between 2006 and 2010.
  - Includes net reductions of $4.8B over the next five years from Medicaid.
  - Provisions related to premiums and cost-sharing, asset transfers and prescription drug payments make up the largest portion of the federal reductions.
  - The DRA also affords greater flexibility to states in establishing cost-sharing provisions and new benefit plan designs.

Deficit Reduction Act (continued)

- Payment for Prescription Drugs
  - Mandates use of Average Manufacturer Price (AMP) to pay pharmacies.
  - Federal upper payment limits set at 250% of AMP for multiple source drugs.
  - Feds to conduct market survey of commonly used drugs and provide results to states on a quarterly basis.
  - Requires use of NDC codes for common physician administered drugs.

Deficit Reduction Act (continued)

- Long-Term Care Under Medicaid
  - Asset Transfer Rules
    - Lengthen asset transfer look-back to 5 years
    - Recipients to disclose all annuities. State must be named as a remainder beneficiary on certain annuities.
    - “Income First” rule – State must consider all income of the institutionalized spouse that could be available to the community spouse.
    - Disqualification for long-term care if individual has more than $500,000 in home equity, unless community spouse or child resides in the house.

Deficit Reduction Act (continued)

- Long-Term Care Under Medicaid (continued)
  - Expanded Access to Benefits
    - Expansion of Long-Term Care Partnership Program
      - States may disregard assets or resources in an amount equal to the insurance benefit payments that are made for an individual under a long-term care insurance policy.

Deficit Reduction Act (continued)

- Eliminating Fraud, Waste and Abuse In Medicaid
  - Enactment of State False Claims Act
    - State enactment of a false or fraudulent claims act that meets certain requirements, will get 10% more FFP for amounts recovered through a State action brought under such law.
  - Employee Education About False Claims Recovery
    - Any entity that receives or makes annual Medicaid payments of more than $5 million, shall have written policies for all employees including information on the federal False Claims Act.
  - Prohibition on Restocking and Double Billing of Prescription Drugs
  - Medicaid Integrity Program
    - Federal contracts to detect fraud and abuse
    - 100 new federal auditors
  - TPL Identification and Payment
    - States must assure the Secretary that it has laws in effect requiring health insurers to:
      - Provide information to Medicaid on coverage;
      - Accept State's right or recovery;
      - Respond to State inquiries regarding claims for payment not older than 3 years; and
      - Agree not to deny a claim solely on the date of submission (within 3 years) or type of claim form.
  - Enforcement of citizenship documentation verification

Deficit Reduction Act (continued)

- Flexibility in Cost Sharing and Benefits
  - State Options for Alternative Medicaid Premiums and Cost Sharing
    - The State, at its option, can impose cost sharing and premiums on certain eligibility groups.
    - Pharmacy copays for non-preferred drugs.
    - Hospitals may be permitted to impose cost sharing for non-emergency services furnished in the hospital emergency department.
  - States may also use “benchmark” benefit plans.

Deficit Reduction Act (continued)

- State Options for Alternative Medicaid Premiums and Cost Sharing
  - Prior to the DRA:
    - Federal rules prohibited states from imposing premiums on children or their parents.
    - States were barred from imposing co-payments on children.
    - Parents and other adults could only be charged nominal co-payments, but providers could not deny services if they were unable to pay.
  - After the DRA:
    - Within limits, children and parents can be charged premiums.
    - Co-payments can be charged to children for certain services
    - Providers can deny care to someone who is unable to meet cost-sharing obligations.

Deficit Reduction Act (continued)

- State Options for Alternative Medicaid Premiums and Cost Sharing

FEDERAL COST SHARING STANDARDS FOR CHILDREN IN THE DRA

	"Mandatory" Children*	Other Children with Family Income upto 150% FPL	Other Children With Family Income Above 150% FPL
Most services	No charges allowed	Up to 10% of the cost of the service	Up to 20% of the cost of the services
Prescription drugs	Up to $3 for non -preferred/ $0 for preferred	Up to $3 for a non - preferred/ may charge less for preferred	Up to 20% of cost for non-preferred/ may charge less for preferred
Non-emergency use of an ER	Up to $6	Up to $6	Any amount
Preventive services	No charges allowed	No charges allowed	No charges allowed
Aggregate cap on charges	No aggregate cap	5% of monthly or quarterly income	5% of monthly or quarterly income
Premiums	Not allowed	Not allowed	Allowed (no upper limit Except 5% aggregate cap)

** "Mandatory children" include children under age six with family income below 133 percent of the federal poverty level and children ages six to 17 with family income below 100 percent of the federal poverty level. (For purposes of the cost sharing and premiums of the DRA, 18-year olds are treated as adults) The rules that apply to mandatory children also apply to children (without regard to age) for whom Title IV foster care or adoption assistance is being provided.*

Deficit Reduction Act (continued)

- State Options for Alternative Medicaid Premiums and Cost Sharing

FEDERAL COST SHARING STANDARDS FOR PARENTS IN THE DRA

	Parents with Family Income Below 100% FPL	Parents with Family Income between 100% and 150% FPL	Parents with Family Income Above 150%
Most services	DRA is unclear	Up to 10% of the cost of the service	Up to 20% of the cost of the service
Prescription drugs	Up to $3 for a non-preferred/ states may charge less for preferred	Up to $3 for a non-preferred/ states may charge less for preferred	Up to 20% of cost for non-preferred/may charge less for preferred
Non-emergency use of an ER	Up to $6	Up to $6	No upper limit
Preventive services	Up to $3 (No special limits)	Up to 10% of the cost of the service	Up to 20% of the cost of the service
Aggregate cap on charges	No cap	5% of monthly or quarterly income	5% of monthly or quarterly income
Premiums	Not allowed	Not allowed	Allowed

Deficit Reduction Act (continued)

- State Options for Alternative Medicaid Premiums and Cost Sharing
  - Cost Sharing for Children
    - Most children in Nevada Medicaid fall under the “mandatory” children’s groups (first column).
    - Children receiving Transitional Medical Assistance would fall in the second and third columns.
  - Cost Sharing for Adults
    - Adults in TANF who are not working or whose income is below 100% of the FPL are in column one.
    - They move to column two or three as their income rises and they move to Transitional Medical Assistance.

Deficit Reduction Act (continued)

- States may also use “benchmark” benefit plans.
  - Before the DRA:
    - States had to provide certain mandatory services (e.g. physician services), while other services were optional (e.g. prescription drugs).
    - States could impose limits on the frequency and duration of mandatory and optional services.
    - However, recipients could not be charged for medically needed services beyond these limits.
    - For children, minimum standards are stronger and defined under Early and Periodic Screening Diagnostic and Treatment (EPSDT)
  - After the DRA:
    - States could create new benefit plans where traditional rules no longer apply.
    - Also allows states to enroll children and parents in “benchmark” plans
    - State must provide “wraparound” EPSDT benefits to children
    - States cannot enroll - Mandatory pregnant women, blind and disabled adults, hospice patients, individuals eligible as institutional, Katie Beckett children, dual eligibles, medically fragile and special needs individuals, recipients qualifying for long-term care, foster care children, and women in the breast and cervical cancer program. Excluded groups can voluntarily enroll in benchmark plans.

Deficit Reduction Act (continued)

- State Financing Under Medicaid
  - Reforms of Case Management and Targeted Case Management
    - Case management will be limited to 50% FFP.
    - Targeted Case Management (TCM)
      - Foster care and juvenile justice TCM payments eliminated
      - Third-Party Liability rules enforced

Deficit Reduction Act (continued)

- **Other Provisions**
  - Option for Families of Disabled Children to Purchase Medicaid Coverage
    - New optional eligibility group for disabled children whose parents fall into certain income levels.
    - Assets may be disregarded.
    - Regulations needed for further evaluation.
  - Demonstration Projects for Home and Community-based Alternatives for Children in Residential Treatment Centers
    - Competitive grants to10 states to test effectiveness of providing home and community based services (HCBS) as alternatives to psychiatric services in an RTC.
  - Money Follows the Person Rebalancing Demonstration
    - Competitive grants to states to expand HCBS by transitioning certain long-term care clients to home and community based services.
  - Medicaid Transformation Grants
    - Secretary can grant payments to states for certain innovative practices including, but not limited to:
      - Methods for reducing payment error rates
      - Methods for improving rates of collection from estates
      - Methods for reducing waste, fraud and abuse
      - Implementation of a medication risk management program
  - Health Opportunity Accounts
    - Similar to Health Savings Accounts
    - Ten states will be allowed demonstration waivers in first 5 years
    - Awaiting regulations
  - Non-Emergency Transportation Broker – NV already uses this service under a waiver
  - HCBS Services through State Plan Option Rather than HCBS Waiver
  - Self-Directed Personal Assistance Option

Deficit Reduction Act (continued)

- State Children's Health Insurance Program (SCHIP)
  - Prohibition Against Covering Non-pregnant Childless Adults with SCHIP funds

HIFA Update

- The Deficit Reduction Act (DRA) recently passed by the Congress as well as recent policy decisions at the Center for Medicare and Medicaid Services (CMS) have impacted the original design of the waiver
  - The DRA prohibits the use of SCHIP funds for non-pregnant individuals without children
    - To the original Nevada waiver design this means that, for example, an ESI product that would be subsidized with SCHIP funds could only be extended to parents; single individuals are not eligible
  - The CMS policy decision bars the inclusion of capped categorical populations on the “without waiver” side of the budget neutrality equation
    - To the Nevada waiver design this means that, for example, a capped eligibility expansion for pregnant women cannot use Medicaid funds without meeting the requirement to prove budget neutrality

HIFA Update

- The Nevada Department of Health and Human Services (DHHS) has submitted a redesigned HIFA waiver. The waiver is funded solely by Title XXI SCHIP funds and only proposes coverage for "categorical populations"
- The populations to be covered under the waiver are:
  - Pregnant women between 133% and 185% of the FPL
  - Parents below 200% of the FPL that have available, but have not taken up, Employer Sponsored Insurance
  - Uninsured parents with incomes below 150% of the FPL that have incurred hospital (and related) charges of at least $25,000

HIFA Update

- Program projections under the revised waiver:

Lives Covered	SFY07	SFY08	SFY09	SFY10	SFY11
Pregnant Women, 134% - 185% FPL	1,188	1,350	1,350	1,350	1,350
Employer Sponsored Insurance	1,138	3,238	5,150	5,500	5,500
Catastrophic Coverage	N/A	N/A	N/A	N/A	N/A

Program Expenditures	SFY07	SFY08	SFY09	SFY10	SFY11
Pregnant Women, 134% - 185% FPL	$9,381,203	$11,464,902	$12,324,798	$13,249,170	$14,242,716
Employer Sponsored Insurance	$1,365,000	$4,237,370	$7,351,728	$8,563,500	$9,340,320
Catastrophic Coverage	$2,400,000	$4,800,000	$4,800,000	$4,800,000	$4,800,000

HIFA Update

- Below is a comparison of the program expenditures between original and revised waiver proposal.

Comparison of Federal & Non-Federal Program Expenditures

	Legislative Approved*				HIFA, SCHIP Only			
Year	Pregnant Women	ESI	Catastrophic	Admin (TXIX)	Pregnant Women	ESI	Catastrophic	Admin (TXXI)
2007	$11,504,193	$1,302,600	$9,000,000	$1,203,355	$9,381,203	$1,365,000	$2,400,000	$1,314,620
2008	22,947,072	3,707,400	9,000,000	2,076,301	11,464,902	4,237,370	4,800,000	2,050,227
2009	24,393,984	6,112,200	9,000,000	2,641,813	12,324,798	7,351,728	4,800,000	2,447,653
2010	25,932,864	8,517,000	9,000,000	3,196,812	13,249,170	8,563,500	4,800,000	2,661,267
2011	27,150,912	9,619,200	9,000,000	3,260,748	14,242,716	9,340,320	4,800,000	2,838,304
Total	**$111,929,025**	**$29,258,400**	**$45,000,000**	**$12,379,029**	**$60,662,789**	**$30,857,918**	**$21,600,000**	**$11,312,071**
Total Program Expenditures				**198,566,454**				**124,432,777**

Note that for the Legislatively approved figures, 50% of pregnant women are funded through TXIX

* Through FY2007

HIFA Update

- Below is a comparison of the program features between the original and revised waiver.

Comparison of Lives Covered

Year	Legislative Approved*				HIFA, SCHIP Only			
	Pregnant Women Enrollment	ESI Enrollment	Catastrophic Expenditures	Required Contribution from Supp	Pregnant Women Enrollment	ESI Enrollment	Catastrophic Expenditures	Required Contribution from Supp
2007	1,292	1,086	$9 Million	$ 4,179,972	1,188	1,138	$2.4 Million	$ 2,289,871
2008	2,048	3,090	$9 Million	8,497,575	1,350	3,238	$4.8 Million	3,636,590
2009	2,048	5,094	$9 Million	9,450,277	1,350	5,150	$4.8 Million	4,341,524
2010	2,048	7,098	$9 Million	10,421,908	1,350	5,500	$4.8 Million	4,720,422
2011	2,048	8,016	$9 Million	10,797,925	1,350	5,500	$4.8 Million	5,034,441
Total	**9,484**	**24,382**	**$45 Million**	**$ 43,347,658**	**6,588**	**20,526**	**$21.6 Million**	**$ 20,022,849**

Note that for the Legislatively approved figures, 50% of pregnant women are funded through TXIX

* Through FY2007

HIFA Update

- Status of the waiver application
  - The waiver application was submitted to CMS on March 10
  - The application included:
    - A completed waiver template
    - The cost and caseload projections that were presented earlier
    - Preliminary funding, eligibility and payment flows for each coverage group

HIFA Update

- Outcome of the meeting with CMS on March 15
  - The meeting was attended by CMS Central Office and Regional Office staff, staff from other areas of HHS, and representatives of OMB
  - Overall, the federal team's response was positive. They were particularly pleased with the reserve for the potential growth of the Nevada Check Up program.
  - The federal team thought the pregnant women eligibility expansion was straight forward and posed no significant issues.
  - The most significant discussion concerned the Catastrophic Coverage Initiative. CMS indicated that this was the most problematic portion of the waiver.
    - Subsequently we have received a letter requesting the state eliminate this group from the waiver, or revise coverage to include expanded outpatient benefits.
  - Continuing to revise waiver and work on implementation plans.
    - Pregnant women and ESI tentatively scheduled to begin July 1, 2006 pending federal approval and ESI fiscal agent contract.
    - Working with Nevada Hospital Association, county social service agencies and NACO on redesign of catastrophic coverage group.

Questions?