Assessing the Medically Frail Among Medicaid Expansion Beneficiaries: Protecting Access to Nonemergency Medical Transportation

The federal requirement for state Medicaid programs to provide Medicaid nonemergency medical transportation (NEMT) is critical to chronically ill beneficiaries' access to health services. Only about 10% of beneficiaries use the benefit and the costs are small (less than $2 billion annually and roughly 1% of total Medicaid spending) in comparison to other Medicaid services. However, the Obama administration granted waivers to several states allowing them to eliminate the mandatory NEMT benefit for their Medicaid expansion populations newly covered under the Affordable Care Act (ACA). Federal statute[1] and regulations[2] require that states exempt certain individuals in the so-called Medicaid expansion population from the waiver, specifically the "medically frail." Federal regulations define medically frail beneficiaries by medical condition but states develop the processes to identify them. As additional states consider asking the new administration to waive NEMT and the new leadership at the Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMS) that administers Medicaid has endorsed[3] NEMT waivers, a robust, state-level assessment process is essential to ensure continued access to health care for medically frail beneficiaries.

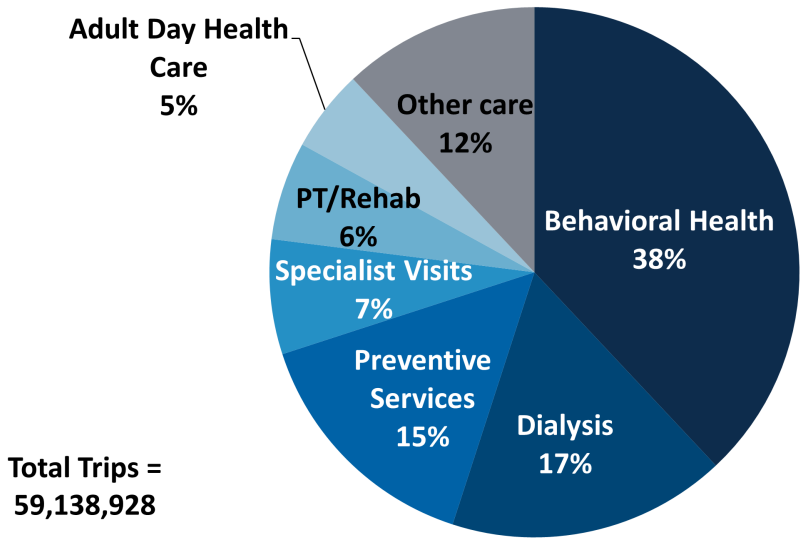
Medicaid NEMT Transportation – Who Uses the Benefit?

State Medicaid programs are required to provide a NEMT benefit to individuals who are unable to provide their own transportation to medical appointments. Only one in ten Medicaid beneficiaries use the benefit, but these beneficiaries have the highest rates of chronic disease. Beneficiaries with cancer, mental health and substance abuse disorders, HIV and end-stage renal disease account for over half of the Medicaid transportation utilization.[4] Without NEMT, these beneficiaries will miss critical repetitive, outpatient treatments, resulting in increased Medicaid expenditures for more expensive, in-patient services. A 2008 study found $1 spent on NEMT transport was estimated to save Medicaid roughly $10 because beneficiaries who regularly make their medical appointments are more likely to slow or avoid expensive and long-term diseases[5].

[1] SEC. 1937. [42 U.S.C. 1396u-7] (a)(vi)
[2] 42 CFR 440.315 --Benchmark Benefit and Benchmark-Equivalent Coverage; - Exempt individuals.
[3] Letter from HHS Secretary Price and CMS Administrator Verma to governors.
[4] Community Transportation Association of America. "Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) To Coordinated Care for Chronically Ill Patients." March 2014.
[5] Cronin, J. Florida Transportation Disadvantaged Programs: Return On Investment Study. The Marketing Institute at Florida State University College of Business. March 2008.

Figure 1

Medicaid Non-Emergency Medical Transportation Trips in 32 States, by Treatment Type (Nov. 2015 year-to-date)



SOURCE: LogisticCare Solutions, *Medicaid Gross Trips by Treatment Type* (Nov. 2015) (data available for 32 states).

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Alternative Benefit Packages for Medicaid Expansion Beneficiaries Include NEMT

The ACA allowed states to expand eligibility for Medicaid to single, adult citizens whose incomes are at or below 133 percent of the federal poverty line (FPL)[6]. States that choose to expand Medicaid may either provide newly eligible beneficiaries health care services covered by the existing state Medicaid benefit, or offer an Alternative Benefit Plan (ABP). Federal regulations implementing the ACA require ABPs to include NEMT.[7] However, beneficiaries who are medically frail may not be covered by the ABP unless they choose that benefit plan. The ABP is intended to offer benefits similar to those provided under employer-based health care coverage.

[6]Effective January 26, 2016, the FPL for a one person is $12,060 and $24,600 for a family of four. Source: Department of Health and Human Services. Notice. "Annual Update of the HHS Poverty Guidelines." Federal Register. 82 FR 8831. 1/31/2017.

[7] HHS. Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule. Federal Register. Vol. 78, No. 135. July 15, 2013. Page 42224.

States are altering their ABP benefits provided to Medicaid expansion beneficiaries through Section 1115 demonstration waivers. Section 1115 waivers allow states to innovate to improve their Medicaid and the Children's Health Insurance Program (CHIP). These innovations include service delivery, coverage of additional populations, new types of service, and payment approaches intended to align financial incentives with program improvements. The waiver submissions must include a research hypothesis related to the demonstration's proposed changes, goals, and objectives and an evaluation plan.

CMS Approved 1115 Waivers That Dropped NEMT

Though NEMT is a mandatory benefit by regulation[8] the Obama administration approved Section 1115 waivers for two states to modify their ABP benefit package by eliminating the NEMT benefit. A similar NEMT waiver is pending for Kentucky. Additionally, Massachusetts, and Arizona have expressed interest in dropping NEMT for the Medicaid expansion population and Arkansas has implemented prior authorization of the benefit. However, because federal law and regulations[9] require that states exempt the medically frail members of the expansion population from mandatory enrollment in an ABP, they must receive the NEMT benefit.

CMS does not require an individual functional assessment for the medically frail, required, for example, to determine the eligibility of children for the Supplement Security Income (SSI) program. Federal regulations[10] require that the medically frail include:

- Individuals with disabling mental disorders
- Individuals with serious and complex medical conditions,
- Individuals with a physical, intellectual or developmental disability that significantly impairs their ability to perform one or more activities of daily living, and
- Individuals with a disability determination[11].

In addition to this minimum federal requirement, states may add other categories to the definition of medically frail. States may not automatically enroll the medically frail in APBs and must allow these beneficiaries to choose either the APB or the traditional Medicaid state benefit plan.[12]

Identifying the Medically Frail

In the preamble to the final regulation, CMS acknowledges that states may not have prior experience with implementation of an ABP or with identifying individuals who meet the criteria for exemption. CMS encourages states to, at a minimum, screen for exempt individuals by allowing beneficiaries to identify themselves as medically frail. Federal regulations require that a

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[8] 42 CFR 431.53 Assurance of transportation.
[9] 42 CFR 440.315 - Exempt individuals.
[10] 42 CFR 440.315(f) - Exempt individuals.
[11] Based on Social Security criteria, or in states that apply more restrictive criteria than the SSI program, as the state plan criteria.
[12] 42 U.S. Code § 1396u–7(a)(2)(B)(vi)

beneficiary be provided with information sufficient to enable the individual to make an informed decision.

The definition and assessment of medically frail is especially important in states that have eliminated NEMT since the overwhelming majority of individuals that utilize this benefit in the traditional Medicaid population are chronically ill.

Assessment of Medically Frail and NEMT: State Practices and Proposals

CMS has approved waivers from Indiana and Iowa that eliminate NEMT for the expansion population. Both states, as required by federal regulations, exempt medically frail beneficiaries from their NEMT waiver. In addition, two other states, Kentucky and Arizona have sought to eliminate NEMT benefits for the expansion population. In Arizona, the waiver proposal did not exempt Medically Frail individuals and, thus, would have violated federal law. Arizona dropped their request to waive NEMT in 2015 for any population and the Kentucky waiver is pending.

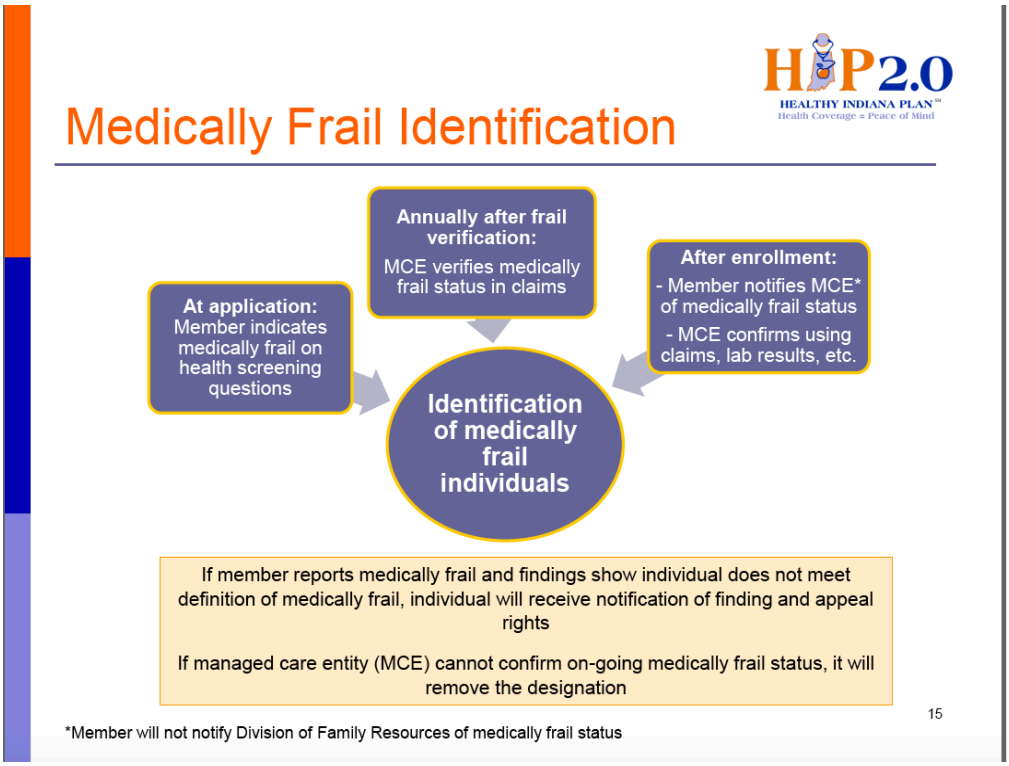
Healthy Indiana Plan 2.0

Healthy Indiana Plan (HIP) 2.0 enrollment was approximately 400,000 enrollees as of October 31, 2016. HIP 2.0 serves nondisabled, low-income adults ages 19-64 with incomes at or below 133% of the FPL. Indiana gained CMS approval to eliminate NEMT benefits for HIP 2.0 demonstration participants except for those that are medically frail.

HIP 2.0 Identification of Medically Frail

Individuals may be identified for medically frail screening during the application process, by self-reporting after enrollment, or as a result of claims reviews after an individual enters the Medicaid program.[13]

[13] http://in.gov/fssa/hip/files/HIP_2_0_Training_-_Special_Populations.pdf



The state allows for medically frail exemptions based on severity of a qualifying medical, mental, or substance abuse disorder or daily living. In defining the federal minimum requirements, the state deems[14] individuals with the following to be medically frail:

- Alcohol and substance abuse,
- Mental illness including
    - Major depression,
    - Schizophrenia,
    - Bipolar disorder, or
    - Post-traumatic stress disorder
- Specific medical conditions including:
    - Amyotrophic lateral sclerosis,
    - Aplastic anemia,
    - Blood-clotting disorders, frequent blood transfusions,
    - Cancer,
    - Cerebral vascular accidents,
    - Chronic Hepatitis B or Hepatitis C,
    - Cirrhosis,
    - Cystic fibrosis,
    - Cytomegalovirus (CMV) retinitis,

[14] IA HealthLink. Welcome to the Community. Accessed April, 2017. https://www.uhccommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/IA-Handbook-EN.pdf

    - Diabetes mellitus with: ketoacidosis, hyperosmolar coma, renal complications, retinopathy, peripheral vascular complications, or coronary artery disease,
    - Human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS),
    - Lipid storage diseases: Tay-Sachs disease, Niemann-Pick disease, Fabry disease,
    - Muscular dystrophy,
    - Paraplegia or quadriplegia,
    - Primary immune deficiencies: DiGeorge Syndrome, Combined Immune Deficiency, Wiskott-Aldrich Syndrome, T-cell deficiency,
    - Primary pulmonary hypertension,
    - Renal failure/end-stage renal disease,
    - Transplant or transplant wait list for heart, lung, liver, kidney, or bone marrow, or
    - Tuberculosis.
- Activities of Daily Living including:
    - Need assistance in an activity of daily living
        - 24 hour supervision and/or direct assistance to maintain safety due to confusion and/or disorientation
        - Turning or repositioning every 2 to 4 hours to prevent skin breakdown per medical plan of care
        - 24 hour monitoring of a health care plan by a license-nurse
        - Eating
        - Transferring from bed or chair
        - Dressing
        - Bathing
        - Using the toilet
        - Walking or using a wheelchair

As of July 2016, the state has identified 35,000 members of HIP 2.0 as medically frail and eligible for transportation. This represents about 10% of total HIP 2.0 enrollment.[15]

According to the state, of the 38,655 individuals in 2015 that were identified as medically frail, a random audit of 10% of the medically frail members revealed a 0.96% error rate, as only 37 HIP 2.0 medically frail members could not be confirmed as medically frail.[16] These results do not speak to the number of individuals that are medically frail that the Indiana screening and assessment process failed to identify.

In Indiana, Some Waiver Beneficiaries Receive NEMT Through Their Medicaid Managed Care Plan without Regard for Medically Frail Status

[15] HIP 2.0 Monthly Report: July 2016 (07/20/2016). Accessed April 27, 2017 at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-monthly-rpt-july-2016-07202016.pdf

[16] Letter from Indiana Governor to HHS. Re: Healthy Indiana Plan Section 1115 Demonstration Waiver Extension Project (Project No. 11-W-00296.5). Access April, 2017. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa4.pdf

All HIP 2.0 members receive care through managed care entities (MCE). Of the four MCE providers (Anthem, CareSource, Managed Health Services and MDwise Providers), only Anthem provides a transportation benefit to the entire expansion population under the waiver. An Anthem Public Policy Institute paper on HIP 2.0 identified lack of transportation as a barrier to care.[17]

Although the state does not reimburse the plan for this benefit, in 2016, Anthem provided up to 20 one-way trips to covered health services for the year (less than 50 miles each)[18]. In 2017, Anthem is making the benefit more generous by allowing for unlimited trips including trips for a prescription refills or a Medicaid redetermination appointment.

Iowa Wellness Plan

Iowa Wellness Plan (IWP) enrollment was approximately 150,000 as of September 2016. IWP serves nondisabled, low-income adults ages 19-64 with incomes at or below to 133% FPL. Iowa gained CMS approval to eliminate NEMT benefits for IWP demonstration populations. The waiver of NEMT does not apply to individuals the state determines to be medically exempt (Iowa uses the term "medically exempt" rather than medically frail).

IWP Identification of Medically Exempt

Individuals can qualify as medically exempt by completing the Medically Exempt Member Survey or if a qualified third party submits a Medically Exempt Attestation and Referral Form. Eligible third parties include a provider with a current National Provider Identification number, an employee of the state Department of Human Services, a designee from a mental health region or a designee from the state Department of Corrections. The provider must receive written consent to provide the information on the Provider Referral form to Iowa Medicaid.

The Iowa Department of Human Services, lists the following conditions as qualifying an individual as Medically Exempt[19]:

- Individuals with disabling mental disorder including:
  - Psychotic disorder
  - Schizophrenia
  - Major depression
  - Delusional Disorder
  - Obsessive-compulsive disorder
  - Individuals with a chronic behavioral health condition and the Global Assessment Functioning score is 50 or less
- Individuals with chronic substance abuse disorder,

[17] Healthy Indiana Plan 2.0: Enhanced Consumer Engagement and Decision-Making are Driving Better Health. July 2016. Retrieved June 5th, 2017 at https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mjuy/~edisp/pw_g252936.pdf

[18] Anthem BlueCross/Blue Shield. Health Indiana Member Handbook. Accessed April, 2017. https://mss.anthem.com/in/inin_caid_hip_memberhandbook_eng.pdf

[19] Details on each category found in the Medically Exempt Toolkit. https://dhs.iowa.gov/sites/default/files/IHAWP_Medically_Exempt_Toolkit.pdf.

- Individuals with serious and complex medical conditions,
- Individuals with a physical disability,
- Individuals with an intellectual or developmental disability,
- Individuals with a disability determination, and
- Individuals with conditions that significantly impair their ability perform one or more activities of daily living.

As of September 2016, the state has identified 18,000 members of the IWP as medically exempt and eligible for transportation.[20] This is approximately 12% of IWP beneficiaries.

In Iowa, Some Waivered Beneficiaries Receive NEMT Through Their Health Plan:
All IWP members receive care through Managed Care Organizations (MCOs, called MCEs in Indiana). Of the three MCOs, only UnitedHealthcare Plan of the River Valley, Inc. provides unlimited NEMT benefits to expansion beneficiaries covered by the state's NEMT waiver[21].

Arkansas Works
Arkansas Works enrollment was approximately 300,000 enrollees as of July 1, 2016. Arkansas Works covers nondisabled, low-income adults ages 19-64 with incomes at or below to 133% FPL. Arkansas gained CMS approval to impose prior authorization of NEMT in their ABP. The state also received approval to waive NEMT for individuals covered through Employer Sponsored Insurance (ESI). Medically frail individuals are excluded from Arkansas Works coverage except for individuals who have access to and choose to enroll in ESI.

Arkansas Works Identification of Medically Frail
Individuals are identified as medically frail by completing the Arkansas health care needs questionnaire[22]. The state worked with researchers from the University of Michigan and the Agency for Healthcare Research and Quality to develop the 12-question screening tool. The screening is administered annually at open enrollment. According to the state, the questionnaire covers the following:

- Self-assessment
- Living situation
- Assistance with activities of daily living (ADLs) or Instrumental Activities of daily living
- Overnight hospital says; and
- Number of physician, physician extender or mental health professional visits.

[20] Iowa Wellness Plan Quarterly Report 1115 Demonstration Waiver July 1, 2016 – September 30, 2016. Accessed April 27th, 2017 at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-jul-sep-2016.pdf
[21] IA HealthLink. Welcome to the Community. Accessed April, 2017. https://www.uhccommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/IA-Handbook-EN.pdf.
[22] http://www.sos.arkansas.gov/rulesRegs/Arkansas%20Register/2015/jan2015/016.06.13-016.pdf

The state relies on Medicaid managed care plans for re-assessments leading to mid-year transitions for the newly identified medically frail individuals to either the fee-for-service or managed care plan offering the standard Medicaid benefit package.

As of July 1, 2016, the state has identified 23,000 members of Arkansas Works as medically frail individuals. This is approximately 8% of total beneficiaries.

Arizona Health Care Cost Containment System

In 2015, Arizona requested approval from CMS to waive NEMT benefits for part of their Medicaid expansion population. However, unlike Iowa and Indiana, the state did not include exemptions for medically frail individuals in their proposal. In response to comments from the public, the state said only "The state…will explore opportunities to exempt certain medically frail populations from the directive to exclude non-emergency medical transportation as a covered service".[23]

Arizona's request to waive NEMT was dropped in negotiations with CMS and was not included in the approved waiver.

Kentucky HEALTH

Kentucky submitted a request to waive NEMT benefits in August 2016[24]. In their proposal, Kentucky offers a process for defining medically frail individuals and says that assessment and approval will be based on objective criteria established by the state. However, no objective criteria or assessment process for identifying the medically frail are included in the waiver request.

Kentucky's waiver is pending with CMS.

Conclusion and Policy Recommendations

Proper assessment and identification of Medically frail beneficiaries is important in states that have waived the NEMT benefit in their ABP, as the benefit is primarily used by chronically ill individuals. The Government Accountability Office (GAO), in a report on NEMT waivers for the Medicaid expansion population, said that research advocacy groups they interviewed "… cited limitations in terms of who can qualify as medically frail, as well as long wait times for such determinations."[25]

[23] Arizona AHCCS. Arizona's Application for a New Section 1115 Demonstration. Accessed April 2017. https://www.azahcccs.gov/shared/Downloads/AZWaiverPackage.pdf

[24] Letter from Governor of Kentucky to HHS. Re: Section 1115 Demonstration Wavier for Kentucky Health. Access April 2017. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf.

[25] Medicaid: Efforts to Exclude Nonemergency Transportation Not Widespread, but Raise Issues for Expanded Coverage. GAO-16-221. Washington, D.C.: January 15, 2016.

To ensure that most medically vulnerable Medicaid beneficiaries are able to access consultations and treatments for their chronic conditions and disabilities, the process to determine medically frail status must ensure all eligible beneficiaries can easily obtain appropriate screening, whether by the state, provider, or other designated entity. Any self-identification questionnaire or provider questionnaire must include functional limitations in addition to specific illnesses. A determination of functional limitations should include an individual, face-to-face assessment by an independent assessment entity. (An independent assessment entity has no direct financial interest or indirect material financial interest in a Medicaid health provider or Medicaid managed care plan).

In addition, there should be a post-enrollment mechanism to monitor changes in health status. The state and health plans must educate providers and beneficiaries about the medically frail exemptions as well.

In an issue brief[26], the National Council for Behavioral Health and Community Catalyst recommended that states consider the following when developing criteria for evaluation and/or reassignment:

- New or changed diagnoses,
- Severity "scores" (e.g., on Global Assessment of Functioning (GAF), DSM-V Severity Index or DLA-20 Functional Assessment)
- Utilization thresholds (e.g., >24 primary care provider (PCP) visits in 12 months
- Psychiatric or substance use treatment admission within 12 months.

States should not rely on a simple list of conditions to determine medically frail status. In the case of Sullivan V. Zebley, the Supreme Court determined that in addition to a list, child Social Security applicants must also receive a functional analysis.

States have experience with such screenings through their use of the Preadmission Screening and Resident Review (PASRR). To ensure Medicaid beneficiaries with disabilities are not inappropriately institutionalized in nursing homes, the PASRR process involves a preliminary screening for serious mental illness and/or intellectual disability. The presence of a disability is confirmed through a robust evaluation of the individual, interviews with caregivers and a review of medical documentation. The PASRR assessment then includes further evaluation of those with confirmed disabilities to determine the need and appropriate setting of care, as well as identifying services that must be included in the beneficiary plan of care. Iowa's PASRR initial screening tools are among the top 20 in the nation.

In addition, Congress should require states to assess and exempt individuals based on their residual functional capacity (RFC), as defined by existing federal regulations[27]. RFC is a useful

[26] National Council for Behavioral Health and Community Catalyst "Promoting Effective Identification of Medically Frail Individuals Under Medicaid Expansion." July, 2015. Retrieved May 25, 2017 at https://www.thenationalcouncil.org/wp-content/uploads/2015/07/15_Medically-Frail-Issue-Brief-v4.pdfNational Council / Community Catalyst

tool for identifying patients whose impairments may not clearly meet criteria specified for medically frail but who have functional limitations and activities the patient can or cannot perform due to those limitations. RFC is used by the Social Security Administration (SSA) to make disability determinations and, therefore, it should not be controversial for states to use an RFC assessment for the medically frail since individuals that meet SSA criteria are required to be exempt as medically frail.

Indiana's process to evaluate medically frail status incorporates screening by the state Medicaid eligibility staff and self-identification. It also includes a claims review component to monitor for any changes in health status after initial Medicaid enrollment. However, the process relies on reviewing claims but does not address claims which may not have been filled if the beneficiary was unable to access the services due to lack of NEMT. Iowa and Arkansas' processes do not have ongoing claims review, which has the potential to omit some beneficiaries who do not know the medically exempt policy.

To avoid unnecessary hospitalizations or institutionalizations due to deterioration of their chronic conditions or complications from their disabilities, the medically frail must be properly assessed and exempted from all waivers of NEMT benefits.

[27] 20 CFR 416.905 - Basic definition of disability for adults.