MEALS ON WHEELS ANNUAL CONFERENCE AND EXPO

AUGUST 27-29, 2019

DALLAS, TX

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An Overview of the Current Medicaid Landscape and Opportunities for Partnership

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Session Overview

- Medicaid Origins
- Basic Building Blocks of Medicaid
- Program Demonstrations/Innovations
- Privatizing Medicaid
- Managed Care Organizations and Social Drivers of Health (SDOH)
- Case Studies
- What does this all mean for Meals on Wheels Programs?

Medicaid Origins

Objectives

- Explain the origin of Medicaid
- Outline the differences between Medicare and Medicaid
- Provide insight on the Federal-State partnership in Medicaid
- Demonstrate the tremendous growth of the Medicaid program since its inception

Medicare & Medicaid enacted in 1965

- Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act.
- Providing hospital, post-hospital extended care, and home health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board)
- Giving states the option of receiving federal funding for providing health care services to low-income children, their caretaker relatives, the blind, and individuals with disabilities.
- At the time, seniors were the population group most likely to be living in poverty; about half had health insurance coverage.

Medicare VS Medicaid

	Medicare	Medicaid
Administration	Federally Administered	State Administered
Funding	Federally Funded	Jointly State and Federally Funded
Beneficiaries	• People 65 and older • Certain people under 65 with disabilities • People of any age with End-Stage Renal Disease	• Low-income adults • Pregnant women • Children
Coverage	Consistent Nationally • Inpatient (Part A) • Outpatient (Part B) • Pharmacy (Part D) • Limited Post Hospitalization Primary Payor	Varies By State • Federal Government specifies mandatory & optional services • Significant LTC (Nursing Home and Home & Community Based Services) and Behavioral Health services Payor of Last Resort

Medicaid is a Federal / State Partnership

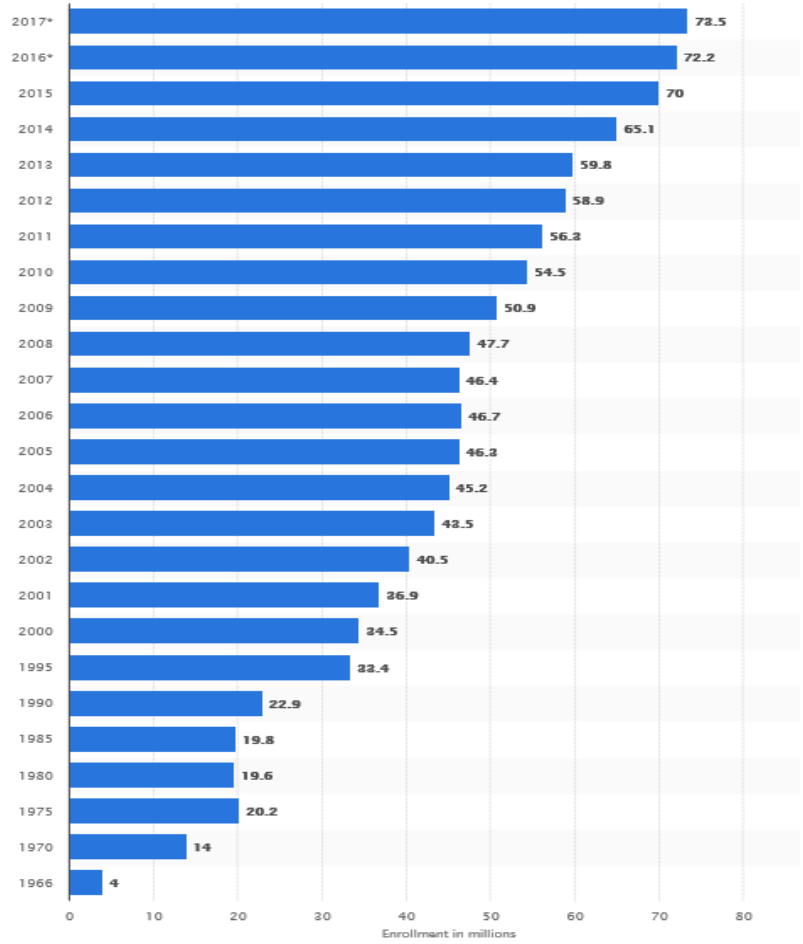
- States are not required to participate in Medicaid
- The federal government provides matching funds to states to enable them to provide medical assistance to residents who meet certain eligibility requirements.
- The objective is to help states provide medical assistance to residents whose incomes and resources are insufficient to meet the costs of necessary medical services.
- The federal Centers for Medicare and Medicaid Services (CMS) monitors the state-run programs and establishes requirements for service delivery, quality, funding, and eligibility standards.
- Participating states must comply with Federal Medicaid laws under which each participating state:
    - Administers its own Medicaid program
    - Establishes eligibility standards
    - Determines the scope and types of services it will cover
    - Sets the rates for payment
- Benefits vary from state to state; because someone qualifies for Medicaid in one state, it does not mean they will qualify in another

Dual Eligibles

Beneficiaries who receive support through **both** Medicare and Medicaid are called “Dual Eligibles.”

- Qualified Medicare Beneficiary (QMB) Program
  - Helps pay premiums, deductibles, coinsurance, and copayments for Part A, Part B, or both programs
- Specified Low-Income Medicare Beneficiary (SLMB) Program
  - Helps pay Part B premiums
- Qualifying Individual (QI) Program
  - Helps pay Part B premiums
- Qualified Disabled Working Individual (QDWI) Program
  - Pays the Part A premium for certain disabled and working beneficiaries

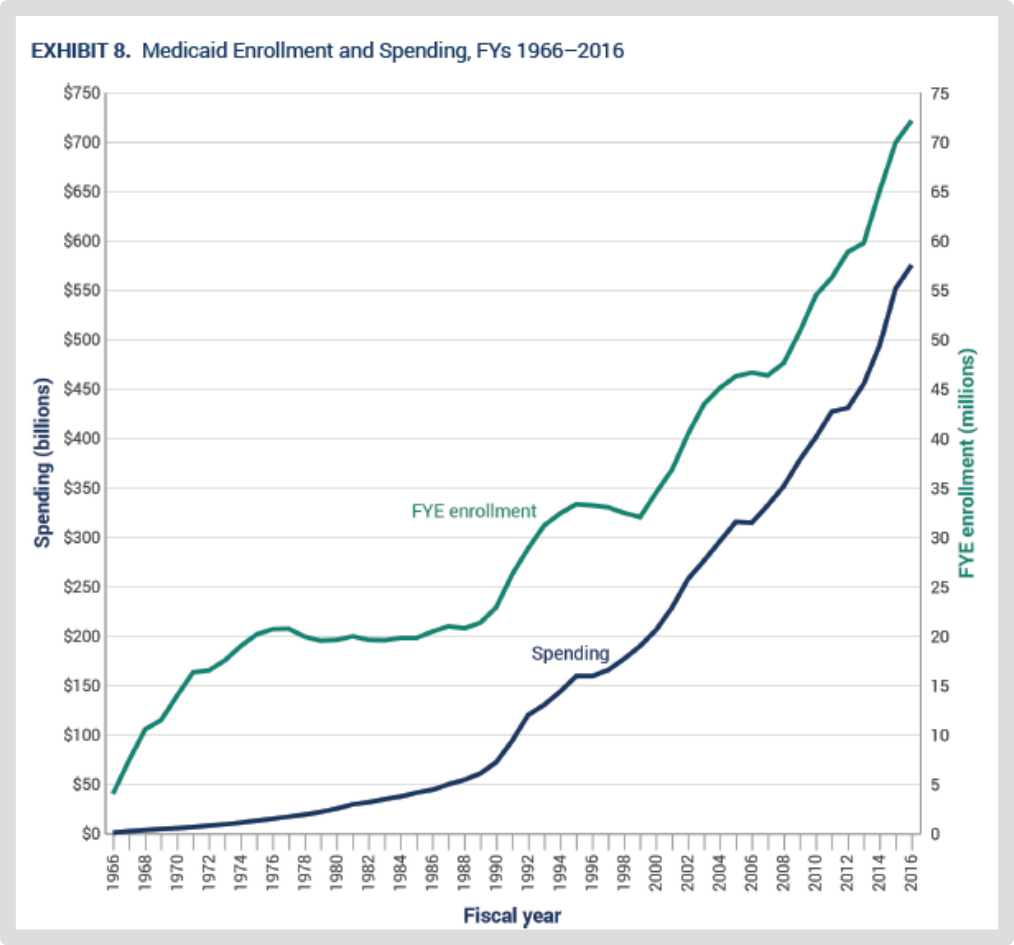
Medicaid Enrollment 1966 to 2017



Almost 75 Million Beneficiaries Today

Source: The Statistical Portal

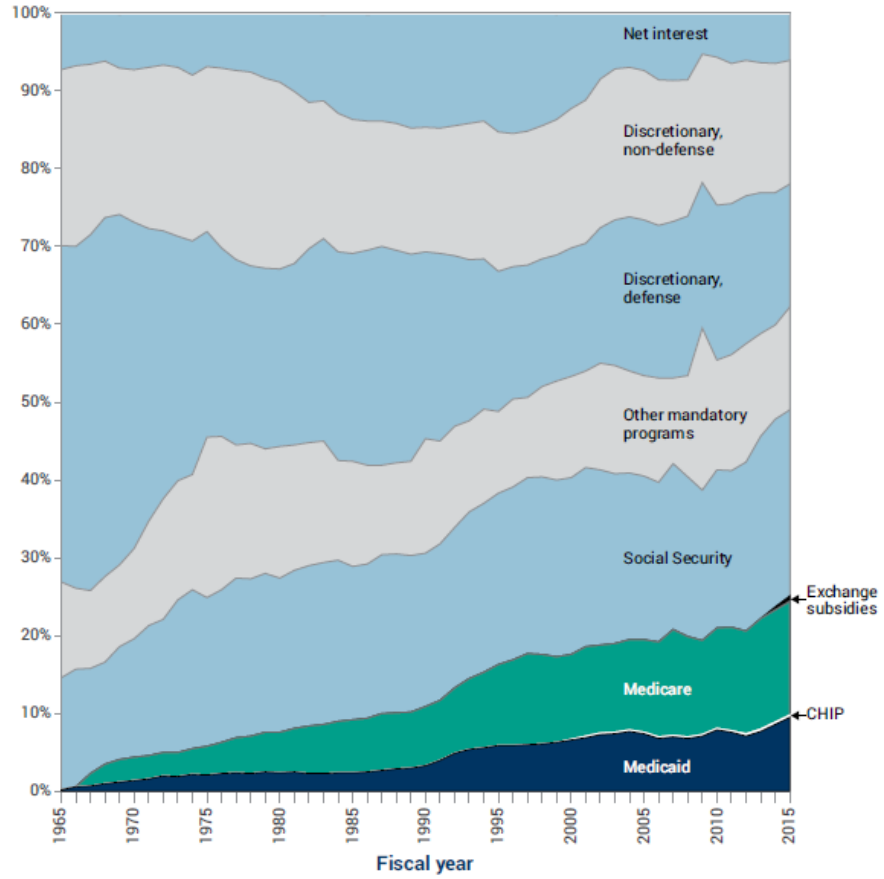
Medicaid spending has grown significantly



Source: MACPAC

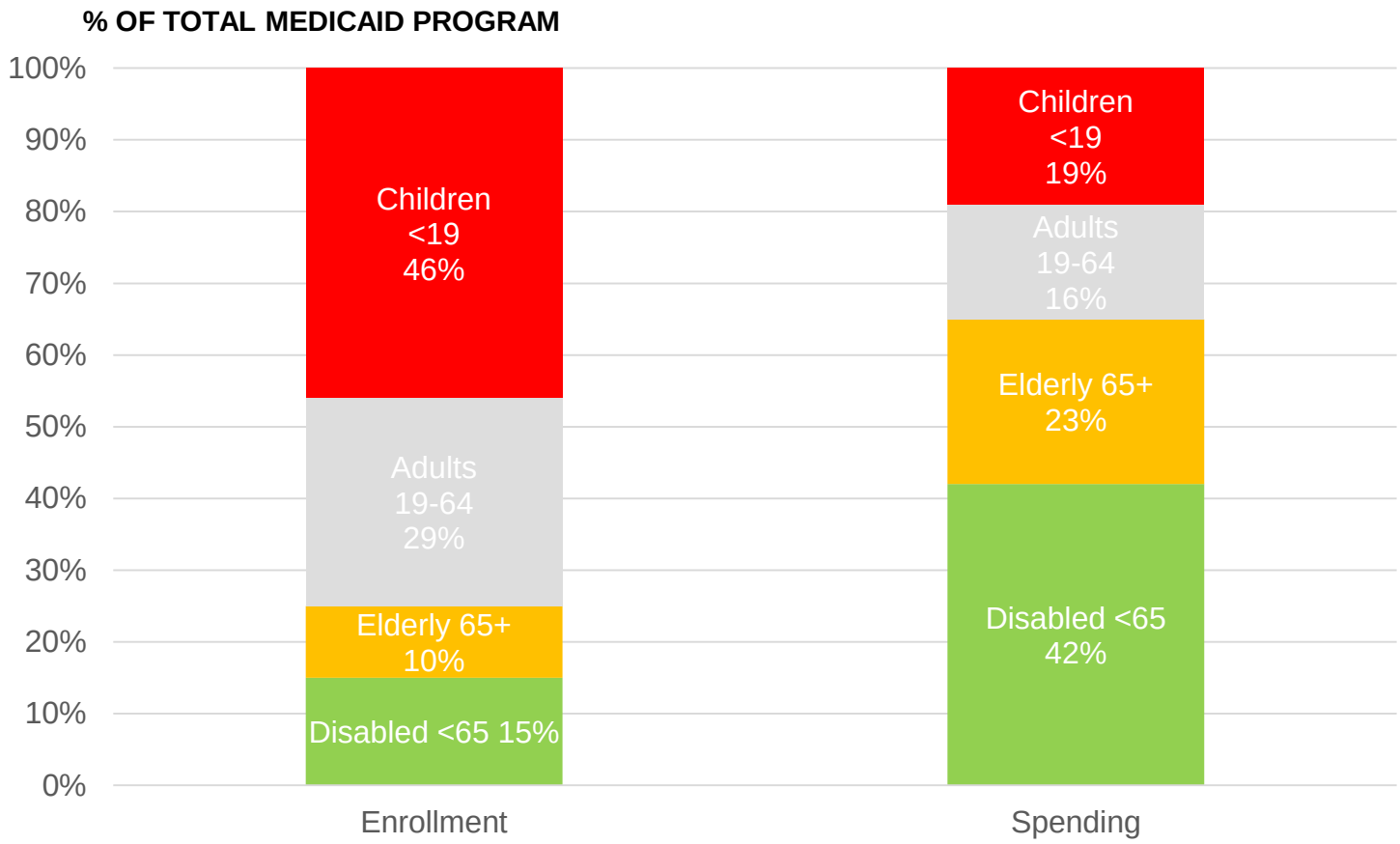
Medicaid is a significant part of the Federal Budget and of State Budgets

EXHIBIT 4. Major Health Programs and Other Components of the Federal Budget as a Share of Federal Outlays, FYs 1965–2015



Source: MACPAC

Today, most Medicaid eligibles are children; most expenditures are for the elderly and disabled



Source: Peter G Peterson Foundation, 2016

Basic Building Blocks of Medicaid

Objectives

- Describe top-level Medicaid eligibility criteria and key changes in eligibility since the ACA
- Describe core Medicaid benefits
- Describe the two primary service delivery models for the Medicaid program
- Understand the overall scale of the program within the context of the larger health care sector

Medicaid Eligibility

Medicaid eligibility is complicated.

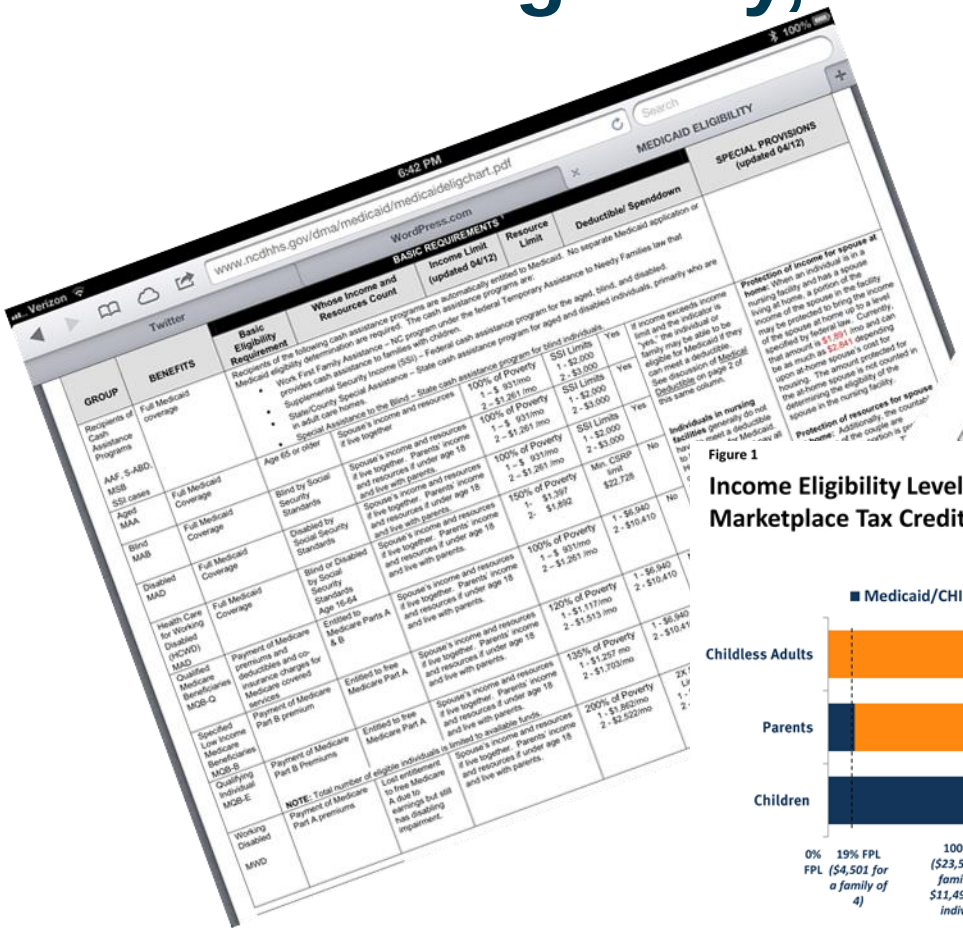
Pre ACA

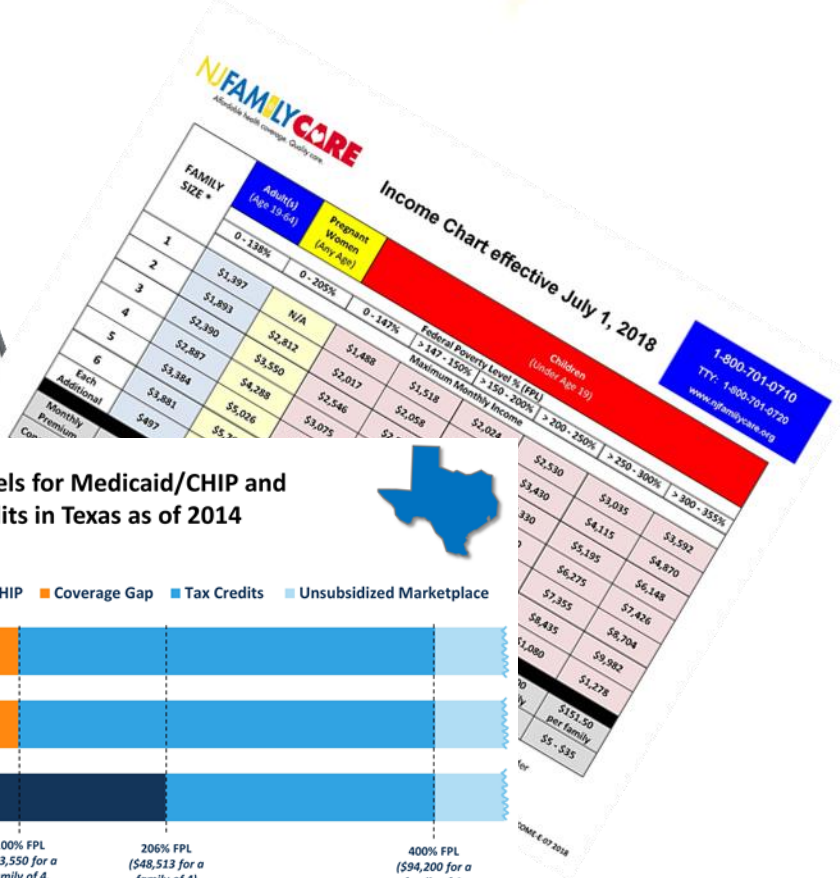
- Until the ACA, adults without children were generally not eligible (no matter how poor), unless elderly or disabled
- Until the ACA, low-income adults with children were generally not eligible, unless they had very low income
- Undocumented immigrants are ineligible for Medicaid, except for emergency services

Post ACA

- Expansion to adults with incomes up to 138% FPL
- Aligned states' minimum Medicaid eligibility threshold for children at 138% FPL
- Standardized how income is determined for Medicaid eligibility ("MAGI")
- Undocumented immigrants are ineligible for Medicaid, except for emergency services

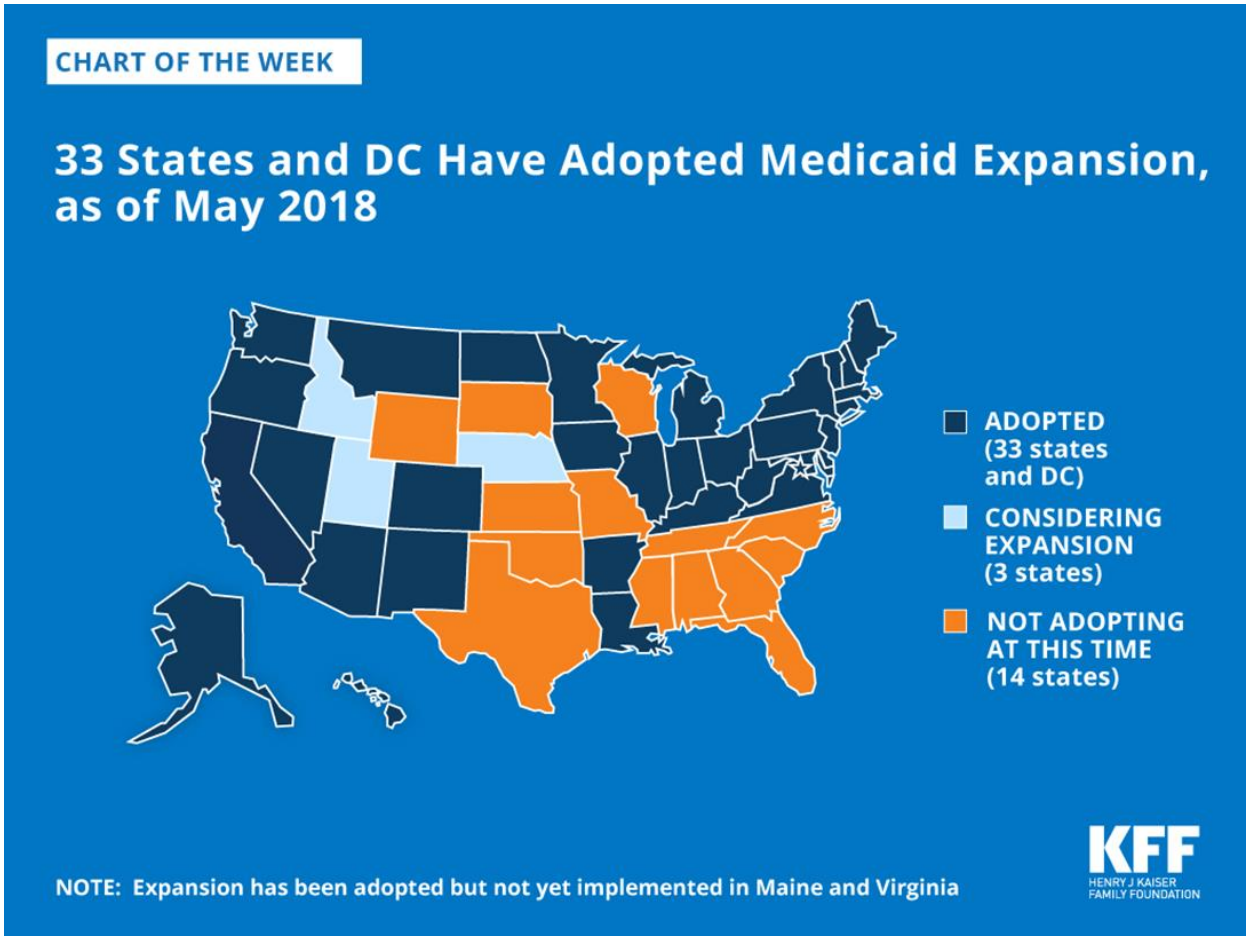
Medicaid Eligibility, continued





Notes: Medicaid eligibility is based on current Medicaid eligibility rules converted to MAGI. Applies only to MAGI populations. Medicaid eligibility levels as a share of poverty vary slightly by family size; levels shown are for a family of four. People who have an affordable offer of coverage through their employer or other source of public coverage (such as Medicare or CHAMPUS) are ineligible for tax credits. Unauthorized immigrants are ineligible for either Medicaid/CHIP or Marketplace coverage.
Source: Kaiser Family Foundation analysis based on 2014 Medicaid eligibility levels.

Medicaid eligibility - Expansion



Medicaid Eligibility - Criteria

General Qualifying Criteria
Citizenship (or certain non-qualified citizens)

Eligibility Category

Mandatory	Optional

Financial Eligibility

Medicaid Eligibility – Mandatory vs. Optional

Mandatory Eligibility Groups	Optional Eligibility Groups
Pregnant women	Childless adults*
Children	Mandatory groups above income thresholds
Parents	Medically needy
Elderly individuals	
Individuals with disabilities	

** Under the ACA, all adults under 138% FPL were added as a categorical group; the subsequent Supreme Court decision made this optional for states*

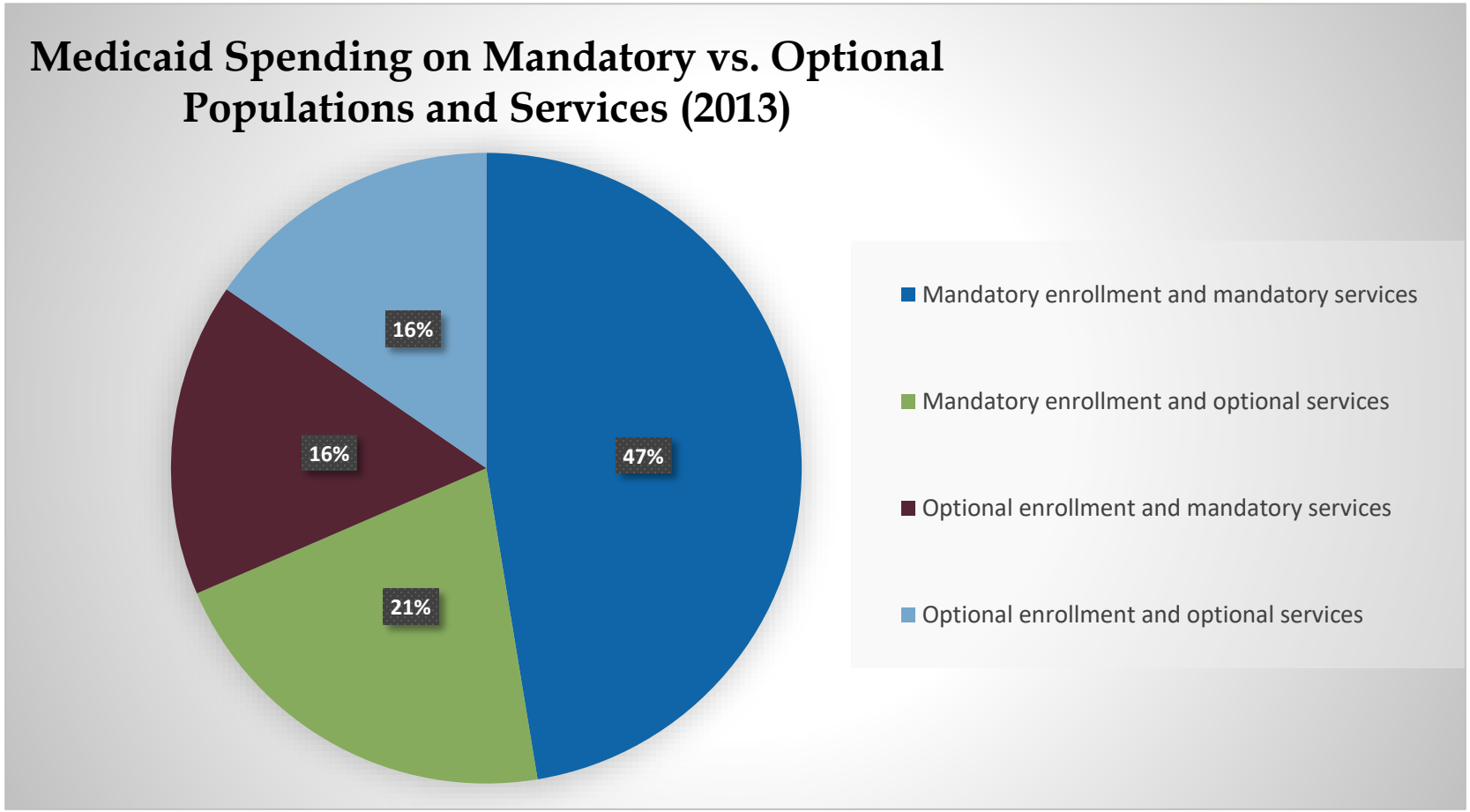
Medicaid Benefits - Mandatory

Mandatory Benefits	
• Inpatient Hospital	• Nurse Midwife Services
• Outpatient Hospital	• Freestanding Birth Center Services
• Early & Periodic Screening, Diagnostic and Treatment Services	• Certified Pediatric and Family Nurse Practitioner services
• Nursing Facility	• Transportation to medical care
• Home Health	• Tobacco cessation counseling for pregnant women
• Physician	
• Rural Health Clinics/FQHCS	
• Lab and X-ray	
• Family Planning	

Medicaid Benefits - Optional

Optional Benefits (selected)	
Prescription drugs	Optometry
Physical therapy	Dental services
Occupational therapy	Dentures
Speech, hearing and language services	Prosthetics
Respiratory care services	Eyeglasses
Podiatry	Chiropractic services
Private duty nursing services	Hospice

Medicaid Spending

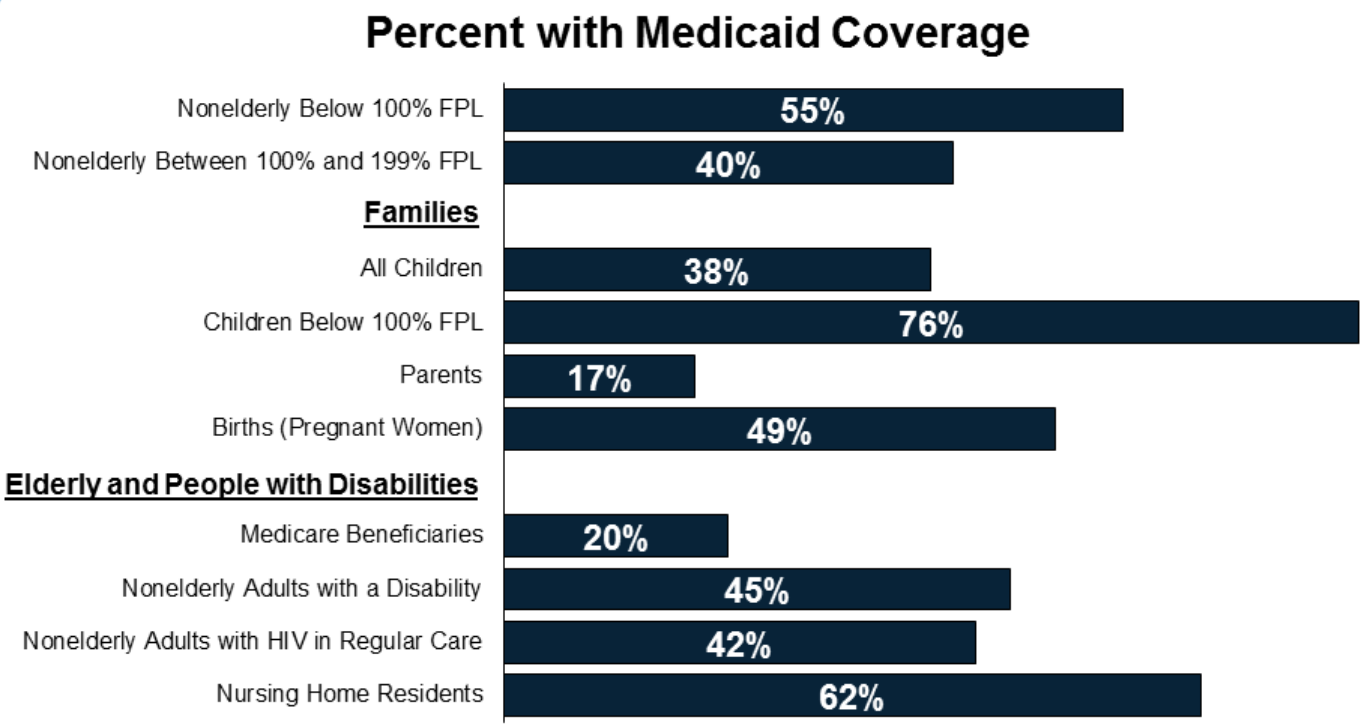


Medicaid Service Delivery

- Medicaid is publicly financed, but it is not "government-run" health care.
- State Medicaid programs have historically paid for services through two models (or a combination of the two):
  - Fee-for-service
  - Direct contracts with Medicaid providers
  - Payment based on utilization of a service
  - Risk-based managed care
  - Managed care entities paid a fixed amount to provide covered services
- The majority of Medicaid beneficiaries now receive services through a managed care plan.
- A variety of newer delivery system reforms and payment models are now emerging across the country, some of which we will touch on later today.

Medicaid Program Scale

Medicaid's role for selected populations.



NOTE: FPL-- Federal Poverty Level. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was $19,318 in 2016.
SOURCES: KFF analysis of 2017 Current Population Survey, Annual Social and Economic Supplement; Birth data -Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, KFF, October 2016.; Medicare data - Medicare Payment Advisory Commission, *Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid* (January 2018), 2013 data; Disability - KFF Analysis of 2016 ACS; Nonelderly with HIV - 2014 CDC MMP; Nursing Home Residents - 2015 OSCAR/CASPER data.

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Medicaid Program Changes

- States have substantial flexibility in designing their Medicaid programs
- States may continually make changes to their programs – within the limitations of federal law and regulation – via “State Plan Amendments”
- States may request “waivers” of certain Medicaid requirements; conditions apply

Program Demonstrations and Innovations

Objectives

- Describe Medicaid program and related federal waivers as mechanisms to give states greater flexibility to innovate
- Outline 1115 Medicaid waivers

What is a Medicaid Waiver?

- State Medicaid programs must comply with federal requirements, but **states seeking additional flexibility** can apply for formal waivers of some rules from the Secretary of Health and Human Services (HHS)
  - Test new payment/delivery approaches, expand coverage, pursue priorities
  - Time limited and can be renewed
  - More flexibility than amending State Plan

Section 1115 Medicaid Demonstration Waivers

Under Section 1115 of the Social Security Act, the HHS Secretary may waive certain Medicaid/CHIP requirements, providing more flexibility to states

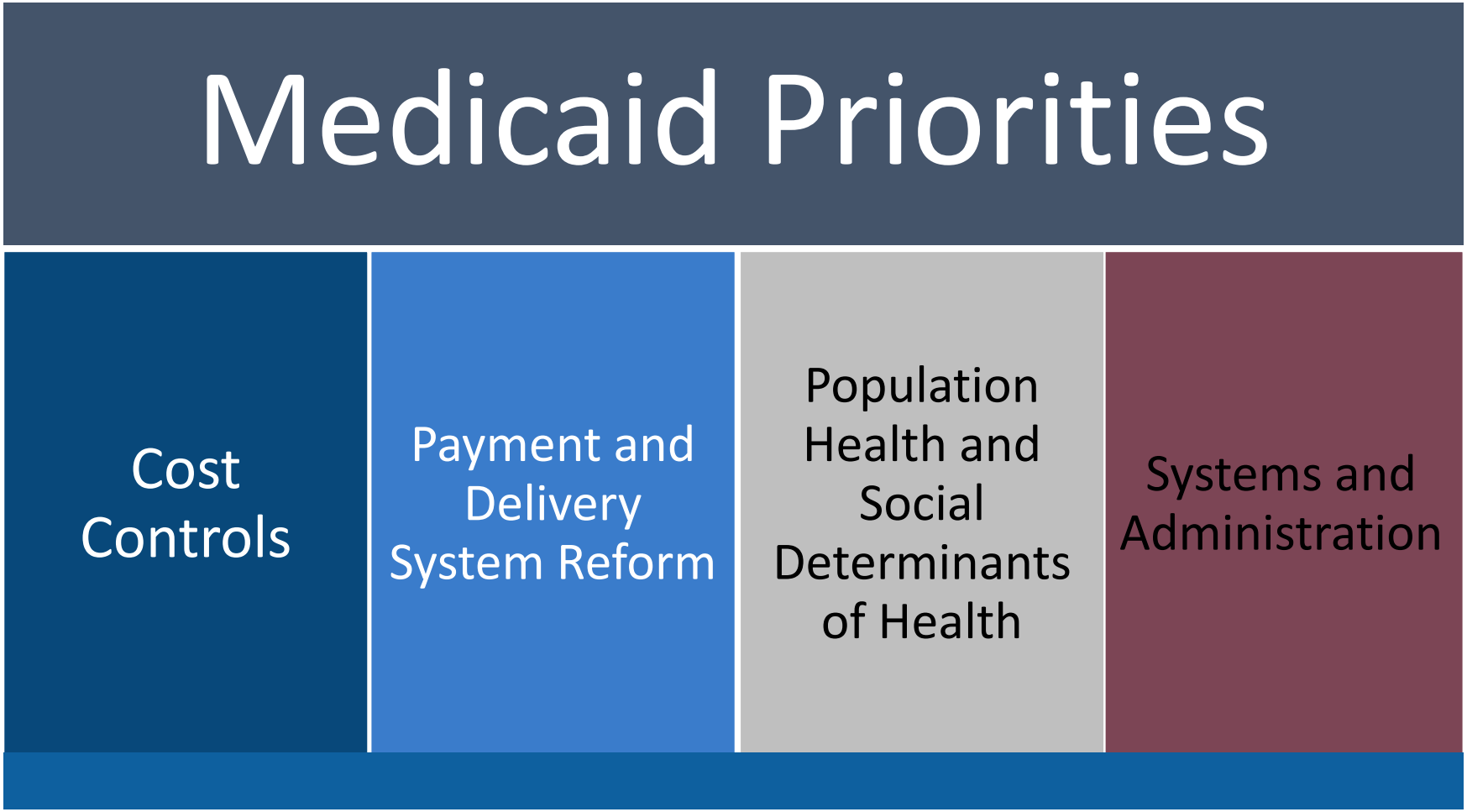
- States request authority from CMS/HHS to waive Medicaid rules
- Must promote objectives of Medicaid program
- Must be budget neutral to the federal government
- Must have transparency, public input, and evaluation

1115 Waiver, cont.

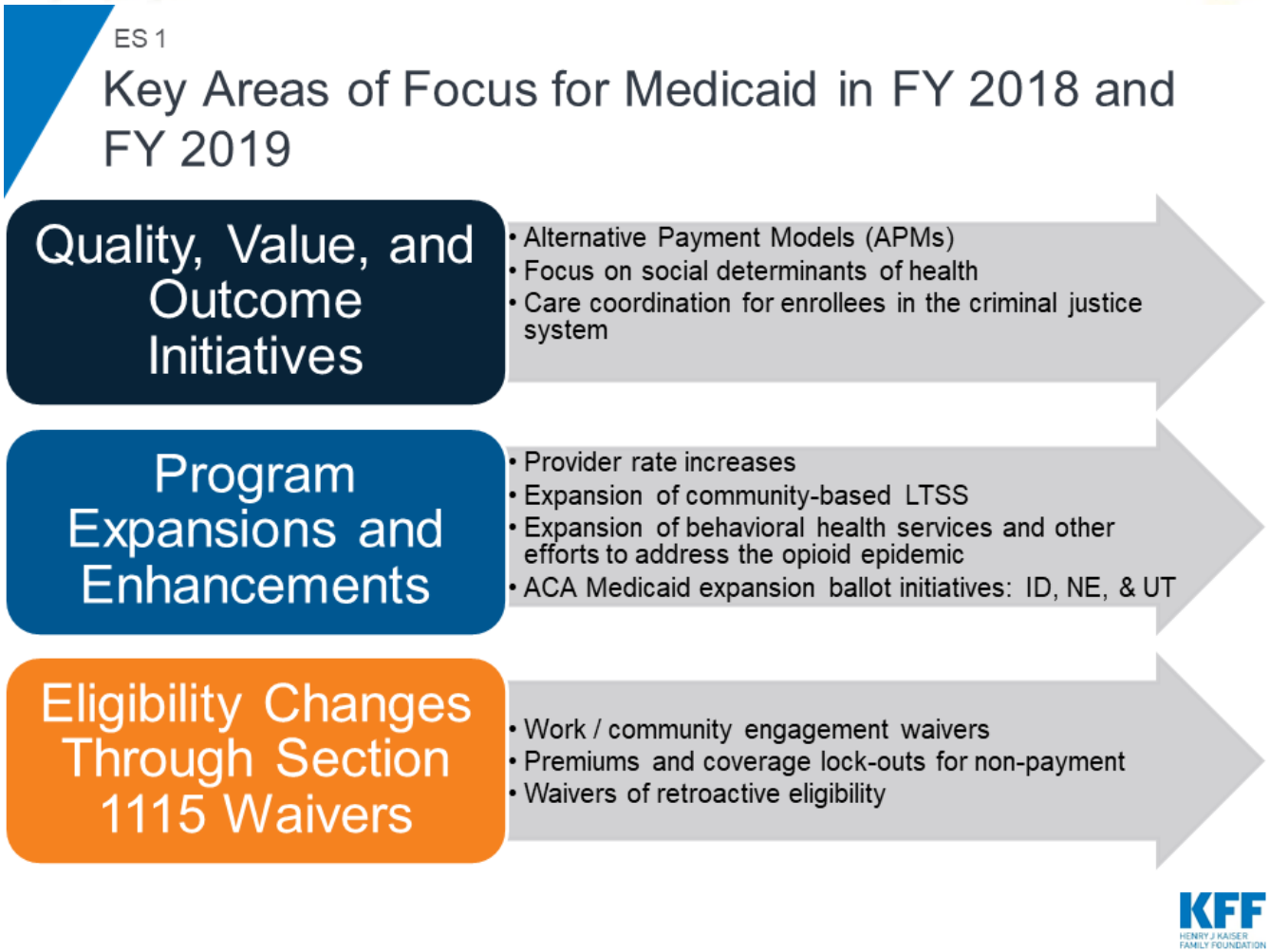
- **Comprehensive or Global waivers**: make broad changes in eligibility, benefits, cost-sharing, provider payments, mandated managed care
- **Narrower waivers**: focus on specific services or groups (e.g., ACA Expansion population) or address emergencies (e.g., Flint water crisis)
- Typically approved for 5 years with 3-year extensions
  - Recently considering 10-year extensions
  - May request amendments
- As of July 26, 2018, 37 states currently have 45 approved 1115 waivers, 21 states have 22 pending and 1 state has 1 waiver invalidated by court

Current Medicaid Priorities

Key Priorities 2018



Key Priorities 2019



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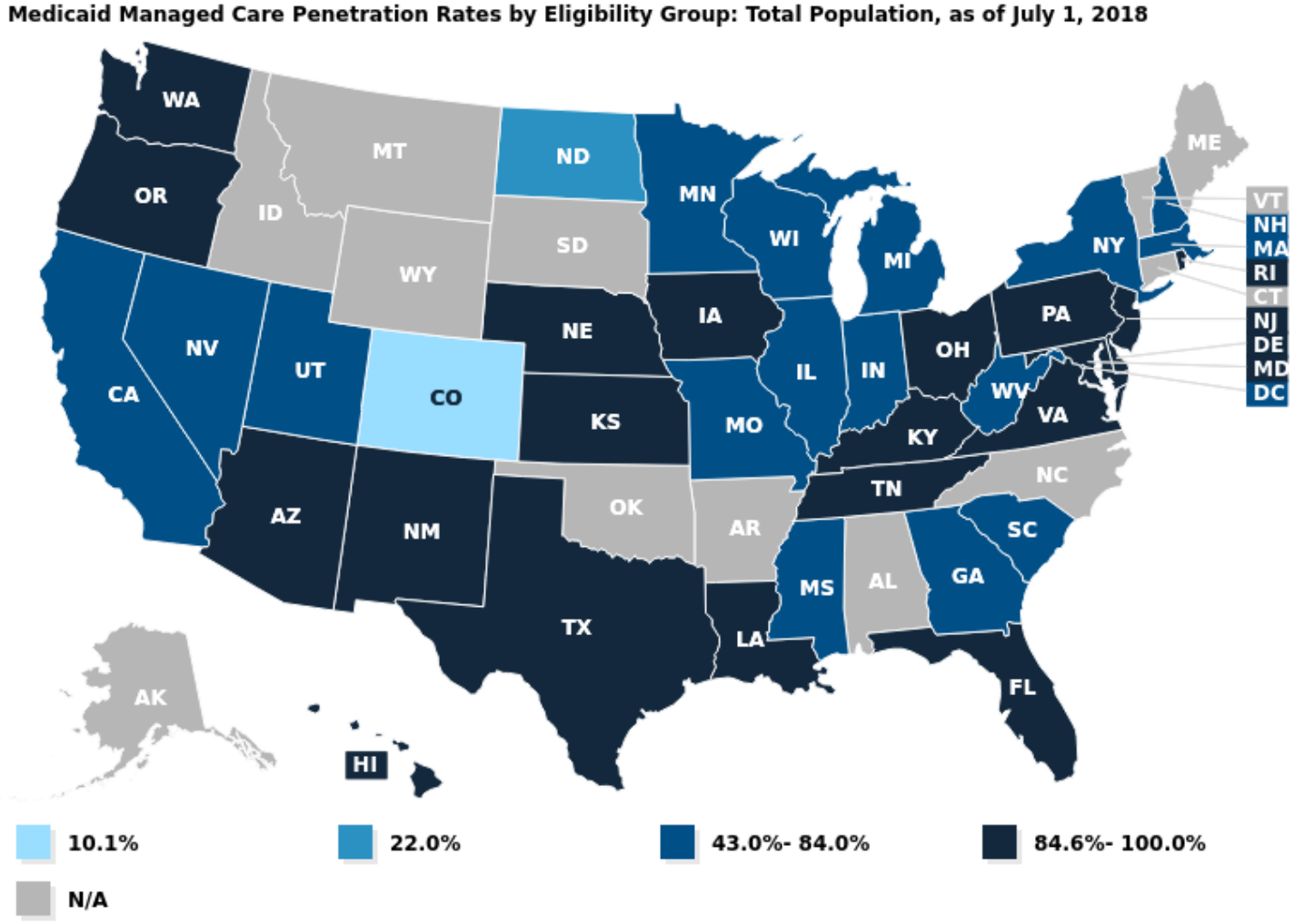
Privatizing Medicaid: Medicaid Managed Care

Objectives

- Gain an understanding of the role of managed care organizations (MCO) in delivering Medicaid benefits
- Learn about the requirements that govern Medicaid Managed Care programs
- Discuss State priorities for their Managed Care partnership
- Learn about State strategies for deploying Medicaid Managed Care

Medicaid Managed Care by State



SOURCE: Kaiser Family Foundation's State Health Facts.

Medicaid Managed Care – Experience

- Medicaid agencies retaining risk for only the most complex beneficiaries is an economically poor insurance design
- The overall results of managed care are positive:
  - Health plans can be hired and fired - Accountability
  - Outcomes are up – Quality
  - Costs are reasonably well under control – Cost/Efficiency
- However, health plans mainly do what Medicaid has always done:
  - Develop vast networks of independent providers
  - Operate FFS payment systems

Medicaid MCO Requirements

Medicaid MCOs are governed by Federal, State, and contractual requirements.

- Federal – The Social Security Act and Federal Regulation – Medicaid and CHIP Managed Care Final Rule
- State – Statutes and regulations
- Contract Requirements – State MCO contracts, reporting requirements, and service level agreements

MCOs: How States Choose Plans

- Competitive RFPs
  - Increasingly competitive
  - Resource intensive (for plans and States)
  - Prone to protests
  - Proposals incorporated into contract (states may get more value from competitively bid contracts)
- Application Process
  - Allow any qualified plan
  - May be rolling, or defined application timeframes (States can open/close application process)
  - May result in large number of plans making oversight by the state more resource intensive

MCO Role in Key State Initiatives

- Payment reforms
- SDOH
- Medicaid reforms
- Must demonstrate improvement in outcomes

MCOs and Social Drivers of Health

Social Drivers of Health (SDOH)

"The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national, and local levels." (World Health Organization)

In other words, things such as our *neighborhoods, schools, food, culture, race, etc*. all have a significant influence on health and wellbeing.

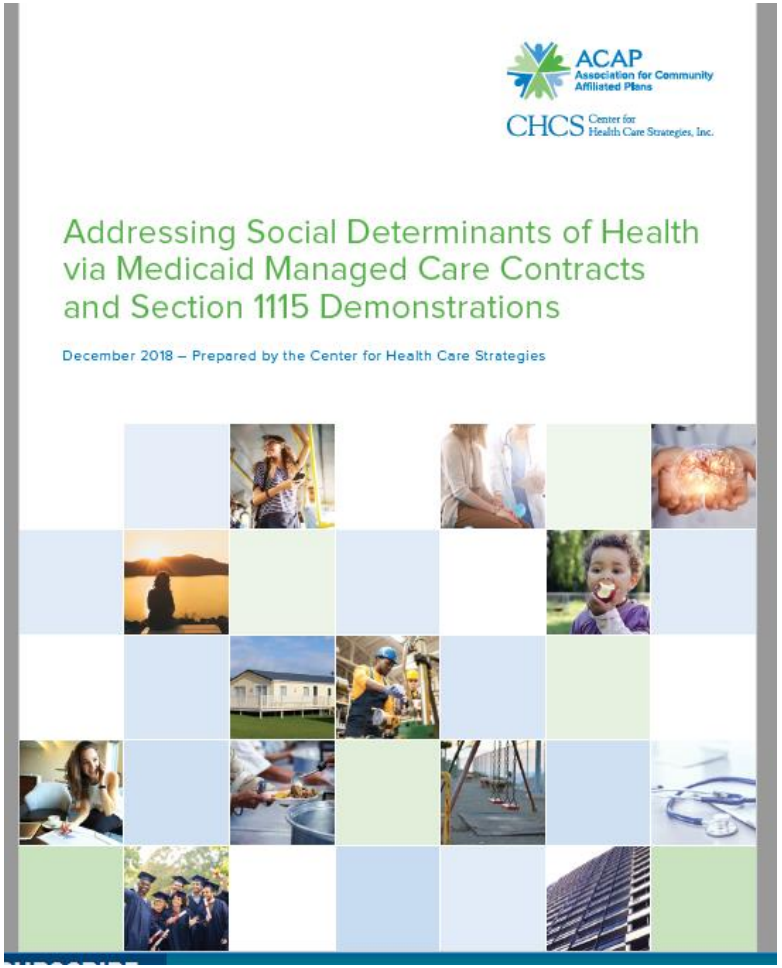
- **SDOH disproportionately affect low-income individuals, many of whom are Medicaid beneficiaries**
- **SDOH are recognized as key drivers to Medicaid enrollee health status and health care costs**

MCOs and SDOH

State Medicaid agencies are using two policy levers drive the adoption of strategies to address SDOH, improve health outcomes, and lower costs:

1. Contractual requirements
2. 1115 Waivers

We will focus on contractual requirements for the remainder of this presentation.



Contractual requirements related to SDOH

1. Care coordination and care management
2. Quality Assessment and Performance Improvement
3. Value-based Payment arrangements
4. Additional Services

MCO Care Coordination and Management

What is Care Management?

Activities that assist patients and their support systems to manage medical and psychosocial problems with the aim of improving health and reducing the need for expensive medical services

The goals are to:

- Improve patients' functional health status
- Enhance coordination of care
- Eliminate duplication of services
- Reduce the need for expensive medical services

MCO Care Coordination/Management

Key Components to Address SDOH

- **Screening to stratify member population from low to high risk**
  - **Particularly for higher risk members, screening for SDOH occurs**
- **Linking members to community and social supports**
  - **For members identified as higher risk, part of care coordination includes referring and linking members to community and social support providers**

MCO Quality Assessment and Performance Improvement (QAPI)

What is QAPI?

- Activities to measure and track member-related utilization and outcomes to identify need and improvement.
- MCOs must have a comprehensive QAPI program.
- Some SDOH-related data is tracked to identify health disparities and root causes of those disparities.
- From this tracking, when a need is identified, MCOs develop an intervention to address it.

MCO Value-based Payment (VBP) Initiatives

What is VBP?

- VBP is the shift from paying for volume to paying for value. Associated with the **Triple Aim** to improve outcomes and patient experience, which reducing cost of care.
- States are requiring MCOs to enter into contractual agreements with their network providers that pay providers to improve patient outcomes and lower cost.
- For example, payments could be based on the % of improved A1c for diabetics in the member population or a reduction in Emergency Room visits among their high-risk members.

MCO Additional Services

What are Additional Services?

- There are two types: Value-added Services (VAS) and *In lieu of* services..
- MCOs may provide VAS as additional benefits offered to their members that are not reimbursed for or included in the development of capitation rates.
- *In lieu of* services are medically appropriate and cost-effective substitute for a covered service. These are considered in development of capitation rates.

Waivers and SDOH

Case Studies:
MCO Contracts and 1115 Waivers

Objectives

- Review two case studies in which state Medicaid agencies address SDOH through MCO contractual requirements or 1115 Waivers
  - North Carolina
  - Oregon

North Carolina's SDOH Strategy

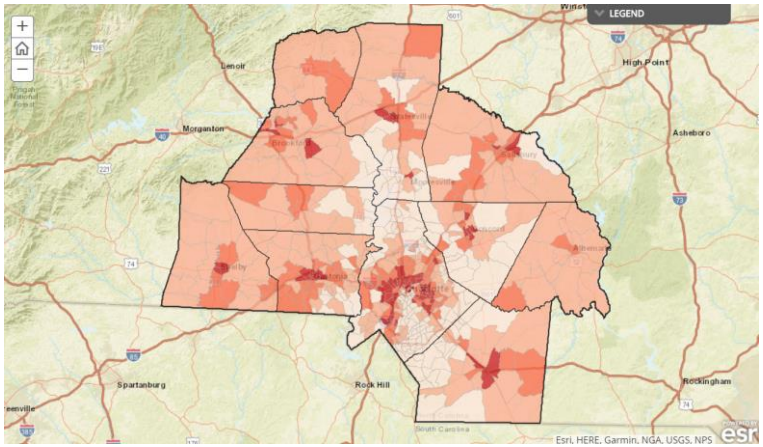
NC issued an RFP that requires MCOs to address SDOH in:

- Care coordination and management
- QAPI
- VBP
- Additional Services

NC developed tools to support MCOs in addressing SDOH:

- Resource referral database
- Hot spot map to identify needs and gaps in resources
- SDOH screening with targeted questions on food, housing, transportation, and interpersonal safety

NC SDOH Hot Spot Map



NC 2018 Medicaid RFP/Contractual Requirements

Vision for NC Medicaid Managed Care Program

a) Delivering whole-person care through the coordination of health, behavioral health, **addressing unmet health-related resource needs** and I/DD care models with the goal of improved health outcomes and more efficient and effective use of resources

b) Utilizing cost-effective resources and uniting communities and health care systems to address the **full set of factors that impact health**

c) Performing **localized care management at the site of care, in the home or in the community** where face-to-face interaction is possible to build on the strengths of North Carolina's care management infrastructure

NC SDOH Screening Tool

Health Screening

We believe everyone should have the opportunity for health. Some things like not having enough food or reliable transportation or a safe place to live can make it hard to be healthy. Please answer the following questions to help us better understand you and your current situation. We may not be able to find resources for all of your needs, but we will try and help as much as we can.

	Yes	No
Food		
1. Within the past 12 months, did you worry that your food would run out before you got money to buy more?		
2. Within the past 12 months, did the food you bought just not last and you didn't have money to get more?		
Housing/ Utilities		
3. Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e. couch-surfing)?		
4. Are you worried about losing your housing?		
5. Within the past 12 months, have you been unable to get utilities (heat, electricity) when it was really needed?		
Transportation		
6. Within the past 12 months, has a lack of transportation kept you from medical appointments or from doing things needed for daily living?		
Interpersonal Safety		
7. Do you feel physically or emotionally unsafe where you currently live?		
8. Within the past 12 months, have you been hit, slapped, kicked or otherwise physically hurt by anyone?		
9. Within the past 12 months, have you been humiliated or emotionally		

NC Contractual Requirements: QAPI and Additional Services

MCOs QAPI Plan must include:

- Mechanisms to assess and address health disparities, including findings from the disparity report that MCOs are required to develop
- Contributions to health-related resources in alignment with improvement in health outcomes outlined in the quality strategy.

MCOs Additional Services :

- Encourages the MCO to voluntarily contribute to health-related resources, and if they do, the resources may count the contributions toward the numerator of its MLR.
- Encourages the use of *in lieu of* services to finance services that improve health through connecting members with resources, social services, and other supports upon receipt of state approval.

NC 1115 Waiver

Pilot Program for enhanced case management and other services

MCOs must work with the state authorized “lead pilot entity” and participate in the pilot program with services that provide assistance with linkages, but can include actual services and support for:

- Housing
- Food
- Transportation
- Interpersonal Violence/Toxic Stress

In December 2023, the state will submit a plan to CMS outlining “how the state anticipates it will incorporate effective pilot program services into its managed care program.”

Oregon Medicaid Managed Care Program

Coordinated Care Organizations (CCOs)

A **coordinated care organization** is a network of all types of health care providers (physical health care, addictions and mental health care and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and helping people manage chronic conditions, like diabetes. This helps reduce unnecessary emergency room visits and gives people support to be healthy.

Oregon Medicaid Managed Care Program

1115 Waiver

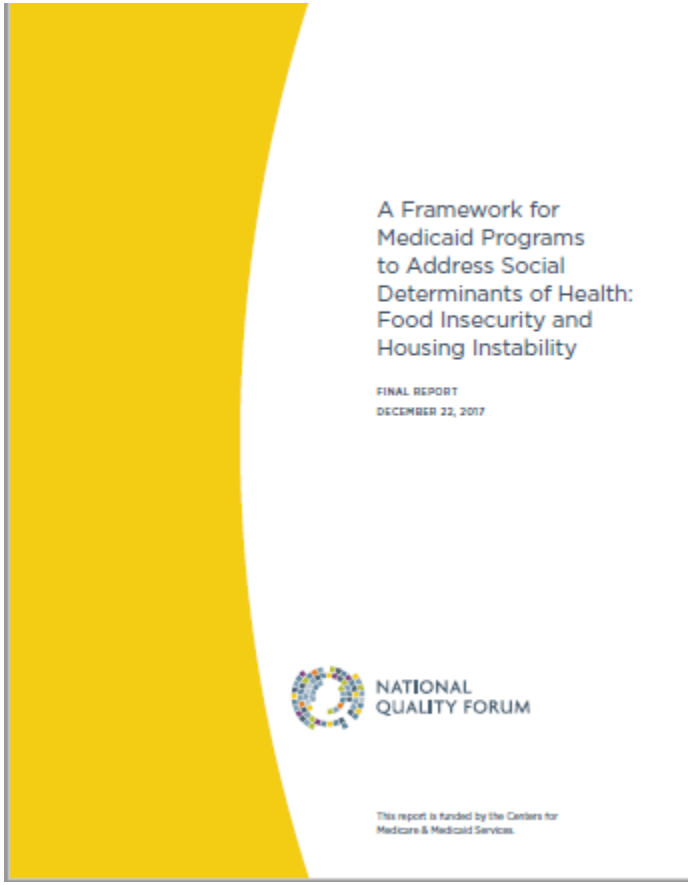
- Under an **1115 waiver,** Oregon uses its Medicaid dollars for health-related supportive services like education/job training and self-help/support groups.
- Oregon's Health Authority has also developed **a provider-level food insecurity screening performance measure** that CCOs can choose for reporting and accountability.
- Oregon Health Authority uses CCOs through the 1115 Medicaid waiver authority to pay for services offered by a diverse group of stakeholders including **community health workers, peer wellness specialists, and patient navigators**.
- CCOs cover services that provide **housing supports and assistance with food and other social resources.** This not only expands access to social services, but also significantly reduced per-member per-month inpatient and outpatient spending.

National Quality Forum Report, 2017

Food Insecurity and Housing Stability

Recommendations

- Acknowledge that Medicaid has a role in addressing social determinants of health.
- Create a comprehensive, accessible, routinely updated list of community resources.
- Harmonize tools that assess social determinants of health.
- Create standards for inputting and extracting social needs data from electronic health records.
- Increase information sharing between government agencies.
- Expand the use of waivers and demonstration projects to learn what works best for screening and addressing SDOH.



Meals on Wheels Programs…
Prepare to leverage this movement!

What you know now

- State Medicaid Agencies and MCOs are going to want and need to ***work with you***
- Medicaid programs have started to and will increasing incorporate requirements for ***MCOs to develop strong and meaningful relationships with community-based organizations*** for SDOH-related services
- This will likely include ***opportunities for reimbursement*** of services, particularly when cost-effectiveness and reduction of cost of care is demonstrated

What can you do to prepare?

Arm yourself with evidence-based research that demonstrates how ***your services reduce the cost of care***.

Small Intervention, Big Impact:

Health Care Cost Reductions Related to Medically Tailored Nutrition

Food is a critical aspect of health care for people living with illnesses like congestive heart failure, chronic obstructive pulmonary disease, and diabetes. Unfortunately, lack of disease-specific nutrition knowledge, low energy, and financial constraints due to hospital bills, co-pays, emergency department visits, and medications can make eating right especially challenging for people managing illness. Many end up being hospitalized due to malnutrition or other nutrition-related complications.

What happens when people living with chronic illness have access to home-delivered, medically tailored meals? Research shows this approach has the potential to reduce total health care costs for patients, insurance companies, and communities alike.

What impacts health the most?

When it comes to health, the quality of your health care matters. But research shows that medical care accounts for only a small fraction of overall health. Other factors, like where you live and what you eat, can have far greater impact.

What is a medically tailored meal?

Medically tailored meals are meals approved by a registered dietitian nutritionist that use evidence-based guidelines to ensure positive health outcomes.

What can you do to prepare?

Get to know your state Medicaid program.

- Medicaid agency priorities
- People – Director, Advisory Committees, etc.
- RFP cycle and scope of services
- Waiver services affecting your populations
- State Requests for Input (RFIs)
- Existing relationships with MCOs and MOW or other community-based organizations

What can you do to prepare?

Join the conversation!

- Respond to public comment opportunities
- Submit responses to RFIs
- Establish relationships with MCOs in your area
- Establish coalitions with other community-based organizations

What can you do to prepare?

Understand MCOs and contracting processes

- Prepare to analyze and negotiate contracts with MCOs
- Know the full costs of your services
- Be ready to track data on program participation and outcomes to ensure you can demonstrate value
- Consider offering bundled services with other related service providers

Questions?

Don’t forget to evaluate today’s session in the Conference App!