Medicaid Sustainability Review Process

Draft Scan of Best Practices and Strategies

Prepared for Arkansas Department of Human Services

June 2, 2023

Arkansas DHS: Medicaid Sustainability Review Process
Scan of Best Practices and Strategies

Table of Contents

Introduction 5

1. Medicaid Coverage of Optional Benefits 5

Optional Benefits Summary 5

Overview 5
National Landscape 6

Coverage of Dental Benefits 7

State Examples 7

2. Institutional Medical Services (Psychiatric Only) 11

Psychiatric Residential Treatment Facilities 11

Overview 11
National Landscape 12
State Examples 12

Section 1115 Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance Demonstrations 14

Overview 14
National Landscape 14

3. Non-Institutional Medical Services 15

Federally Qualified Health Centers 15

Overview 15
National Landscape 16
State Examples 16

Physicians and Nurse Practitioners 18

Overview 18
National Landscape 18
State Examples 19

Maternal Health 20

Overview 20
National Landscape 21

Early Child Health 23

Overview 23
National Landscape 23

Durable Medical Equipment 24

Overview 24
National Landscape 24
State Examples 24

Ambulatory Surgery Centers 25

Overview 25
State Examples 25

Telehealth **26**
Overview 26
National Landscape 26
4. Long-Term Services and Supports **27**
Home and Community-Based Services and Value-Based Payments **27**
Overview 27
National Landscape 27
State Examples 28
Long-Term Services and Supports (LTSS) Rebalancing **29**
Overview 29
National Landscape 29
State Examples 31
5. Habilitative & Rehabilitative Services **32**
School-Based Services **32**
Overview 32
National Landscape 32
State Examples 33
6. Pharmacy **34**
Pharmacy and Value-Based Payments **34**
Overview 34
National Landscape 35
State Examples 35
Dispensing Fees **36**
Overview 36
National Landscape 37
State Examples 37
90-Day Medication Supply **39**
Overview 39
National Landscape 39
State Examples 39
7. Capitated Payments **41**
Medicaid Managed Care **41**
National Landscape 43
Overview 46
National Landscape 46
State Examples 47
Medicaid Expansion **48**
Overview 48
National Landscape 49
Dental **50**

Overview 50
National Landscape 50
8. Transportation 51
Non-Emergency Transportation (NET) 51
Overview 51
National Landscape 51
State Examples 52
Day Treatment Transportation (DTT) 54
Overview 54
National Landscape 54
State Examples 54
9. Non-Claims Based Payments 55
Government Contracts 55
Overview 55
National Landscape 56
10. Supplemental, Cost Settlement, and Access Payments 58
Disproportionate Share Hospital Allotments 58
Overview 58
National Landscape 60
State Examples 60
Non-Federal Share Funding Mechanisms 61
Overview 61
National Landscape 65
State Examples 65
Provider Payments through Cost Settlements 65
Overview 65
National Landscape 66
State Examples 66
Cost Settlements for Out-of-State Hospitals 67
Overview 67
National Landscape 67
State Examples 67
11. Third Party Liability 68
Coordination of Benefits 68
Overview 68
National Landscape 68
State Examples 68
Crossovers 70
National Landscape 70
12. Tax Equity and Fiscal Responsibility Programs 71

Arkansas DHS: Medicaid Sustainability Review Process
Scan of Best Practices and Strategies

Overview 71
National Landscape 71
State Examples 72

Arkansas DHS: Medicaid Sustainability Review Process
Scan of Best Practices and Strategies

Introduction

As part of the Medicaid Sustainability Review Process (MSRP), Guidehouse conducted an environmental scan to identify best practices and strategies for key workstream areas covered under the MSRP. Guidehouse focused the research on topics identified as areas of opportunity or of interest during the current state review of Arkansas data and documents and during key informant interviews with Department of Human Services (DHS) staff.

This draft document presents summarized information from a scan of best practices and strategies, using research from national organizations such as Kaiser Family Foundation, the Medicaid and CHIP Payment and Access Commission (MACPAC), as well as review of state approaches. The information in this scan, combined with the Arkansas Medicaid current state assessment, will inform the development of strategic options for improving the sustainability of Arkansas's Medicaid program.

1. Medicaid Coverage of Optional Benefits

Optional Benefits Summary

Overview

Under federal law, states are required to cover a set of mandatory benefits. There are also benefits that states have the option to cover in their State Plan, referred to as optional benefits. Optional benefits include:[1]

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing, and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental Services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for Individuals with Intellectual Disability
- State Plan Home and Community Based Services- 1915(i)
- Self-Directed Personal Assistance Services- 1915(j)
- Community First Choice Option- 1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21

[1] CMS. (n.d.). *Mandatory & Optional Medicaid Benefits* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html.

States are also required to provide all services covered under the Early, Periodic, Diagnostic, and Treatment (EPSDT) benefit that correct or ameliorate physical or mental conditions found by a screening, even of that treatment is not part of a state's traditional Medicaid benefit package.[2]

National Landscape

The Kaiser Family Foundation conducted a 2018 survey in which they asked states to report coverage of benefits in their fee-for-service programs for categorically needy traditional Medicaid beneficiaries aged 21 and older. Figure 1 summarizes the number of states that reported that their Medicaid program cover select optional benefits.[3]

Figure 1. Number of States Covering Optional Benefits

Optional Benefit	Number of States		
	Covered	Not Covered	Not Reported
Clinic Services (excluding Federally Qualified Health Centers and Rural Health Clinics)	42	2	7
Practitioner Services			
Dental Services	39	6	6
Podiatrist Services	40	5	6
Optometrist Services	43	2	6
Chiropractor Services	24	21	6
Prescription Drugs			
Prescription Drugs	51	0	0
Over-the-Counter Drugs	42	4	5
Physical Therapy and Other Services			
Physical Therapy Services	40	6	5
Occupational Therapy Services	39	7	5
Services for Speech, Hearing, and Language Disorders	37	9	5
Products and Devices			
Dentures	31	15	5
Prosthetic and Orthotic Devices	45	1	5
Eyeglasses and Other Visual Aids	33	13	5
Targeted Case Management	36	8	7
Long-Term Care			
Private Duty Nursing Services	25	21	5
Hospice	46	0	5

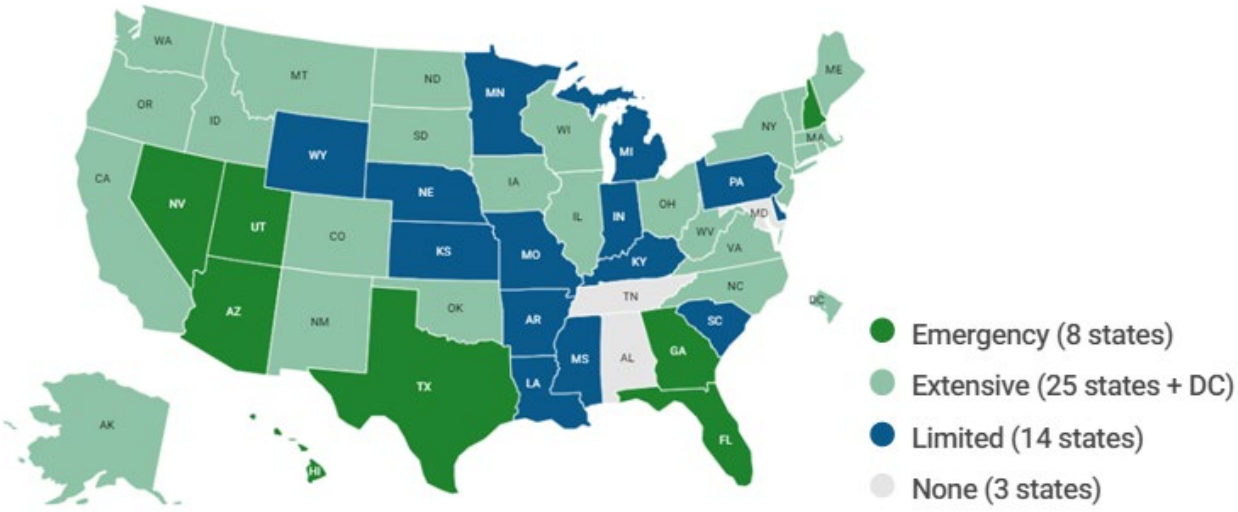
[2] MACPAC. (n.d.). *Mandatory and Optional Benefits* [Webpage].Retrieved from: https://www.macpac.gov/subtopic/mandatory-and-optional-benefits/
[3] Kaiser Family Foundation. (n.d.). *Medicaid & CHIP Indicators: Medicaid Benefits* [Webpage]. Retrieved from: https://www.kff.org/state-cateory/medicaid-chip/medicaid-benefits/

Optional Benefit	Number of States		
	Covered	Not Covered	Not Reported
Personal Care Services (State Plan)	34	17	0
Self-Directed Personal Assistance Services	21	24	6
Services in Institutions for Mental Disease, 65+	42	4	5
Intermediate Care Facility Services for Individuals with Intellectual Disabilities	44	2	5

Coverage of Dental Benefits

Figure 2 shows a visual representation of adult dental coverage levels nationwide as of October 2022.

Figure 2. State Medicaid Coverage of Adult Dental Benefits, October 2022[4]



State Examples

The National Academy for State Health Policy (NASHP) further details each state's coverage for adults and specifically adults who have coverage while pregnant, illustrated below in Figure 3. Coverage definitions include:

- **None:** No dental services covered.
- **Emergency:** Services provided for the relief of pain and infection under defined emergency situations.
- **Limited:** Fewer than 100 diagnostic, preventive, and minor restorative procedures recognized by the American Dental Association (ADA); per-person annual expenditure for care is $1,000 or less.
- **Extensive:** A comprehensive mix of services, including more than 100 diagnostic, preventive, and minor and major restorative procedures approved by the ADA; per-person annual expenditure cap is at least $1,000.

[4] National Academy for State Health Policy (2022). *State Medicaid Coverage of Dental Services for General Adult and Pregnant Population* [Webpage]. Retrieved from: https://nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/

Figure 3. State Medicaid Coverage of Adult Dental Benefits, October 2022[5]

State	General Adult Coverage	Pregnancy-only Coverage for Adults > 21 yrs	Income limit as percent of the Federal Poverty Level (FPL) for pregnancy-only coverage (does not include 5% FPL disregard)	Notes
Alabama	None	Extensive	146%	
Alaska	Extensive	Extensive	200%	Pregnant people are covered under Alaska's CHIP program up to 200% FPL.
Arizona	Emergency	Emergency	156%	Individuals in the Arizona Long Term Care System (ALTCS) have access to a limited dental benefit. Arizona Medicaid reimburses Indian Health Services and Tribal 638 facilities for dental services provided to American Indian/Alaska Native adults beyond the $1000 limit.
Arkansas	Limited	Limited	209%	
California	Extensive	Extensive	213%	
Colorado	Extensive	Extensive	195%	
Connecticut	Extensive	Extensive	263%	
Delaware	Limited	Limited	212%	
District of Columbia	Extensive	Extensive	319%	Pregnant people eligible for TANF or with incomes up to 185% of FPL are eligible for the dental benefit.
Florida	Emergency	Emergency	191%	All Florida Medicaid recipients enroll in one of 3 managed care plans for dental services. These plans offer expanded benefits that are above and beyond State Plan covered services. They include preventive dental care and treatment for recipients over the age of 21.
Georgia	Emergency	Limited	220%	
Hawaii	Emergency	Emergency	185%	The FY23 budget includes funding to restore a dental

[5] National Academy for State Health Policy (2022). *State Medicaid Coverage of Dental Services for General Adult and Pregnant Populations* [Webpage]. Retrieved from: https://nashp.org/state-medicaid-coverage-of-dental-services-for-general-adult-and-pregnant-populations/

State	General Adult Coverage	Pregnancy-only Coverage for Adults > 21 yrs	Income limit as percent of the Federal Poverty Level (FPL) for pregnancy-only coverage (does not include 5% FPL disregard)	Notes
				benefit for Medicaid members. The benefit will begin January 2023.
Idaho	Extensive	Extensive	133%	
Illinois	Extensive	Extensive	209%	
Indiana	Limited	Extensive	209%	Limited coverage for most adult members (Healthy Indiana Plan Basic and State Plus). Extensive coverage for all other populations including pregnant people.
Iowa	Extensive	Extensive	375%	
Kansas	Limited	Limited	166%	2022 budget includes $3.5 million to expand adult dental services in Medicaid.
Kentucky	Limited	Limited	195%	
Louisiana	Limited	Limited	133%	
Maine	Extensive	Extensive	209%	Beginning July 1, 2022, all individuals over age 21 will have access to comprehensive preventive, diagnostic and restorative dental services to maintain good oral and overall health in accordance with rules adopted by the department.
Maryland	None	Extensive	259%	Limited dental coverage for adults up to 133% FPL to begin January 2023.
Massachusetts	Extensive	Extensive	200%	Pregnant people receive the same benefit as adults; there is no separate plan for pregnant people.
Michigan	Limited	Extensive	195%	
Minnesota	Limited	Extensive	278%	
Mississippi	Limited	Limited	194%	
Missouri	Limited	Extensive	196%	Limited dental benefit for individuals receiving ambulatory prenatal care only.

State	General Adult Coverage	Pregnancy-only Coverage for Adults > 21 yrs	Income limit as percent of the Federal Poverty Level (FPL) for pregnancy-only coverage (does not include 5% FPL disregard)	Notes
Montana	Extensive	Extensive	157%	
Nebraska	Limited	Limited	194%	
Nevada	Emergency	Extensive	160%	
New Hampshire	Emergency	Emergency	196%	Extensive adult dental benefit to begin April 1, 2023.
New Jersey	Extensive	Extensive	200%	There is no dental benefit for pregnant individuals who are undocumented and have pregnancy-only coverage.
New Mexico	Extensive	Limited	250%	
New York	Extensive	Extensive	218%	
North Carolina	Extensive	Extensive	196%	
North Dakota	Extensive	Extensive	157%	
Ohio	Extensive	Extensive	200%	
Oklahoma	Extensive	Extensive	133%	
Oregon	Extensive	Extensive	185%	
Pennsylvania	Limited	Limited	215%	Pregnant people may request a benefit limit exception, resulting in extensive dental coverage.
Rhode Island	Extensive	Extensive	253%	
South Carolina	Limited	Limited	194%	
South Dakota	Extensive	Extensive	133%	
Tennessee	None	Limited	200%	2022 budget signed in April 2022 includes $25.5 million for an adult dental benefit.
Texas	Emergency	Emergency	198%	Dental is a Value-Added Service under most health plans. Includes $250-$500 for X-Rays, exams, and fillings. Pregnant people with incomes up to 185% FPL can also get more comprehensive dental benefits under the Title V Program for Maternal and Child Health.
Utah	Emergency	Extensive	139%	N/A
Vermont	Extensive	Extensive	208%	N/A

State	General Adult Coverage	Pregnancy-only Coverage for Adults > 21 yrs	Income limit as percent of the Federal Poverty Level (FPL) for pregnancy-only coverage (does not include 5% FPL disregard)	Notes
Virginia	Extensive	Extensive	143%	N/A
Washington	Extensive	Extensive	193%	N/A
West Virginia	Extensive	Extensive	185%	N/A
Wisconsin	Extensive	Extensive	301%	N/A
Wyoming	Limited	Limited	154%	N/A

As shown in Figure 4, Arkansas has the lowest published annual spend limit for adults with Medicaid dental coverage. This Figure illustrates a sample of states that have published annual spend limits.[6]

Figure 4. Published Dental Spend Limit for Medicaid Adults

State	Published Dental Spend Limit for Medicaid Adults
Arkansas	$500
Vermont	$510
Nebraska	$750
Connecticut	$1,000
Iowa	$1,000 (but not applied to most services)
South Dakota	$1,000
Colorado	$1,500 (raised from $1,000 in 2019)
Montana	$1,525
California	$1,800 (or more if medically necessary)

2. Institutional Medical Services (Psychiatric Only)

Psychiatric Residential Treatment Facilities

Overview

PRTFs are non-acute facilities that have a provider agreement with a state Medicaid agency to provide inpatient services to Medicaid-eligible individuals under the age of 21 ("psych" under 21 benefit). To be certified as a PRTF, the facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations or another accrediting organization with comparable standards recognized by the state. PRTFs provide a critical role the continuum of care for the youth behavioral health system by providing short-term intensive psychiatric treatment for high-

[6] Center for Health Care Strategies, Inc. (2019). *Advancing innovations in health care delivery for low-income Americans* [Webpage]. Retrieved from: http://www.chcs.org/media/Medicaid-Adult-Dental-Benefits-Overview-Appendix_091519.pdf

acuity youth. PRTFs are intended to be a step down from an inpatient psychiatric setting for youth who are unable to be treated in their local community.[7]

PRTF services are an optional Medicaid benefit and states may choose not to include PRTFs in their State Plan.[8] However, states are required to cover PRTF services for youth under age 21 through the EPSDT benefit. States that choose not to include PRTF services in their State Plan must provide PRTF level services through another psychiatric resource or send their youth out-of-state for PRTF services.[9]

National Landscape

Providers across the nation are reporting an increase in the need for behavioral health services for youth. In particular there has been an increased need for psychiatric inpatient and residential treatment for youth with severe emotional and behavioral health issues.[10] Federal statute restricts the location where state Medicaid agencies are able to access federal financial participation (FFP) for residential psychiatric services for individuals under age 21 to psychiatric hospitals, psychiatric units of general hospitals, and PRTFs.

In 2022, the American Psychiatric Association released a report noting that while the demand for inpatient psychiatric beds for youth has been increasing, the supply of beds has been decreasing.[11] The COVID-19 pandemic exacerbated pressures on PRTFs as facilities struggled with workforce shortages and increased costs. These pressures have led to a further decrease in available beds and an increase in the number youth waiting for an open bed. PRTFs across the nation report waitlists causing youth to go weeks to months without treatment at an appropriate level of care. As youth wait for open beds, they often occupy beds in unsuitable locations such as emergency departments, inpatient hospitals, and lower levels of care.

Admission challenges are compounded for youth with high acuity and/or exclusionary criteria. Many PRTFs have exclusionary criteria that automatically trigger a treatment denial. For example, many PRTFs do not serve youth under age 12 or youth with aggressive behavior and/or sexualized behavior diagnosis. In addition, many PRTFs lack the programmatic ability to serve youth with a secondary and/or co-occurring diagnosis such as a low intelligence quotient, a developmental disorder, or an eating disorder. When in-state PRTFs are unable to meet these youth's needs, state Medicaid programs will often attempt an out-of-state placement, but even those can be limited.

State Examples

Figure 5 below describes state examples of Medicaid PRTF policies and reimbursement methodologies. Many state Medicaid programs have recently increased reimbursement rates as they compete for available beds with private pay and other state Medicaid programs. In addition, some states have begun offering modified rates to incentivize PRTFs to accept youth with exclusionary criteria.

---

[7] CMS. (n.d.). *What is a PRTF* [Webpage]. Retrieved from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/WhatisaPRTF.pdf
[8] Social Security Act, Section 1905(a)(16)
[9] CMS. (n.d.). *What is a PRTF* [Webpage]. Retrieved from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/Whatis aPRTF.pdf
[10] Commonwealth Fund. (2023). *Strengthening Home- and Community-Based Services to Stabilize Young People with Behavioral Health Problems and Keep Them Out of Hospitals* [Webpage]. Retrieved from: https://www.commonwealthfund.org/blog/2023/strengthening-home-and-community-based-services-stabilize-young-people-out-of-hospitals
[11] American Psychiatric Association. (2022). *The Psychiatric Bed Crisis in the US* [Webpage]. Retrieved from: https://www.psychiatry.org/getmedia/81f685f1-036e-4311-8dfc-e13ac425380f/APA-Psychiatric-Bed-Crisis-Report-Full.pdf

Figure 5. State Reimbursement Approaches for PRTFs

State	Description
Colorado	**Rate increase to incentivize acceptance of in-state youth:** In 2021, Colorado Medicaid increased their PRTF per diem rate by 46% from $406.23 to $750.00. As part of a larger initiative to increase access to youth behavioral health services, the Colorado legislature allocated the increase to incentivizing in-state PRTFs to accept a higher percentage of in-state Medicaid youth. The in-state PRTF per diem rate is inclusive of all services provided to a youth in the facility, by facility staff. Non psychiatric services (i.e., vision or dental) provided outside the facility or by non-facility staff are reimbursed outside of the PRTF per diem rate.[12] In 2022, the rate was further increased to $765 per day.[13]
Connecticut	**Rate increase to expand access:** Effective January 1, 2023, Connecticut Medicaid increased their PRTF per diem rate by 30% from $610 to $792.46.[14]
Georgia	**Example of reimbursement methodology for hard to place youth:** In addition to its standard PRTF reimbursement rate, Georgia Medicaid offers a modified PRTF per diem rate for youth with a co-occurring diagnosis of autism. Georgia Medicaid reimburses PRTFs a facility-specific per diem based on submitted cost reports for all admitted youth. In 2022, the average PRTF reimbursement rate was $523.89. If a youth is admitted with a co-occurring autism diagnosis PRTFs receive an increased reimbursement rate. In 2022, the modified PRTF reimbursement rate for youth with a co-occurring diagnosis of autism was $597.65.[15]
Kentucky	**Example of reimbursement methodology for hard to place youth:** Kentucky Medicaid uses an acuity-based reimbursement methodology to address the needs of special populations. These populations included youth with an intelligence quotient lower than 70, youth with intellectual and/or developmental disabilities, and youth with severe and persistent aggressive behaviors. To differentiate between a standard PRTF level of care and a high acuity-based level of care, Kentucky introduced two levels of PRTFs, with separate reimbursement methodologies. The two levels have age range brackets to encourage PRTFs to open levels of care for younger youth. Level II PRTFs can provide treatment to youth as young as four.[16]
South Carolina	**Rate increase to incentivize acceptance of in-state youth:** In 2022, the State increased the PRTF per diem rate by 33% from $330 to $500 to address the impact of market forces surrounding the PRTF program.[17] [18]
Wyoming	**Rate increase to increase cost coverage:** Wyoming Medicaid increased in-state PRTF per diem rates by 12% in SFY 2023.

[12]Colorado Department of Health Care Policy and Financing. (2022). *Psychiatric Residential Treatment Facility Billing Manual* [Webpage]. Retrieved from: https://hcpf.colorado.gov/ptrf-manual
[13]Colorado Department of Health Care Policy and Financing. (2022). *Psychiatric Residential Treatment Facility Fee Schedule* [Webpage]. Retrieved from: https://hcpf.colorado.gov/sites/hcpf/files/CO_Fee%20Schedule_PRTF_07012022_v1.0.pdf
[14]Connecticut Medical Assistance Program. (2022). *Rate Increase on Select Behavioral Health Services* [Webpage]. Retrieved from: https://www.ctdssmap.com/CTPortal/Information/Get-Download-File?Filename=pb22_107.pdf&URI=Bulletins/pb22_107.pdf
[15]Georgia Department of Behavioral Health and Developmental Disabilities. (2022). Psychiatric *Residential Treatment Facilities (PRTF) Rate Adjustment* [Webpage]. Retrieved form: https://dch.georgia.gov/document/document/psychiatric-residential-treatment-facilities-rate-adjustment-public-notice-1/download
[16] Kentucky General Assembly. (2022). *Title 907* | *Chapter 009* | *Regulation 010* [Webpage]. Retrieved from: https://apps.legislature.ky.gov/law/kar/titles/907/009/010/
[17] South Carolina Department of Health and Human Services. (2022). *Rate Increase for Psychiatric Residential Treatment Facilities* [Webpage]. Retrieved from: https://www.scdhhs.gov/press-release/rate-increase-psychiatric-residential-treatment-facilities-prtfs
[18] South Carolina Department of Health and Human Services. (2022). *Psychiatric Residential Treatment Facility Rate Increase* [Webpage]. Retrieved from: https://www.scdhhs.gov/sites/default/files/Public%20Notice%20of%20Final%20Action%20for%20the%20Psychiatric%20Residential20Treatment%20Facility%20%28PRTF%29%20Rate%20Increase.pdf

Section 1115 Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance Demonstrations

Overview

Federal statute generally prohibits state Medicaid agencies from claiming FFP for services provided to individuals under age 65 in institutions for mental disease (IMDs). IMDs are defined in section 1905(i) of the Social Security Act and 42 CFR § 435.1010 as any healthcare facility (including a hospital or other institution) with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental disease. This includes substance use disorder (SUD), serious mental illness (SMI), and serious emotional disturbance (SED) services.

In 2017, the Centers for Medicare and Medicaid Services (CMS) via State Medicaid Director Letter #17-003 provided an opportunity for state Medicaid agencies to request an exemption to the IMD exclusion for SUD services through a Section 1115 SUD Demonstration. The exemption allows state Medicaid agencies to access FFP for SUD services provided in IMD. CMS later clarified that they would also approve Section 1115 Demonstrations for SMI/SED services. States can apply for Section 1115 Demonstrations that focus on SUD or SMI/SED or both concurrently.

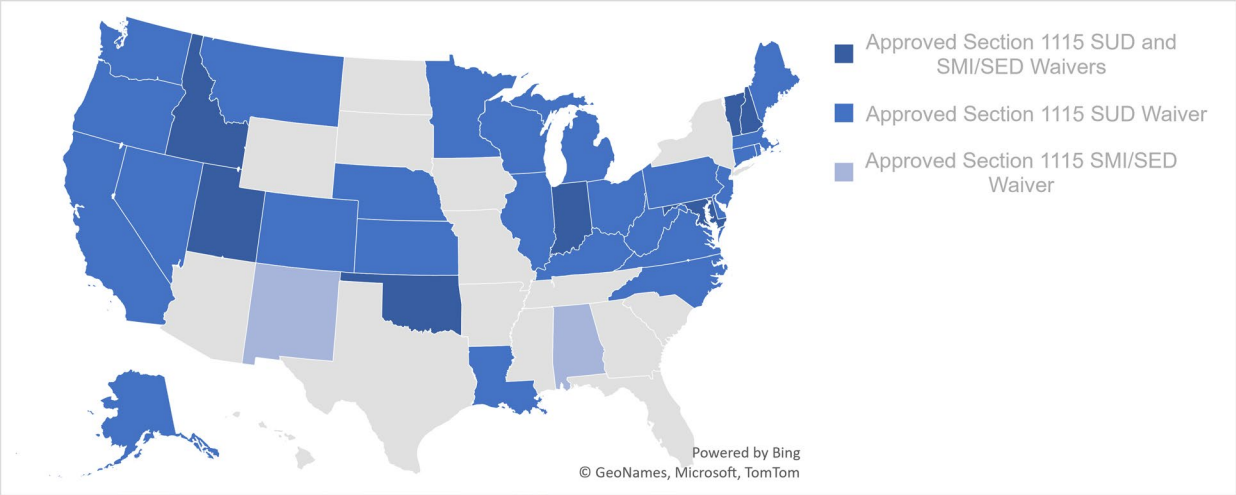
The opportunity requires states to develop a comprehensive approach to treating SUD and SMI/SED and provides an ability to access FFP for short-term inpatient and residential SUD and SMI/SED treatment in an IMD. States that implement a SUD 1115 Demonstration are required to increase provider capacity, increase access to a continuum of care, implement an evidence-based patient assessment tool, implement opioid prescribing, naloxone, and prescription drug monitoring, improve access to medication assisted treatment, and improve strategies for care coordination and transitions between levels of care. States that implement a SMI/SED 1115 Demonstration are required to ensure quality of care in psychiatric hospitals and residential settings, increase access to the continuum of SMI/SED care, increase integration of services, improve early identification and treatment, and improve strategies for care coordination and transitions to community-based care.

National Landscape

As shown in Figure 6 below, 34 states and the District of Columbia have approved Section 1115 SUD Waivers and 10 states and the District of Columbia have approved Section 1115 SMI/SED Waivers. Section 1115 SUD Waivers are pending for 5 additional states (AZ, MA, MO, NY, WA) and Section 1115 SMI/SED Waivers are pending for 6 additional states (MA, NJ, NY, OR, WA, WV).[19]

[19] Kaiser Family Foundation. (2023). *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State* [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/

Figure 6. States with an Approved Section 1115 SUD or SMI/SED Waiver



3. Non-Institutional Medical Services

Federally Qualified Health Centers

Overview

FQHCs are community-based healthcare providers that offer a range of services in underserved areas. FQHCs must provide primary and preventive care and may also offer other services included in a state's Medicaid plan such as dental, behavioral health, and vision services.

Under federal statute, FQHCs receive a cost-based reimbursement through an encounter or "all inclusive" rate. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) required all state Medicaid agencies to establish a baseline prospective payment system (PPS) rate for each FQHC. Under BIPA, states are also allowed to establish an Alternative Payment Methodology (APM) as long as the reimbursement is equal to or greater than the PPS rate and the FQHC consents to receiving the APM rate. If a FQHC receives less reimbursement than they would have been eligible for under the PPS rate, the facility must receive the difference as part of an additional payment. CMS requires approval of APMs through a state plan amendment.

The PPS rate establishes a baseline rate for each FQHC based on the methodology required under BIPA (100% of a facility's average costs per encounter during state fiscal years 1999 and 2000). States are required to update the PPS rates annually for inflation and based on changes in the scope of services provided to patients. For annual inflation, most states use the Medicare Economic Index (MEI) for rate updates, but states also have the option of using the FQHC-specific market-based update developed by CMS for the Medicare FQHC PPS. The MEI is the CMS published index used in the calculation of the increases in the prevailing charge levels that help to determine allowed charges for physician services. In 1992 and later, this index is considered in connection with the update factor for the physician fee schedule.

All states that operate managed care programs and pay FQHCs an APM capitated rate must calculate the difference between the APM and PPS annually and make supplemental payments

to FQHCs if the APM is lower than the FQHCs PPS.[20]

National Landscape

Currently over 20 states use an APM for Medicaid reimbursements. Several states recently received CMS approval for an APM that uses updated fiscal years cost reports for rebasing purposes. For example, CMS recently approved Minnesota's request to rebase using fiscal years ending 2017 and 2018. Several states have also received CMS approval to reimburse for select services outside of the PPS rate.

State Examples

Figure 7 summarizes state reimbursement approaches for FQHCs.

Figure 7. State Reimbursement Approaches for FQHCs

State	Description
Idaho	**Value-based payment model:** Idaho Medicaid received CMS approval in 2019 to integrated FQHCs into the State's Health Connections Value Care (HCVC) program as an APM. Under the HCVC program, primary care providers receive a fee-for-service reimbursement plus a PMPM care management fee. FQHCs receive higher PMPM fees based on qualifications such as patient make-up, opening for extended hours, and meeting program data requirements (being able to send and receive data to the state health exchange). FQHCs participate as an accountable primary care organization and are required to contain Medicaid costs and improve quality. The accountable primary care organization shares savings and losses with a limit on losses to the total amount of care management fees paid to an FQHC. This limit on losses allows FQHCs to participate within BIPA guidelines that require FQHCs to receive at least their PPS rate.[21]
Louisiana	**Reimbursement for services outside of the PPS:** Louisiana Medicaid received CMS approval in 2022 for an APM that allows additional reimbursement for community health worker services provided by a FQHC when these services are provided on the same date as a medical/dental/behavioral health visit. Community health workers are unlicensed providers that render preventive and other health services. The APM pays FQHCs an add-on amount, equivalent to the fee schedule rate for the community health worker service, in addition to the PPS.[22]
Minnesota	**APM for rate rebasing:** Minnesota Medicaid received CMS approval in 2022 for an APM that uses updated fiscal years (2017 and 2018) as the new base years. The methodology mimics the PPS with the encounter rate calculated based on the more recent base years costs divided by the number of qualifying encounters in the base years. Allowable costs are based on current Medicare cost principles including direct patient care costs and patient-related support services costs. Qualifying encounters are defined as encounters in which the patient is seen by a practitioner eligible to independently bill for the services provided.[23]
Nebraska	**APM for rate rebasing:** Nebraska Medicaid bases their APM methodology on a facility's Medicaid allowable cost. They multiply the FQHCs' Medicaid allowable

[20] NACHC (2019) *Health Centers and State Environments Chartbook* [Webpage]. Retrieved from:http://www.nachc.org/wp-content/uploads/2019/03/NACHC-2018-State-Chartbook-FINAL-1.pdf
[21] NASHP. (2019). *Idaho Develops a Medicaid Value-Based Payment Model for its FQHCs, Based on Cost and Quality* [Webpage]. Retrieved from: https://nashp.org/idaho-develops-a-medicaid-value-based-payment-model-for-its-fqhcs-based-on-cost-and-quality/
[22] CMS. (2022). *State Plan Amendment (SPA) LA: 22-0002* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/spa/downloads/LA-22-0002.pdf
[23] CMS. (2022). *State Plan Amendment (SPA) #: 21-0013* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/spa/downloads/MN-21-0013.pdf

State	Description
	costs by the blended average cost per visit for the past three years, projected using a three-year trend of the MEI. The APM base rate is updated annually based on the MEI and the base APM is rebased periodically using the FQHC's most recently available cost report.[24]
North Carolina	**APM for rate rebasing:** North Carolina Medicaid currently operates several APMs, including an option to cost settle rates annually. North Carolina recently received CMS approval for an APM that uses updated fiscal year 2018 as the new base year. The base rate was increased based on approved changes in the scope of services furnished during fiscal years 2019 and 2020. The base rate was also increased by the percentage increase in the MEI for primary care services in 2019 and 2020.[25]
Oklahoma	**Reimbursement for services outside of the PPS:** Oklahoma Medicaid received CMS approval in 2021 to reimburse for LARC devices outside of the PPS rate. LARCs are reimbursed under the Physician Administered Drugs benefit.[26]
Oregon	**Value-based payment model:** Oregon Medicaid implemented a value-based APM where FQHCs receive a per member per month (PMPM) payment for all members attributed to a FQHC or rural health clinic (RHC) based on historic PPS payments. The APM rate is calculated based on a wrap-around payment plus reconciliation of revenue divided by health center member months. The APM is only applied to primary care services, mental health, dental and obstetric services are paid at the PPS rate.[27] FQHCs that participate in the APM program complete quarterly reconciliations to compare revenue received under the APM to potential revenues that would have been received under the PPS. The reconciliation verifies that revenue received under the APM is equal to or greater than revenue that would have been received under the PPS. To hold FQHCs accountable for quality of care, Oregon Medicaid tracks quality measures on a quarterly basis, including metrics for colorectal cancer screening, depression screening, diabetes poor control and hypertension.[28]
Washington	**Value-based payment model:** Washington Medicaid has implemented several APMs as they work with FQHCs to refine and advance reimbursement models. APM-3 allowed FQHCs to act as Patient Centered Medical Homes and offered the opportunity for FQHCs to rebase their rate using an updated cost report. The APM was increased annually using a Washington-state specific inflation index instead of the MEI to inflate base rates. One of the limitations of APM-3 was that under the Patient Centered Medical Homes model only certain providers were billable (physicians, advanced practice nurses, physician assistants, certain behavioral health clinicians). This limited the ability of the FQHCs to provide a team approach

[24] Nebraska Medicaid. (2016). *State Plan Amendment 4.19-B* [Webpage]. Retrieved from: http://dhhs.ne.gov/Medicaid%20State%20Plan/Attachment%204.19b%20Item%202c%20-%20Federally-qualified%20health%20centers;%20telehealth.pdf#search=payment%20methodology%20FQHC
[25] CMS. (2021). *State Plan Amendment (SPA) #: 21-0016* [Webpage]. Retrieved from: https://www.medicaid.gov/Medicaid/spa/downloads/NC-21-0016
[26] CMS. (2021). *State Plan Amendment (SPA) #: 21-0007* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/spa/downloads/OK-21-0007.pdf
[27] MACPAC. (2017). *Medicaid Payment Policy for Federally Qualified Health Centers*. [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2017/12/Medicaid-Payment-Policy-for-Federally-Qualified-Health-Centers.pdf
[28] Oregon.Gov. (2020). *Oregon APM Program FAQ* [Webpage]. Retrieved from: https://www.oregon.gov/oha/HSD/OHP/Tools/APM%20FAQs.pdf

State	Description
	to care as certain providers could not practice at the top of their license and still be billable.[29] The most recent iteration, APM-4 attempted a value-based payment model to encourage use of primary care and improved quality. FQHCs remained Patient Centered Medical Homes, but instead of billing per encounter, Washington Medicaid established a budget-neutral, baseline PMPM rate for each FQHC. The FQHCs received a monthly PMPM payment for each managed care client assigned to them by a managed care organization (MCO).[30] The MCOs encouraged members to access care through their primary care provider (PCP) and quality of care was monitored using performance measures for which PCPs are solely or predominantly the accountable provider. For example, performance measures included comprehensive diabetes care, childhood immunization status, well-child visits and Medicaid management for children with asthma.[31]

Physicians and Nurse Practitioners

Overview

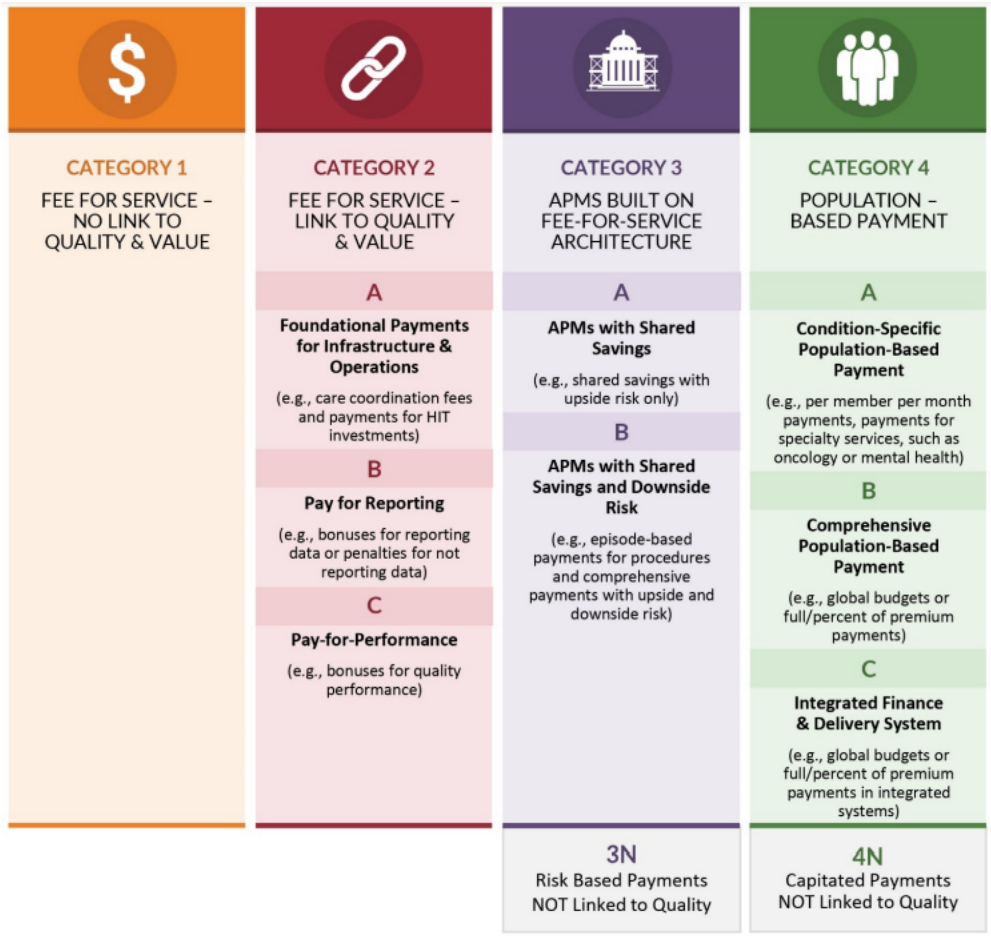
Guidehouse conducted an environmental scan of states' physician and nurse practitioner policies and reimbursement methodologies to identify leading practices and promising alternative reimbursement methodologies.

National Landscape

In recent years, CMS has encouraged state Medicaid programs to move services provided by physicians towards value-based care strategies. By doing so, states would help hold providers accountable for high quality care and cost savings by eliminating unnecessary procedures. Under value-based care there are multiple APMs including payment models built on fee-for-service systems, payments for episodes of care, and payment models for total cost of care accountability. CMS highlighted several value-based payment (VBP) models based on the Health Care Payment Learning & Action Network (HCP-LAN) VBP / APM framework.[32]

[29] NACHC (2018) *Spotlight on Health Center Payment Reform: Washington State's FQHC Alternative Payment Methodology* [Webpage]. Retrieved from: https://www.nachc.org/wp-content/uploads/2018/05/NACHC-WA-APM-Case-Study-2018.pdf
[30] Washington State Legislature (2023) *WAC 182-548-1400 Federally Qualified Health Centers- Payment Methodologies* [Webpage]. Retrieved from: *https://apps.leg.wa.gov/wac/default.aspx?cite=182-548-1400*
[31] NACHC (2018) *Spotlight on Health Center Payment Reform: Washington State's FQHC Alternative Payment Methodology* [Webpage]. Retrieved from: https://www.nachc.org/wp-content/uploads/2018/05/NACHC-WA-APM-Case-Study-2018.pdf
[32] CMS. (n.d.). *Value-Based Care Opportunities in Medicaid* [Webpage]. Retrieved from: https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd20004.pdf

Figure 8. HCP-LAN VBP / APM Framework



State Examples

Figure 9 summarizes state approaches to reimbursement and VBP arrangements for physicians and nurse practitioners.

Figure 9. State Reimbursement for Physicians and Nurse Practitioners

State	Description
Colorado	• In 2018, Colorado created seven Regional Accountable Entities (REAs) regions. The REAs implemented value-based payment and quality metrics to integrate primary care with behavioral health services. Medicaid beneficiaries access care through their REA who are responsible for ensuring Medicaid members have access to primary care and behavioral health services, coordinating members' care and meeting quality metrics. • REAs reimburse PCPs bonus payments to encourage value-based care and coordination with behavioral health services. • Colorado Medicaid's goal is to have 50% of Medicaid payments tied to VBP that link financial rewards to performance measures that achieve shared goals, such as improving health, closing disparities, and improving healthcare affordability.

State	Description
	• Colorado Medicaid has implemented several iterations of their APM program. In 2016, PCPs were able to receive enhanced payment rates if specific quality metrics were met. In 2021, PCPs were able to receive a percentage of their revenue as a fixed PMPM payment to provide stable revenue and incentivize providers to improve patient care. The APM also integrated quality metrics around chronic care management that, if met, resulted in shared savings.
Indiana	• Physicians, limited license practitioners, and other nonphysician medical practitioners that bill on a fee-for-service basis receive a resource-based relative value scale (RBRVS) method of reimbursement.[33] Practitioners, outside of those contracted with a risk-based MCO, are reimbursed at the lower of the submitted charge or the established statewide RBRVS fee schedule allowance for the procedure. • Reimbursement amounts are varied to reflect differences in education in training and range from 60-100% of the physician fee.**Error! Bookmark not defined.** • Reimbursement for independently practicing nurse practitioners is at 75% of the rate on file; nurse practitioners not independently enrolled bill services are reimbursed at 100% of the Medicaid-allowed amount.
Wisconsin	• Wisconsin Medicaid reimburses physicians the lesser of the physician's billed amount for a service or Wisconsin Medicaid's maximum allowable fee.[34] • Maximum allowable fees are based on various factors, including a review of usual and customary charges submitted, the Wisconsin State Legislature's Medicaid budgetary constraints, and other relevant economic limitations.[35] • Wisconsin makes a 10% adjustment for physician assistants performing services that would otherwise be performed by a physician. • Wisconsin reduces reimbursement to physicians and other professional service providers for services that are typically provided in an office-based setting when those services are instead provided in a hospital or an ambulatory surgical center (ASC). The reduced reimbursement is intended to account for the lower overhead costs typically realized by physicians and other professional services providers when services are provided in a hospital or an ASC.[36] • Nurse practitioners are reimbursed at the lesser of the nurse practitioner's usual and customary charge for a service or the physician's maximum allowable fee for the procedure. Nurse practitioners use the physician maximum allowable fee schedule.[37]

Maternal Health

Overview

Maternal health outcomes in the United States trend lower than other developed nations,

[33] Indiana Health Coverage Programs. (2022) *Indiana Medical Practitioner Reimbursement* [Webpage]. Retrieved from: https://www.in.gov/medicaid/providers/files/modules/medical-practitioner-reimbursement.pdf
[34] ForwardHealth. (n.d.) *Reimbursement, Topic #652* [Webpage]. Retrieved from: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=5&c=30&nt=
[35] ForwardHealth. (n.d.)Reimbursement, Topics #260 and #7777 [Webpage]. Retrieved from: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=5&c=30&nt=
[36] ForwardHealth. (n.d.) *Reimbursement - Amounts, Topic #13297* [Webpage]. Retrieved from: https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=5&c=30&nt=
[37] ForwardHealth. (n.d.) *Reimbursement - Amounts, Topic #866* [Webpage]. Retrieved from https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=50&s=5&c=30&nt=

especially when it comes to maternal mortality rates for black women which are three times those of white women.[38] With Medicaid paying for nearly half of all births in the US, state programs play a significant role in the financing and delivery of maternity and early childcare.

National Landscape

States have implemented a variety of payment models and policies for maternity services to best support beneficiaries and improve maternal health, which include:[39]

- **Blended payments:** State offers providers a single payment amount for delivery, regardless of whether it was cesarean or vaginal. (2 states)
- **Bundled payments:** State uses a single fixed payment for a group of maternity services (e.g., prenatal care, delivery, and postpartum visit). (10 states, including AR)
- **Pay-for-performance:** State gives providers (hospitals or doctors) financial incentives to meet quality metrics related to maternal health, such as low rates of cesarean sections. (14 states, including AR)
- **Reduced- or non-payment policies**: State has a policy to reduce payments or not cover procedures that do not follow clinical guidelines (e.g., early elective deliveries, elective inductions, and cesarean sections that are not medically indicated). (20 states)
- **Postpartum LARC:** State has payment policy to encourage LARC immediately postpartum, outside of general Medicaid coverage for LARC of beneficiaries of reproductive age. (31 states)
- **Other:** State has other payment models or policies that are intended to improve maternal health. (4 states)

As mentioned above, Arkansas and 13 other states are implementing pay-for-performance or value-based care payments for maternity beneficiaries as a way to improve the quality of care delivered. These models have been designed to build off of already existing delivery and payment systems by focusing on ensuring that beneficiaries receive the professional standard of care regardless of the facility they visit. Figure 10 provides examples of reimbursement approaches that states have used for maternal health.[40]

Figure 10. State Reimbursement Approaches for Maternal Health

State	Description

Colorado	• Voluntary pay-for-performance program for hospitals serving Medicaid beneficiaries
	  ○ Hospitals receive bonus payments based on their reporting and performance on a set of 13 quality measures related to maternal health and perinatal care, patient safety, and patient experience
	  ○ Hospitals do not face financial penalties if their performance scores are low

[38] Petersen, E.E., N.L. Davis, D. Goodman, et al. 2019b. Racial/ ethnic disparities in pregnancy-related deaths: United States, 2017–2016. Morbidity and Mortality Weekly Report 68, no. 35: 762–765. [Webpage]. Retrieved from: https://www.cdc.gov/mmwr/volumes/68/wr/ pdfs/mm6835a3-H.pdf

[39] MACPAC. (2020). *Inventory of state-level Medicaid policies, programs, and initiatives to improve maternity care and outcomes. March 2020 contractor report* [Webpage]. Retrieved from: https://www.macpac.gov/publication/inventoryof-state-level-medicaid-policies-programs-and-initiatives-toimprove-maternitycare-and-outcomes/

[40] MACPAC. (n.d.) *Value-Based Payment for Maternity Care in Medicaid: Findings from Five States* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/09/Value-Based-Payment-for-Maternity-Care-in-Medicaid-Findings-from-Five-States.pdf

State	Description

	• Episode of care payment model covering the entire prenatal episode, delivery, and postpartum care
	  ○ Providers are paid on a fee-for-service basis, but payment may be adjusted retrospectively based on the average cost and quality
	  ○ The program provides principal accountable providers credit for tracking and reporting on the following quality metrics:[41]
	  ▪ Prenatal Behavioral Risk Assessment
	  ▪ Postpartum Depression Screening
	  ▪ Caesarean Birth
	  ▪ Postpartum Contraceptive Care
	  ▪ Elective Delivery
	  ▪ Prenatal HIV Screening
	  ▪ Screenings: Group B Strep, Gestational Diabetes, Hep B
	  ▪ Prenatal Immunization Status
	  ▪ Prenatal and Postpartum Care
	  ▪ Unexpected Complications in Term Newborns
	  ▪ Percentage of Low Birthweight Babies
	  ▪ Exclusive Breastmilk Feeding

Connecticut	• Voluntary pay-for-performance program in which participating providers are paid on a fee-for-service basis but are eligible for retrospective bonus payments based on their performance on eight quality and access to care measures
	  ○ Measures address care provided during prenatal, delivery, and postpartum period
	  ○ Measures are weighted differently based on where the state would like to see improvements
	  ○ Funding is determined through the state budget process
	  ○ Providers face no downside risk

North Carolina	• Pregnancy Medical Home (PMH) to enhance comprehensive care delivery and improve both maternal and birth outcomes
	  ○ Program run through a contract with a primary care case management entity
	  ○ Medicaid program provides a PMPM payment
	  ○ PMH providers may receive two lump sum incentive payments for completing risk assessment screening and postpartum visits
	  ○ All maternity services are paid using a bundled payment instead of paying for each individual service, regardless of whether a provider is a participating PMH

Tennessee	• Mandatory model for Medicaid MCOs and their contracted providers and voluntary for the commercial market to reward providers who deliver cost-

[41] Colorado Department of Health Care Policy & Financing. (2020). *Maternity Bundled Payment Program Specifications*. [Webpage]. Retrieved from: Maternity Bundled Payment Program Specifications 3.pdf (colorado.gov)

State	Description
	effective, quality care, and promote patient-centered, high-value health care for pregnant women ○ Tennessee sets a statewide threshold for what is considered acceptable cost and each MCO sets a cost threshold for what it considers low cost ○ Providers with average costs that are greater than the considered acceptable cost are required to make a risk-sharing payment ○ Providers with average costs that are lower than the considered acceptable cost may share in any savings if quality thresholds are met ○ Exclusion of high-risk pregnancies ○ Vaginal and cesarean deliveries receive the same amount regardless of delivery modality

Early Child Health

Overview

One early child health program, the HealthySteps program, is part of the ZERO TO THREE non-profit organization. This program is designed to foster healthy child development to ensure all babies have a strong start to the beginning of their lives. The model is flexible, with no two sites being funded in the same way, but aims to create an affordable setup.[42] The program follows a risk-stratified, population-based model and is organized into three Tiers of Service and eight Core Components to ensure all families with children ages 0-3 receive support aligned with their needs.[43] This includes:

- Tier 1: Universal Services – For All Families with Children Ages 0 – 3
  - Core Component 1: Child Development, Social Emotional & Behavioral Screening
  - Core Component 2: Screening for Family Needs
  - Core Component 3: Family Support Line
- Tier 2: Short Term Supports – For Families with Mild Concerns
  - Core Component 4: Child Development & Behavior Consults
  - Core Component 5: Care Coordination & Systems Navigation
  - Core Component 6: Positive Parenting Guidance & Information
  - Core Component 7: Early Learning Resources
- Tier 3: Comprehensive Services
  - Core Component 8: Ongoing, Preventative Team-based Well-Child Visits

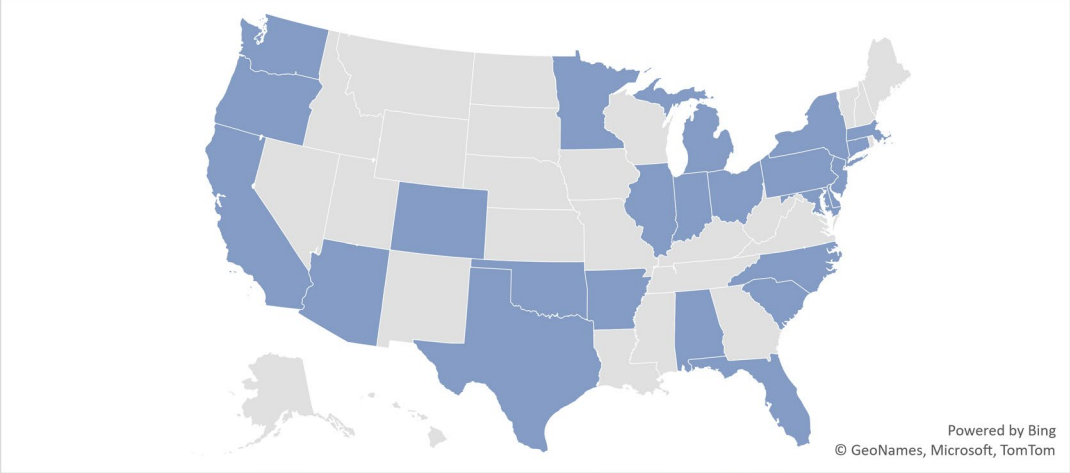
National Landscape

The HealthySteps program spans across 24 states and Washington, DC and is in 231 pediatric primary care practices (not specific to Medicaid programs).[44] According to ZERO TO THREE, the average Medicaid return on investment in HealthySteps is 163%, with child-focused interventions including flu vaccine, oral health, and appropriate use of care for ambulatory

[42] HealthySteps. (n.d.) *How to Pay for HealthySteps* [Webpage]. Retrieved from: https://www.healthysteps.org/what-we-do/our-model/how-to-pay-for-healthysteps/
[43] HealthySteps (n.d.) *Tiers and Core Components* [Webpage]. Retrieved from. https://www.healthysteps.org/what-we-do/our-model/tiers-and-core-components/
[44] HealthySteps. (n.d.). *The HealthySteps Network* [Webpage]. Retrieved from: https://www.healthysteps.org/who-we-are/the-healthysteps-network/

sensitive conditions and caregiver-focused interventions including breastfeeding, postpartum maternal depression, intimate partner violence, healthy birth spacing, and smoking cessation.[45]

Figure 11. States with a HealthySteps Program (All Payers)



Durable Medical Equipment

Overview

Guidehouse conducted an environmental scan of Medicare and states Durable Medical Equipment (DME) policies and reimbursement methodologies to identify leading practices and promising alternative reimbursement methodologies.

National Landscape

State Medicaid coverage of DME for adults is an optional benefit and there are no federal minimum requirements for State Medicaid programs to cover adult DME services. Most states choose to cover medically necessary DME services. State Medicaid programs are required to cover medically necessary DME for youth under the age of 21 through the EPSDT benefit.

State Examples

Most states cap rental items and have policies that convert rental items to purchased items after a specified amount of time.

Figure 12. Federal and State Reimbursement Approaches to DME

State	Description
Medicare	• Medicare reimburses for most DME items using the Medicare DME fee schedule.[46] The fee schedule is updated quarterly and is set at 80% of the lower of either the actual charge for the item, or the fee schedule amount calculated for the item, less any unmet deductible payments. • As a cost saving effort, in 2003, Congress passed Section 302 of the Medicare Modernization Act of 2003 which required CMS to establish a national

[45] ZERO TO THREE. (2021). *HealthySteps Interventions Drive Short-Term Medicaid Cost Savings*. Retrieved from: https://www.healthysteps.org/wp-content/uploads/2021/09/HS_Return_on_Investment-Final.pdf.
[46] CMS. (2019). *DMEPOS Fee Schedule* [Webpage]. Retrieved from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS-Fee-Schedule.html

State	Description
	Competitive Bidding Program for certain DME items (hospital beds, oxygen and oxygen equipment, walkers, etc.). Under the CBP program DME suppliers were divided into competitive bidding areas and were required to submit a bid for selected products. The program has gone through multiple rounds and in 2020, Medicare renewed the competitive bidding program for limited DME items (knee and back braces) effective January 1, 2021, through December 31, 2023.[47]
Idaho	• Idaho Medicaid reimburses DME on a fee-for-service basis calculated at 90% of the Medicare fee schedule. Usual and customary fees are paid up to Medicaid Maximum allowance. • Reimbursement for rental DME is based on 1/10 of the Medicaid allowance. Most DME rental items are considered purchased after ten months of rental payments.[48]
South Dakota	• South Dakota Medicaid reimburses at the lesser of a provider's usual and customary charge or the amount listed on the South Dakota DMEPOS fee schedule. The DME fee schedule is calculated at 90% Medicare fee schedule (using the rural calculation). If there is no Medicare reimbursement rate, reimbursement is set at the lesser of: 75% of the provider's usual and customary charge for supplies or MSRP or 90% of the lesser of the provider's usual and customary charge for supplies or MSRP. Providers may not bill South Dakota Medicaid at a higher rate than MSRP. • Most DME rental items are considered purchased after twelve months of rental payments. • Equipment maintenance and repairs are charged at the lesser of the provider's usual and customary charge or the purchase price of a new piece of equipment.[49]

Ambulatory Surgery Centers

Overview

ASCs are distinct entities that provide a surgical setting for individuals to receive outpatient services who do not require hospitalization. If an ASC is associated with a hospital, the ASC facility must be physically separated from all other health services offered at the hospital. Typically, ASCs must be certified as an ASC by CMS.

State Examples

Figure 13 summarizes state reimbursement approaches for ASCs.

[47] CMS. (2022.) *DMEPOS Competitive Bidding – Home* [Webpage]. Retrieved from:https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid#:~:text=The%20DMEPOS%20Competitive%20Bidding%20Program%20was%20mandated%20by%20Congress%20through,Act%20of%202003%20(MMA).
[48] Idaho Medicaid. (2022) *Idaho Medicaid Provider Handbook Suppliers.* [Webpage]. Retrieved from: https://www.idmedicaid.com/Provider%20Guidelines/Suppliers.pdf
[49] South Dakota Medicaid. (2022) *Billing and Policy Manual DMEPOS*. [Webpage]. Retrieved from: https://dss.sd.gov/docs/medicaid/providers/billingmanuals/Professional/Durable_Medical_Equipment.pdf

Figure 13. State Reimbursement Approaches for ASCs

State	Description
Colorado	Colorado Medicaid reimburses for ACSs using bundled rates that are updated annually. Surgical procedures are assigned to one of ten reimbursement categories and ASCs are reimbursed the lesser of the maximum allowable payment amount or the billed charges. The billed charges must be the usual and customary amounts and cannot be adjusted for the anticipated Medicaid payment.[50]
Montana	Montana Medicaid uses the Medicare ASC fee schedule and ASC facilities are reimbursed at 100% of Medicare allowable amount for reimbursement. Montana Medicaid adopted and incorporated by reference the Medicare reimbursement methodology at 42 CFR part 416, subpart F, and the schedule listing the allowable amounts for ASC services in the Medicare Claims Processing Manual.[51]
Oklahoma	Oklahoma Medicaid uses the Medicare ASC fee schedule and ASC facilities are reimbursed at 100% of Medicare allowable amount for reimbursement. Services are paid on a rate per services basis with separate reimbursement for covered ancillary services that are integral to covered surgical procedures. Minor procedures that can normally be performed in a physician's office are not covered in an ASC unless medically necessary. [52]

Telehealth

Overview

In the wake of the COVID-19 pandemic, the use of telehealth to deliver services to Medicaid beneficiaries increased substantially. Telehealth services can be delivered through a variety of methods which have gained popularity of differing degrees across states.

National Landscape

Telehealth reimbursement methodologies and their utilization nationally are shown in Figure 14.

Figure 14. National Telehealth Reimbursement Utilization (as of 2022)[53]

Telehealth Reimbursement Methodology	State Count
Live Video Fee-for-Service	50 states and Washington, D.C.
Store- and-forward	25 states
Remote Patient Monitoring	34 states
Audio-only Telephone	34 states and Washington, D.C.
All four modalities	17 states

[50] Colorado Department of Health Care Policy and Financing. (2022). *Ambulatory Surgery Centers (ASC) Billing Manual* [Webpage]. Retrieved from: https://hcpf.colorado.gov/asc-manual
[51] Administrative Rules of Montana. (n.d.). *"37.86.1406 Clinic Services, Reimbursement."* [Webpage]. Retrieved from: https://rules.mt.gov/gateway/RuleNo.asp?RN=37%2E86%2E1406
[52] Oklahoma Health Care Authority. (n.d.). *OHCA Policies and Rules- 317:30-5-566. Ambulatory Surgery Center services* [Webpage]. Retrieved from: https://oklahoma.gov/ohca/policies-and-rules/xpolicy/medical-providers-fee-for-service/individual-providers-and-specialties/ambulatory-surgical-centers-asc-/ambulatory-surgery-center-services.html
[53] Center for Connected Health Policy. (2022). *State Telehealth Laws and Medicaid Program Policies*, Retrieved from: Fall2022_ExecutiveSummary8.pdf (cchpca.org)

In Arkansas, services delivered via telehealth are reimbursed at the same rate as those provided in person. Services can be provided through a variety of modes including live video, remote patient monitoring, and through audio only. Notably, Arkansas does not allow for telehealth to be provided through a store-and-forward method, which is when a provider uses information to evaluate a case or render a service outside of real-time or live interaction.

As telehealth has become more prevalent, some states have chosen to enter into multi-state licensing compacts to offer a faster pathway to interstate telehealth practice.[54] Compacts can decrease the time and administrative burden of providers seeking to practice telehealth in multiple states. Depending on the compact and state licensing requirements, the compact agreement authorizes telehealth, and in some cases, in-person practice across state lines. Generally, a compact agreement states that a telehealth appointment occurs in the state where the beneficiary is located.

One such compact is the Interstate Medical Licensure Compact, which is an agreement among participating states and territories that makes it easier for physicians to obtain licenses to practice in multiple states. The Compact currently includes 37 states along with the District of Columbia and Guam.[55]

4. Long-Term Services and Supports

Home and Community-Based Services and Value-Based Payments

Overview

VBP refers to programs that reimburse providers based on the value and quality of services provided. The HCP-LAN developed a VBP / APM framework which demonstrates a continuum of payment mechanisms.[56] Within home and community-based services (HCBS), VBP methods tend to align with linking quality and value with existing fee-for-service architecture by focusing on payments for compliance, goal-achievement, and performance.

National Landscape

Although VBP had historically been used more for acute care than HCBS, several states began incorporating VBP into their HCBS programs with support from CMS' Medicaid Innovation Accelerator Program (IAP) beginning in 2016.[57] In more recent years, the COVID-19 public health emergency (PHE) accelerated the use of these types of payment structures as states experienced workforce retention challenges and were presented with additional HCBS funding (e.g., American Rescue Plan Act Section 9817) and program restructuring opportunities.

During the PHE, several states implemented VBP into 1915(c) HCBS waiver programs via Appendix K authorities, which allow states to temporarily amend their active programs during a period of emergency. To make the VBP changes permanent, several states have added VBP

[54] HHS. (n.d.). *Licensure Compacts* [Webpage]. Retrieved from: https://telehealth.hhs.gov/licensure/licensure-compacts
[55] Interstate Medical Licensure Compact. (n.d.) [Webpage]. Retrieved from : https://www.imlcc.org/a-faster-pathway-to-physician-licensure/
[56] Health Care Payment Learning & Action Network. (2017). Alternative Payment Model. [Webpage]. Retrieved from: https://hcp-lan.org/workproducts/apm-refresh-whitepaper-final.pdf
[57] Centers for Medicare & Medicaid Services.(n.d.). *Value-Based Payment for Home and Community-Based Services* Webpage]. Retrieved from: https://www.medicaid.gov/resources-for-states/innovation-accelerator-program/program-areas/promoting-community-integration-through-long-term-services-and-supports/value-based-payment-for-home-and-community-based-services/index.html

into waiver applications through renewals and amendments.

VBP in Appendix Ks and 1915(c) waivers were mostly related to increasing rates or additional payments for providers. VBP payments includes incentives for providers to: comply and use states' systems, such as adding electronic visit verification (EVV) requirements or adding pay-for-reporting incentives, encourage providers to take additional trainings and courses, and refer and recruit new providers into the workforce. Many states are using VBP for supported employment (or similar) services, adding financial incentives when waiver participants achieve certain milestones or goals.

State Examples

Figure 15 below describes examples of the use of VBP in 1915(c) waiver programs, based on review of 1915(c) waiver applications.[58]

Figure 15. State Examples of Value-Based Payments

State	Description
Missouri	Missouri participated in the CMS IAP and has since incorporated VBP into its HCBS waivers, supported by additional FMAP funding from the American Rescue Plan Act (ARPA).[59] Missouri developed nine incentive and supplemental payment initiatives described below: 1. *Additional trainings for direct support professionals:* The State created levels of training for providers to accomplish. As providers meet these levels they can earn percentages of paid Medicaid claims. 2. *Participation in the registered apprenticeship program:* As each employee apprentice enrolls in the program, providers can earn two payments of $1,560 for each credential completed. 3. *Reporting for employment services:* As providers complete activity and outcome reports, they can earn $55 per report per individual. 4. *Compliance and use of the EVV system:* Providers meeting at least 80% compliance with EVV usage can earn 1% of total claims for personal assistant claims made, every six months. 5. *Use of a Health Risk Screening Tool:* Providers that collect initial screenings can earn $72.20 for each initial screen conducted. 6. *Participation in the National Core Indicator (NCI) Staff survey:* Providers who complete the annual survey by the deadline receive $2,000 annual payment per provider. 7. *Sharing data related to Individualized Supported Living service:* Upon completion of a monthly data report, providers can earn $174. 8. *Transition of individualized supported living and in home respite services to remote supports:* As providers transition from staff support hours to remote hours, providers can earn 15% of the total savings in a 6-month period. 9. *Implementation of benchmarking data for Tiered Supports:* Providers earn additional payments for the level of implementation achieved in tiered supports benchmarking data. Many of these structures aid in issues related to workforce retention, adding additional financial incentives for providers. Other justifications for these

[58] Centers for Medicare & Medicaid Services. (n.d.). *State Waivers List*. [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html
[59] Missouri Department of Mental Health. (n.d.). *Value Based Payments*. [Webpage]. Retrieved from: https://dmh.mo.gov/dev-disabilities/value-based-payments

State	Description
	payments include reducing overall spending on service delivery and providing the State with additional data on services that did not previously have adequate data collection processes. Many of these incentives rely on self-reported data from providers, which may ultimately be a challenge for the State.
Oregon	Oregon added incentive programs in two of its waiver programs, Adults' HCBS Waiver and Behavioral (ICF/IDD) Model Waiver for the supported employment service. The incentive is based on the hours and level of need for service. The goal of this incentive is to gradually fade support needed as the participant spends more time in their workplace. In order for providers to receive these incentive payments, participants must be placed and retain their job for 90 days.
South Dakota	South Dakota added VBP for several services in its 1915(c) waiver programs. The CHOICES waiver developed an Individual Resource Allocation model. This requires providers to submit to an online information system with the service plan and needs of participants. Rates are then set based on the services and needs detailed. Payments are made based on high preforming providers, addressing person-centered care plans, and meeting needs of participants.
Tennessee	Tennessee added an outcome-based payment for the supported employment service in its three 1915(c) HCBS waivers. The State uses a tiered model with the goal to fade the use of coaching supports overtime. The tiered system evaluates the fading of the service, level of support needed by the participant, and the amount of time the participant has held their job. In addition to achieving payments from the tiered system, there is an additional incentive payment, available to providers twice a year, for quality and special effort in delivering integrated employment. Tennessee also introduced another incentive payment for provider outcomes to align with "system transformation values, such as person-centered practices, independence, community integration, dignity of choice, competitive integrated employment, enabling technology, and workforce development."

Long-Term Services and Supports (LTSS) Rebalancing

Overview

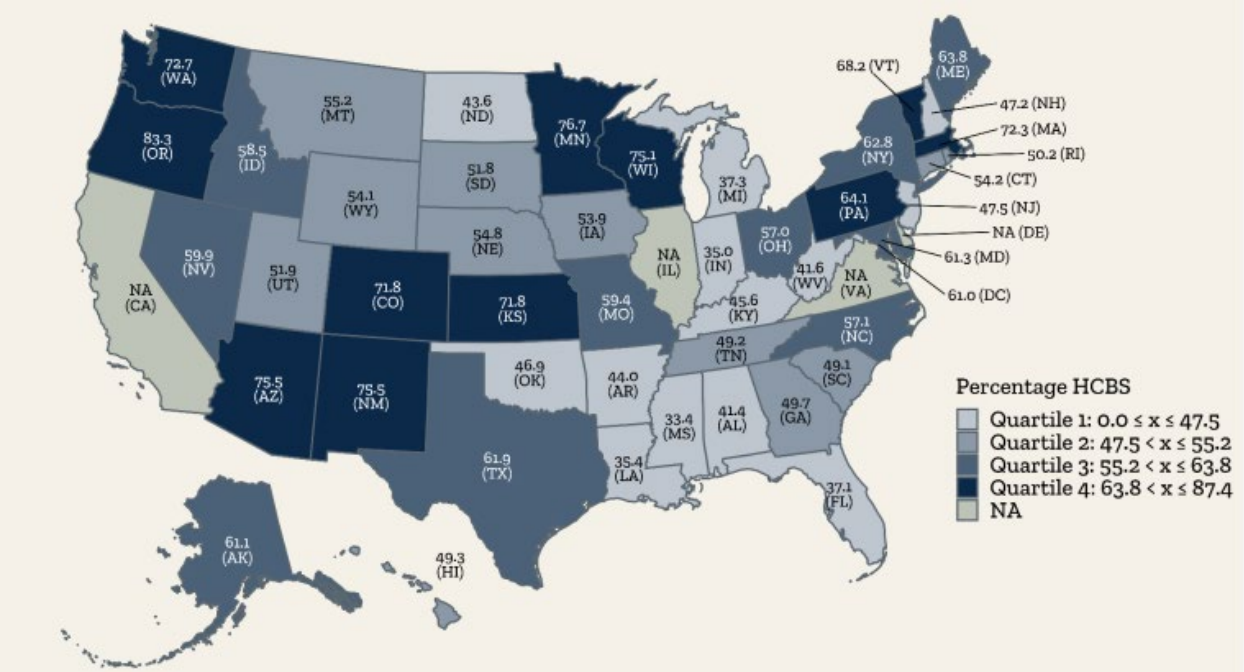
Increasing the number of participants in HCBS in a state can ultimately reduce the Medicaid spend and provide higher quality care. States' efforts to move more participants into HCBS settings can reduce spend in nursing facilities.

National Landscape

LTSS rebalancing has seen continual progress over the past decade with HCBS expenses exceeding institutional expenses since FY 2013. In FY 2019, national Medicaid LTSS expenditures were $162.1 billion, comprised of **58.6% HCBS** and **41.4% institutional services**. Illustrated below in Figure 16, state performance on Medicaid LTSS rebalancing varies, ranging from 33.4% in Mississippi to 83.3% in Oregon.[60]

[60] Centers for Medicare and Medicaid Services.(n.d.). *Medicaid Long Term Services and Supports Annual Expenditures Report.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf

Figure 16. Map of State Medicaid HCBS Expenditures as Percentage of Total Medicaid LTSS Expenditures, FY 2019



A study conducted in 2016 reviewed California Medicaid beneficiaries in HCBS versus nursing facilities. The study found that the services being delivered in nursing facilities had a higher cost and that the program could benefit from directing participants from institutional to community care. The study concluded that "on average, the monthly LTSS expenditures were higher for Medicare $1,501 and for Medicaid $1,344 when LTSS was provided in a nursing facility rather than in the community."[61]

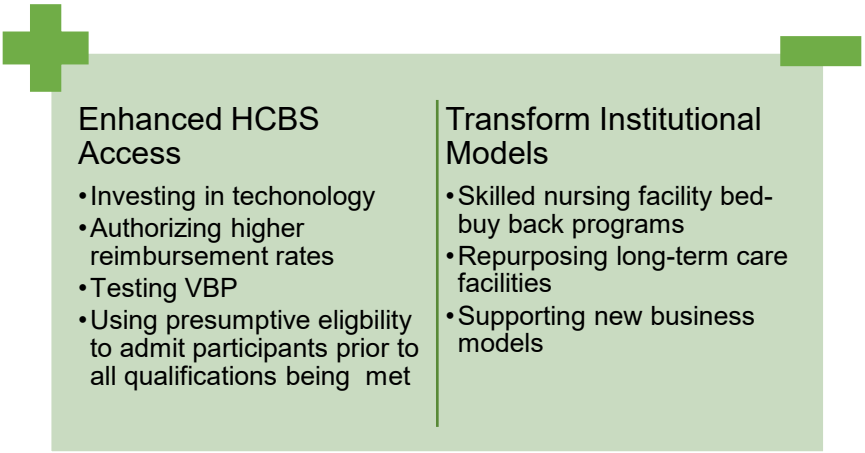
States also use the Money Follows the Person (MFP) program to support rebalancing efforts. The MFP program encourages states to reduce the use of institutional care for individuals receiving LTSS and ensure those services are being delivered in the community.[62] A 2019 study reviewed the impact of the MFP program and found that an effort in increased spending to rebalance LTSS yields an overall reduction in institutional spending and provides overall LTSS cost savings. Research shows that on average states who invest in rebalancing can decrease spending in institutional settings when moving to community-based care.[63] States that were successful in reducing overall spend did so by reviewing policies in both HCBS and institutional access as well as updating Medicaid policy and addressing spend as a whole.

There are two main methods states are using in rebalancing HCBS – enhancing and expanding HCBS access and transforming institutional models.[64] Figure 78 below details methods to

[61] Newcomer RJ, Ko M, Kang T, Harrington C, Hulett D, Bindman AB. H*ealth Care Expenditures After Initiating Long-term Services and Supports in the Community Versus in a Nursing Facility*. Med Care. [Webpage]. Retrieved from: https://pubmed.ncbi.nlm.nih.gov/26759982/
[62] Centers for Medicare and Medicaid Services.(n.d.). *Money Follows the Person.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html
[63] Kaye S. (2019). *Evidence for the Impact of the Money Follows the Person Program*. [Webpage]. Retrieved from: https://clpc.ucsf.edu/sites/clpc.ucsf.edu/files/reports/Evidence%20for%20the%20Impact%20of%20MFP_0.pdf
[64]CMS. (n.d.) *Long-term Services and Supports Rebalancing Toolkit*. [Webpage]. Retrieved from: www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf

address those rebalancing efforts.[65,66]

Figure 17. Efforts to Rebalance LTSS



State Examples

Figure 18 describes example strategies states have used to support LTSS rebalancing. States are also using Managed Long-Term Services and Supports (MLTSS) to support LTSS rebalancing as discussed in the Capitated Payments chapter.

Figure 18. State Examples of LTSS Rebalancing

State	Description
Indiana	During the PHE, Indiana began using presumptive eligibility in its HCBS program. The goal of the program was to provide services ten days within authorization, ensuring these individuals would not have to move to a nursing facility. The State uses a separate application for presumptive eligibility which includes specific income limits and metrics that can be quickly verified to confirm presumptive eligibility. Specific qualified providers review those metrics to verify presumptive eligibility.[67]
Oregon	Oregon has taken multiple approaches to rebalance LTSS, including a bed-buyback program and increasing waiver capacity. In 2013, Oregon conducted a bed-buyback program to reduce nursing facility capacity by 1,500 beds.[68] Oregon has leveraged the use of additional waivers, such as a community first choice waiver to expand HCBS across the State.[69] In 2019, the majority (83.3%) of Oregon's LTSS expenditures were from HCBS.

[65] AARP. (n.d.) *LTSS Choices: Presumptive Eligibility for Medicaid Home and Community-Based Services Can Expand Consumer Choice.* [Webpage]. Retrieved from: https://www.aarp.org/pri/topics/health/coverage-access/ltss-choices-presumptive-eligibility-medicaid-home-community-based-services/
[66] Kaiser Family Foundation. (n.d.). *Medicaid Public Health Emergency Unwinding Policies Affecting Seniors & People with Disabilities: Findings from a 50-State Survey*. [Webpage]. Retrieved from: https://www.kff.org/report-section/medicaid-public-health-emergency-unwinding-policies-affecting-seniors-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/
[67] Indiana Medicaid for Providers. (n.d.). *Qualified Provide Presumptive Eligibility*. Retrieved: https://www.in.gov/medicaid/providers/business-transactions/qualified-provider-presumptive-eligibility-pe/
[68] CMS. (n.d.). *Long-term Services and Supports Rebalancing Toolkit.* [Webpage].Retrieved from: www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf
[69] CMS. (n.d.). *Medicaid Long Term Services and Supports Annual Expenditures Report.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf

State	Description
Texas	Texas used a 1915(i) State Plan program to target populations with specific risk factors that did not meet institutional care qualifications. By creating this program, participants received HCBS-like services, while high risk situations were addressed and the use of emergent or ambulatory care declined.[70]
Washington	Washington uses Section 1115 waiver authority to provide presumptive eligibility to provide care to older adults and their caregivers. The State amended its waiver to extend presumptive eligibility for LTSS. While risk is split between the State and the federal government, the State notes that using presumptive eligibility yields minimal risk to both entities and keeps participants out of institutionalized care.[71]

5. Habilitative & Rehabilitative Services

School-Based Services

Overview

School-based services (SBS) are Medicaid-covered services provided to children in a school setting. Every state operates some form of a SBS program, seeking reimbursement from the federal government for these programs and for the services explicitly detailed in each state's Medicaid State Plan. Over time, states have added services, provider types, and/or eligibility criteria to increase the amount of services eligible for reimbursement.

National Landscape

In 2014, CMS reversed the "free care" rule that had previously limited the ability of schools to bill Medicaid for student healthcare services. The rule reversal allowed states more flexibility in their school-based Medicaid programs by allowing Federal reimbursement for a wider array of circumstances.[72]

The Bipartisan Safer Communities Act, signed into law in June 2022, established additional resources to support mental health services in school settings, including requirements for CMS to enhance the EPSDT program. CMS released an informational bulletin in August 2022 discussing expansion of services. This bulletin also discussed that CMS would establish an SBS-specific technical assistance center and issue $50 million in discretionary grant funding to states in support of implementing, enhancing, or expanding SBS.[73]

CMS also released a new guide for School-Based Administrative Claiming on May 18, 2023. The guide provides new opportunities and considerations for states in regard to billing, documentation, and time studies. Flexibilities include:

- Billing that uses cost-based reimbursement, such as per child per month payments and

[70] CMS. (n.d.). *Medicaid Long Term Services and Supports Annual Expenditures Report.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures2019.pdf
[71] Kaiser Family Foundation. (n.d.) *State Options to Expand Medicaid HCBS: Examples & Evaluations of Section 1115 Waivers* [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/state-options-to-expand-medicaid-hcbs-examples-evaluations-of-section-1115-waivers/
[72] Georgetown University Health Policy institute. (n.d.). *Recent Changes to the free Care Rule Put Federal Funds Back on the Table.* [Webpage]. Retrieved from: https://ccf.georgetown.edu/2016/05/06/recent-changes-free-care-rule-put-federal-funds-back-table/#:~:text=Though%20the%20Health%20and%20Human,was%20no%20longer%20in%20effect
[73] CMS. (n.d.). *Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services.* [Webpage]. Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf

roster-based billing.
- Billing using rate-based payments, such as fee schedules beyond community rates and clarification of restrictions on bundled payments.
- Documentation flexibilities, such as using de-identified data and time studies at one-step allocations.
- Ability to adapt different qualifications for school-based providers to increase the access to these services.
- Flexibilities for time studies, such as adding an error rate and a notification / response period to speed up the process.

The Guide also provides additional opportunities for states to request technical assistance from CMS to support these efforts, update State Plan Amendments, and ensure ongoing collaboration to make this program efficient and effective across states.[74]

State Examples

Figure 19 below describes examples of school-based services.

Figure 19. State Examples of School-Based Services

State	Description
Kentucky	Kentucky SBS include the below covered services: • Assistive technology (IEP only) • Audiology • Evaluation services • Incidental interpreter (IEP Only) • Behavioral health • Nursing services • Occupational therapy • Orientation and mobility (O&M) • Physical therapy • Respiratory therapy (Nursing Services) • Speech-language therapy • Specialized transportation (IEP only)[75] With the expanded access program and reversal of the free care act, Kentucky added programs for students who are eligible for Medicaid but may not have an Individualized Education Plan (IEP).[76] In Kentucky, the administrative claiming program in school districts operates as a separate program and is reimbursed separately.
Louisiana	Louisiana's school-based Medicaid program includes the following services: • Chronic medical condition management • Transportation services • Personal care services • Therapy services

[74]CMS. (n.d.). *CMCS Informational Bulletin.* [Webpage]. Retrieved from: https://www.medicaid.gov/federal-policy-guidance/downloads/cib051823.pdf
[75] Kentucky Department for Medicaid Services. (2022) *Kentucky School-based Services Technical Assistance Guide*. [Webpage]. Retrieved from: https://education.ky.gov/districts/SiteAssets/Pages/School-Based-Medicaid-Services/TAG%20111822%20(002).pdf
[76] Kaiser Family Foundation.(n.d.). L*everaging Medicaid for School-Based Behavioral Health Services: Findings from a Survey of State Medicaid Programs*. [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/leveraging-medicaid-for-school-based-behavioral-health-services-findings-from-a-survey-of-state-medicaid-programs/

State	Description
	• Applied behavior analysis[77] The chronic medical condition management service ensures students with chronic conditions are getting all services necessary to maintain and address the care needed and that care is coordinated, as detailed in students' health plans. Louisiana began delivering this service in 2009 as a way to better manage and improve quality and care coordination for those with chronic medical conditions.[78]
Oklahoma	Covered services in Oklahoma SBS include: • Therapy (physical, occupational, speech language) • Psychological testing • Psychotherapy counseling • Nursing • Hearing and vision • Assistive technology • Transportation services • Personal care services[79] Oklahoma signed a bill into law in May 2022 to expand behavioral health services in schools, including crisis services for school based mental health.[80]
Oregon	Oregon received approval in May 2023 through a State Plan Amendment to add transportation as a reimbursable service in its school-based Medicaid program. The State also updated the State Plan to increase the reimbursement rates for students covered IDEA.[81]

6. Pharmacy

Pharmacy and Value-Based Payments

Overview

VBP within Medicaid pharmacy programs is a relatively new arrangement but one that states, including Arkansas, are seeking to expand. The need for VBP in drug purchasing has become more important with the advent of new high-cost gene therapies which, while providing the possibility of curing diseases, can approach or exceed a million dollars for a course of therapy.[82] The current pharmaceutical reimbursement system was designed to reimburse for less expensive treatments that are taken routinely to manage chronic disease as opposed to high dollar treatments that may cure a disease. While these new treatments are very expensive, by curing the disease they may help reduce overall health care costs. Health insurers are seeking new ways to cover and pay for these high-cost drugs without substantial increases to insurance

[77] Louisiana Medicaid. (2021). *Chapter 95. School-Based Health Services*. [Webpage]. Retrieved from: https://ldh.la.gov/assets/medicaid/Rulemaking/NoticesofIntent/March2021/SBHS_NOI_Jan2021LAC.pdf
[78] Louisiana Medicaid. (n.d.).*Chronic Care Management Program Targets Better Outcomes, More Efficient Health Care* [Webpage]. Retrieved from: https://ldh.la.gov/news/268
[79] Oklahoma Health Care Authority. (2022). *School-Based Services*. [Webpage]. Retrieved from: https://oklahoma.gov/content/dam/ok/en/okhca/docs/providers/training/2022/SBS%20Fall%202022.pdf
[80] Oklahoma Mental Health & Substance Abuse.(n.d.) *School-Based Services.* [Webpage]. Retrieved from: https://oklahoma.gov/odmhsas/treatment/children-youth-treatment-services/systems-of-care/school-based-services.html
[81] CMS. *Financial Management Group/ Division of Reimbursement Review.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/spa/downloads/OR-19-0011.pdf
[82] Verma, Seema, et al. *Value-Based Purchasing Rule for Medicaid Rx Drugs: Continuing to Shift from FFS towards Accountability" Health Affairs, 18 Jan. 2021.* [Webpage]. Retrieved from: https://www.healthaffairs.org/do/10.1377/forefront.20210119.109892/

premiums.[83] VBP arrangements are one of the ways states and insurers are exploring to do this. CMS projects that VBP approaches for prescription drugs could save up to $225 million in state and federal dollars through 2025.[84]

National Landscape

To date, state adoption of VBP arrangements has been fairly limited, but that is anticipated to change with updates CMS made to the Medicaid Drug Rebate Program in a final rule effective July 1, 2002. The new rule, *Establishing Minimum Standards in Medicaid State Drug Utilization Review and Supporting VBP for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability Requirements,* removes regulatory barriers that had historically discouraged adoption of VBP arrangements and established the following definition for VBP:[85]

> *Value-based purchasing arrangement* means an arrangement or agreement intended to align pricing and/or payments to an observed or expected therapeutic or clinical value in a select population and includes, but is not limited to:
>
> (1) Evidence-based measures, which substantially link the cost of a covered outpatient drug to existing evidence of effectiveness and potential value for specific uses of that product; and/or
>
> (2) Outcomes-based measures, which substantially link payment for the covered outpatient drug to that of the drug's actual performance in patient or a population, or a reduction in other medical expenses

Following the final rule, CMS also issued Technical Guidance to states on adopting VBP arrangements for drugs, *VBP Arrangements for Drug Therapies using Multiple Best Prices; State Reporting of VBP Supplemental Rebate Agreements*.[86]

State Examples

As described above, state adoption of VBP arrangements has been relatively limited. Several identified examples are provided below.

Figure 20. States with Pharmacy VBP Arrangements

State	Description
Massachusetts	Massachusetts has a VBP arrangements for Zolgensma, a new gene therapy for treating spinal muscular atrophy in infants. The VBP agreement includes an upfront discount off the $2.1 million per patient price for Zolgensma, and the manufacturer's commitment to provide rebates to the State if the drug does not perform against

[83] Verma, Seema, et al. *"Value-Based Purchasing Rule for Medicaid Rx Drugs: Continuing to Shift from FFS towards Accountability." Health Affairs, 18 Jan. 2021* [Webpage]. Retrieved from: https://www.healthaffairs.org/do/10.1377/forefront.20210119.109892/
[84] CMS. (2020) *Press Release. "CMS Issues Final Rule to Empower States, Manufacturers, and Private Payers to Create New Payment Methods for Innovative New Therapies Based on Patient Outcome."* [Webpage]. Retrieved from: https://www.cms.gov/newsroom/press-releases/cms-issues-final-rule-empower-states-manufacturers-and-private-payers-create-new-payment-methods
[85] 42 CFR § 447.502
[86] CMS (2022) *"Release # 189: Medicaid Drug Rebate Program Notice for Participating States: Value-Based Purchasing (VBP) Arrangements for Drug Therapies using Multiple Best Prices; State Reporting of VBP Supplemental Rebate Agreements."* [Webpage]. Retrieved from: https://www.medicaid.gov/prescription-drugs/downloads/state-rel-189-vbp.pdf

State	Description
	agreed upon outcome measures.[87]
Oklahoma	Oklahoma value-based arrangements using supplemental rebate agreements for products that manufacturers agree upon with the State. Oklahoma currently has agreements on long-acting injectable antipsychotics, an epilepsy drug, and an antibiotic used mainly in the emergency room. The State's value-based arrangements relate to financial outcomes, including adherence, costs and hospitalizations. If the drug fails to meet certain benchmarks, the manufacturer will make additional payments to the Sate in the form of a supplemental rebate. [88]
Washington	Washington negotiated a guaranteed net unit price up to a certain threshold for a hepatitis C antiviral drug after which the cost to the State is nominal. [89]

Eight additional states reported plans to submit VBP State Plan Amendments to CMS or implement a VBP.

Dispensing Fees

Overview

State Medicaid programs pay pharmacies for two components of a drug: 1) an amount to cover the estimated cost of the drug, known as the ingredient cost, and 2) an amount to cover the pharmacist's overhead and services to fill the prescription, known as the dispensing fee.

Dispensing fees are defined by 42 CFR § 447.502 Subpart I as follows:[90]

> *Professional dispensing fee* means the professional fee which:
>
> (1) Is incurred at the point of sale or service and pays for costs in excess of the ingredient cost of a covered outpatient drug each time a covered outpatient drug is dispensed;
>
> (2) Includes only pharmacy costs associated with ensuring that possession of the appropriate covered outpatient drug is transferred to a Medicaid beneficiary. Pharmacy costs include, but are not limited to, reasonable costs associated with a pharmacist's time in checking the computer for information about an individual's coverage, performing drug utilization review and preferred drug list review activities, measurement or mixing of the covered outpatient drug, filling the container, beneficiary counseling, physically providing the completed prescription to the Medicaid beneficiary, delivery, special packaging, and overhead associated with maintaining the facility and equipment necessary to operate the pharmacy; and
>
> (3) Does not include administrative costs incurred by the State in the operation of the covered outpatient drug benefit including systems costs for interfacing with pharmacies.

[87] National Academy for State Health Policy. (2020). *CMS Proposes Rule to Support Value-Based Purchasing for Drugs* [Webpage]. Retrieved from: https://nashp.org/cms-proposes-rule-to-support-value-based-purchasing-for-drugs/
[88] Gifford, Kathleen, et al. "How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020." Kaiser Family Foundation, 29 Apr 2020. Retrieved: https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/
[89] Gifford, Kathleen, et al. (2020) How State Medicaid Programs are Managing Prescription Drug Costs: Results from a State Medicaid Pharmacy Survey for State Fiscal Years 2019 and 2020." Kaiser Family Foundation. [Webpage]. Retrieved from: https://www.kff.org/medicaid/report/how-state-medicaid-programs-are-managing-prescription-drug-costs-results-from-a-state-medicaid-pharmacy-survey-for-state-fiscal-years-2019-and-2020/
[90] 42 CFR § 447.502. [Webpage]. Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-I

States may vary the professional dispensing fee by type of pharmacy, pharmacy prescription volume, or type of drug. For example, Medicaid may pay more in dispensing fees for a specialty drug or to a pharmacy filling fewer prescriptions.[91]

When proposing changes to professional dispensing fee reimbursement, states are required to evaluate their proposed changes in accordance with the requirements of 42 CFR § 447 Subpart I and must consider both the ingredient cost reimbursement and the professional dispensing fee reimbursement when proposing such changes to ensure that total reimbursement to the pharmacy provider is in accordance with requirements of section 1902(a)(30)(A) of the Act. States must provide adequate data such as a state or national survey of retail pharmacy providers or other reliable data other than a survey to support any proposed changes to the dispensing fee. States must submit to CMS the proposed change in reimbursement and the supporting data through a State Plan Amendment through the formal review process.[92]

National Landscape

All 50 states incorporate a dispensing fee into their outpatient pharmacy reimbursement methodologies. As discussed above, states have flexibility in how they design their dispensing fee structures, including developing tiered fees based on prescription volume, drug type or geography, for example. Arkansas uses a tiered approach that pays $9.00 for brand and non-preferred brand drugs and $10.50 for preferred brand and generic drugs. Based on a review of Medicaid outpatient prescription drug reimbursement information by state as of the end of September 2022, dispending fees can be divided into the following categories:[93]

- 32 states have a **single statewide dispending fee** ranging from $4.09 (Missouri) to $12.45 (North Dakota)
- 8 states have implemented **prescription volume-based tiers** which provide higher fees for lower volume providers and lower fees for higher volume providers.
- Two states, Arkansas and North Carolina, have different fees based on whether the drug is **brand, generic, and/or preferred or non-preferred**.
- Two states, Alaska and Utah, have **geography-based tiers**, which pay different fees based on the location of the provider. For example, Utah pays a higher fee to pharmacies located in rural areas. Alaska varies fees based on whether the pharmacy is located on or off the State's road system.

Other states have developed dispensing fees based on pharmacy type (e.g., retail vs. institutional, 340b entity, critical access) or based on specialty drug type. Some other states may also incorporate "add-on" fees, including for pill splitting and compounding.

State Examples

Figure 21 provides dispensing fee information for Arkansas' neighboring states.

[91] Dolan, Rachel, et al (2020). "Pricing and Payment for Medicaid Prescription Drugs." Kaiser Family Foundation, [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/pricing-and-payment-for-medicaid-prescription-drugs/
[92] 42 CFR § 447.518 [Webpage]. Retrieved from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-447/subpart-I/section-447.518
[93] CMS. (2022). *Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State*. [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/medicaid-covered-outpatient-prescription-drug-reimbursement-information-state/index.html)

Figure 21. Neighboring State Dispending Fees[94]

State	Dispensing Fee
Louisiana	Professional dispensing fee is $10.99
Mississippi	• Professional dispensing fee is $11.29 • Professional dispensing fee for specialty drugs not dispensed by a retail community pharmacy and dispensed primarily through the mail is $61.14
Missouri	Professional dispensing fee is $4.09
Oklahoma	Professional dispensing fee is $10.87

Tennessee	• For ambulatory pharmacies, the professional dispensing fee is tiered based on annual prescription volume. The tiers are:
	  ○ $11.98 for pharmacies with a prescription volume of less than 65,000 claims per year
	  ○ $8.37 for pharmacies with a prescription volume of 65,000 or more claims per year
	  ○ $11.98 for pharmacies that opened within one year of the State's cost-of-dispensing survey
	• For claims submitted as 340B claims, the professional dispensing fee is set at $15.40.
	• For claims submitted as non-340B claims, the professional dispensing fee is set at $11.98
	• Long-term care pharmacies is set at $11.98
	• Specialty Pharmacies:
	  ○ Dispensing fee for non-specialty drugs dispensed by in-state specialty pharmacies is set at $11.98
	  ○ The professional dispensing fee for specialty drugs (regardless of which type of pharmacy dispenses them) is set at $45.94
	  ○ Blood Clotting Factors dispensing fee of $172.69
	• Out-of-State Pharmacies:
	  ○ Prescription volume of less than 65,000 claims per year and that are located in border areas closer to TennCare members than Tennessee pharmacies are, the professional dispensing fee for drugs other than specialty drugs and blood clotting factors is set at $11.98
	  ○ For all other out-of-state pharmacies serving TennCare members (including out-of-state specialty pharmacies), the professional dispensing fee for drugs other than specialty drugs and blood clotting factors is set at $8.37
	  ○ The professional dispensing fee for specialty drugs dispensed by out-of-state pharmacies is set at $45.94
	  ○ The professional dispensing fee for blood clotting factors and other blood products dispensed by out-of-state pharmacies is set at $172.69
	• Reimbursement for Compounded prescriptions:
	  ○ Level 1 (0-15 minutes) – $11.98 for pharmacies with a prescription volume of less than 65,000 claims per year and $10.00 for pharmacies with a prescription volume of 65,000 or more claims per year

[94] CMS (2022). *Medicaid Covered Outpatient Prescription Drug Reimbursement Information by State* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/prescription-drugs/state-prescription-drug-resources/medicaid-covered-outpatient-prescription-drug-reimbursement-information-state/index.html

State	Dispensing Fee
	○ Level 2 (16-30 minutes) – $15.00 ○ Level 3 (31 or more minutes) – $25.00 • Pharmacies failing to respond to the State's mandatory pharmacy reimbursement survey receive a lower dispending fee
Texas	Professional dispensing fee is based on the following calculation: • ((Acquisition Cost + Fixed Component) divided by (1 – the percentage used to calculate the Variable Component)) - Acquisition Cost) + Delivery Incentive + Preferred Generic Incentive

90-Day Medication Supply

Overview

Arkansas currently limits prescriptions to a 30-day supply. However, a number of states allow for 90-day supplies of certain drugs, particularly maintenance medications. A 2012 CMS study that looked at patients prescribed statin, antihypertensive, selective serotonin reuptake inhibitor (SSRI), or oral hypoglycemic medications found that across these four drug categories and compared to 30-day refills, patients with 90-day refills had greater medication compliance, nominal wastage, and greater savings.[95]

National Landscape

While we were unable to identify a comprehensive survey that identified which states offer 90-day supplies, several studies published by the Kaiser Family Foundation and the Department of Health and Human Services Office of Inspector General (OIG) found that many states made changes to their prescription drug programs to increase access in response to the COVID-19 pandemic.[96,97] For example, of the 24 states the OIG collected information from, 18 states responded that they had implemented policies to allow pharmacies to dispense 90-day (or more) supplies of certain prescription drugs. Another three states did not implement changes because they had already allowed 90-day (or more) supplies prior the pandemic.[98] With the wind-down of the PHE, it is still too soon to determine which states will make some of these changes permanent and which states will discontinue them.

State Examples

Figure 22 provides examples of states we identified that have implemented policies allowing for 90-day (or more) supplies of certain drugs, including Arkansas' neighboring states. The majority of these policies pertain to 90-day supplies of medications for treatment of chronic conditions and ongoing maintenance therapies.

[95] Taitel, Michael, et al. *Medication Days' Supply, Adherence, Wastage, and Cost Among Chronic Patients in Medicaid*. Centers for Medicare & Medicaid Services, Medicare & Medicaid Research Review 2022: Vol 2, No. 3. [Webpage]. Retrieved from https://www.cms.gov/mmrr/Downloads/MMRR2012_002_03_A04.pdf
[96] Kaiser Family Foundation. (April 30, 2020). *States are Shifting How They Cover Prescription Drugs in Response to COVID-19.* [Webpage]. Retrieved from: https://www.kff.org/policy-watch/states-are-shifting-how-they-cover-prescription-drugs-in-response-to-covid-19/
[97] Department of Health and Human Services Office of Inspector General. (October 2021). *Changes Made to States' Medicaid Programs to Ensure Beneficiary Access to Prescriptions During the COVID-19 Pandemic.* [Webpage]. Retrieved from: https://oig.hhs.gov/oas/reports/region6/62004007.pdf
[98] Department of Health and Human Services Office of Inspector General. (October 2021). *Changes Made to States' Medicaid Programs to Ensure Beneficiary Access to Prescriptions During the COVID-19 Pandemic.* [Webpage]. Retrieved from: https://oig.hhs.gov/oas/reports/region6/62004007.pdf

Figure 22. Select States' 90-Day Medication Supply Policies

State	Description
Bordering States	
Mississippi	• Voluntary 90-day drug maintenance list which includes certain medications used for chronic conditions and ongoing maintenance therapies[99] • Participation in the program is optional for both patients and pharmacies
Missouri	For beneficiaries eligible for any of the FFS programs, select medications require a 90-day supply per dispensing once a beneficiary has demonstrated stability on a given medication for at least 60 days[100]
Oklahoma	Many maintenance medications can be processed for a 90-day supply without the need for an override[101,102]
Tennessee	• 90-day refill policy in place for certain maintenance drugs[103] • Beneficiaries can receive 90-day refills at participating "Retail-90" or mail order pharmacies ○ Medications available through these avenues could have a lower out-of-pocket cost to the beneficiary
Other States	
Arizona	90-day refills are available for chronic illnesses, when a member will be out of a provider's service area for an extended period of time, or if the medication is prescribed for contraception[104]
Colorado	Unless otherwise communicated in the Prescription Drug List, maintenance medications may be filled for up to a 100-day supply[105]
Illinois	90-day supply is allowed for certain generic, oral, non-narcotic, maintenance medications for certain disease states including hypertension, diabetes, and hypothyroidism[106]
Indiana	Fee-for-service claims for maintenance medications are limited in quantity to no more than 100-day supply for dispensation. These include drugs that are prescribed for chronic, long-term conditions and are taken on a regular, recurring basis.[107]

[99] Mississippi Division of Medicaid. (2019). *Medicaid updates Voluntary 90-Day Drug Maintenance List for Providers* [Webpage]. [Webpage]. Retrieved from: https://medicaid.ms.gov/medicaid-updates-voluntary-90-day-drug-maintenance-list-for-providers/
[100] MO HealthNet. (2022). *State of Missouri Pharmacy Manual* [Webpage]. Retrieved from: https://manuals.momed.com/collections/collection_pha/print.pdf
[101] Oklahoma Health Care Authority. (2020). *MDL* [Webpage]. Retrieved from: https://oklahoma.gov/content/dam/ok/en/okhca/docs/providers/types/pharmacy/drug-lists/03.22.2023%20-%20MDL.pdf
[102] Oklahoma Health Care Authority. (2023). *Maintenance Drugs and Quantity Limits* [Webpage]. Retrieved from: https://oklahoma.gov/ohca/providers/types/pharmacy/quantity-limits.html
[103] Division of TennCare. (2022). *Division of TennCare Pharmacy Provider Manual* [Webpage]. Retrieved from: https://www.tn.gov/content/dam/tn/tenncare/documents/PharmacyProviderManual.pdf
[104] Arizona Health Care Cost Containment System. (2021). *310-V – Prescription Medications/Pharmacy Services* [Webpage]. Retrieved from: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/310-V.pdf
[105] Colorado Department of Health Care Policy and Financing. (n.d.). *Pharmacy Billing Manual* [Webpage]. Retrieved from: https://hcpf.colorado.gov/pharmacy-billing-manual
[106] Illinois Department of healthcare and Family Services. (2016). *Handbook for Providers of Pharmacy Services* [Webpage]. Retrieved from: https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/p200.pdf
[107] Indiana Health Coverage Programs Provider Reference Module. (2023). *Pharmacy Services* [Webpage]. Retrieved from: https://www.in.gov/medicaid/providers/files/modules/pharmacy-services.pdf

State	Description
Kentucky	Maintenance drugs are medications that generally require regular, long-term use and are prescribed for the treatment of a chronic medical condition and can be processed for up to a 92 days' supply for KY Medicaid residents.[108]
Massachusetts	• There is a required 90-day supply for designated generic drugs, other designated low-net-cost drugs, and drugs listed as preferred in the Brand Name Preferred section of the MassHealth Drug after a trial supply is dispensed in up to a 30-day supply[109] • 90-day supplies are allowed if the drug is designated in the MassHealth Drug List or when the MassHealth agency is not the primary payer, but for which payment is available from the MassHealth agency for any portion of the claim (including any copayment or deductible), provided that the primary payer will pay for the drug when dispensed in up to a 90-day supply[110]
North Carolina	Birth control and hormone replacement therapies can be supplied for twelve months for oral birth control medications and up to three months for prepackaged hormone replacement therapies[111] Medicaid beneficiaries can receive a 90-day supply of a non-controlled, maintenance medication
Ohio	A drug supply of under 120 days can be dispensed at a time for drugs to treat chronic conditions[112]
Virginia	• Select maintenance drugs can be covered for a maximum of 90 days after two, 34-day or shorter duration fills[113] • Routine contraceptives may be covered for up to a 12-month supply

7. Capitated Payments

Medicaid Managed Care

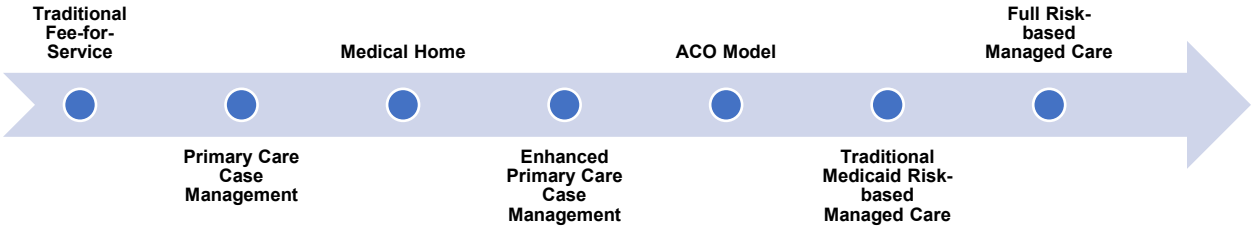
Managed care in Medicaid is a healthcare delivery model wherein a state agency contracts with managed care organizations (MCOs) to provide Medicaid health benefits and additional services to beneficiaries. Unlike the fee-for-service model, where states pay providers for each covered service, MCOs accept a set PMPM payment (capitation) to cover a defined set of services. The MCO is at-risk and may lose money if costs for services and administration exceed payments. Managed care "encourages providers to keep enrollees healthy in order to keep costs within the capitation rate, through preventive and appropriate care to avoid

[108] Magellan Rx Management. (2023. *Kentucky Medicaid Pharmacy Program Single Preferred Drug List (PDL)* [Webpage]. Retrieved from: https://kyportal.magellanmedicaid.com/public/client/static/kentucky/documents/PreferredDrugGuide_full.pdf
[109] Cornell Law School. (2022). *130 CMR 406.411 – Prescription Requirements* [Webpage]. Retrieved from: https://www.law.cornell.edu/regulations/massachusetts/130-CMR-406-411
[110] MassHealth. (2023). *MassHealth 90-Day Supply*. [Webpage] Retrieved from: https://mhdl.pharmacy.services.conduent.com/MHDL/pubdownloadpdfwelcome.do?docId=488&fileType=PDF
[111] NC Medicaid. (2021). *Outpatient Pharmacy Medicaid and Health Choice Clinical Coverage Policy No: 9* [Webpage]. Retrieved from: https://medicaid.ncdhhs.gov/9/open
[112] Ohio Department of Medicaid. (n.d.). *Prescriptions* [Webpage]. Retrieved from: https://medicaid.ohio.gov/families-and-individuals/srvcs/prescriptions
[113] Virginia Medicaid. (2022). *Pharmacy Manual* [Webpage]. Retrieved from: https://vamedicaid.dmas.virginia.gov/sites/default/files/2022-10/Chapter-4%20Covered%20Services%20and%20Limitations%20%28Pharmacy%29.pdf

expensive hospital stays and emergency department visits."[114]

There is a continuum of approaches to deliver benefits under Medicaid programs, ranging from fee-for-service to full-risk based managed care, as illustrated in Figure 23. From the left, traditional fee-for-service implies low or no care management or care coordination and potentially more unnecessary service utilization and lower potential cost savings. At the far right, full risk-based managed care implies a higher level of care management and care coordination, as well as potential for improved quality of care, reduced inappropriate utilization, and cost savings.

Figure 23. Spectrum of Delivery Systems – Least to Most Comprehensively Managed



The traditional FFS system, in which beneficiaries may see any provider willing to accept Medicaid patients, offers no explicit mechanism for measuring or ensuring access to care, quality care, or containing costs. Moving across the continuum, states have more options for monitoring and improving key cost, quality, and access indicators.[115]

Full-risk managed care models are often used by states to better manage cost, utilization, and quality.[116] However, per the Kaiser Family Foundation, "the evidence about the impact of managed care on access to care and costs is both limited and mixed."[117]

When comparing payment models, fee-for-service and managed care provide both advantages and disadvantages, as illustrated in Figure 24.

[114] MACPAC. (n.d.). *Managed care's effect on outcomes* [Webpage]. Retrieved from: https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/
[115] Navigant (2012). *Medicaid and PeachCare for Kids ® Design Strategy Report* [Webpage]. Retrieved from: https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/document/Navigant%20Final%20Report%20_%20Chapter%201-5%20and%20Executive%20Summary.pdf
[116] Medicaid.gov. (n.d.). *Managed Care* [Webpage]. Retrieved: https://www.medicaid.gov/medicaid/managed-care/index.html
[117] Kaiser Family Foundation. (March 10, 2023). *10 Things to Know About Medicaid Managed Care.* [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

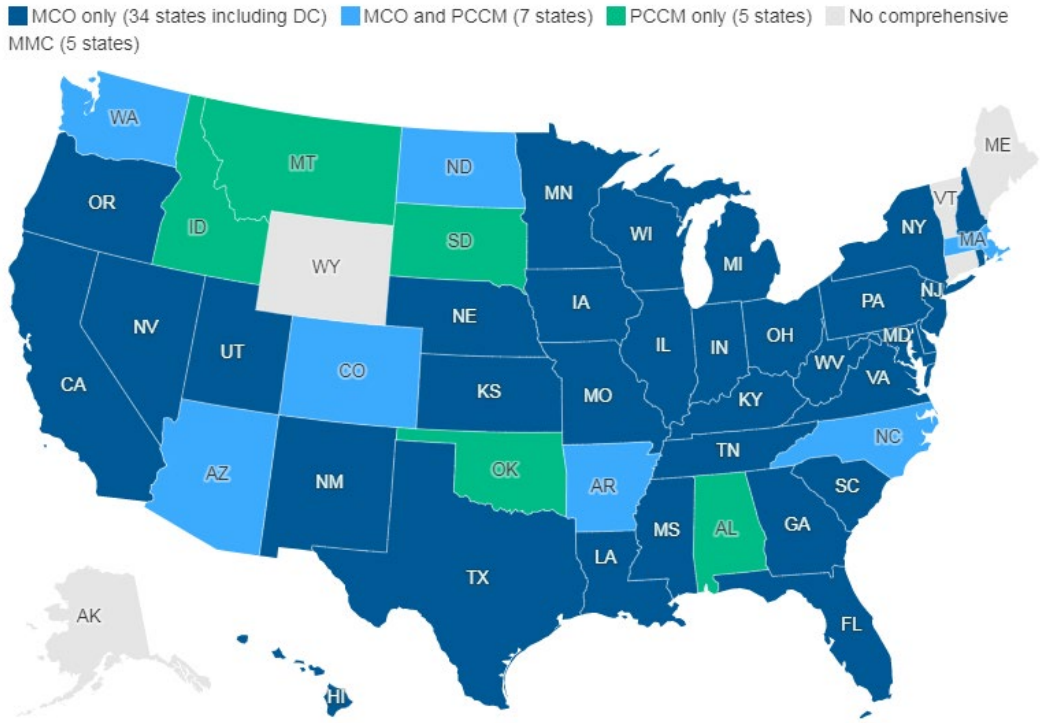
Figure 24. Advantages and Disadvantages of FFS and Medicaid Managed Care

	Fee-for-Service	Managed Care
Advantages	• One provider network, not dependent on specific MCO contracting • Clear utilization data available based on direct payments to providers for services • Comparatively fewer layers of administration between participants and the state • Less contract management capacity required to operate • Flexibility and ability to enact policy changes quickly (i.e., consistent interpretation of statewide policy)	• Enables states to delegate operational responsibilities to third party MCOs • Incentivizes preventive care that may result in overall savings to the system and state Medicaid programs • Provides opportunities for management of high-cost services and appropriate utilization of services • Conducive to pay-for-performance initiatives and value-add service that can address social determinants of health and/or support health promotion • Provides predictable budget commitments
Disadvantages	• Fewer incentives to deliver cost-effective care or innovate around patient outcomes (i.e., value-based care) • Potential overutilization of unnecessary services • Fewer safeguards to prevent fraud, waste, and abuse • Reliant on large teams of state staff to administer • Potentially inadequate monitoring and auditing of critical incidents, complaints, and provider training • Under-utilized statewide quality improvement strategy and implementation • Limited coordination of care	• Limited provider network based on MCO contract (i.e., providers contract with each MCO) • Potentially increased risk of compromised quality of care to minimize costs • Reliant on encounter rather than payment data to understand services rendered • Additional CMS operational and reporting requirements as well as periodic authority renewals • High costs related to initial implementation • State staffing changes to adjust the needs of managed care implementation and oversight

National Landscape

Figure 25 below shows the 41 states, including Washington, D.C., which contract with comprehensive, risk-based managed care plans to provide care to at least some of their Medicaid beneficiaries.

Figure 25. Status of State Medicaid Service Delivery (March 2023)[118]



Quality and VBP

CMS encourages states to "move toward paying providers based on the quality, rather than the quantity of care they give patients."[119] States use quality metrics in their managed care programs and often link financial incentives to quality performance through mechanisms such as performance bonuses or penalties, capitation withholds, or state-directed VBP. According to the Kaiser Family Foundation, as of July 2021, over three quarters of MCO states reported using at least one financial incentive to promote quality. Behavioral health, chronic disease management, and perinatal/birth outcomes are financial incentive performance areas most frequently targeted by states.[120]

The Kaiser Family Foundation also found that, as of July 2021, about half of states with MCOs reported using a specific target in their MCO contracts for the percentage of provider payments or plan members that MCOs must cover via APMs. Of the states that are using such a target, about half stated that their MCO contracts also had incentives or penalties related to meeting (or not meeting) the APM targets. For most states, the requirements for APMs were in the 25 – 50% range. States reported setting different percentage requirements depending on the services and population served under the managed care contract.

Figure 26 includes options states can use to move managed care programs towards VBP.

[118] Kaiser Family Foundation. (2023). *10 Things to Know About Medicaid Managed Care* [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/
[119] Centers for Medicare & Medicaid Services (n.d.). *Value Based Programs* [Webpage]. Retrieved from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs
[120] Kaiser Family Foundation. (2023). *10 Things to Know About Medicaid Managed Care* [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

Figure 26. VBP Programs in Medicaid Managed Care[121]

	Option	Description	Example
1	Require MCOs to adopt a standardized VBP model	State requires MCOs to adopt a specific payment model developed by the Medicaid agency or other stakeholders/purchasers.	TN requires its Medicaid MCOs to implement its patient-centered medical home (PCMH) and retrospective episode-of-care models.
2	Require MCOs to make a specific percentage of provider payments through approved VBP arrangements	Arrangements may include performance incentives or penalties, shared savings and/or risk based on quality and cost targets, episode or bundled payments, or global payment programs.	AZ and SC both withhold a portion of the capitation payment, subject to the MCO meeting the annual VBP benchmarks as well as state-defined quality performance and improvement standards.
3	Require the MCOs to move toward implementation of more sophisticated VBP approaches over the life of the contract	Goal is to move providers along a continuum of risk-based models with increasing accountability over time.	NY set a five-year goal of having 80-90 percent of all provider payments in certain broadly defined VBP models by 2020, and a goal of 35 percent covered in risk-based arrangements by the same date.
4	Require MCOs to actively participate in a multi-payer VBP alignment initiative	Multi-payer VBP initiatives could be facilitated by the state to create consistency, reduce burden, and align incentives across MCO VBP efforts for the provider community.	TN adopted a specific, uniform payment strategy in launching its multi-payer model.
5	Require MCOs to launch VBP pilot projects subject to state approval	State requires MCOs to submit VBP proposals encompassing specific goals, payment models, and provider partners for input, review, and approval.	NM took this approach as part of its Centennial Care waiver selecting uniform quality and cost metrics and created a template that the MCOs must use to report quantitative and qualitative results for each approved project.

Comprehensive Managed Care Serving BH and ID/DD populations

The Provider-Led Arkansas Shared Savings Entities (PASSE) program serves Medicaid clients with complex behavioral health, developmental, or intellectual disabilities. It is one of only two such provider-led solutions nationwide (the other being New York) that coordinates healthcare services for behavioral health and ID/DD beneficiaries through care management entities, each requiring at least 51% ownership by local health care providers. Nationally, there are a limited number of states that include people with ID/DD in mandatory Medicaid MLTSS.

[121] Center for Health Care Strategies, Inc. (2016). *Value Based Payments in Managed Care: An Overview of State Approaches* [Webpage]. Retrieved from: https://www.chcs.org/media/VBP-Brief_022216_FINAL.pdf

According to a 2020 report to the Medicaid and CHIP Payment and Access Commission (MACPAC), there are limited states that include people with ID/DD in mandatory Medicaid managed care for long-term services and supports; only seven states require this population to enroll in mandatory Medicaid managed long-term services and supports programs. As of 2019, three states, Iowa, Kansas, and Tennessee require people with ID/DD to receive all Medicaid-funded services, including LTSS, through full-risk managed care plans.[122]

Managed Long-Term Services and Supports

Overview

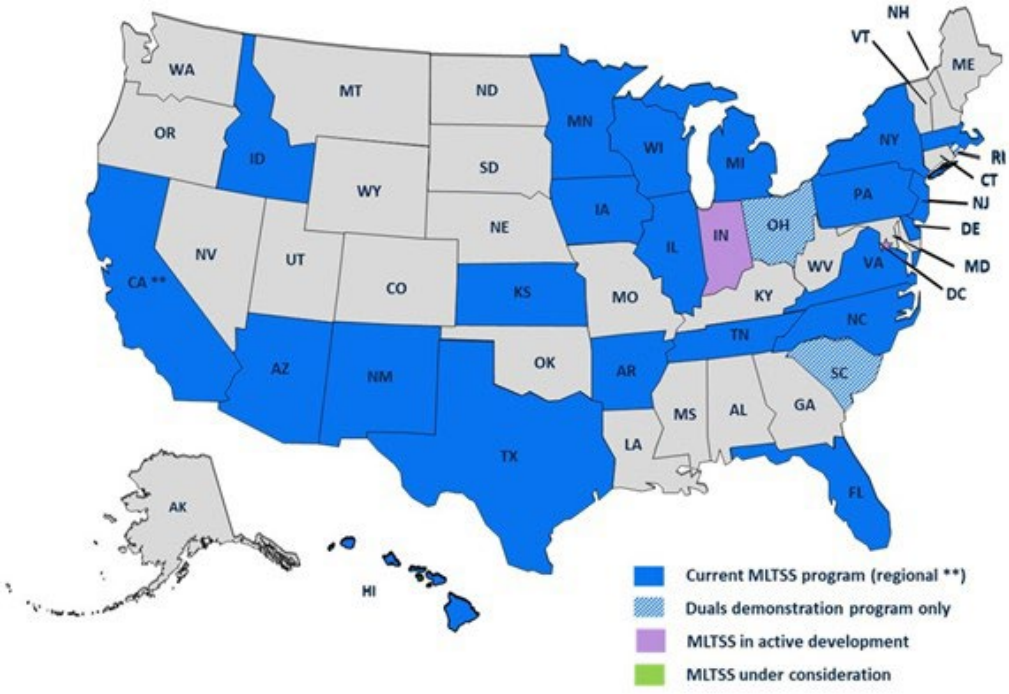
MLTSS is one method to expand the use of HCBS across a state by providing LTSS through Medicaid managed care programs. MLTSS can be operated under 1915(a), 1915(b), and 1115 waivers and can operate concurrently with a 1915(c) program.[123] MLTSS programs can support states' rebalancing strategies by providing financial incentives for MLTSS plans to offer HCBS instead of institutional care, use contract incentives to promote the delivery of services in HCBS settings, and promote the use of VBP with providers to increase the value and quality of HCBS services.[124]

National Landscape

As of 2021, 22 states have MLTSS programs, up from eight states in 2004.[125] Under MLTSS, HCBS are provided through a capitated rate that is intended to control expenditures and keep beneficiaries living in their home or community settings given the lower costs of these settings compared to nursing facilities. Figure 27 shows the landscape of MLTSS as of November 2022.[126] Arkansas is included as a state with a MLTSS program due to PASSE.

[122] Barth, S., Lewis, S., & Simmons, T. (2020). Health Management Associates, *Medicaid Services for People with Intellectual or Developmental Disabilities – Evolution of Addressing Service Needs and Preferences* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2021/01/Medicaid-Services-for-People-with-Intellectual-or-Developmental-Disabilities-–-Evolution-of-Addressing-Service-Needs-and-Preferences.pdf
[123] Centers for Medicare and Medicaid Services. *Managed Long-Term Services and Supports* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/managed-care/managed-long-term-services-and-supports/index.html
[124] CMS. (November 2020). *Long-Term Services and Supports Rebalancing Toolkit.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltss-rebalancing-toolkit.pdf.
[125] Advancing States. (2021). *Demonstrating the Value of Medicaid MLTSS Programs*. [Webpage]. Retrieved from: http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf
[126] Advancing States. (n.d.). *MLTSS MAP*. [Webpage]. Retrieved from: *http://www.advancingstates.org/initiatives/managed-long-term-services-and-supports/mltss-map*

Figure 27. Landscape of MLTSS as of November 2022



States may also use models that do not employ full risk, capitated models for the LTSS populations. For example, Alabama uses a Primary Care Case Management entity delivery model for beneficiaries receiving care in a nursing facility or through select HCBS waiver programs.

As states contemplate implementing MLTSS, they have additional considerations to account for. LTSS is used by many vulnerable and high-risk populations served by Medicaid. In considering MLTSS, states should assess and design MLTSS around the following:

1. Consider the goals of LTSS in comparison to traditional Medicaid managed care. For example, many LTSS program goals are to improve or sustain the participant's quality of life, not to totally rehabilitate function or health.
2. The provider network needs of the LTSS community will differ from traditional Medicaid. While traditional Medicaid is focused on meeting the medical and primary care needs of participants, LTSS includes a broader spectrum of providers including providing care in the home and community settings rather than outpatient and inpatient medical facilities.
3. LTSS is grounded in a person-centered, social, and community model, while traditional Medicaid is centered in a medical model, requiring a heightened level of ongoing engagement and relationship building between participants, caregivers, and providers.

State Examples

Figure 28 below describes examples of the use of managed care programs to deliver LTSS.

Figure 28. State Examples of Managed Care Programs to Deliver MLTSS

State	Description
Alabama	Alabama uses a Primary Care Case Management delivery model, called the Integrated Care Network, to deliver improved education and outreach to beneficiaries about the options to receive LTSS. The program aims to better identify beneficiaries who could benefit from community options and alternatives to institutional stays and provide more comprehensive case management that better integrates the full range of medical and social services. This program coordinates closely with Alabama's Area Agencies on Aging and nursing facilities.[127] The statewide Integrated Care Network receives a financial incentive if they successfully change the LTSS mix towards more HCBS.[128]
Kansas	Kansas' MLTSS program led to an increase in primary care visits and a decrease in expensive hospital says for MLTSS participants.[129] The program operates with three MCOs across the State and covers various services, including: EPSDT, prescriptions, outpatient and inpatient visits, nursing facilities, home-health care, HCBS, and more.[130] Kansas operates MLTSS within the overall KanCare Medicaid managed care program.
Tennessee	Tennessee transitioned to MLTSS in 2010 and is nationally recognized for its program in relation to enhanced quality of life and cost-savings.[131] In 2018, a report indicated that nursing home expenditures decreased by 11.32% as the State operated their MLTSS program and provided more HCBS. The report also noted that the "annual HCBS expenditures remained lower each year than nursing facility expenditures."[132] Since the transition, the State reported increased waiver participant enrollment, ability to meet national quality standards, and enhanced participant satisfaction.[133] MLTSS is delivered in the same contract in the State as other managed care activities in the State.
Virginia	Virginia began its statewide MLTSS program in January 2018. The State works with six MCOs to provide care through a 1915(b) waiver program. A survey of the program's beneficiaries showed high satisfaction with their health plans.[134] Virginia operates MLTSS in a separate contract than the rest of its Medicaid managed care program.

Medicaid Expansion

Overview

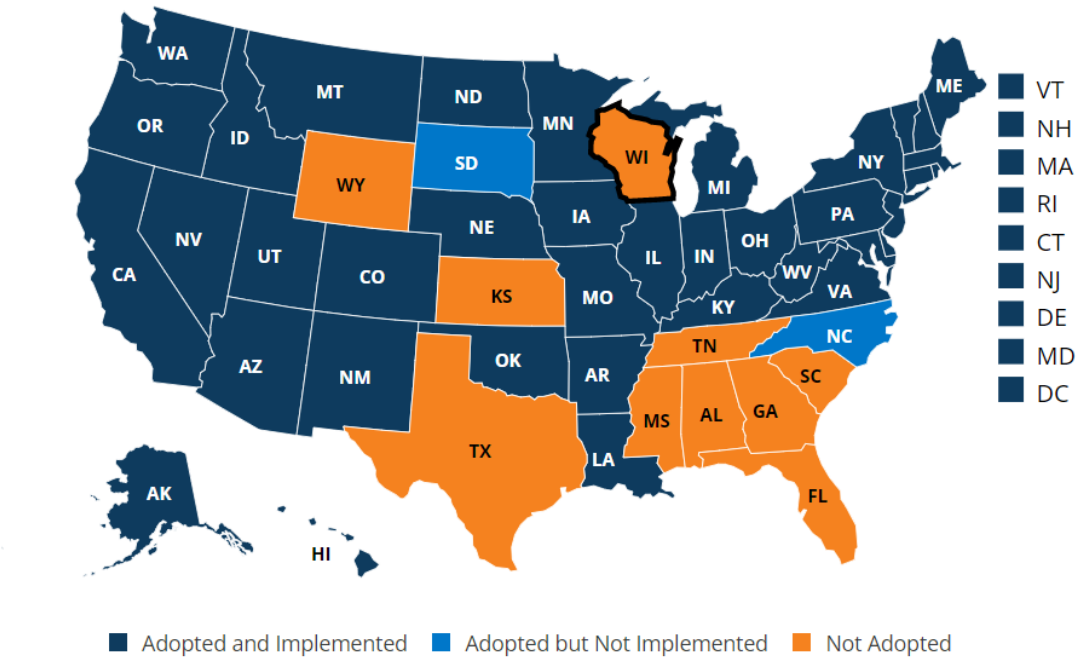
As part of the Affordable Care Act, beginning January 1, 2014, states could provide coverage under Medicaid expansion to cover nearly all adults with incomes up to 138% of the FPL. States receive an enhanced FMAP for services delivered to their expansion populations.

[127] Alabama Medicaid Agency. (October 23, 2018). *Integrated Care Network.* [Webpage]. Retrieved from: https://medicaid.alabama.gov/documents/5.0_Managed_Care/5.2_Other_Managed_Care_Programs/5.2.4_ICNs/5.2.4_ICN_Fact_Sheet_10-23-18.pdf
[128] Alabama Medicaid Agency. (October 23, 2018). *Integrated Care Network.* [Webpage]. Retrieved from:: https://medicaid.alabama.gov/documents/2.0_Newsroom/2.5_Media_Library/2.5.1_Slide_Presentations/2.5.1_ICN/2.5.1_ICN_Overview_10-23-18.pdf.
[129] Arizona for Better Medicaid. (2021) *Managed LTSS Improves Quality of Care*. [Webpage]. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/ABM_HMA_MLTSS-Quality-Care_FINAL.pdf
[130]CMS (2020). *Kansas Managed Care Program Features, as of 2020.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/managed-care/downloads/ks-2020-mmcdcs.pdf

National Landscape

Per the May 2023 Kaiser Family Foundation update, 41 states, including the District of Columbia, have adopted Medicaid expansion, and each has implemented with the exception of NC and SD, which are directed by state law to begin in June 2023 and July 2023, respectively.

Figure 29. Status of State Action on the Medicaid Expansion Decision as of 2023



Of the 39 states that have implemented Medicaid expansion, 32 states are using MCOs to provide services to the Medicaid expansion population.[135] Arkansas, Iowa, and New Hampshire received approval under 1115 waivers to use the exchanges created under the Affordable Care Act as the delivery model for the Medicaid expansion population.[136] However, Arkansas is the only remaining state using these exchanges to deliver benefits to the Medicaid expansion population.

Iowa discontinued the use of its exchange plans to deliver benefits to the Medicaid expansion population in 2015 and moved the population to traditional Medicaid managed care. This change occurred after Iowa's program saw double-digit premiums increases and both exchange

[131] Arizona for Better Medicaid. (2021) *Managed LTSS Improves Quality of Care*. [Webpage]. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/ABM_HMA_MLTSS-Quality-Care_FINAL.pdf
[132]Advancing States. (2021). *Demonstrating the Value of MLTSS*. [Webpage]. Retrieved from: http://www.advancingstates.org/sites/nasuad/files/2021%20-%20Demonstrating%20the%20Value%20of%20MLTSS.pdf
[133] Arizona for Better Medicaid. (2021) *Managed LTSS Improves Quality of Care*. [Webpage]. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/ABM_HMA_MLTSS-Quality-Care_FINAL.pdf
[134] Arizona for Better Medicaid. (2021) *Managed LTSS Improves Quality of Care*. [Webpage]. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/ABM_HMA_MLTSS-Quality-Care_FINAL.pdf
[135] Kaiser Family Foundation. (March 1, 2023). *10 Things to Know About Medicaid Managed Care.* [Webpage]. Retrieved from: https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/
[136] Robert Wood Johnson Foundation and Urban Institute. (May 2015). *The Use of Section 1115 Waivers to Implement Medicaid Expansion under the ACA*. [Webpage]. Retrieved from: https://www.urban.org/sites/default/files/publication/53236/2000235-Medicaid-Expansion-The-Private-Option-and-Personal-Responsibility-Requirements.pdf.

carriers left the program.[137] New Hampshire discontinued using the exchange plans to deliver benefits to the expansion population in January 2019, when it switched to a Medicaid managed care delivery model for the expansion population.[138] Approval for many of the other program features permitted through Section 1115 waivers has since been vacated or states have amended their waivers to remove the features (e.g., eligibility and enrollment provisions related to work requirements, personal responsibility programs requiring monthly premiums).[139]

Dental

Overview

States use a variety of models to deliver dental benefits to Medicaid beneficiaries.

National Landscape

A 2020 Milliman white paper highlights the following options for state dental delivery systems and the number of states using each model:

1) **Fee-for-Service** where the state assumes all risk and pays dentists directly – **12 states** had this model
2) **Administrative Services Only/Third Party Administrator** where the state assumes all risk but can outsource certain administrative functions to a vendor – **9 states** had this model
3) **Carve-in** where the state contracts with MCOs which then integrate dental into their medical programs in exchange for a PMPM capitation rate – **19 states** had this model
4) **Carve-out** where the state contracts with dental managed care organization(s), separate from any medical MCOs, in exchange for a PMPM capitation rate – **11 states** had this model

Milliman describes that different dental delivery models all have trade-offs that states much evaluate, such as trade-offs around program cost, administrative control, and desire for managed care program elements.[140]

The Kaiser Family Foundation found similar information as Milliman, identifying 12 states that operated carve-out dental delivery systems through Dental Prepaid Ambulatory Health Plans that provide limited-benefit plans that only include dental services.[141]

Figure 30. States with Carve-Out Medicaid Dental Delivery Systems

State	Enrollment
Florida	3,458,285
Texas	3,115,343

[137] Forbes. (September 14, 2015). *Iowa Scraps Waiver for ObamaCare Medicaid Expansion.* [Webpage]. Retrieved from: https://www.forbes.com/sites/theapothecary/2015/09/14/iowa-scraps-waiver-for-obamacare-medicaid-expansion/?sh=68522715d5ce
[138] MACPAC. (June 2020). *Testing New Program Features through Section 1115 Waivers.* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2019/10/Testing-New-Program-Features-through-Section-1115-Waivers.pdf.
[139] MACPAC. (June 2020). *Testing New Program Features through Section 1115 Waivers.* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2019/10/Testing-New-Program-Features-through-Section-1115-Waivers.pdf.
[140] Fonatana, J., Hallum, A., & Lewis, C., (2020), Medicaid dental program delivery systems [Webpage]. Retrieved from: https://us.milliman.com/-/media/milliman/pdfs/articles/medicaid-dental-program-models-factors.ashx
[141] Kaiser Family Foundation. (n.d.) Limited Benefit Medicaid Managed Care Program Enrollment as of 2020. [Webpage]. Retrieved from: https://www.kff.org/medicaid/state-indicator/limited-benefit-managed-care-program-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Dental%22,%22sort%22:%22desc%22%7D

State	Enrollment
Louisiana	1,480,707
Michigan	975,356
California	805,658
Arkansas	608,149
Nevada	556,987
Iowa	419,105
Idaho	344,074
Nebraska	260,100
Utah	215,742
Rhode Island	113,513

8. Transportation

Non-Emergency Transportation (NET)

Overview

Guidehouse conducted a review of nationwide NET, sometimes known as NEMT (non-emergency medical transportation), program transformation strategies, including incentives, oversight, modernization, and rideshare. While some modernization options may result in cost savings and enhanced quality, the vendors and technology may not be available in Arkansas at this time.

National Landscape

State Medicaid programs have flexibility to design their NET delivery system to accommodate its operational, demographic, and geographic needs and characteristics. Options include administering NET in-house, carving the benefit into a managed care program, and contracting with a transportation broker on either a fee-for-service or capitated basis.[142] Arkansas uses a multi-pronged approach, carving NET services into some of its managed care programs, contracting with regional transportation brokers via capitated arrangement, and providing reimbursement to family/friends.

As of 2020, 18 states operated Transportation Prepaid Ambulatory Health Plans (NET PAHPs) that cover transportation services only, similar to Arkansas: [143]

Figure 31. Enrollment in Transportation Prepaid Ambulatory Health Plans

State	Enrollment
Texas	4,073,144

[142] Silow-Carrol, S., Gifford, K., Rosenzweig, C., Ryland, K. & Pham, A. (2021). Medicaid's Non-Emergency Medical Transportation Benefit: Stakeholder Perspectives on Trends, Challenges, and Innovations. Health Management Associates [Webpage]. Retrieved: https://www.healthmanagement.com/wp-content/uploads/HMA_NEMT_Report_MACPAC_Aug-21.pdf

[143] Kaiser Family Foundation. (n.d.) Limited Benefit Medicaid Managed Care Program Enrollment as of 2020. [Webpage]. Retrieved from: https://www.kff.org/medicaid/state-indicator/limited-benefit-managed-care-program-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Dental%22,%22sort%22:%22desc%22%7D

State	Enrollment
Washington	1,830,122
Georgia	1,766,478
New Jersey	1,587,896
Kentucky	1,418,458
South Carolina	1,277,117
Arkansas	815,723
Oklahoma	701,359
Pennsylvania	650,241
Nevada	650,160
Idaho	344,074
Rhode Island	301,740
Utah	274,825
Missouri	267,575
Maine	265,968
Delaware	217,895
District of Columbia	53,900
Iowa	9,803

State Examples

In an August 2021 study for MACPAC, researchers reviewed NET programs in every state and selected six states for a more detailed study based on diversity of delivery system models, geography, innovations, and quality requirements. Three of these six states reported use of incentive payments in their NET contracts:

Figure 32. NET Incentive Payment Examples[144]

State	Incentive Payment Description
Connecticut	Statewide broker can earn up to five percent of the contract price if they meet **quality metric thresholds** related to call center performance, on-time pick-ups, complaint rates, and satisfaction survey results.
Indiana	FFS broker can earn an incentive payment by meeting a 99.5 percent **trip fulfillment metric**. (A state official reported that the state is amending the contract to also provide a partial incentive payment for meeting a lower metric.) The broker contract also requires a performance withhold of 3 percent of the broker's capitation, which can be earned back based on the broker's score card performance.
Massachusetts	Since 2009, has used shared cost-savings incentives whereby brokers are rewarded for **reducing trip expenses and improving efficiency**. The broker must

[144] Silow-Carrol, S., Gifford, K., Rosenzweig, C., Ryland, K. & Pham, A. (2021). *Medicaid's Non-Emergency Medical Transportation Benefit: Stakeholder Perspectives on Trends, Challenges, and Innovations. Health Management* [Webpage]. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/HMA_NEMT_Report_MACPAC_Aug-21.pdf

State	Incentive Payment Description
	reinvest these incentive payments to, for example, upgrade software, buy new computers, or hire additional staff.

Oversight, Modernization, and Innovation

A study published in the March 2019 *American Journal of Public Health* used the National Academies' NET cost-effectiveness model to perform a baseline cost savings analysis for provision of NET for transportation-disadvantaged Medicaid beneficiaries. This study concluded that modern NET, using digital transportation networks, has the potential to achieve greater cost savings than traditional NET while also improving patient experience.[145] For modern NET, **estimated savings on ride costs varied from 30% to 70%**. In comparison with traditional, modern NET was estimated to save $268 per expected user and $537 million annually when scaled nationally.[146]

New NET technologies have the ability to improve timeliness, efficiency, and beneficiary satisfaction. NET brokers have technologies that use GPS, electronic scheduling software, and other forms of advanced technology. These technologies have the ability to:

- "Verify beneficiary eligibility and that the requested trip is for an approved, valid medical purpose
- Assign the trip to a transportation provider qualified to offer the appropriate level of service at the lowest cost
- Document the date, time, and location for each NEMT encounter and completion in real time
- Schedule NEMT trips with one call or 'click'
- Track driver location in real time, view when a driver is running late and might cause a missed appointment, and send a new driver
- Provide real-time information and updates to riders about late pick-ups
- Track and report transportation performance metrics (specifically on-time performance)
- Connect transportation and health care datasets to help measure the impact of NEMT on health outcomes"[147]

Rideshare

In April 2023, the Arkansas Legislature approved House Bill 1009, now Act 484, to establish the NET Rideshare Expansion Study Workgroup. The group will study the need for expanded rideshare services, benefits of using rideshare services as compared to traditional NET

[145] Rochlin, D.H., Lee, C., Scheuter, C., Milstein, A. & Kaplan, R.M. (2019). Economic Benefit of "Modern" *Nonemergency Medical Transportation That Utilizes Digital Transportation Networks. American Journal of Public Health* [Webpage]. Retrieved from: https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304857?role=tab
[146] Rochlin, D.H., Lee, C., Scheuter, C., Milstein, A. & Kaplan, R.M. (2019). Economic Benefit of "Modern" *Nonemergency Medical Transportation That Utilizes Digital Transportation Networks. American Journal of Public Health* [Webpage]. Retrieved from: https://ajph.aphapublications.org/doi/full/10.2105/AJPH.2018.304857?role=tab
[147] Silow-Carrol, S., Gifford, K., Rosenzweig, C., Ryland, K. & Pham, A. (2021). *Medicaid's Non-Emergency Medical Transportation Benefit: Stakeholder Perspectives on Trends, Challenges, and Innovations*. Health Management [Webpage]. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/HMA_NEMT_Report_MACPAC_Aug-21.pdf

providers, financial implications of such a change, and other alternatives to expand services and improve cost effectiveness.

Rideshare leaders Uber and Lyft are partnering with some health plans to expand access in some areas of the country. NEMT brokers such as such as American Logistics Corporation, National MedTrans, American Medical Response, and Access2Care are all now piloting rides with transportation network companies like Uber and Lyft. New companies have been created, such as Circulation and RoundTrip, which provide platforms to help hospitals and health plans offer rides through companies like Uber and Lyft.[148]

Uber and Lyft have their systems built into some electronic health record platforms, allowing physicians to schedule directly through a patient's medical record. These companies have also developed programs available in limited cities, called Lyft Assisted and Uber Assist, where drivers assist riders to get from door to door rather than just taking riders curb to curb.[149] Some challenges of rideshare vs NET brokers include lack of training for handling physical or behavioral challenges, lack of logos/markings to identify vehicles, and lack of familiarity with drivers.

Day Treatment Transportation (DTT)

Overview

While DTT is similar to NET in providing non-emergency transportation, the DTT schedule is typically more predictable as the majority of beneficiaries are transported from home to early intervention day treatment (EIDT)/adult developmental day treatment (ADDT) facilities in the morning and then transported home again in the late afternoon. In contrast, NET rides occur more sporadically, for shorter appointments to medical offices or pharmacies, throughout the day.

National Landscape

During our key informant interview, Melissa Weatherton noted that Arkansas is the only remaining state in the nation with a DTT program which was essentially eliminated through the 1989 Omnibus Bill. If, at any point in the future, Arkansas DHS elects to provide DTT through another solution, it cannot then later reinstate the current program.

State Examples

While other states may not have a specific program for DTT, research shows models that:

- Moved this population into their existing NET program
- Provide beneficiaries with a monthly stipend to purchase transportation services from a broker
- Deem it the responsibility of the day treatment facility/provider to manage transportation for Medicaid beneficiaries

[148] Powers, B., Rinefort, S., & Jain, S.H. (2018). *Shifting Non-Emergency Medical Transportation To Lyft Improves Patient Experience And Lowers Costs*, Health Affairs [Webpage]. Retrieved from: https://www.healthaffairs.org/do/10.1377/forefront.20180907.685440/full/
[149] Wetsman, N. (2022). *Uber and Lyft are taking on healthcare, and drivers are just along for the ride.* The Verge [Webpage]. Retrieved from: https://www.theverge.com/2022/2/17/22937849/uber-lyft-health-transport-safety

Figure 33. Examples of DTT Models

State	DTT Model
Colorado	Non-Medical Transportation (NMT) provides access to non-medical community services and supports to prevent institutionalization.[150] DTT **is provided inside Colorado's NMT benefit** for Brain Injury Waiver, Community Mental Health Supports, Complementary and Integrative Health Waiver, Developmental Disabilities Waiver, Elderly, Blind, and Disabled Waiver, and Supportive Living Services Waiver.
Illinois	"Non-Medical transportation includes services for individuals in the DHS Division of Developmental Disabilities, Adult Home-Based Services (HBS) program. The Home-Based Service (HBS) program is one option available to children and adults with intellectual and developmental disabilities that have been approved to receive DD Medicaid waiver services. The HBS program provides individuals with a monthly allotment they can use to purchase needed services and supports that allow a person to continue to live in the family residence or a live in their own home in the community. **Transportation services may be purchased from the monthly allotment for the individual to gain access to waiver and community services, activities and resources** as specified by the Personal Plan."[151]
Missouri	"Adult Day Care service is defined as the continuous care and supervision of disabled adults in a licensed adult day care setting for up to 10 hours (forty (40) 15-minute units) per day for a maximum of 5 days. **The provider must arrange or provide transportation to the adult day care facility at no cost to the participant.** Reimbursement will be made for up to 120 minutes per day of transportation that is related to transporting an individual to and from the Adult Day Care setting."[152]
South Carolina	Effective July 1, 2022 "The South Carolina Department of Health and Human Services (SCDHHS) is **transitioning adult day health care (ADHC) transportation** for Healthy Connections Medicaid members within 15 miles of their ADHC **to the state's NEMT broker**, Modivcare. Previously, transportation for trips less than 15 miles from the ADHC was provided directly by the ADHC while transportation for trips longer than 15 miles from the ADHC was provided by either the ADHC or the NEMT broker."[153]

9. Non-Claims Based Payments

Government Contracts

Overview

The Governing Institute estimates that $1 out of every $3 spent by government goes to

[150] Colorado Department of Health Care Policy & Financing. (n.d.). *Non-Medical Transportation (NMT) Benefit* [Webpage]. Retrieved from: https://hcpf.colorado.gov/nmt
[151] Illinois Department of Human Services. (n.d.). *Home Based Services – Transportation, Non-Medical* [Webpage]. Retrieved from: https://www.dhs.state.il.us/page.aspx?item=47506
[152] Missouri Department of Health & Senior Services. (n.d.). *Adult Day Care Services* [Webpage]. Retrieved from: https://health.mo.gov/seniors/hcbs/adhcproposalpackets.php
[153] South Carolina Healthy Connections (2022). *Updates to Adult Day Health Care Transportation*. South Carolina Department of Health & Human Services [Webpage]. Retrieved from: https://www.scdhhs.gov/taxonomy/term/18

purchasing something to help provide services.[154]

National Landscape

Contract administration, monitoring activities that take place from the time the contract has been awarded or signed until the contract is closed out, is at the forefront of the national procurement conversation. In fact, effective contract administration and monitoring contractor/supplier performance was identified as the 8th highest priority in the National Association of State Procurement Officials (NASPO) 2022 Top 10 Priorities for State Procurement, and the 4th highest priority in the Southern Region of which Arkansas is a part.[155] [156] A best practice in post-award contract administration is having contract administration plans for critical, high-dollar or high-impact contracts, however, only 22% of Governing Institute survey respondents report having these plans in place.[157]

Another government procurement priority is analytics for data-driven decision making, which ranks as the 7th highest priority by NASPO. The National Institute of Governmental Purchasing (NIGP) notes that procurement organizations should use spend analysis to leverage buying power, reduce costs, and provider better management and oversight of vendors.[158] The spend analysis process uses data to analyze current, past, and forecasted expenditures to understand spend data by vendor, supplier, and department within an organization. Spend analysis can help organizations to reduce costs through informed strategic sourcing strategies based on the data, eliminate duplicate vendors, and improve contract compliance, among other outcomes.

States are also looking for ways to expand their system capabilities, such as fully integrating with the state accounting system (55% of survey respondents have this capability), integrating with accounts payable (45% of survey respondents have this capability), and including data analytics and business intelligence for projections, spend analysis, and customer satisfaction (41% of survey respondents have this capability). As a leading practice, Missouri implemented an e-procurement solution that is fully integrated into the State's financial management system.[159]

Tracking performance metrics to achieve procurement goals is also noted as a common priority by NASPO. NIGP states that is it important to regularly measure a variety of areas to ensure that goals are being met effectively and efficiently, such as:

- Efficiency (i.e., cost of operations)
- Effectiveness (i.e., savings)
- Quality (i.e., number of errors, number of change orders)
- Timeliness (i.e., time in process against agreed upon time)

[154] Governing Institute. (February 16, 2016). *Purchase Power: A Special Report on State Procurement.* [Webpage]. Retrieved from: https://www.governing.com/archive/gov-procurement-special-report.html
[155] NASPO. (n.d.). *2022 Top 10 Priorities for State Procurement* [Webpage]. Retrieved from: https://www.naspo.org/wp-content/uploads/2021/12/2022_Top10_Final.pdf
[156] NASPO. (n.d.). *2022 Top Regional Priorities for State Procurement* [Webpage]. Retrieved from: https://www.naspo.org/wp-content/uploads/2021/12/2022_Top10_Regional_Final.pdf
[157] Governing Institute. (2019). *5 Trends That Are Reshaping How Governments Buy.* [Webpage]. Retrieved from: https://papers.governing.com/Buying-Smarter-Insights-and-best-practices-from-the-2019-Governing-Procurement-Survey-117716.html.
[158] NIGP. (2012). *Spend Analysis.* [Webpage]. Retrieved from: https://www.nigp.org/resource/global-best-practices/Spend%20Analysis%20Best%20Practices.pdf?dl=true#:~:text=Spend%20analysis%20can%20be%20used,was%20paid%20for%20the%20item
[159] Governing Institute. (2019). *5 Trends That Are Reshaping How Governments Buy.* [Webpage]. Retrieved from: https://papers.governing.com/Buying-Smarter-Insights-and-best-practices-from-the-2019-Governing-Procurement-Survey-117716.html.

- Customer satisfaction (internal and external)[160]

The Governing Institute identified that Utah is employing a leading practice whereby it implemented a tool that automatically alerts contract managers about important dates and milestones associated with a contract to monitor performance.[161]

Figure 34. NASPO Ranked Priorities for State Procurement[162] [163]

Priority	National	Southern	Eastern	Midwestern	Western
Analytics for data-driven decision making	7	6	8	-	5
Central procurement office as a strategic leader	2	5	1	7	8
Change management	-	-	6	-	9
Continuous process improvement	3	2	7	4	3
Customer service to stakeholders	1	1	2	2	4
Effective contract administration	8	4	10	9	-
eProcurement	4	3	4	1	-
Innovative solution-based solicitation methods	-	7	-	-	10
Promoting supplier diversity	9	-	3	5	6
Talent management and succession planning	6	-	5	10	1
Tracking performance metrics to achieve procurement goals	10	9	-	6	7
Training and certifications	5	8	9	3	2
Transparency and integrity	-	10	-	8	-

[160] NIGP. (2012). *Public Procurement Practice Performance Measurement.* [Webpage]. Retrieved from: https://www.nigp.org/resource/global-best-practices/Performance%20Measurement%20Best%20Practice.pdf?dl=true
[161] Governing Institute. (2019). *5 Trends That Are Reshaping How Governments Buy.* [Webpage]. Retrieved from: https://papers.governing.com/Buying-Smarter-Insights-and-best-practices-from-the-2019-Governing-Procurement-Survey-117716.html.
[162] NASPO. (n.d.). *2022 Top 10 Priorities for State Procurement.* [Webpage]. Retrieved from: https://www.naspo.org/wp-content/uploads/2021/12/2022_Top10_Final.pdf
[163] NASPO. (n.d.). *2022 Top Regional Priorities for State Procurement.* [Webpage]. Retrieved from: https://www.naspo.org/wp-content/uploads/2021/12/2022_Top10_Regional_Final.pdf

10. Supplemental, Cost Settlement, and Access Payments

Disproportionate Share Hospital Allotments

Overview

Over the last five years, Arkansas has consistently been unable to distribute large sums of money from their annual disproportionate share hospital (DSH) allotment. The below screenshots from the CMS-64.9D (the federal expenditure form that tracks state DSH spend vs. their annual DSH allotment) illustrates how much the Arkansas has been able to distribute to hospitals for federal fiscal years 2021 and 2022.

	Total Computable (g)	Federal Share (h)
FFY 2021 (10/1/2020 - 9/30/2021)		
1) FFY 2021 Allotment	71,874,158	55,658,611
2) Amount Previously Reported - Title XIX	20,879,692	16,173,596
2A) Amount Previously Reported - CHIP Related - PE	0	0
3) Line 6 - Title XIX	0	0
3A) Line 6 - CHIP Related - PE	0	0
4) Line 7 - Title XIX	0	0
4A) Line 7 - CHIP Related - PE	0	0
5) Line 8 - Title XIX	0	0
5A) Line 8 - CHIP Related - PE	0	0
6) Line 10 - Title XIX	0	0
6A) Line 10 - CHIP Related - PE	0	0
7) Subtotal - Title XIX	0	0
7A) Subtotal - CHIP Related - PE	0	0
8) Total To Date - Title XIX	20,879,692	16,173,596
8A) Total - CHIP Related - PE	0	0
9) Unused FFY 2021 Allotment	50,994,466	39,485,015
10) Excess Expenditures	0	0

	Total Computable (g)	Federal Share (h)
	0	0
FFY 2022 (10/1/2021 - 9/30/2022)		
1) FFY 2022 Allotment	73,850,266	57,470,276
2) Amount Previously Reported - Title XIX	18,858,051	14,675,334
2A) Amount Previously Reported - CHIP Related - PE	0	0
3) Line 6 - Title XIX	0	0
3A) Line 6 - CHIP Related - PE	0	0
4) Line 7 - Title XIX	0	0
4A) Line 7 - CHIP Related - PE	0	0
5) Line 8 - Title XIX	6,286,017	4,891,778
5A) Line 8 - CHIP Related - PE	0	0
6) Line 10 - Title XIX	0	0
6A) Line 10 - CHIP Related - PE	0	0
7) Subtotal - Title XIX	6,286,017	4,891,778
7A) Subtotal - CHIP Related - PE	0	0
8) Total To Date - Title XIX	25,144,068	19,567,112
8A) Total - CHIP Related - PE	0	0
9) Unused FFY 2022 Allotment	48,706,198	37,903,164

Arkansas is required to distribute DSH payments to any hospital that meets the qualification requirements of their Medicaid State Plan and has available DSH limit to absorb a DSH payment. In Arkansas, very few hospitals qualify to receive DSH payments. This is due to Arkansas state specific DSH State Plan qualification and payment requirements.

DSH Payment Program in Arkansas for DSH Year 2021

For DSH year 2021, 28 out of 102 hospitals met the State Plan definition of a qualified DSH provider. However, of those 28, only 7 hospitals received a DSH payment. The following data concerns noted in the "*2021 AR DSH Payment Calculation worksheet*" (provided by DHS provider audit and reimbursement) illustrate the primary reason that only a limited number of hospitals participate in the Arkansas DSH program.

- The Arkansas Medicaid State Plan contains qualification provisions that are not required by the federal government to qualify an inpatient safety net provider to participate in state's DSH program.
- Several hospitals need to respond to whether they meet the "OB qualification requirement."
- Several hospitals are not providing the data necessary to support a hospital specific DSH limit (uncompensated care cost or UCC).
- The UCC calculation is showing 16 hospitals with a longfall (that make a profit) when accounting for all of their Medicaid and uninsured cost and payment activity.

Other Characteristics of Arkansas' DSH Program

Psychiatric DSH allotment

Per the Arkansas Medicaid State Plan, Arkansas State Hospital (ASH) is the only inpatient hospital in Arkansas that qualifies for IMD DSH payment. When reviewing the UCC data noted in the "*2021 AR DSH Payment Calculation worksheet,*" ASH had over $30 million of uncompensated care but only received a DSH payment of $819,351 to offset these costs. This is because ASH qualifies for the IMD DSH allotment, which is an allotment separate from the regular inpatient hospital DSH allotment provided to states. Arkansas expends the full amount of the IMD allotment and CMS has confirmed that ASH cannot qualify for any DSH payments above this allotment.

Review of "Deemed" Safety Net Provider Requirements

§ 1923(b) of the Social Security Act requires states to pay DSH payments to hospitals that are "deemed" a safety net inpatient hospital provider. A "deemed" safety net provider is defined as an inpatient hospital with a:

> A Medicaid inpatient utilization rate at least one standard deviation above the mean for hospitals in the state that receive Medicaid payments, or a low-income utilization rate that exceeds 25 percent. Deemed DSH hospitals are required to receive Medicaid DSH payments (§ 1923(b) of the Social Security Act (the Act)).

The Arkansas' Medicaid State Plan contains this language to ensure that all hospitals that are not only eligible but are required to receive DSH payments participate in Arkansas' Medicaid DSH program. Note that the Medicaid State Plan requires urban hospitals to meet the definition of a "deemed" hospital provider to qualify for DSH payments, however, for rural hospitals, it only requires one-half standard deviation above the Medicaid inpatient utilization rate to qualify for DSH payments.

Out-of-State DSH Payments

The Arkansas Medicaid State Plan requires the state to distribute DSH payments to out of state "border" hospitals who provide inpatient hospital services to Arkansas Medicaid recipients. DSH federal rules and regulations do not require states to distribute DSH payments to out of state providers. Per the "*2021 AR DSH Payment Calculation worksheet,*" Arkansas paid $842,203 to out of state hospital providers.

National Landscape

Nationally, 42% of hospitals received DSH payments in 2018. In that same year, 7% of Arkansas' hospitals received DSH payments. Based on a March 2022 MACPAC report, DSH allotment reductions are scheduled to begin for all states in FFY 2024. Arkansas can expect to have its total state and federal DSH allotment reduced by $17.2 million or 21%.[164]

State Examples

Figure 35 displays the percentage of hospitals receiving DSH payments in select states in FFY 2018.

Figure 35. Percent of Hospitals Receiving DSH Payments in Select States, FFY 2018[165]

State	Total Hospitals	Hospitals Receiving DSH	Percentage of Hospitals Receiving DSH
Arkansas	104	7	7%
Kentucky	116	98	84%
Mississippi	108	59	55%
Missouri	136	102	75%

Figure 36 summarizes DSH payment requirements from State Plans for the select states included in Figure 35 above.

Figure 36. Example State DSH Payment Requirements[166]

State	State Plan DSH Requirements
Arkansas	1. A full twelve-month cost report period ending in the previous state fiscal year 2. **Rural Hospitals** - A Medicaid inpatient utilization rate at least one-half standard deviation above the mean Medicaid patient utilization rate for all in state hospitals, or a low-income utilization rate exceeding 25%. 3. **Urban Hospitals** - A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for all in state hospitals, or a low-income utilization rate exceeding 25%. 4. The hospital must have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a Medicaid State Plan. 5. A minimum Medicaid utilization rate of 1%.

[164] MACPAC. (March 2023). *Annual Analysis of Disproportionate Share Hospital Allotments to States.* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf.
[165] MACPAC. (March 2023). *Annual Analysis of Disproportionate Share Hospital Allotments to States.* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2023/03/Chapter-4-Annual-Analysis-of-Medicaid-DSH-Allotments-to-States.pdf.
[166] Information was pulled from State Plans

State	State Plan DSH Requirements
Kentucky	1. The hospital has an inpatient Medicaid utilization rate of one percent or higher; and meets the criteria established in 42 U.S.C. 1396r-4(d). 2. The hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State Plan. 3. Meets the requirements established in section 1923(d) of the Act.
Mississippi	1. No hospital may qualify as a disproportionate share hospital for Medicaid unless the hospital has at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to Medicaid under an approved State Plan. 2. The hospital's Medicaid inpatient utilization rate must be not less than 1%. 3. The hospital's low-income utilization rate exceeds 25%. 4. No hospital may qualify as a disproportionate share hospital under this State Plan unless it is domiciled within the State of Mississippi.
Missouri	1. Missouri does not have any additional DSH requirements apart from the federal requirements of 2 obstetricians and at least 1% Medicaid utilization rate.

Non-Federal Share Funding Mechanisms

Overview

Federal law requires that at least 40% of a state's share of Medicaid benefit spending must come from the state itself. The other 60% may come from the state or from local government, such as through the use inter-governmental transfers (IGTs), certified public expenditures (CPEs), and provider assessments to fund the non-federal share of reimbursements to health care providers. In most cases, the IGTs, CPEs, and provider assessments are used to fund supplemental payments, although, in theory, they can be used to fund claim payments as well.

IGTs and CPEs can only be used with state-owned and non-state government owned providers. Provider assessments can be used with all providers, independent of ownership type. Also, IGTs and CPEs allow for all of the federal portion of the Medicaid reimbursement to be paid to the provider who contributes the non-federal share. In contrast, provider assessments have more restrictions on disbursement of funds, which often result in a small number of providers paying more into the program than what they receive back in Medicaid reimbursements. The providers who receive little or no benefit from provider assessments are those who treat very few Medicaid recipients.

How Providers Qualify for a CPE or IGT Program
Each state is required to justify that public funds used to fund the state share of Medicaid payments meets the following requirements per 42 CFR 433.51.

> *(a) Public Funds may be considered as the State's share in claiming FFP if they meet the conditions specified in paragraphs (b) and (c) of this section.*
>
> *(b) The public funds are appropriated directly to the State or local Medicaid agency, or are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or certified by the contributing public agency as representing expenditures eligible for FFP under this section.*

(c) The public funds are not Federal funds, or are Federal funds authorized by Federal law to be used to match other Federal funds.

In addition, states are required to answer the following IGT/CPE funding questions pursuant to all payment methodologies described in Medicaid State Plan attachments 4.19-A, 4.19-B, and 4.19D.

- A complete list of the names of entities transferring or certifying funds
- The operational nature of the entity (state, county, city, other)
- The total amounts transferred or certified by each entity
- Clarify whether the certifying or transferring entity has general taxing authority
- Whether the certifying or transferring entity received appropriations (identify level of appropriations)

Intergovernmental Transfers

Many states have turned to IGT programs to raise their state Medicaid share. As the name implies, IGTs are fund exchanges among or between different levels of government and are a common feature in state finance. Here is a typical example of how an IGT program works:

1. A county government also operates a public hospital.
2. Therefore, the county is wearing two hats: (1) a local government that may help cover a portion of the state share of Medicaid and (2) a Medicaid provider (as owner of a facility).
3. The county voluntarily sends the state money to help cover the state (non-federal) share of Medicaid expenditures. This is the IGT. (This may also be done through county certifying county spending on federally-matchable Medicaid services such as a facility operating deficit and a portion of that is then applied to Medicaid based on utilization mix.)
4. The state runs the county dollars through Medicaid as normal, receiving the applicable federal Medicaid match.

The following are basic rules and requirements for implementing an IGT-based Medicaid payment.

- Only units of government are eligible to contribute the nonfederal share through an IGT.
- The non-federal share of the Medicaid payment has to be funded by a transfer of money from an eligible governmental entity to the state Medicaid agency and are under that agency's administrative control.
- IGT is the transfer of funds (non-federal share of the Medicaid payment) from another government entity (e.g., a county, city, or another State agency) to the State Medicaid agency.
- Providers should keep the Medicaid payment funded by the IGT and not recycle back to the government entity.
- IGT money used as transfer to the state should not come from private provider donations.
- IGT can be used to fund Medicaid payments consistent with approved reimbursement methodology in the State Plan. The reimbursement methodology is not controlled by the IGT funding it can be cost-based reimbursement or otherwise.
- Simple example: County transfers tax revenues back to the state. The state uses that to fund the non-federal share of Medicaid supplemental payments to the providers.

Providers cannot recycle any portion of the Medicaid supplemental payments back to the county.

- The IGT funding mechanism is not generally memorialized in the State Plan. The state's response is just accounted for in the standard funding questions.

IGTs in Arkansas

Currently, Arkansas uses IGTs to fund hospital payments (UPL, DSH, physician supplemental and contracts) as well as Health Department payments.

Certified Public Expenditures

The CPE is a financing mechanism used by states to draw down federal matching dollars based on actual expenditures incurred by the provider or facility. The expenditures certified should be the full cost of providing an eligible service to a Medicaid client or an uninsured individual in the case of DSH. The actual expense/cost incurred of providing that service represents the state or local government funding contribution of the Medicaid program. The term CPE was adopted to mean **certified** by the contributing **public** agency as representing **expenditures** eligible for FFP and thus may be used by states to draw down federal funds. Only a unit of government can certify its public expenditures for the purposes of providing the non-federal share of a Medicaid expenditure.

Basic Rules and Requirements of Implementing a CPE Program

If the governmental unit is not the provider of the Medicaid service, it can certify its actual expenditures in an amount equal to the State Plan rate for the services. If the unit of government is also the provider of the service, then it may generate a CPE from its own costs, if the State Plan contains an actual cost reimbursement methodology. Because the provider is funding a "Medicaid payment" and the funding provided is based on incurred costs, the payment methodology in the State Plan must be costs. These costs are the basis for drawing down federal matching dollars. All states implementing a new funding mechanism based on CPEs must modify their Medicaid State Plan to indicate that their reimbursement methodology for participating government providers must be actual incurred costs.

The State Plan cost reimbursement methodology must be approved by CMS to ensure that allowable Medicaid costs are identified and reported to support a CPE. As part of the cost identification process, a state must furnish to CMS, for review and approval, a cost report (with instructions) that recognizes the total Medicaid costs incurred by the provider. States are permitted to use an audited national costs report (such as the Medicare cost reporting form CMS-2552-10) or develop a state specific report to capture Medicaid service costs. Typically, state specific reports will identify the salary and fringe benefits of qualified Medicaid service providers, medical supplies and equipment used to render Medicaid services, and the cognizant indirect cost rate (or another approved source of indirect costs absent a cognizant agency rate). For providers with non-medical service duties, such as targeted case managers, a CMS-approved time study must be used to capture and delineate medical and non-medical costs on the cost report. Further, a Medicaid allocation statistic (such as Medicaid service charges over total service charges) must be used to derive Medicaid costs from the total reported service cost pool.

Most states pay certifying Medicaid providers interim rates for claims submitted to the MMIS

throughout the rate year. On an annual basis, the provider submits the certified cost report to document total computable Medicaid service expenditures for the rate year and the Medicaid agency reconciles the report to the paid interim claims. The federal share of overpayments to the provider must be returned to CMS. However, the state is not required to make a provider "whole" if the interim rate does not satisfy the reported costs. The interim payment and cost identification, reporting, and reconciliation process must be detailed in the Medicaid State Plan.

CMS indicates that under the CPE rules, the expenditure is made "when it is paid, or recorded, whichever is earlier, by any State agency." There must be a record of an actual expenditure, either through cash or transfer of funds in accounting records and it cannot merely be a refund or reduction in accounts receivable. The CPE must be an expenditure by another unit on behalf of the single state Medicaid agency in order to qualify under these rules.

States cannot wait to draw federal dollars based on costs that may not be finalized until two weeks after the costs actually incurred. Payments funded by CPEs are cost estimates based on prior year's cost reports. States may trend these costs forward to determine an estimated "interim cost" on which federal dollars will be claimed. States are required to institute interim settlement when a hospital files its cost report. Federal matching dollars claimed as "cost reimbursement" are matched against actual incurred costs from the initial "as-filed" cost report. States must also include a final reconciliation based on costs identified in the finalized cost report and measured against actual federal dollars claimed in the interim settlement period.

Any state that wishes to use CPE funding must follow standard guidelines:

- The state must provide CMS with a CPE protocol that details how the provider costs are identified.
- The cost reporting tool must be subject to an audit process or be based on audited source documents.
- The state must modify their State Plan to include cost reimbursement as the method of payment.
- The reimbursement and cost protocol must be approved by CMS and include an interim payment, interim settlement (for institutionalized payments), and a final settlement.

CPE Funding in Arkansas

Currently, Arkansas uses CPE to fund the non-federal share of Medicaid school-based services (ARMAC).

Provider Assessments

Code of Federal Regulations §433.55 governs health care-related taxes and assessments. This regulation allows for the use of a tax/assessment levied on health care providers as a source of funding for the non-federal share of expenditures. A uniformity requirement of health care-related taxes mandates that the tax applies to all items or services or providers (or all providers in a class) in the area that the unit of government has jurisdiction.[167] Generally, health care

[167] Code of Federal Regulations, Title 42, Section §433.68(c)(2)

related taxes must meet the following requirements:

- The tax is broad based and uniform
- The amount of the tax is not directly correlated to Medicaid payment
- The net impact of the tax and any payments made to the providers by the state under the Medicaid program is generally redistributive
- Providers are not guaranteed to be held harmless from the tax

National Landscape

Information regarding states' use of IGTs, CPEs and provider assessments is not publicly available in State Plans.

State Examples

Examples provided in this section are from states in which Guidehouse has experience working.

- Wyoming Medicaid collects IGTs from government owned hospitals and ground ambulance providers to fund hospital, physician, and ground transportation UPL payments. Wyoming Medicaid uses a provider assessment program applied only to privately owned hospitals to fund hospital, physician, and ground ambulance UPL payments. UPL payments are only made to in-state providers.
- Alabama uses IGTs, assessments, and CPEs to fund the non-federal share of all Medicaid FFS inpatient and outpatient hospital service payments (rates, supplementals, and DSH). Alabama also uses a prescription drug tax to fund the non-federal share of retail prescription drug costs.
- Indiana implemented a hospital assessment to fund Medicaid FFS payments which includes a supplemental payment baked into their rate structure.
- Minnesota and California use CPE to fund cost settlements for county-based targeted case management services.
- Colorado uses CPE to fund the non-federal share of hospital-based physician cost settlements.
- Louisiana uses CPE to fund the non-federal share of school-based services.
- Tennessee created an 1115 waiver to fund all hospital FFS payments (rates, supplemental, and DSH) through a CPE program.

Provider Payments through Cost Settlements

Overview

Based on data supplied by DHS, Arkansas Medicaid paid $196 million through cost settlements funded by state general revenue in SFY 2022. (This excludes cost settlements to University of Arkansas for Medical Sciences (UAMS), who funds their cost settlement payments through an intergovernmental transfer.) This equals approximately 15% of total hospital reimbursement for the fee-for-service population. Using the enhanced FMAP available in SFY 2022 because of the COVID-19 PHE, hospital cost settlement payments in SFY 2022 used just under $44 million in state general revenue. Without the PHE enhanced FMAP, the hospital cost settlement payments would have used just under $56 million in state general revenue. Of the $196 million, approximately $110 million, or 56% is paid to a single hospital, Arkansas Children's Hospital. In addition, in SFY 2022, Arkansas Children's Hospital received another $48 million through an Upper Payment Limit supplemental payment.

FQHC cost settlement payments in SFY 2022 was just under $21 million and comprised 31% of total reimbursement to FQHCs for the fee-for-service population.[168]

National Landscape

As indicated in a review of Medicaid State Plans by MACPAC in 2017, relatively few state Medicaid agencies still provide cost settlement payments, and some that do, settle to less than 100% of cost.[169] In place of cost settlements, many states allow for fee-for-service UPL supplemental payments with the non-federal share of these payments often coming from intergovernmental transfers, certified public expenditures, and/or provider assessments, not from state general revenue.

State Examples

From a review of Medicaid State Plans performed by MACPAC in 2017, 16 state Medicaid agencies other than Arkansas perform cost settlements for hospital inpatient services. In addition, of the 16, 15 limit the types of hospitals that receive cost settlement payments, as follows:

- 5 agencies apply cost settlements only to psychiatric specialty hospitals (Maine, Utah, Pennsylvania, West Virginia, Wisconsin)
- 1 agency applies cost settlements only to psychiatric specialty and rural hospitals (Oregon)
- 4 agencies apply cost settlements only to rural hospitals (Iowa, Michigan, South Carolina, Washington)
- 1 agency applies cost settlements only to children's and cancer hospitals (North Dakota)
- 1 agency applies cost settlements only for direct graduate medical education costs (Virginia)
- 1 agency applies cost settlements only to Safety Net hospitals (Massachusetts)
- 1 agency applies cost settlements only to children's specialty and state-owned teaching hospitals (Texas)

Only Idaho and Tennessee (for the limited fee-for-service population) Medicaid agencies perform cost settlements to all hospitals for inpatient services.

For hospital outpatient services, MACPAC performed a similar review of Medicaid pricing in 2015 and determined that 15 state Medicaid agencies other than Arkansas perform cost-based reimbursement. In addition, 13 state Medicaid agencies other than Arkansas perform cost settlement for hospital outpatient services, again with several settling to less than 100 percent of cost and several limiting the types of hospitals that receive cost settlement payments.[170]

Less information is available regarding cost settlement payments to FQHCs. Guidehouse's experience working with other Medicaid agencies and limited research on this topic has uncovered only one state other than Arkansas that currently offers cost settlement supplemental payments to FQHCs. That state is North Carolina.

[168] Spreadsheet "PK - Master Summary of Multi-Year AR Medicaid Expenditures – 2019 – 2023 YTD.xlsx"
[169] MACPAC. (2018). *Medicaid Inpatient Hospital Services Fee-for-Service Payment Policy Issue Brief* [Webpage]. Retrieved from: https://www.macpac.gov/wp-content/uploads/2016/03/Medicaid-Inpatient-Hospital-Services-Fee-for-Service-Payment-Policy.pdf
[170] MACPAC. (2016) *State Medicaid Payment Policies for Outpatient Hospital Services Summary Spreadsheet*. [Webpage]. Retrieved from: https://www.macpac.gov/publication/state-medicaid-payment-policies-for-outpatient-hospital-services/

Cost Settlements for Out-of-State Hospitals

Overview

Arkansas Medicaid pays hospital inpatient cost settlements to out-of-state hospitals in border states and for services provided to children under the age of 1 by hospitals in any state. The out-of-state hospitals receiving inpatient cost settlements regardless of patient age include Methodist Healthcare in Memphis, Regional One Health in Memphis, all out-of-state pediatric specialty hospitals, and hospitals in the cities of Poplar Bluff, Missouri, Greenville, Mississippi, Poteau, Oklahoma, Memphis, Tennessee, Texarkana, Texas, and Springfield, Missouri.

National Landscape

As mentioned above, very few state Medicaid agencies still offer cost settlement payments. Even fewer states offer cost settlement payments to out-of-state hospitals. Many state Medicaid agencies designate key border state hospitals to be treated similarly to in-state hospitals. In most cases, these hospitals are paid the same rates as in-state hospitals, which most often equates to less than 100% of hospital cost. Rarely do state Medicaid agencies offer cost settlements or supplemental payments to key border state hospitals.

In unusual cases in which an individual Medicaid recipient needs medical care only offered in a small number of out-of-state hospitals, Medicaid agencies generally negotiate a rate with the out-of-state hospital that applies only for one or more hospital inpatient stays. This removes any need for cost settlement and allows payment to be made immediately after medical services are rendered.

State Examples

Figure 37 summarizes how other states pay for out-of-state hospital services.[171]

Figure 37. Example State Out-of-State Hospital Payment Approaches

State	Description
Mississippi	Mississippi Medicaid pays for inpatient services provided by out-of-state hospitals at the same rate as used for in-state hospitals without cost settlement.
Oklahoma	The Oklahoma State Plan indicates that covered inpatient services provided to eligible recipients of the Oklahoma Medicaid program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. In the event an out-of-state provider will not accept the Oklahoma Medicaid rate, the State will negotiate a different rate, most often being a Medicare rate. Specialty out-of-state hospitals that provide a unique service may be reimbursed at a negotiated rate not to exceed 100% of the cost to provide the service.
Texas	Texas Medicaid pays for hospital inpatient services provided at non-pediatric out-of-state hospitals the standard rate (without wage adjustment) used for in-state urban hospitals with no cost settlement. Texas Medicaid pays for hospital inpatient services provided at pediatric out-of-state hospitals the standard rate (without wage adjustment) used for in-state pediatric hospitals with no cost settlement.

[171] Information retrieved from each state's State Plan Attachments 4.19-A and 4.19-B.

11. Third Party Liability

Coordination of Benefits

Overview

Third Party Liability (TPL) refers to the legal obligation of third parties including individuals, entities, insurers, or programs, to pay part or all of the expenditures for medical assistance furnished under a Medicaid State Plan. Before the Medicaid program pays for the care of a beneficiary, it is a state's obligation to take all reasonable measures to ensure all available third-party resources are being utilized.[172]

National Landscape

Federal regulation 42 CFR 433.139 describes payment rules for Medicaid claims subject to third party liability. These include:[173]

- **Cost Avoidance:** If the state is aware of a Medicaid enrollee having a potential third-party coverage when a claim is filed, the state must reject the claim and instruct the provider to submit the claim to the potential primary payer. Once the potential primary payer has processed the claim, it can be resubmitted to Medicaid which will pay if the Medicaid payment amount exceeds the amount of the primary payment. States should not pay for services covered by third parties when the third party denied the claim for administrative reasons, such as the provider being out of network, prior authorization required, or timely filing. This methodology accounts for most of the savings to Medicaid associated with TPL.
- **Pay and Chase:** If after a claim is filed and paid a TPL is identified, the state Medicaid agency pays for the claim and then requests reimbursement from the primary insurer.
- **Benefit Exceptions:** In the case that a Medicaid beneficiary has TPL but the policy does not cover certain specific Medicaid services, claims can be paid by the state without first pursuing TPL.
- **Cost Effectiveness:** In the case that the agency determines the cost of pursuing recovery exceeds the potential TPL recoupment, or if pursuing a recovery duplicates another activity (e.g., child support enforcement), states do not need to pursue TPL. With this methodology, states must define the threshold amount of guideline that will be used to determine whether to seek recovery.

State Examples

Figure 38 highlights information from select states regarding their policies surrounding TPL.

Figure 38. Example State TPL Policies

State	Description
Alabama[174]	• Alabama cost avoids for medical services when a TPL policy exists, unless excluded by federal law.

[172] Medicaid.gov. (n.d.) *Coordination of Benefits & Third Party Liability.* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html
[173] MACPAC (n.d.) *Third party liability.* [Webpage]. Retrieved from: https://www.macpac.gov/subtopic/third-party-liability/
[174] Alabama Medicaid State Plan Under Title XIX of the Social Security Act. *Requirements for Third Party Liability – Payments of Claims. AL-21-0009 Attachment 4.22-B Page 1 (2022).* [Webpage]. Retrieved from: 9.8_A4.22-B_Third_Party_Collection_Procedures_Cost_Effective_2-17-22.pdf (alabama.gov)

State	Description

	• Alabama excludes pediatric prevention services from cost avoidance
	• Alabama has identified specific TPL denial reason codes that allow providers to bill TPL claims electronically to Medicaid for payment consideration. Providers must provide third party denials when billing Medicaid for services denied by the third party. Any denial reasons not included in the list of valid denial reason codes that can be submitted electronically must be billed on paper for consideration. [175]
	• Alabama uses thresholds for TPL recovery:
	  ○ $50 threshold for non-drug claims (Note: Paid claims under $50 are saved and accumulated and once the total paid for a member exceeds $50, the claims are submitted to the TPL carrier. The claims are accumulated for up to 12 months)
	  ○ $25 threshold for drug claims (Note: uses same accumulation approach as non-drug claims)
	  ○ $250 threshold for casualty recovery. Once the accumulated total related to the injury exceeds $250, Medicaid seeks recovery from the liable third party.

Colorado[176]	• An estimated 10% of Health First Colorado members have other health insurance resources available to pay for medical expenses.
	• Apart from a few exceptions, Colorado uses cost avoidance.
	• Colorado uses the following to ensure appropriate TPL payment:
	  ○ Providers ask beneficiaries about other insurance coverage and the Health First Colorado program maintains a reference file of known commercial health insurance and Medicaid coverage information used to deny claims that do not show payment or denial by the commercial health insurer.
	  ○ Providers may access Health First Colorado's TPL reference information through electronic eligibility verification.
	  ○ The Health First Colorado program maintains up to date TPL information to the best of their abilities and collects information about members' TPL from several sources.
	  ○ In the situation that Health First Colorado records do not identify commercial health insurance coverage, providers who find coverage pursue those benefits before billing the Health First Colorado program.
	  ○ Providers report members' discontinued insurance coverage to the Department's fiscal agent by sending a copy of the insurance carrier's letter or denial notice and identifying the member by name and State ID so records can be updated.

Ohio[177]	• In 2012, Ohio signed a Memorandum of Understanding with CMS to extend coordinated care to its dual eligible population through an Integrated Care

[175] Alabama Medicaid Provider Billing Manual: *Chapter 5 - Filing Claims, Section 5.7* [Webpage]. Retrieved from: https://medicaid.alabama.gov/content/Gated/7.6.1G_Provider_Manuals/7.6.1.2G_Apr2023/Apr23_05.pdf
[176] Colorado Department of Health Care Policy & Financing. (n.d.) *General Provider Information Manual: Third Party Liability Coordination of Benefits* [Webpage]. Retrieved from: General Provider Information Manual | Colorado Department of Health Care Policy & Financing
[177] Ohio Medicaid (2019). *Contract between United States Department of Health and Human Services Centers for Medicare & Medicaid Services in Partnership with State of Ohio Department of Medicaid* [Webpage]. Retrieved from: https://medicaid.ohio.gov/static/Providers/ProviderTypes/Managed+Care/ICDS/3-WayContract-072019.pdf

State	Description

	Delivery System (ICDS), or a system of managed care plans selected to coordinate the physical, behavioral, and long-term care services for individuals over the age of 18 who are eligible for both Medicare and Medicaid.[178]
	• The ICDS plan cost avoids costs in all cases other than in the case of prenatal services.
	• Ohio Department of Medicaid (ODM) provides the ICDS plan with all TPL insurance information on beneficiaries where it has verified that third party health liability insurance coverage exists.
	• ICDS Plan:
	  ○ Designates a TPL benefit coordinator to serve as a contact person for benefit coordination issues
	  ○ Designates one or more recovery specialists whose function is to investigate and process all transactions related to the identification of TPL
	  ○ Performs benefit coordination
	  ○ Works with Ohio via interface transactions with the MMIS using HIPAA standard formats to submit information with regard to TPL investigations and recoveries
	• ICDS plan uses the following sources to determine if a beneficiary has other commercial health insurance and identify other health insurance that may be obtained by a beneficiary:
	  ○ HIPAA 834 outbound Enrollment File
	  ○ Claims activity
	  ○ Points of Service Investigation (customer service, Beneficiary services, and Utilization Management)
	  ○ Any TPL information self-reported by a beneficiary

Crossovers

National Landscape

State Medicaid agencies have a legal obligation to pay Medicare costs for Medicare beneficiaries who are also eligible for some type of Medicaid assistance. These individuals fall into two categories: those who are Qualified Medicare Beneficiaries (QMBs) and those who receive Medicaid coverage while being above the 100% federal poverty level, which is the ceiling for QMB eligibility. For QMBs, all cost-sharing relating to Part A and Part B is the responsibility of the state, regardless of whether a service is also a Medicaid covered service. For non-QMBs, states must pay up to the Medicaid rate for Medicaid services rendered by Medicaid providers in excess of any third-party liability.[179]

While Medicaid programs are not required to pay the full Medicare coinsurance and deductibles for Medicaid enrollees dually enrolled in Medicare, in the past, some states made full payments to providers for the Medicare cost sharing amounts anyway. This meant that providers would receive the same payment for Medicare-Medicaid enrollees and Medicare-only enrollees in the

[178] Primary Care Collaborative (2019). *Integrated Care Delivery System (ICDS)- Ohio* [Webpage]. Retrieved from: https://www.pcpcc.org/initiative/integrated-care-delivery-system-icds-ohio
[179] Medicare Advocacy. (n.d.). *Medicare Cost-Sharing for Dual Eligibles: Who Pays What for Whom?* [Webpage]. Retrieved from: https://medicareadvocacy.org/medicare-cost-sharing-for-dual-eligibles-who-pays-what-for-whom/

state and made Medicare-Medicaid enrollees more attractive for providers. In recent years, there has been a shift away from full payment policies and states have begun to employ a "lesser of" payment policy, which is when a provider receives no more than the Medicaid-approved rate.[180] According to a September 2018 state policy compendia from MACPAC, the vast majority of states use a lesser of crossover claims policy for hospital inpatient, hospital outpatient, nursing facilities, and physician services, as illustrated in Figure 39.[181] Arkansas uses the lesser of claims policy for QMB for hospital inpatient services, and a full payment claims policy for hospital outpatient, nursing facilities, and physician services.

Figure 39. Number of States using Different Crossover Claims Policy, by Service Type

Crossover Claims Policy	Hospital Inpatient	Hospital Outpatient	Nursing Facilities	Physician Services
Full Payment	8	8**	8**	6**
Lesser Of*	41*	39	40	44
Other	2	4	3	1

* 4 states have variations on the lesser of policy (e.g., lesser of for in-state, full payment for out-of-state; lesser of for QMB, other for SLMB; Medicare Advantage plans have full payment)

** 1 state uses full payment for QMB and other for SLMB

12. Tax Equity and Fiscal Responsibility Programs

Overview

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 gave states the option to provide Medicaid benefits to children living with disabilities who would not ordinarily qualify for Supplemental Security Income benefits because of parents' income or resources. It allows states the ability to waive parental income and resources for children under 19 years old who have a disability and who meet a level of care that would make them eligible for placement in a hospital, nursing facility, or intermediate care facility for persons with intellectual disabilities. This eligibility option is also referred to as the Katie Beckett eligibility option.

National Landscape

According to a 2019 Kaiser Family Foundation survey, 50 states offer a TEFRA/Katie Beckett program, and over half of these states cover these children solely through a waiver, 17 states cover all eligible children under the State Plan Option, and four states cover some children though the State Plan Option and other children through a comparable waiver.[182] Covering a TEFRA/Katie Beckett program through a waiver allows states to limit enrollment, which is not allowed under the State Plan Option.

Overall, approximately 10% of states (6 of 50) reported charging premiums or monthly fees for

[180] MACPAC. (2014). *Effect of State Medicaid Payment Policies for Medicare Cost Sharing on Access to Care for Dual Eligibles* [Webpage]. Retrieved from: Effect of State Medicaid Payment Policies for Medicare Cost Sharing on Access to Care for Dual Eligibles (macpac.gov)
[181] MACPAC. (September 2018). *State Medicaid Payment Policies for Medicare Cost Sharing.* [Webpage]. Retrieved from: https://www.macpac.gov/publication/state-medicaid-payment-policies-for-medicare-cost-sharing/
[182] Kaiser Family Foundation. (June 14, 2019). *Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey.* Retrieved: https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/

the TEFRA/Katie Beckett population according to the Kaiser Family Foundation survey. States that charge premiums use different approaches based on family size and income.

Based on Guidehouse review of publicly available information on state TEFRA/Katie Beckett programs, it appears that most states conduct both eligibility and medical redeterminations on an annual basis.

State Examples

Figure 40 highlights information from select states regarding their premium structures and medical redetermination frequencies.

Figure 40. State TEFRA/Katie Beckett Programs

State	Description
Connecticut	• Katie Beckett program authorized under a 1915(c) waiver • Authorized to provide services to 325 clients and maintains a waiting list[183] • Determines cost-effectiveness of the service plan by determining the monthly cost of each Medicaid covered service included in the plan of care and the cost of nurse case management services; then compares those costs to the monthly alternative institutionalized care cost[184]
Georgia	• Katie Beckett program authorized under the State Plan Option • To determine the cost-effectiveness, the treating physician/service provider develops the treatment plan; the costs of the treatment plan services are compared to the cost of institutionalization for the individual; if the home cost is lower than the institutionalized cost, the child's care is determined to be cost-effective[185] • In September 2017, Georgia modified the frequency for medical level of care determinations so that all medical level of care determinations that are verified to meet the standard for Katie Beckett approval are authorized for a period of no less than two years[186] ○ Eligibility review continues to occur on an annual basis and consists of basic demographic, income, resource, and cost neutrality information

Minnesota	• All parents with an adjusted gross income of 275 percent of FPL or higher are required to pay a fee
	  ○ Fee is based on a sliding scale that ranges from 1.65% to 7.49% of adjusted gross income based on where the family's adjusted gross income compares to the FPL
	  ○ Parents not living with each other may each have to pay a fee[187]

Idaho	• TEFRA/Katie Beckett program authorized under the State Plan Option • Idaho imposes the following cost sharing: ○ Co-payment of $3.65 for certain types of practitioner visits for

[183] Connecticut Department of Social Services. (n.d.). *The Katie Beckett Waiver Program.* Retrieved: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Community-Options/Katie-Becket-Waiver-Program.pdf.
[184] State of Connecticut. (March 2012). *Katie Beckett Waiver Program.* [Webpage]. Retrieved from: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/OLCRAH/OperationalPolicyKatieBeckettWaiver.pdf.
[185] State of Georgia Department of Law. (April 20, 2023). *Georgia Medicaid State Plan.* [Webpage]. Retrieved from: https://medicaid.georgia.gov/document/document/state-georgia-medicaid-state-plan/download
[186] Georgia Department of Community Health. (September 18, 2017). *Katie Beckett Program Review Process.* [Webpage]. Retrieved from: https://medicaid.georgia.gov/programs/all-programs/tefrakatie-beckett.
[187] Minnesota Department of Human Services. (n.d.) *Medical Assistance under the TEFRA option for children with disabilities.* [Webpage]. Retrieved from: https://mn.gov/dhs/people-we-serve/people-with-disabilities/health-care/health-care-programs/programs-and-services/ma-tefra.jsp

State	Description
	individuals who do not have private insurance as primary payer ○ Premiums of $15-$30 per month for families with income greater than 150% FPL and less than or equal to 185% FPL ○ Sliding scale premiums for families with incomes above 185% FPL[188]
Tennessee	• Katie Beckett program authorized through a Section 1115 waiver • Covers both State Plan services and essential wraparound home and community-based services • Program has an enrollment target • Program requires payment of monthly premiums as a condition of enrollment if the family income is above 150% of the FPL ○ Families pay a percentage of their income that ranges from 1.5% for household income >150% FPL - 250% FPL to 5% for household income of >400% FPL - 500% FPL ○ A premium is required for each child participating in the program, regardless of whether they are in the same family • The waiver requires families to purchase and maintain minimum essential coverage private or employer-sponsored insurance or qualify for a hardship exception; however, TennCare may choose to offer premium assistance for such coverage in lieu of granting a hardship exception ○ The child's portion for the coverage is deducted from the premium charged to the family[189] ○ Hardship exceptions apply if 1) the cost of the private health insurance for the child is more than 5% of the parents' income or 2)if the parents' employer doesn't offer insurance and the family's income is less than 400% of the FPL[190]

[188] Centers for Medicare and Medicaid Services. (December 21, 2022). *Idaho State Plan Amendment Transmittal Number 11-016.*
[189] CMS. (December 27, 2022). *TennCare III Medicaid Section 1115 Demonstration* [Webpage]. Retrieved from: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-appvl-12272022.pdf
[190] TennCare. (November 2022). *Katie Beckett Program Answers to Your Questions* [Webpage]. Retrieved from:https://www.dropbox.com/s/kzvl07dzkseyx8y/FINAL%20KB%20Questions%20and%20Answers%2011.18.20%20.pdf?dl=0