



MEDICAL CARE ADVISORY COMMITTEE

Senior Deputy Director/ Medicaid Director Report

Department of Health Care Finance

June 23, 2021



Presentation Overview

DHCF Budget Follow Up

- ▶ Practice Transformation Collaborative
- ▶ Medicaid Disability Eligibility Buy-In
- ▶ Neuro-Behavioral Enhancement
- ▶ Alliance Changes

Enrollment Update



DC Practice Transformation Collaborative Enhancement



- ▶ In order to move towards better integrated care for District residents, the DC Practice Transformation Collaborative (DCPTC) will establish a permanent resource to support healthcare providers in delivering whole-person care across the care continuum, using population health analytics to address complex medical, behavioral health, and social needs, and transitioning to value-based purchasing.
- ▶ The DCPTC will augment and build on past and current technical assistance, including the www.IntegratedCareDC.com program supported by HMA.
- ▶ The DCPTC will serve as a community-wide place for best practices and learning and provide individualized practice support for providers. This initiative aligns with the recommendations from Mayor's Commission on Healthcare Transformation specific to the value-based purchasing of health care services. DHCF, DOH, and DBH will collaborate on this initiative.



DC Practice Transformation Collaborative Enhancement will Fund Three Main Components

- **Individualized TA and Community Outreach:**
 - Expand community outreach efforts
 - Extend additional individualized TA with a focus on behavioral health providers and adding more emphasis on acute care settings, including hospital-based practice groups and hospital discharge planners.
 - Incorporate social determinants of health data and CBO partners using the Community Resource Information Exchange (CoRIE)
- **New multi-year grant to support consulting for providers on legal, financial and business operation considerations in the transition to VBP:**
 - This grant will ensure the DC Practice Transformation Collaborative is responsive to the recommendations of the Committee on Equitable Geographic Distribution of Acute, Urgent, and Specialty Care’s, Recommendation #2: Facilitate health system integration by providing legal and regulatory technical assistance to providers who wish to develop clinically integrated networks (CINs), Accountable Care Organizations (ACOs), and Independent Physician Associations.
- **FTE Staff Position**
 - Will work across agencies and District partners to build awareness and collaboration through the project, ultimately working to support consensus and collaboration on key outcome measures that will be the focus of TA efforts and public reporting.



Medicaid Disability Eligibility Buy-In



What is the "Medicaid Buy-In Option" for States?

- ▶ Under the Balanced Budget Act of 1997 and the Ticket to Work Incentives Improvement Act (TWIIA), State Medicaid programs have the option to allow working disabled individuals to enroll in Medicaid and require to pay own premiums
 - Programs known as BBA or TWIIA (“Basic Coverage” or “Medical Improvement Group”)
- ▶ Allows working disabled individuals to sustain medical coverage – individuals don’t have to choose between being self-sufficient and having health coverage
 - 46 States now provide this optional benefit



Medicaid Buy-In Option – Key Factors



Eligibility Group	Population	Key Requirements	Considerations
BBA Group	Working individuals who meet the SSI disability definition and have a family income that does not exceed 250% of the federal poverty level (FPL).	<ul style="list-style-type: none"> Income may not exceed 250% FPL Resources may not exceed SSI standards All earned income is automatically disregarded State may not establish minimum hours or earnings to be considered employed 	<ul style="list-style-type: none"> Income limit too low given DC's generous income eligibility for CAs
TWIIA – Basic Coverage	Working individuals aged 16 to 64 who meet the SSI disability definition.	<ul style="list-style-type: none"> States have discretion to set or exclude income limits and/or resource limits If a state chooses to set an income or resource standard, SSI methodologies apply in determining eligibility. Earned income is not automatically disregarded but states may disregard income above SSI standards States may not establish minimum hours or earnings to be considered employed 	<ul style="list-style-type: none"> Allows maximum flexibility for establishing income/resource eligibility
TWIIA – Medical Improvement Group	Working individuals aged 16 to 64 previously covered under the basic eligibility group who lost coverage because they no longer meet the SSI disability definition.	<ul style="list-style-type: none"> States have discretion to set or exclude income limits and/or resource limits If a state chooses to set an income or resource standard, SSI methodologies apply in determining eligibility. Earned income is not automatically disregarded but states may disregard income above SSI standards States must use federal employment definition or establish own definition 	<ul style="list-style-type: none"> Would allow us to retain individuals in coverage if they lost SSI disability coverage



Medicaid Disability Eligibility Buy-In



- ▶ DHCF requested to provide options for the development and implementation of a Buy-In program which is in progress.

- ▶ Considerations in the development of options include:
 - Population
 - Income Limits
 - Resource Limits
 - Cost Sharing
 - Administrative Structures
 - Stakeholder Engagement



Neurobehavioral Health Enhancement



- ▶ Goal of the neurobehavioral enhancement is to permit Medicaid to cover a comprehensive suite of services and providers to address brain health screening and treatment needs for a broader range of diagnosis, including for individuals with TBI/ABI, ASD, or other neurological or developmental disorders

- ▶ Coverage, in the near term, would include increasing access to a variety of outpatient services with the potential, over the long term, to expand to an additional array of services as informed by further stakeholder engagement:
 - Diagnostic, Screening, Assessment, & Testing
 - Neuropsychological Evaluation
 - Treatment Planning and Care Coordination
 - Other Neurobehavioral Health Services: ST, OT, PT, Counseling, ABA



Alliance Changes



▶ Alliance Program and Immigrant Children's Program Policy Changes

Source	Policy Change
Unjust Imprisonment Act	Creates a new Alliance eligibility group for individuals who are determined unjustly convicted and imprisoned in the District of Columbia
Alliance Recertification	Eliminates the interview requirement for the Alliance Program at initial application and renewal Retains 6-month recertification requirement
Immigrant Children's Program	Update ICP financial eligibility to align with eligibility levels for children in Medicaid



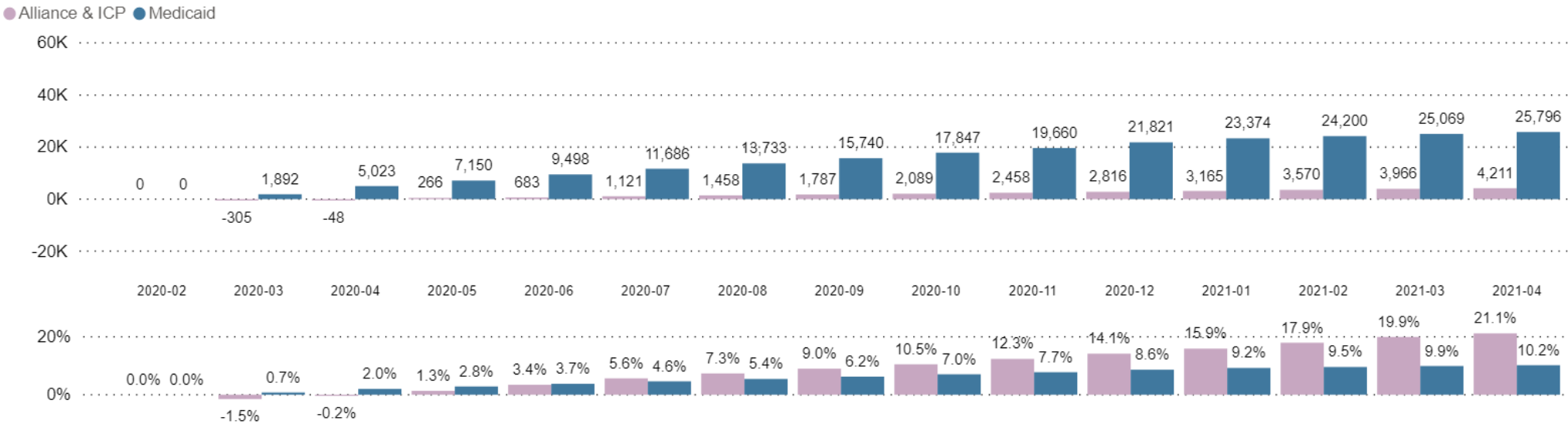
Update on Enrollment Through April 2021



► DHCFC enrollment for April was **303,662**

- **Medicaid** (279,518) has grown by **10.2%** since February 2020 (prior to the public health emergency)
- **Alliance** (20,127) and **ICP** (4,017) combined have grown by **21.1%** since February 2020
- Monthly reports with additional detail are on the DHCFC website: <https://dhcf.dc.gov/node/1180991>

Number and Percentage Change in Enrollment Since February 2020 by Program





American Rescue Plan Act: Enhanced Funding for Home and Community-Based Services

June 23, 2021



Government of the District of Columbia

Department of Health Care Finance

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Overview

- ARPA Funding Opportunity Summary
- Guiding Principles and Key Considerations
- Public Engagement
- Areas of Interest/Target Areas
- Open Discussion



ARPA Provides a One Time Opportunity to Enhance Home & Community Based Services (HCBS)



- **The American Rescue Plan (ARPA) of 2021 was signed into law on March 11, 2021**
- **ARPA Section 9817 Enhances Medicaid Funding for Medicaid Home and Community Based Services**
 - 10% FMAP bump for services provided between April 1, 2021, and March 31, 2022;
 - New funds must supplement not supplant level of state funds for programs in effect as of April 1, 2021
 - Eligibility for enhanced requires states to enhance, expand, and strengthen home and community-based services under the state's Medicaid program
- **Funds are not administered like traditional grant funds; states must maintain current service / benefit levels and new initiatives must be sustainable**
- **District must submit initial and ongoing spending plans detailing proposed enhancement activities for review and approval by CMS**



Eligible HCBS Services are More Broadly Defined Under ARPA



- Federal guidance permits States to use funds equivalent to the amount of federal funds attributable to the increased FMAP through **March 31, 2024** on enhancement activities
- **The increased FMAP is only attributable to Medicaid expenditures for certain HCBS services. HCBS defined to include:**
 - Home health care services;
 - Personal care services;
 - Case management and targeted case management;
 - All rehabilitative services defined at 42 CFR § 440.130(d))
 - In-Home Private Duty Nursing
 - All 1915(c) services, including CMS-approved “other” services;
 - All 1915(i) services, including CMS-approved “other” services;
 - PACE Services; and
 - HCBS delivered through managed care or approved under 1115 Demonstration
- **Increase additive to increased FMAP for FFCRA; Childless Adults, 1915(k) Community First Choice, etc.**



There is an Array of Allowable Activities Because Funding is More Flexible Than What is Usually Allowed Through Medicaid Reimbursement



- **States may spend funds attributable to increased FMAP on both HCBS services and HCBS-related administrative activities (non-exhaustive list):**
 - Increase amount, duration, scope of HCBS services
 - New/Special Provider Payments and Rate Enhancements
 - Provider Workforce Training/Recruitment/Support Initiatives
 - Quality Improvement/measurement/oversight initiatives
 - Information Technology Implementation
 - Strengthening Assessments practices
 - Changes to streamline Eligibility Systems
 - Expanding use of technology/telehealth
 - Conducting Care Surveys
 - Addressing Social Determinants of Health
 - Enhancing Care Coordination Infrastructure



There are No Local Savings as With Other Enhanced FMAP Opportunities: States Must “Supplement, Not Supplant” HCBS Funding



- **ARPA legislation required increased FMAP be used to Supplement not supplant level of state funds for programs/services in effect as of April 1, 2021**
- **To meet these requirements States must:**
 - Use funds attributable to the increased FMAP to expand, strengthen, enhance HCBS
 - Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
 - Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
 - Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.
- States are expected to retain temporary changes made under Appendix K; Emergency SPA for as long as allowable under those authorities, but will not be penalized/deemed non-compliant when/if those changes expire



DHCF's Guiding Principles in Developing Potential ARPA Activities



- **Level the playing field**: Coordinating across provider types and building out equally for any one-time infrastructure initiatives; especially in areas where HCBS providers uptake has trailed other provider types
- **Build on existing efforts**: Interested in areas where the District can build on existing work/existing efforts to be inclusive of HCBS providers
- **Strengthen system capacity**: Interested in areas where the District can potentially minimize or eliminate existing gaps in the Medicaid service array

- **Key Considerations**:
 - Must consider impact on local budget / cost neutrality while considering any programmatic changes
 - Must consider long term sustainability of initiatives funded via time-limited enhanced FMAP
 - Must consider parity/equity of enhancement activities across HCBS programs/providers



Public Engagement

- **Goal:** Give interested stakeholders an opportunity for input ahead of our planned submission CMS on July 12
 - DHCF expects to post planned submission documents during week of July 5
- **DHCF landing page:** <https://dhcf.dc.gov/page/arpa-hcbs-planning>
- **Public Meetings:**
 - DHCF Special Budget Presentation: June 2
 - DDS Provider Forum: June 18
 - MCAC: June 23
 - Additional meeting to be scheduled week beginning June 28
- **Written comments received from:**
 - National Association for Home Care and Hospice
 - Letter to DM Turnage from Coalition for Long Term Care, DCHCA, and other signatories



Areas of Interest/Priority Areas Identified by Stakeholders To Date



- **Payment Rate Increases; Rate Add-Ons for Services Provided to Beneficiaries with Complex Care Needs**
- **Provider Infrastructure/Capacity Building**
 - EHR/EMR Uptake, HIE Connectivity, etc.
- **Workforce Retention/Recruitment; Workforce Development**
 - Training, Apprenticeship programs for Direct Care Workers
- **Additional Support during Transitions of Care/Coverage**
- **Access to Services**
 - Expand Options for State Plan HCBS for Beneficiaries Below NF LOC
 - Telehealth in Congregate Care Settings
 - Increase Waiver Slots



Discussion





Next Steps and Timeline

- **Ongoing cross-agency collaboration to finalize enhancement activities scope, narrative, and corresponding spending plans**
- **Development and Public Engagement Timeline:**
 - Additional meeting to be scheduled week of June 28
 - DHCF posts planned submission documents week of July 5
 - Submission to CMS on July 12
 - CMS expects review and approval within thirty (30) days of initial submissions
- **Additional Updates will be posted at <https://dhcf.dc.gov/page/arpa-hcbs-planning>**
- **Email written comments to Eugene Simms, Special Assistant, Office of the Director, at eugene.simms@dc.gov**