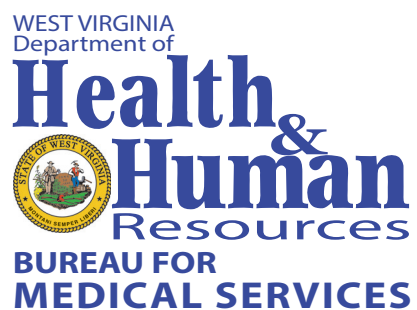




MEDICAID 101

An Overview of West Virginia's Medicaid Program

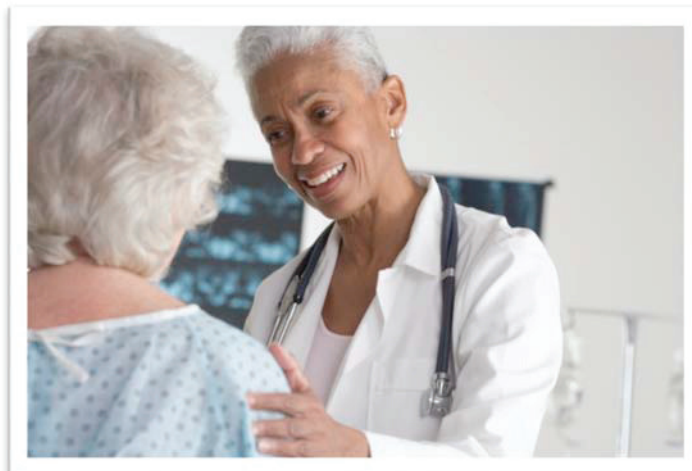


Medicaid: The Basics

Medicaid is a public benefit program that provides health insurance and medical services to eligible individuals. Medicaid is financed by state and federal governments and is administered by states. In West Virginia, the Bureau for Medical Services (BMS) within the West Virginia Department of Health and Human Resources (DHHR) is the single state agency responsible for administering the West Virginia Medicaid program.

Across the country, Medicaid is the nation's single largest health insurer, covering more than 73 million individuals in May 2018, or about 22% of the US population.¹ Medicaid contributes substantially to the financing of the US health care system, supporting local public health infrastructure, hospitals, mental health centers, at-home-care, community clinics, nursing homes, physicians, and many other health professionals and administrators.

The Medicaid program is critical to the health and well-being of hundreds of thousands of West Virginians. This manual is intended to provide you with a brief overview of the West Virginia Medicaid program, including how the Medicaid program is financed, Medicaid care delivery models, covered services, and trends in Medicaid enrollment and spending. The information in this manual should not be considered Medicaid policy. Rather, this manual is intended to serve as an accessible resource to answer frequently asked questions related to the Medicaid program. Every effort was taken to document data sources used in the creation of this book. If you have additional questions related to Medicaid program, or any of the information in this manual, please see the contact information in the Appendix.



MEDICAID VS. MEDICARE

Medicaid: A public assistance program that serves low-income people of all ages. Medicaid is jointly funded by states and the federal government but is administered by states. Patients with Medicaid usually do not have out-of-pocket costs related to covered medical expenses.

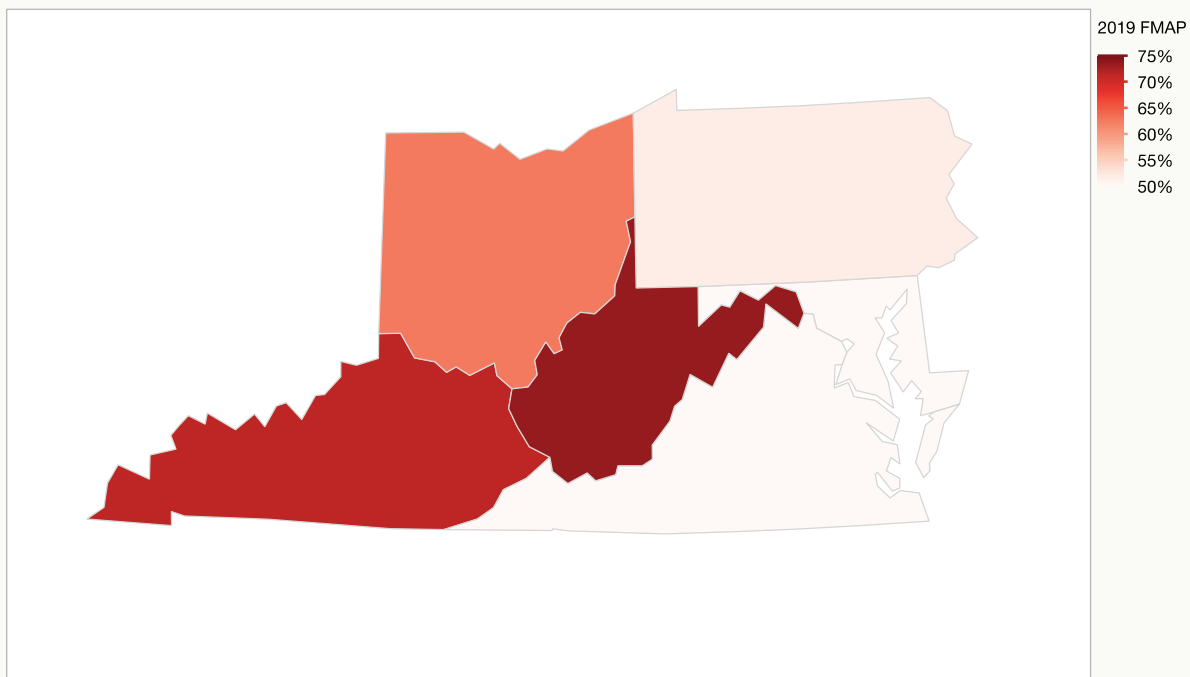
Medicare: An insurance program funded and administered by the federal government. Medicare provides health insurance for hospital and medical care to seniors age 65 and older and some individuals under age 65 with disabilities. Medicare beneficiaries typically have some out-of-pocket costs.

Who pays for Medicaid?

A state-federal partnership

Medicaid is jointly funded by state and federal governments. The majority of Medicaid funding is provided by the federal government. The federal government shares financial responsibility for the Medicaid program by matching state spending with federal dollars. The federal share of those costs is determined by the Federal Medical Assistance Percentages (FMAP). The FMAP is calculated annually using a formula set forth in federal statute and is inversely proportional to a state's per capita income relative to the US average. States with lower per capita incomes have higher FMAPs. As seen in Figure 1, West Virginia has the highest FMAP in the region.

Figure 1: Fiscal year 2019 FMAP in West Virginia and surrounding states



In fiscal year 2019, West Virginia's FMAP is 74.3%.² This means that the federal government pays for 74.3% of the costs for eligible Medicaid services, while BMS is only responsible for 25.7% of the costs. In practice, if a Medicaid member has a hospital stay that results in \$1,000 in costs, the federal government will pay \$743, while BMS will pay only \$257. In this sense, the FMAP acts as a multiplier for state spending. For example, in West Virginia, every \$100 in state spending on Medicaid services will bring in \$290 in matching federal funds. States may also receive an enhanced FMAP for covering certain services or populations. Perhaps most notably, states currently receive a 94% FMAP for the Medicaid expansion population.³ These matching funds directly benefit patients receiving medical care while also helping to finance the healthcare infrastructure in areas with large Medicaid populations.

State Medicaid programs are often seen as low-hanging fruit when financially strapped states are forced to make budget cuts. However, thanks to the FMAP, Medicaid spending acts as a tremendous financial boon for the state. The Kaiser Commission on Medicaid and the Uninsured recently compiled findings from 29 different studies examining the economic impact of Medicaid spending and found that in all studies examined Medicaid spending had a positive impact on local economies.³ These studies also found that Medicaid spending generates economic activity within the state by providing jobs, personal income, and state tax revenues. While most state government expenditures reallocate spending from one sector to another, Medicaid is one of the few state government spending opportunities that is guaranteed to pull in money from outside the state and directly benefit the local economy.

Medicaid care delivery systems



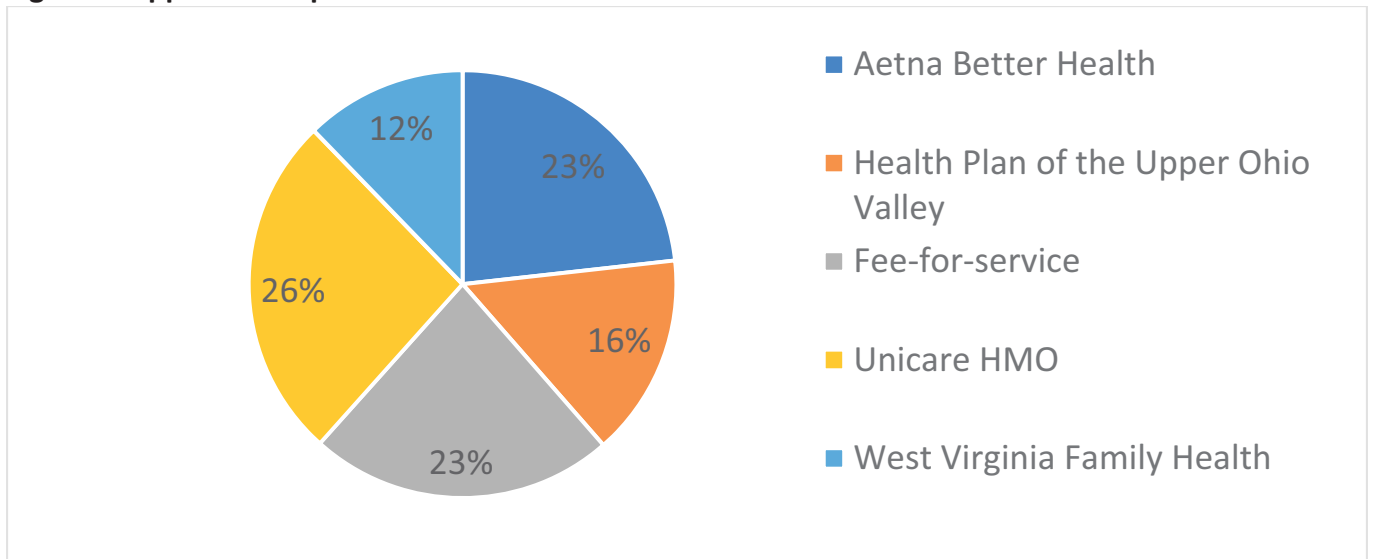
States are generally given leeway to set standards and policies for how they deliver medical and pharmacy services to Medicaid enrollees. States are also able to choose how services are purchased and payments distributed to Medicaid providers. The two most common care delivery systems are fee-for-service and managed care.

Fee-for-service: States directly pay providers a flat fee for each service delivered.

Managed care: States contract with health plans or managed care organizations (MCOs) and pay these groups a monthly per member capitation payment to provide all covered Medicaid services.

More than 75% of West Virginia Medicaid beneficiaries receive their benefits via the managed care delivery system through the Mountain Health Trust program. The Mountain Health Trust program contracts with four Managed Care Organizations (MCOs) for the provision of medical benefits. The four MCOs contracted through the program include Aetna Better Health of West Virginia (formerly Coventry Health Care of West Virginia), Health Plan of the Upper Ohio Valley, Unicare, and West Virginia Family Health. Individuals who are not covered by an MCO receive all benefits via the fee-for-service delivery system and are typically eligible for Medicaid through a waiver program such as the Intellectual/Developmental Disabilities Waiver or the Traumatic Brain Injury Waiver. Importantly, some Medicaid benefits, including pharmacy benefits, long-term care services, and non-emergency medical transportation are still paid via the fee-for-service delivery system for all Medicaid beneficiaries.

Figure 2: Approximate percent of Medicaid beneficiaries enrolled in each MCO



Covered benefits and services

The federal government requires every state Medicaid program to cover a specific set of benefits and services. The services that programs are required to cover have changed greatly since the Medicaid program's inception in 1965, given advancements in medical technologies and changes in the makeup of the Medicaid population. In addition to the required covered services, states are allowed some flexibility in terms of offering additional benefits so long as services are equitable in terms of availability and scope for all Medicaid beneficiaries.

Medicaid programs are required to cover the following services:

- Inpatient and outpatient hospital services
- Physician services
- Nursing facility services
- Early periodic screening, diagnostic and treatment services for children, including dental services
- Laboratory and x-ray services
- Home health services including nursing services, home health aides, and medical supplies and equipment
- Rural health clinic services
- Federally qualified health center services
- Transportation to medical care
- Certified pediatric and family nurse practitioner services
- Emergency medical services for certain noncitizens, also known as emergency medical assistance
- Family planning services, including nurse midwife services
- Tobacco cessation counseling for pregnant women

West Virginia's Medicaid program also covers the following optional services:

- Alcohol and drug treatment
- Chiropractic services
- Emergency dental care for adults
- Orthodontics for children
- Emergency hospital services
- Post-cataract eyeglasses for adults
- Hearing aids for children
- Home care including personal care assistant services
- Hospice care
- Medical equipment and supplies
- Prescriptions and medication therapy management
- Both physical and mental rehabilitative services
- Inpatient and outpatient substance use disorder treatment
- Case management
- Care coordination
- Autism spectrum disorder services

Who is eligible for Medicaid in West Virginia?

West Virginia Medicaid provides health insurance to a diverse population of individuals. All individuals who meet federally established income eligibility requirements are guaranteed Medicaid coverage. However, states are also allowed some flexibility in terms of eligibility requirements and can extend coverage to certain optional populations. The vast majority of Medicaid beneficiaries in West Virginia fall into one of the following categories:

Pregnant women and children

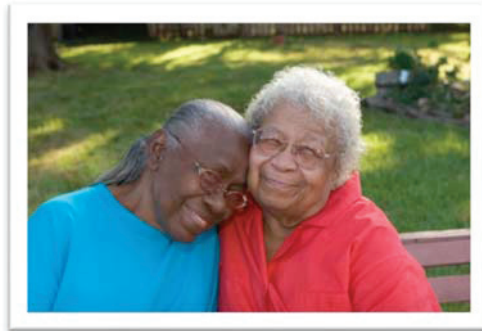
It is extremely important that women receive adequate medical care while they are pregnant. Fortunately, Medicaid provides prenatal care to many pregnant women without other forms of insurance. More than half of all births in West Virginia are paid for by Medicaid. Medicaid is also the primary health insurance program for low-income children from birth to age 18. Nearly half of all West Virginia children receive health care and



important developmental services through Medicaid. Ensuring the health and developmental success of pregnant women and children is a sound investment in West Virginia's future.

Aged and disabled population

Medicaid is the primary insurer for many individuals with mental or physical disabilities. Individuals who are aged, blind, or disabled, and who have limited assets to support themselves may be eligible for



supplemental security income (SSI) from the federal government. In West Virginia, all individuals who receive SSI automatically become eligible for Medicaid. Once enrolled, these individuals may receive health care, therapy, and long-term care services with few or no out-of-pocket costs. Medicaid also supports seniors in West Virginia by paying for some low-income Medicare beneficiaries' co-pays, deductibles, and premiums as well as certain medical services. For example, Medicaid pays for the majority of all nursing home care for West Virginia seniors.

Expansion adults

Historically, adults aged 19-64 without dependent children were not eligible for Medicaid coverage. However, with the passage of the Patient Protection and Affordable Care Act, states were given the option of expanding Medicaid eligibility to adults with incomes up to 133% of the federal poverty



level. West Virginia is one of 36 states to expand Medicaid eligibility to this population. Importantly, the federal government pays an enhanced FMAP for Medicaid services provided to this population.

MEDICAID VS. CHIP

While Medicaid insures many children in West Virginia, some children receive benefits through the Children's Health Insurance Program (CHIP). Medicaid is intended to provide health benefits to the poorest children in the state. CHIP expands health insurance coverage to children in families who have incomes above the Medicaid eligibility threshold who do not have commercial insurance. Services provided through CHIP are generally comparable to those offered under the Medicaid program, however states have more flexibility in determining the breadth of coverage for CHIP services.

How is Medicaid eligibility determined?

Medicaid eligibility is dependent on a host of factors including household income, family size, age, disability, and citizenship status. The specifications for these criteria vary by eligibility category. For example, pregnant women may make up to 158% of the federal poverty level (FPL) and qualify for Medicaid eligibility, while adults in the expansion population may only

make up to 133% of the FPL. West Virginia Medicaid’s income eligibility thresholds, as a percentage of the FPL, for various groups are displayed in Figure 3. Figure 4 displays the 2018 FPL designations for different family sizes; families that make less than this amount are deemed in poverty. Regardless of eligibility group, individuals must pass an annual asset test to become eligible for Medicaid benefits. Assets include items such as a car above a certain value, personal savings, and life insurance policies. Notably, a family home is not considered an asset for Medicaid eligibility.

Figure 3: Eligibility thresholds as a percent of the FPL for various Medicaid groups⁵

Population	Eligibility threshold as a percent of FPL
Children	
Ages 0 – 1	158%
Ages 1 – 5	141%
Ages 6 – 18	133%
CHIP	300%
Adults	
Aged and Disabled*	Up to 300% of SSI Limit
Expansion population	133%
Pregnant Women	158%

*Eligibility for the aged and disabled population is based on social security income (SSI) limits. Certain individuals can make up to 300% of the SSI limit and qualify for Medicaid benefits

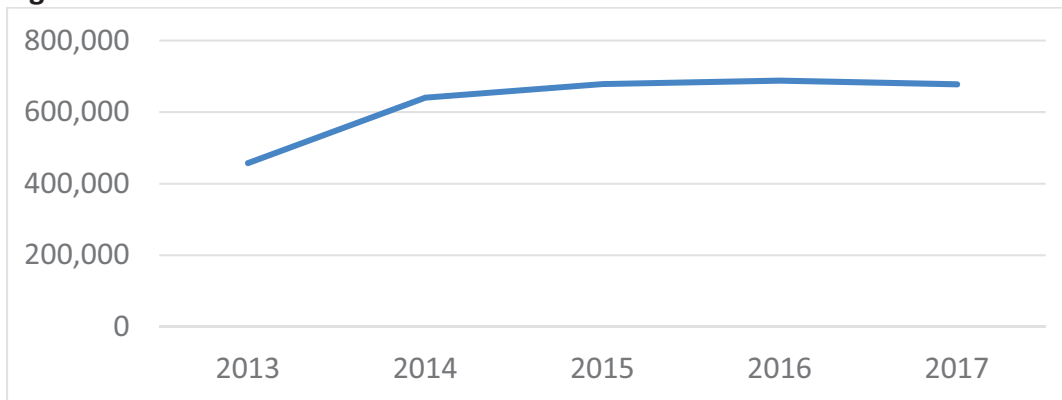
Figure 4: 2018 FPL by family size⁶

Family Size	FPL Threshold
Individuals	\$12,140
2	\$16,460
3	\$20,780
4	\$25,100
5	\$29,420
6	\$33,740
7	\$38,060
8+	\$42,380

Medicaid enrollment by the numbers

Figure 5 displays the number of individuals enrolled with West Virginia Medicaid at any point in a calendar year from 2013 – 2017. Please note that the number of individuals enrolled with Medicaid on any given day will be significantly less than the number enrolled at any point in the calendar year. For example, there are about 530,000 individuals enrolled in Medicaid on any particular day of the month, while there are generally more than 650,000 individuals enrolled at some point over the course of an entire year.

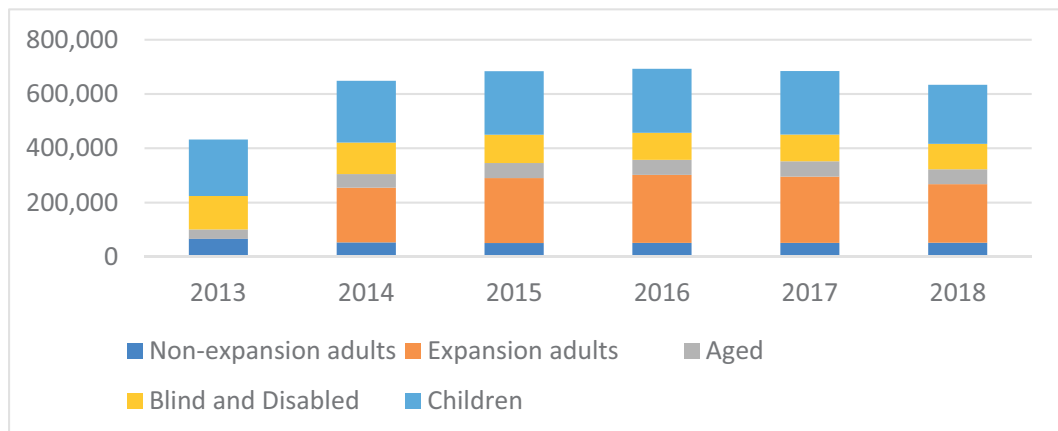
Figure 5: Total annual Medicaid enrollment 2013 – 2017



In 2017, more than 675,000 West Virginians were enrolled in Medicaid at some point during the year. This represents approximately one third of the state’s total population in 2017. West Virginia chose to expand Medicaid eligibility under the Affordable Care Act in 2014. From 2013 to 2014, Medicaid enrollment increased by more than 50%, and has remained relatively stable since then.

Figure 6 displays trends in Medicaid enrollment from 2013 – 2017 by Medicaid eligibility category. Changes in Medicaid enrollment from 2013 – 2017 have been driven almost entirely by the adult expansion population. The number of blind and disabled individuals enrolled in Medicaid has decreased slightly over this time period.

**Figure 6:
Annual
Medicaid
enrollment
by eligibility
group
2013 – 2017**



Given the dramatic increases in Medicaid enrollment over the last five years, West Virginia now has one of the lowest uninsured rates in the country. Figure 7 displays trends in the percentage of West Virginians with Medicaid coverage relative to the percent of uninsured West Virginians. While more than one-third of the state’s population was enrolled with Medicaid at some point in 2017, only about 6% of the state’s population was uninsured for the majority of the year.

Figure 7: Percent of West Virginians with Medicaid relative to percent uninsured 2013 – 2017^{7,8}

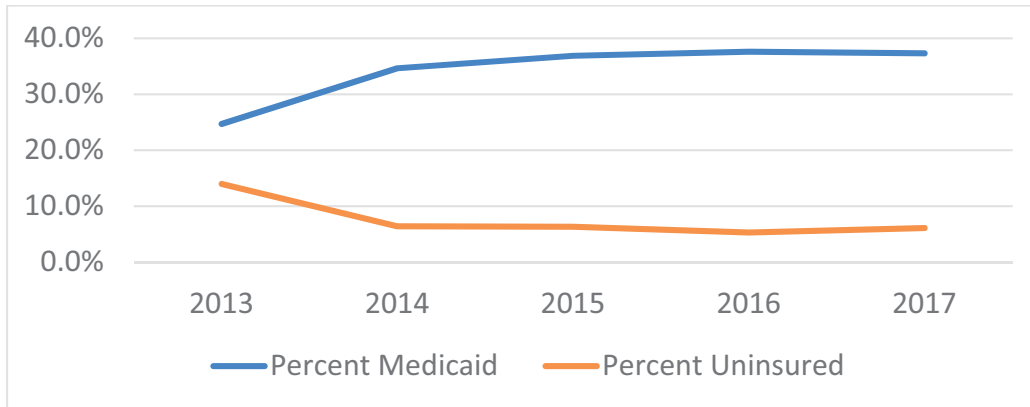
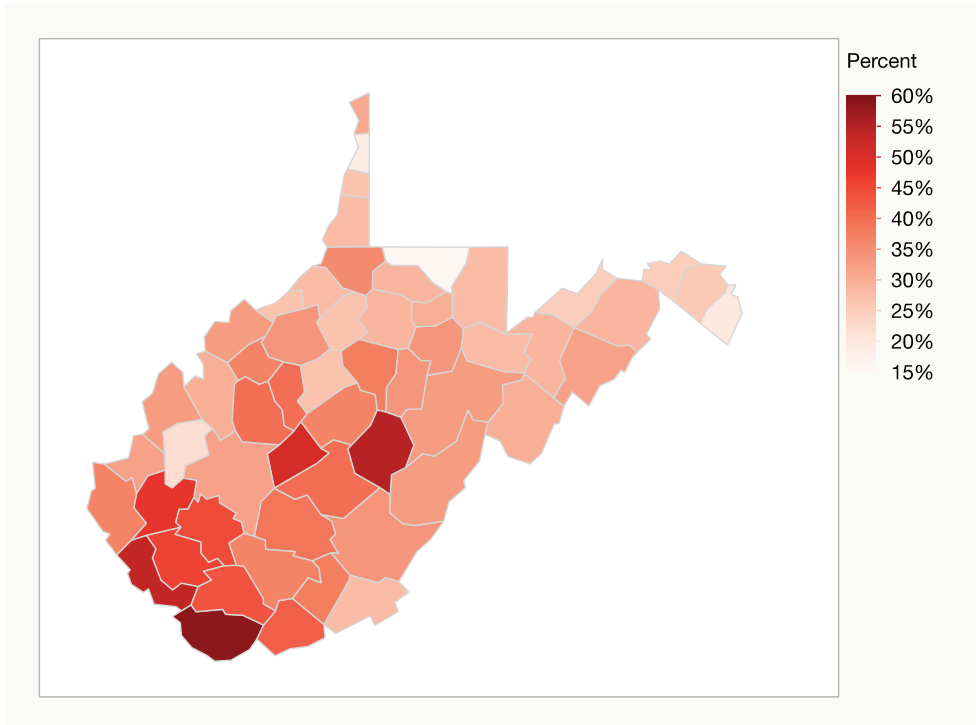


Figure 8 displays the percent of individuals enrolled in Medicaid in each county in West Virginia during calendar year 2017. Generally speaking, counties in the southern region of the state had higher rates of Medicaid coverage relative to counties in the Northern region or Eastern Panhandle.

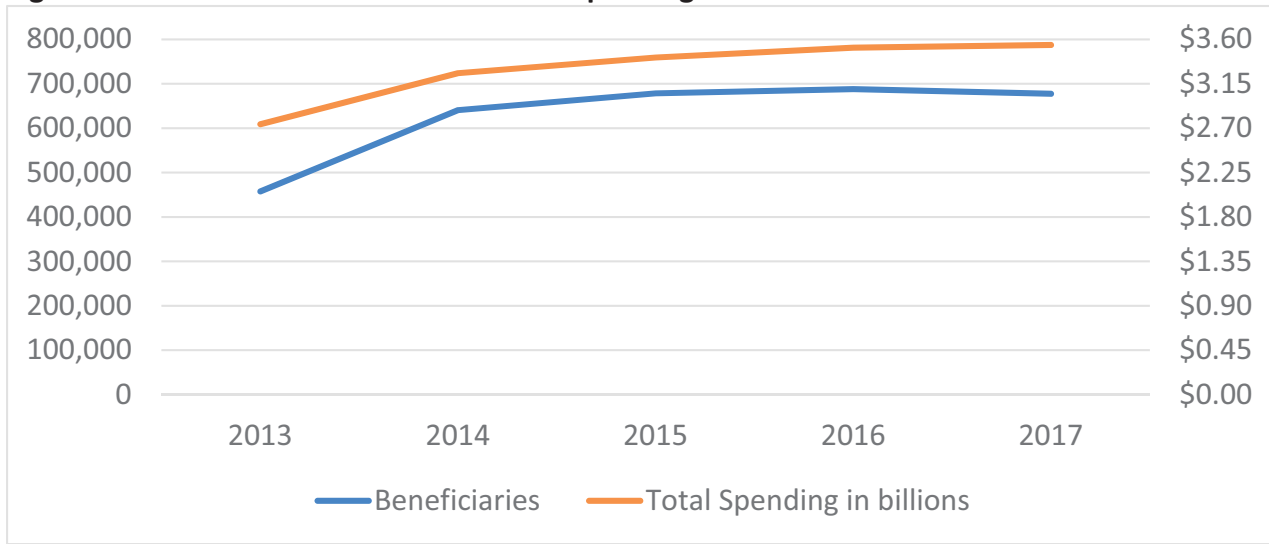
Figure 8: Percent of individuals with Medicaid in each county in calendar year 2017



Medicaid spending by the numbers

Annual Medicaid enrollment increased substantially following implementation of Medicaid expansion under the Affordable Care Act. Understandably, Medicaid spending also increased over this time period, however it was outpaced by increases in Medicaid enrollment. Figure 9 displays trends in annual Medicaid enrollment and spending from 2013 – 2017.

Figure 9: Annual Medicaid enrollment and spending 2013 – 2017



Medicaid enrollment increased by more than 50% from 2013 to 2014, but total Medicaid spending increased by less than 20% over the same time period. While the adult expansion population has largely driven increases in Medicaid enrollment, this population accounts for a relatively small proportion of total Medicaid spending. Figure 10A displays the percent of Medicaid beneficiaries by eligibility category in calendar year 2017, while Figure 10B displays the percent of spending attributable to each eligibility category in the same year.



Figure 10A: Percent of Medicaid beneficiaries by eligibility group in calendar year 2017

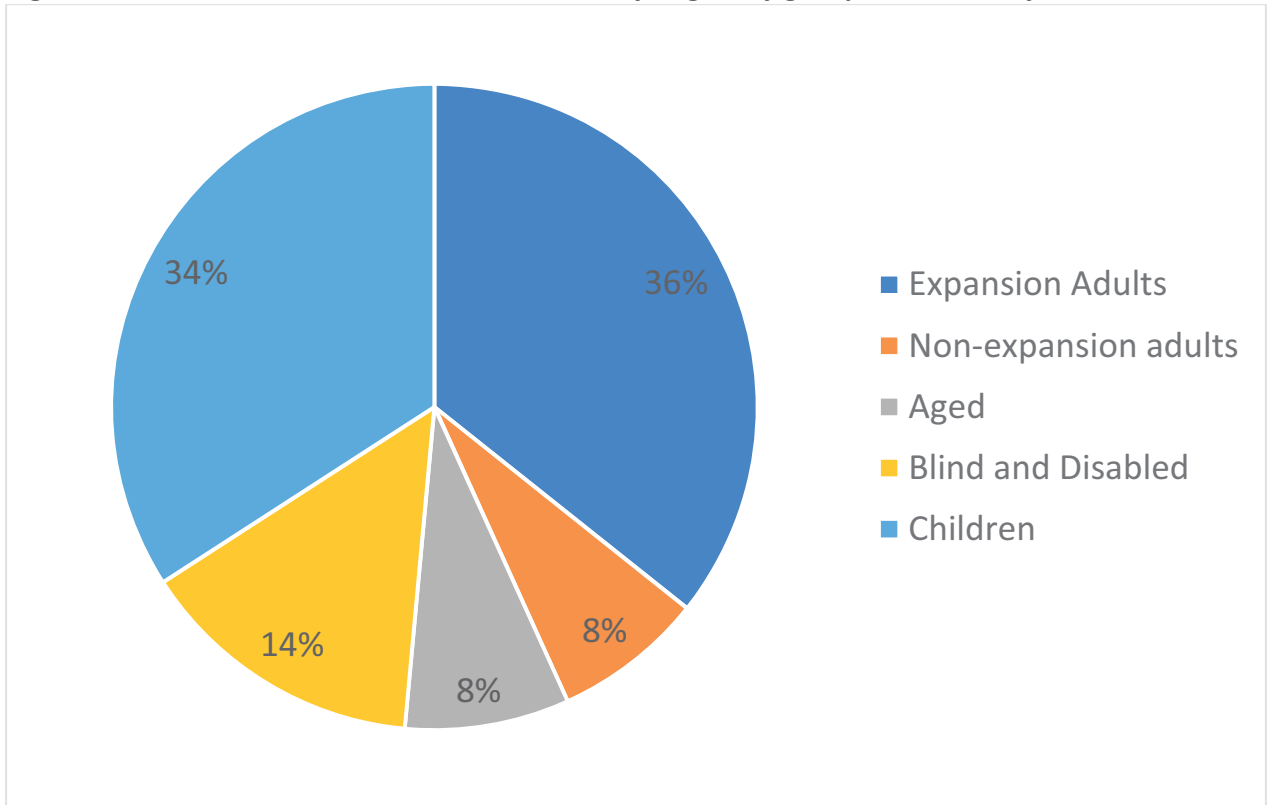
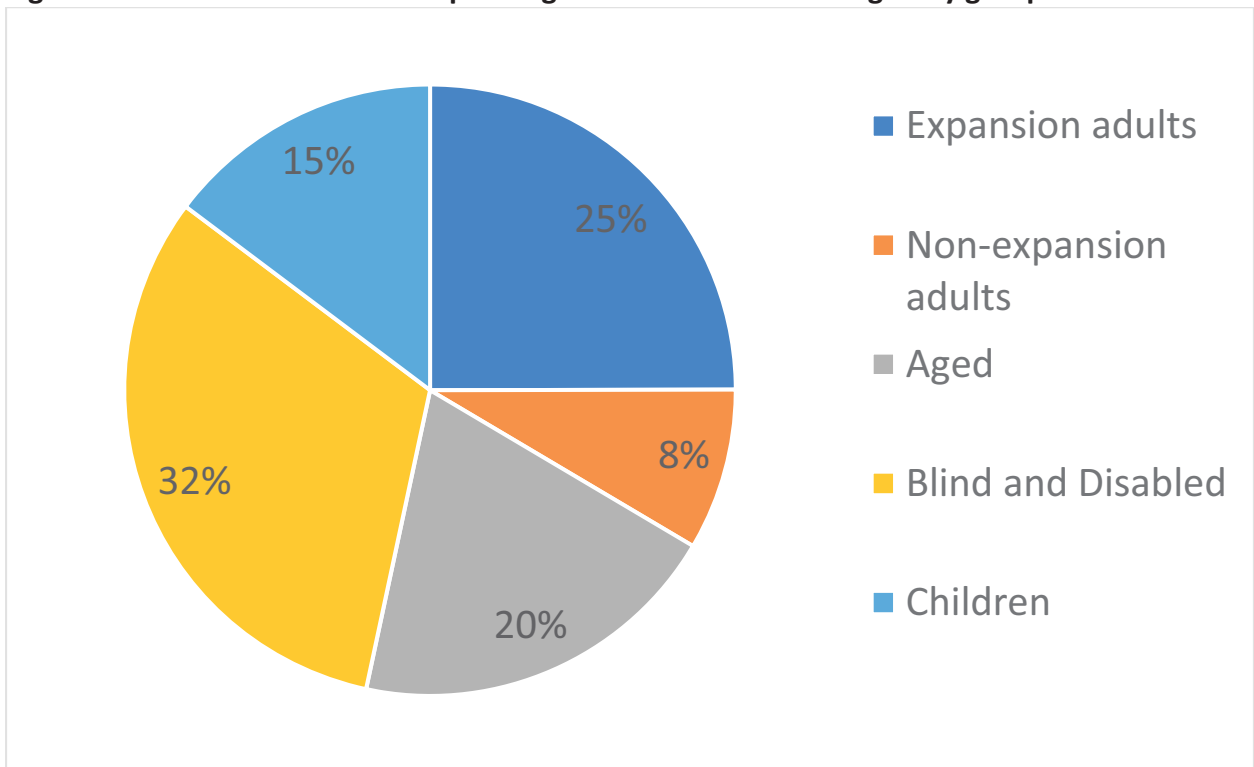


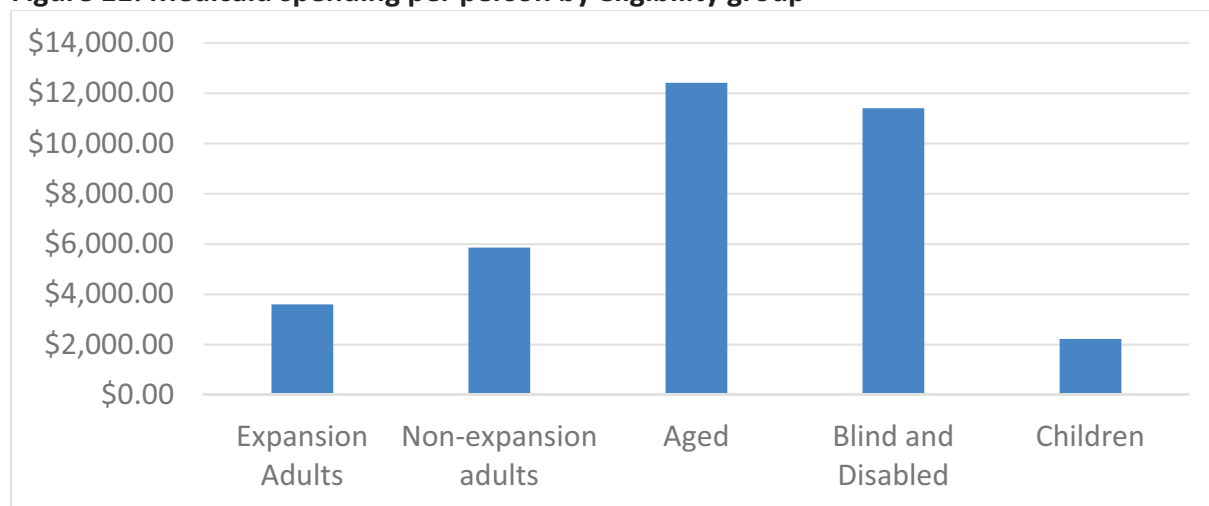
Figure 10B: Percent of Medicaid spending attributable to each eligibility group in 2017



In 2017, more than one-third of Medicaid beneficiaries were part of the adult expansion population, however, these individuals accounted for only about 25% of total Medicaid spending during the calendar year. On the other hand, the aged population and the blind and disabled populations together comprised only about 22% of the Medicaid population in 2017, however they accounted for more than 50% of all Medicaid spending. The aged population and the blind and disabled Medicaid populations tend to have special healthcare needs and require more frequent Medicaid services than other groups. It is understandable that the expansion population accounts for a smaller proportion of Medicaid spending relative to populations with greater healthcare needs.

Figure 11 displays average Medicaid spending per person by eligibility group. Individuals in the aged population and the blind and disabled Medicaid populations account for a much greater share of Medicaid spending than individuals in other eligibility groups. Beneficiaries in the aged population and blind and disabled population accounted for two to four times greater average spending per person relative to beneficiaries in any of the other eligibility groups.

Figure 11: Medicaid spending per person by eligibility group



Medicaid innovations and successes

Innovative approaches to treating Substance Use Disorder

West Virginia has been at the epicenter of the nation’s drug crisis. In 2017, West Virginia had the highest drug overdose death rate in the country, with a rate that was greater than double the national average.⁹ This crisis has dramatically impacted our Medicaid program, which insures many individuals suffering from Substance Use Disorder (SUD). In the last year, BMS has implemented several innovative policies to improve the quality and availability of SUD treatment for Medicaid beneficiaries. Ultimately, these policies will bolster the SUD care delivery network in the state and improve the health and well-being of West Virginians.

BMS was recently awarded a Medicaid 1115 waiver by the Centers for Medicare and Medicaid Services (CMS) to enhance the continuum of care for beneficiaries with SUD. This waiver is

intended to improve the availability, quality, and coverage of SUD treatment services for Medicaid beneficiaries. The waiver allows Medicaid beneficiaries with SUD to receive the full continuum of care for SUD treatment as defined by the American Society of Addiction Medicine. Medicaid enrollees with SUD are now eligible to receive additional behavioral therapies including peer recovery support and withdrawal management services, as well as short-term residential treatment. The 1115 waiver also expands access to medication assisted treatment (MAT) including methadone treatment services from opioid treatment programs. Additionally, emergency medical service providers can now be reimbursed for administration of naloxone to Medicaid beneficiaries suffering an overdose. Importantly, the new services provided under the 1115 waiver are consistent with the industry standard best practices set forth by the American Society of Addiction Medicine.

In addition to the 1115 waiver, BMS is also taking an innovative approach to treating babies born with neonatal abstinence syndrome (NAS). NAS is a disorder caused by prenatal exposure to opioids or other drugs. Babies with NAS experience a host of symptoms including tremors, vomiting, seizures, excessive crying and sensitivity to stimuli, and these infants require around-the-clock care during the first few weeks of life. BMS is the first Medicaid program in the country to have an approved state plan



amendment (SPA) specifically to bolster NAS treatment services. The SPA allows health facilities to be recognized as NAS Treatment Centers, and allows them to receive Medicaid reimbursement for providing NAS treatment. Services that can now be reimbursed under the SPA include comprehensive assessment and care plan development; housing in a low or reduced stimuli environment; pharmaceutical withdrawal management; therapeutic swaddling; rocking; newborn massage; and other services.

Home and Community-Based Services for person-centered care

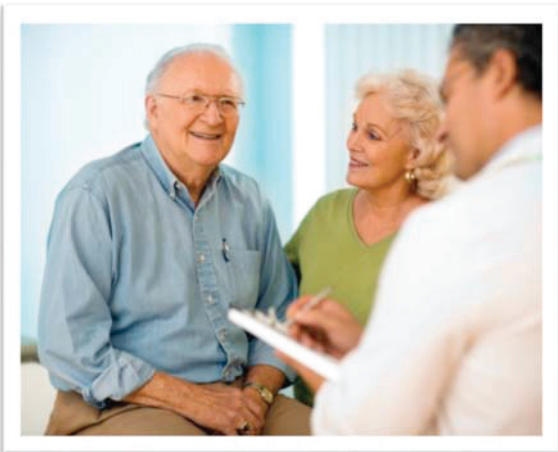
The Medicaid Home and Community-Based Services (HCBS) waiver program allows state Medicaid agencies to provide services to members in their homes or communities to avoid institutionalization. HCBS programs work to create sustainable, person-centered, long-term support systems for people with disabilities, chronic conditions, and the elderly. The goal of HCBS waiver programs is to improve members' independence, health, and quality of life. Within broad federal guidelines, states can develop HCBS programs tailored to the needs of Medicaid beneficiaries who prefer to receive treatment in their home or communities rather than an institutional setting. West Virginia has three HCBS waiver programs:

1. Aged and Disabled Waiver—This program is a long-term care alternative that provides services that enable an individual to remain at or return home rather than receiving nursing home care. The goals and objectives of this program are focused on providing services that are person-centered, promote choice, independence, respect, and community integration.



2. Intellectual/Developmental Disabilities (I/DD) Waiver—This program provides services that instruct, train, support, supervise, and assist individuals who have intellectual and/or developmental disabilities in achieving the highest level of independence and self-sufficiency possible. The I/DD waiver program provides services in natural settings where the member resides rather than in intermediate care facilities.

3. Traumatic Brain Injury (TBI) Waiver—This program provides services to individuals with a documented traumatic brain injury, defined as a non-degenerative, non-congenital injury to the brain resulting in the need for a nursing facility level of care. The purpose of the program is to prevent unnecessary institutionalization by providing services and supports that are person-centered and promote independence and community integration.



Health Homes for at risk populations

The Affordable Care Act gave state Medicaid programs the option of creating the Health Homes program to provide a comprehensive system of care coordination for Medicaid beneficiaries with multiple chronic conditions. The Health Homes program does not act as a place where patients live, but as a system for holistically providing medical, behavioral, and social support services for individuals with complex healthcare needs. Individuals enrolled in Health Homes are assigned a multidisciplinary

team of healthcare providers who collaboratively provide services and supports in a coordinated manner. Health Homes services include comprehensive care management, care coordination, health promotion, and community and social support services. Each patient enrolled in the program is also assigned a personal care manager who is required to contact the patient at least bi-weekly to ensure the patient's needs are being addressed. West Virginia currently has two Health Homes. The first Health Home began in July 2014 for members with bipolar disorder who have, or are at risk of having, hepatitis B or C. The second Health Home

began in April 2017 and is designed for Medicaid beneficiaries with pre-diabetes, diabetes or obesity, who are at risk of also having anxiety or depression.

Reducing pharmacy spending and investing in the state

On July 1, 2017, BMS carved out pharmacy services from the managed care program and began delivering these services as part of the fee-for-service delivery model. With this model, pharmacy benefits are managed by the State Pharmacy Services program, which serves as its own Pharmacy Benefits Manager (PBM). This model unbundles incurred costs and creates a more transparent method of payment for pharmacy services. Claims processing is handled by DXC, the fee-for-service medical/dental claims processor, and processing fees are transparent. Supplemental rebates on preferred drugs are negotiated through a multi-state consortium of Medicaid programs. The collection of federal and supplemental rebates is overseen in-house and the entire amount collected is retained by the Medicaid program. So far, this initiative has paid dividends, with significant cost-savings in the first year alone. In addition to savings on administrative costs and increased rebates, BMS increased the dispensing fee to \$10.49 per prescription, providing a significant re-investment back into the pharmacy business community.

Looking to the future

BMS is committed to providing innovative, high quality, and accessible healthcare to the citizens of West Virginia. As part of this commitment, BMS recently completed a strategic planning initiative to more formally establish the Bureau's mission, core values, and major strategic initiatives. This plan will be used to guide the overall direction that BMS will take over the next five years. Development of this strategic plan is only the first step in continuing efforts to improve transparency and better serve the citizens of West Virginia. A copy of the BMS strategic plan can be found on the website: dhr.wv.gov/bms.



Appendix

For additional information about the West Virginia Medicaid program, please contact BMS at: 304-558-1700

For additional information pertaining to preparation of this manual, please contact Nathan Pauly at Nathan.J.Pauly@wv.gov.

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