Medicaid Overview

Presentation to the Legislative Committee on Senior Citizens, Veterans and Adults with Special Needs

May 15, 2012

EXHIBIT F **Meeting Date: 5-15-12**
Senior Citizens, Veterans and Adults With Special Needs (NRS 218E.750)
Document consists of 27 pages.
Entire Exhibit provided.

Medicaid – Unique by State

- If you've seen one Medicaid program, you've seen one 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 another state.
  - Rules governing services and eligibility are defined in each state's Medicaid State Plan. The State plan is negotiated between the State and the federal Center for Medicare and Medicaid Services (CMS).
  - Changes to the State Plan are done through a negotiated process with CMS called a State Plan Amendment.

Medicaid – Publicly Financed but Private Sector Services

- Publicly Financed but not a Government Run Healthcare Delivery System
- Medicaid procures almost all services in the private health care market through purchasing services on a fee for service basis or through contracted managed care organizations.

Nationally

- Covers 1 in 3 Children.
- Covers 1 in 3 births (Covers maternity and prenatal care and more than 40% of all births).
- *<u>The largest source of financing for nursing home and community-based long term care.</u>*
- The largest source of funding for safety-net providers (health centers and public hospitals).
- Represents the largest source of federal funds to states.

Kaiser Family Foundation, Kaiser Commission on Medicaid and the Uninsured Key Facts March 2011

Medicaid – 5 Programs in 1

- Medicaid is the nations safety net for vulnerable populations:
  - Health coverage for low-income families;
  - Health coverage for infants, children and pregnant women in low-income households;
  - Health coverage for individuals with disabilities who may not otherwise be eligible for commercial coverage;
  - *<u>Largest source of long-term care coverage in the State; and</u>*
  - *<u>Provides supplemental coverage for low-income Medicare beneficiaries.</u>*

Nevada Categories of Coverage

- Aged (65 and over)
- Blind
- Disabled
- Pregnant women and 0 to 6 year olds
- Children ages 6 to 19 years of age
- Families with blood related and/or adopted dependent children in the home

(Note: Each group must meet specific income and asset standards to qualify)

The Medicaid/Medicare Relationship

- The Medicare program (Title XVIII of the Social Security Act) provides hospital insurance, known as Part A coverage, and supplemental medical insurance, known as Part B coverage. Coverage for Part A is automatic for persons aged 65 and older and for certain persons with disabilities that have insured status under Social Security or Railroad Retirement. Coverage for Part A or Part B may be purchased by individuals who do not have insured status through the payment of monthly premiums.

The Medicaid/Medicare Relationship (continued)

- Dual Eligibles - Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from Nevada Medicaid.
- There are various benefits available to "dual eligibles" that are entitled to Medicare and are also eligible for some type of Medicaid benefit.
  - Total Dual Eligibles: 42,967
    - Full Benefit Duals: 18,529

Medicare Rx Coverage

- Medicare Drug Coverage - The Medicare Modernization and Improvement Act (MMA) conveyed prescription drug benefits to Medicare beneficiaries under the newly created Part D Program beginning January 1, 2006.
- MMA includes a provision called the phased-down state contribution (clawback) that requires States to make payments to Medicare in exchange for federal assumption of these prescription costs.
- Clawback payment for 2012: $25,215,833

Medicaid Mandatory/Optional Services

- Mandatory services include:
  - Physician services
  - Hospital services (inpatient and outpatient)
  - Laboratory and x-ray services
  - *Nursing facility services for individuals 21 and older*
  - Early and Periodic Screening, Diagnosis, and Treatment for children under age 21
  - Federally-qualified health center and rural health clinic services
  - Family planning services
  - *Home health care for persons eligible for nursing facility services*
    - *Durable medical equipment and supplies*
  - Pregnancy related services-nurse midwife services
  - *Non-emergency Transportation services*
- Optional services include:
  - Prescription drugs
  - Nursing facility care for individuals age 20 and under
  - *Podiatric care*
  - *Adult Day Health Care*
  - Preventive and restorative care for individuals age 21 and older
  - *Home and community based waiver programs/ personal care services*
  - Dental services and dentures
  - Eye glasses

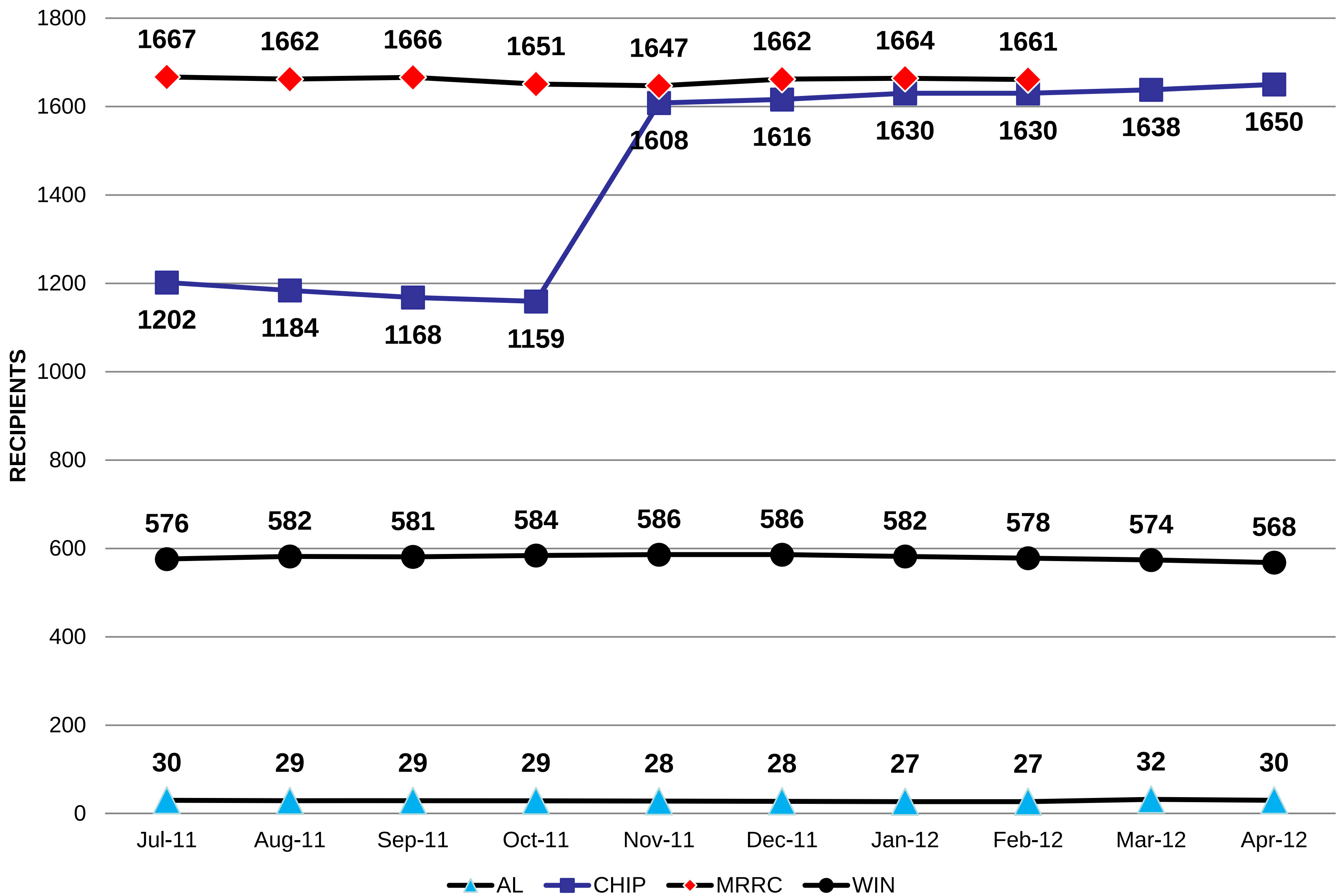
Long-Term Care Eligibility

- Financial eligibility:
  - Allowable income is 300% of the Federal Benefit Rate for Supplemental Security Income (SSI), or $2,094 per month.
  - There is also a resource limit of $2,000 for an individual.
  - Spousal Impoverishment rules allow for a minimum of $22,728.00 (up to a maximum of $113,640) in resources to be set aside for the community spouse.
- Service eligibility:
  - Person must be determined to be at a nursing facility level of care.
  - Other specific criteria apply depending on the program.

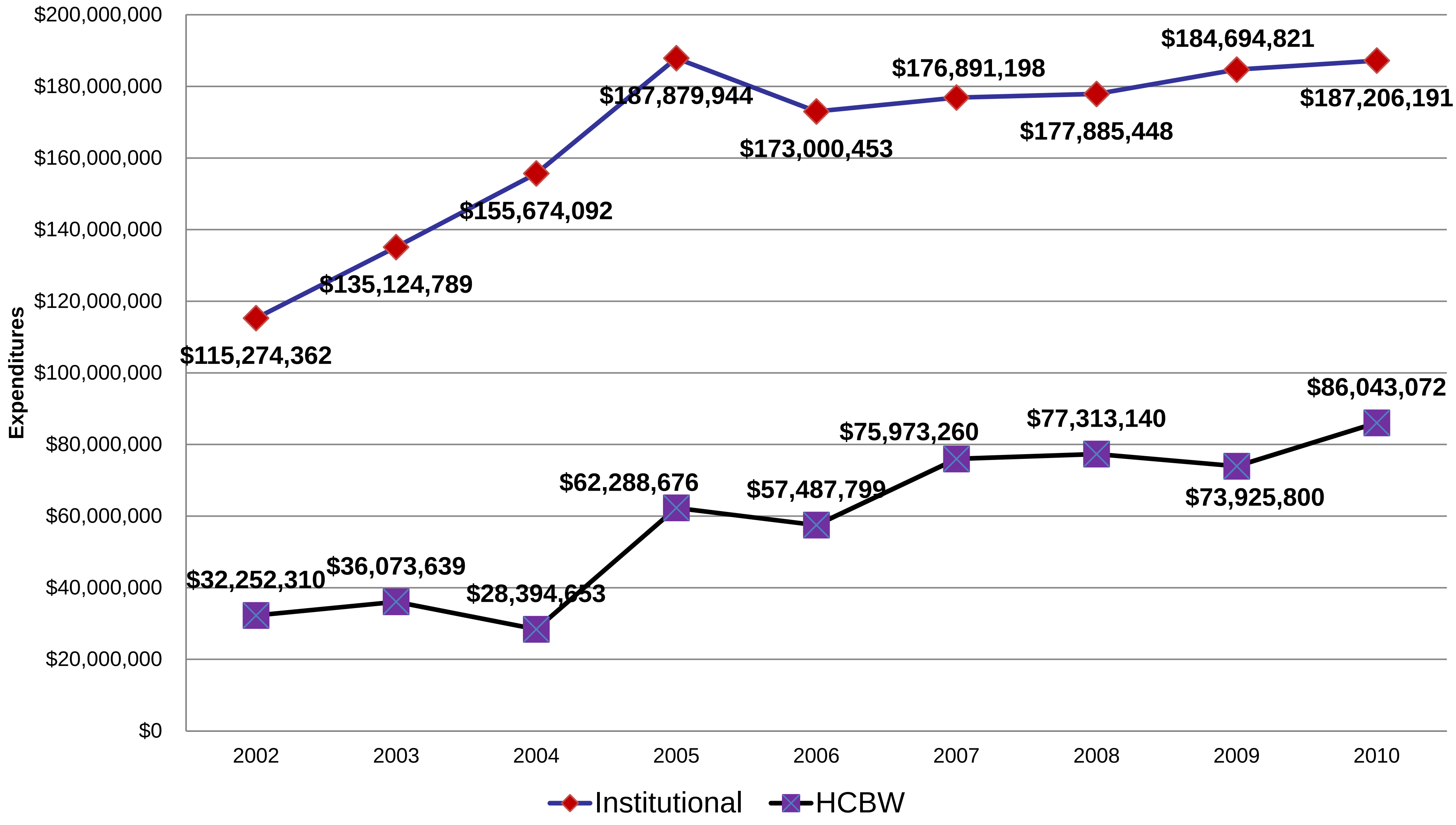
Home and Community Based Services (HCBS) Long Term Care

- Nevada Medicaid operates under four special programs, called HCBS Waiver programs. These programs allow the State to serve individuals in their homes or the community in lieu of a nursing home. Each waiver provides a special set of services for the people served. The waivers include:
  - Mental Retardation / Developmental Disabilities and Related Conditions Waiver - MHDS
  - Home and Community Based Waiver for the Elderly at Home and in Group Care – ADSD
  - Physical Disabilities Waiver – DHCFP
  - Assisted Living Waiver– ADSD
- Other home based programs
  - Adult Day Health Care
  - Habilitation/brain injury community re-integration
  - Day Treatment or Partial Hospitalization Services for Individuals with Chronic Mental Illness

Current HCBS Waiver Caseloads



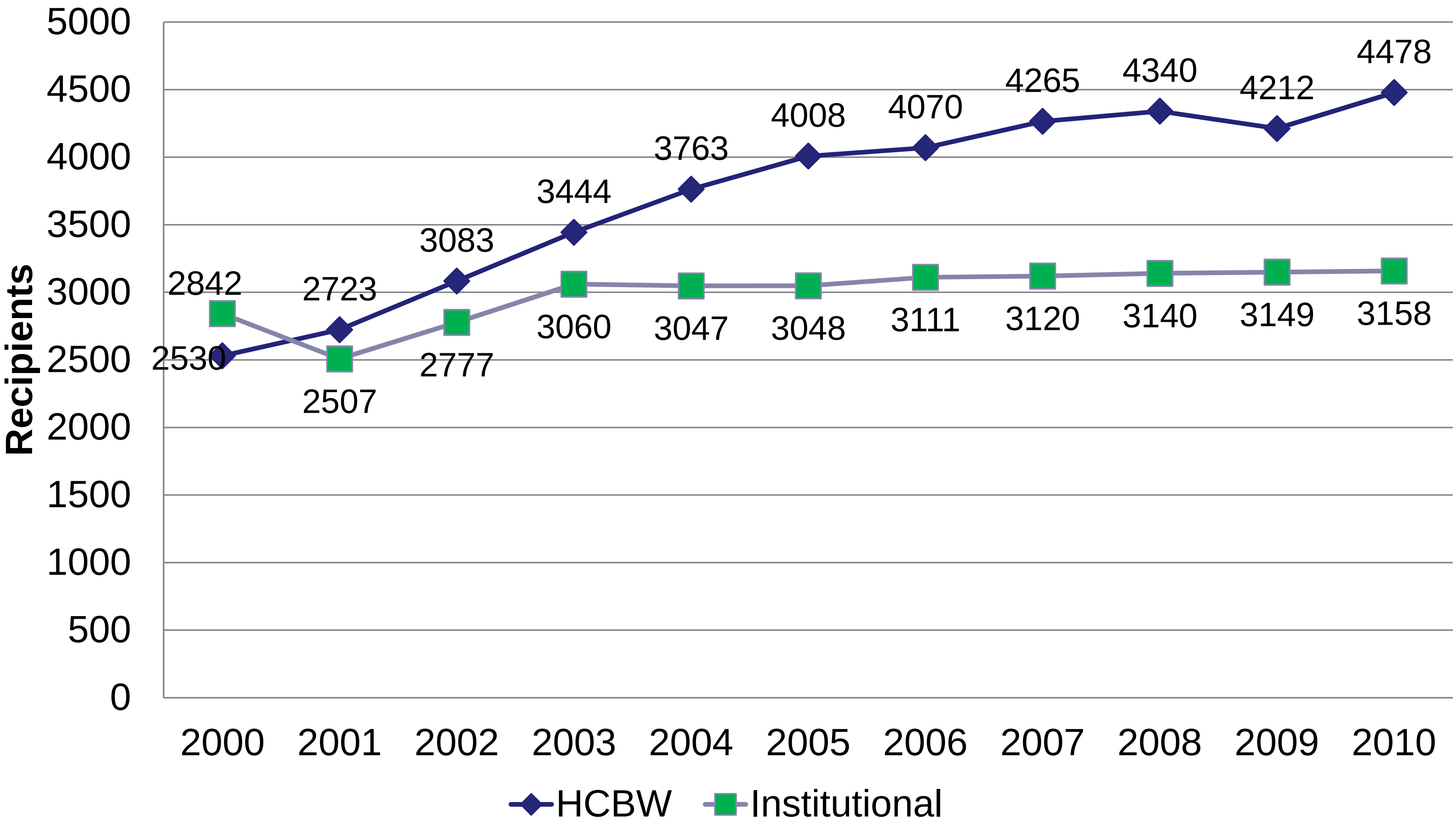
Institutional and HCBS Waiver Spending by State Fiscal Year



Nursing Facility Care

- Nursing facilities provide health related care and services on a 24-hour basis to individuals who, due to medical disorders, injuries, developmental disabilities, and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative, and psychosocial management above the level of room and board.
- Nursing facility services include services for people who cannot live on their own because they need assistance with certain activities of daily living such as bathing, dressing, eating, toileting and transferring.
- Nursing Facility Facts:
  - Total Licensed Facilities: 50
  - Total Licensed Beds: 5,971

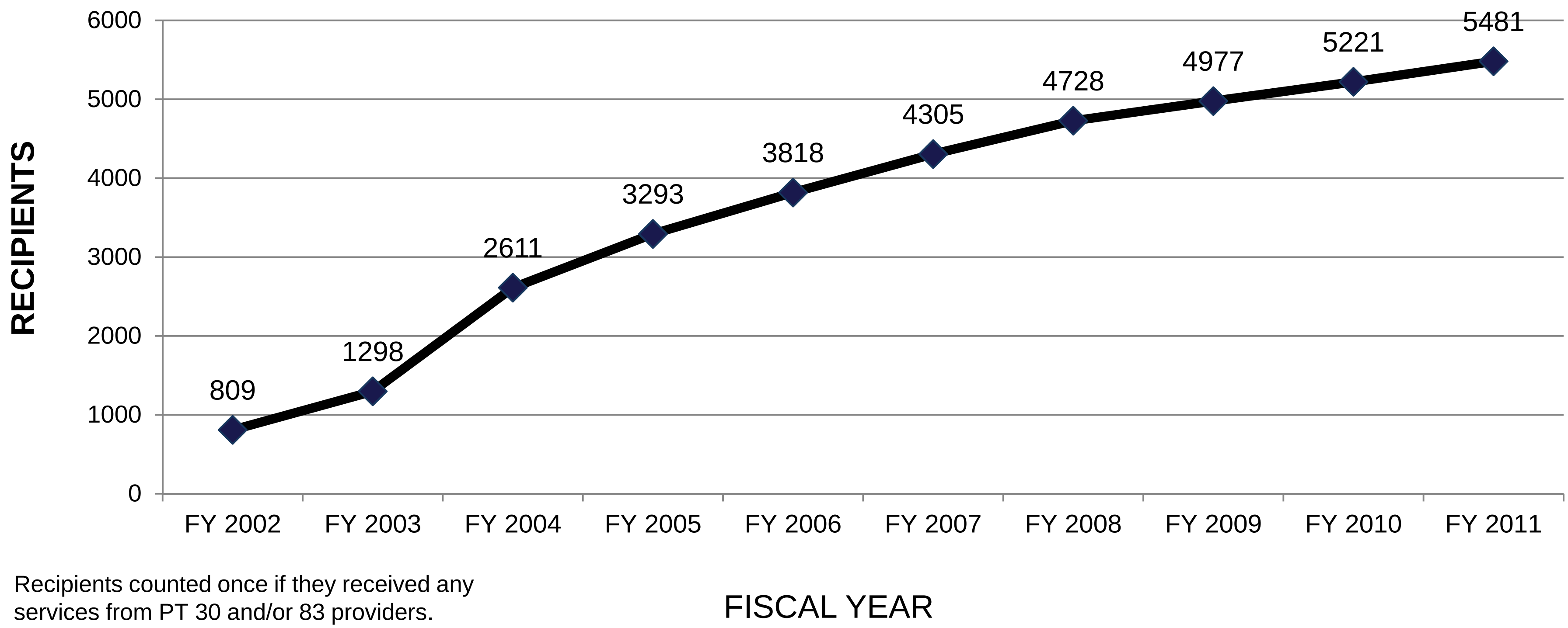
Nursing Facility Care vs. HCBS Clients



Personal Care Services

- The objective of Personal Care Services (PCS) is to assist, support, and maintain recipients living independently in their homes. PCS are also provided in settings outside the home, including employment sites.
- Services are provided by:
  - Personal Care Agencies (58)
  - Intermediary Service Organizations (8)
- A Functional Assessment is used to determine the persons ability to perform Activities of Daily Living.

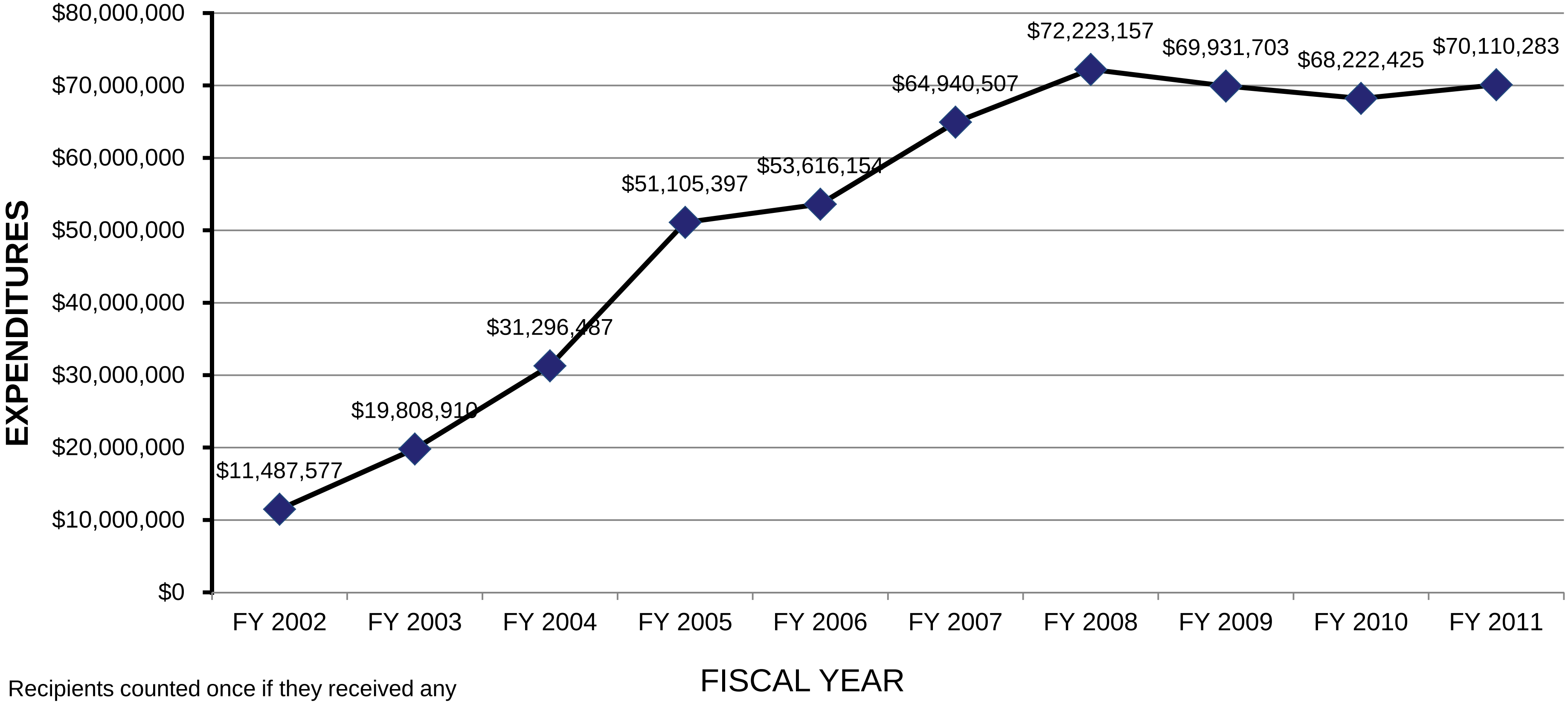
Personal Care and Intermediary Service Organization (ISO) Recipients



Recipients counted once if they received any services from PT 30 and/or 83 providers.
All statistics are estimates only and must be qualified as such if used either verbally or in written form.

May 11, 2012

Personal Care and ISO Expenditures



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Facility Oversight and Community Integration (FOCIS)

- FOCIS began as a pilot program in northern Nevada in 2002, was expanded to southern Nevada in 2003, and became available throughout the state in 2004.
- Goals of FOCIS
  - Transition recipients out of nursing facility care to the community; and
  - Divert recipients from nursing facility placement.

FOCIS (Continued)

FOCIS by Year	Transitions	Diversions
SFY 2007	163	155
SFY 2008	128	254
SFY 2009	170	188
SFY 2010	160	111

Money Follows the Person (MFP) Grant

- The MFP Grant is helping to rebalance and redesign the long-term care system. We will do the following:
  - Create an innovative long-term care services.
  - Build on the considerable success of FOCIS.
  - Develop State and Federal infrastructure.
  - Introduce national individual performance indicators.
  - Collect and analyze data
  - Transition 524 individuals over the grant term (until March 30, 2016).
  - Partnership of DHCFP, MHDS, ADSD and DHHS .
- Grant total: $9.9M

Increasing Federal Revenue for Nevada

- Nursing Facility Quality Improvement Fee
  - Projected SFY 2012 payments to Nevada nursing facilities: $176,078,596.22
  - Projected SFY 2012 Provider Tax Revenue: $27,761,034.65
  - Average Nursing Facility Standard Per Diem Rate: $116.66 (Budget reduction of $5/day – started July 1, 2011)
  - Weighted Average Equivalent Daily Rate: $186.85

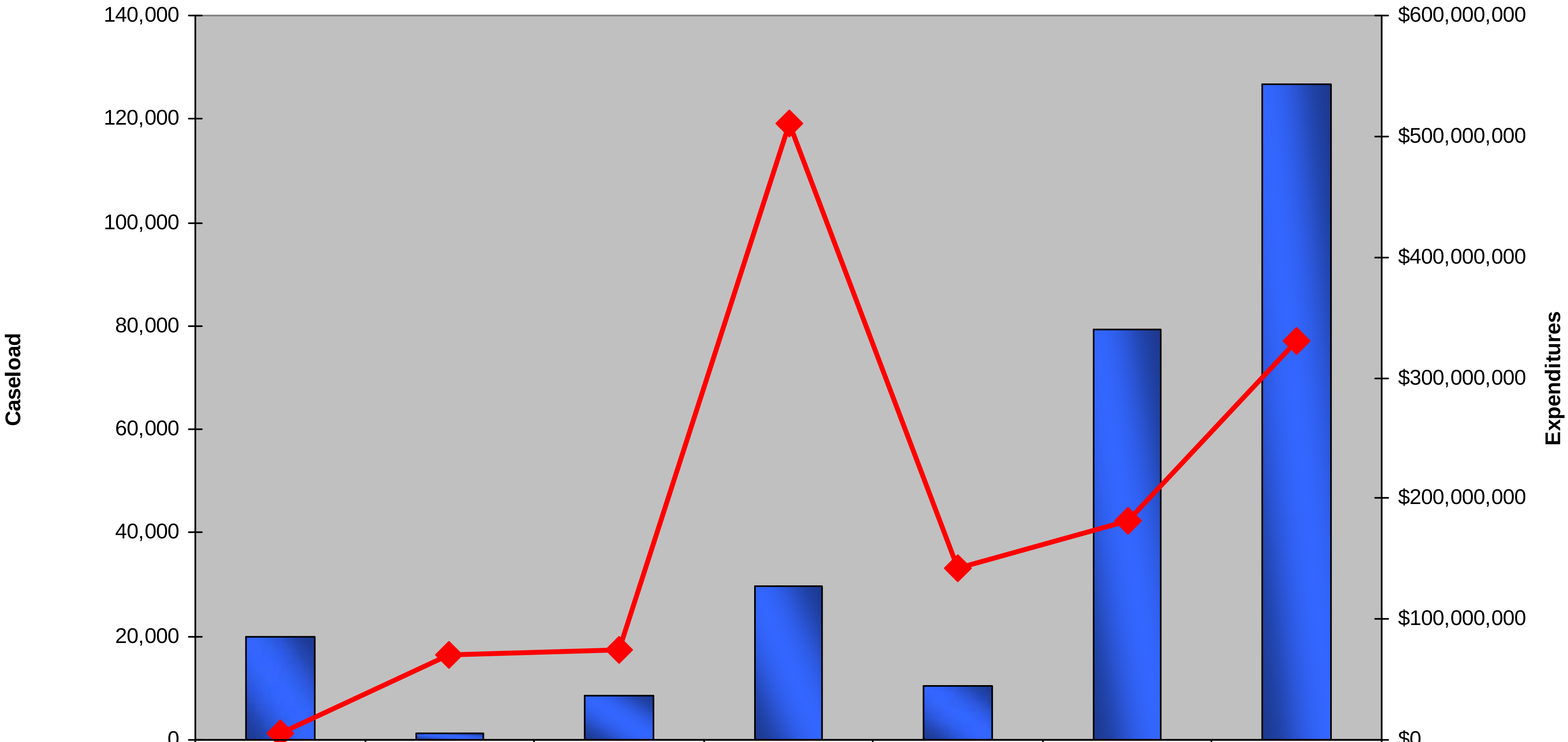
Increasing Federal Revenue for Nevada (continued)

- County Match Program
  - Effective July 1, 2011 this program supports county care of the medically indigent by providing federal matching funds for individuals in hospitals, nursing facilities, and home/community based services with incomes between 142% and 300% of the SSI level.
  - The income level for SFY 2013 will be lowered to between 132% and 300% of the SSI level.

Increasing Federal Revenue for Nevada (continued)

- County Match Program (continued)
  - The Director of DHHS implemented a “stop-loss” to provide relief to the counties in SFY 2012. The capped amount is for the newly eligible population which is all waiver recipients as well as institutionalized recipients with income at 142% - 155.99% of the SSI level. The capped amounts are based on the Legislatively approved Budget.
    - SFY 2012: $6,046,549
    - SFY 2013: $8,498,757

Annual Expenditures by Eligibility Category (SFY 2011)



	QMB/SLMB	Co Match	Child Welf	Blind/Disabled	Aged	CHAP	TANF
Caseload	20,048	1,372	8,395	29,847	10,344	79,215	126,766
Expenses	$5,776,739	$71,037,854	$75,115,193	$510,168,882	$141,981,174	$181,110,699	$329,899,209

Questions?

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