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STATES



# Medicaid Managed Care and MLTSS: An Overview

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# Overview of Presentation

- Scope of Medicaid Managed Care
- Type of Plans
- Managed Care Authorities
- State Requirements
- MCO Requirements
- Managed Long-Term Services and Supports

# Scope of Managed Care

# Medicaid Managed Care

Managed care is the predominant delivery system for Medicaid beneficiaries

- 82% of all Medicaid beneficiaries in 2017 enrolled in a health plan (for some or all services)
  - Most are children, pregnant women and parent but include disabled and elderly adults, as well as those receiving long-term services and supports in a number of states
  - 69% of all beneficiaries are enrolled in a comprehensive MCO
- Virtually all of the 10 million adults receiving coverage under the ACA are in managed care plans

Source: CMS 2017 Medicaid Managed Care Enrollment Report

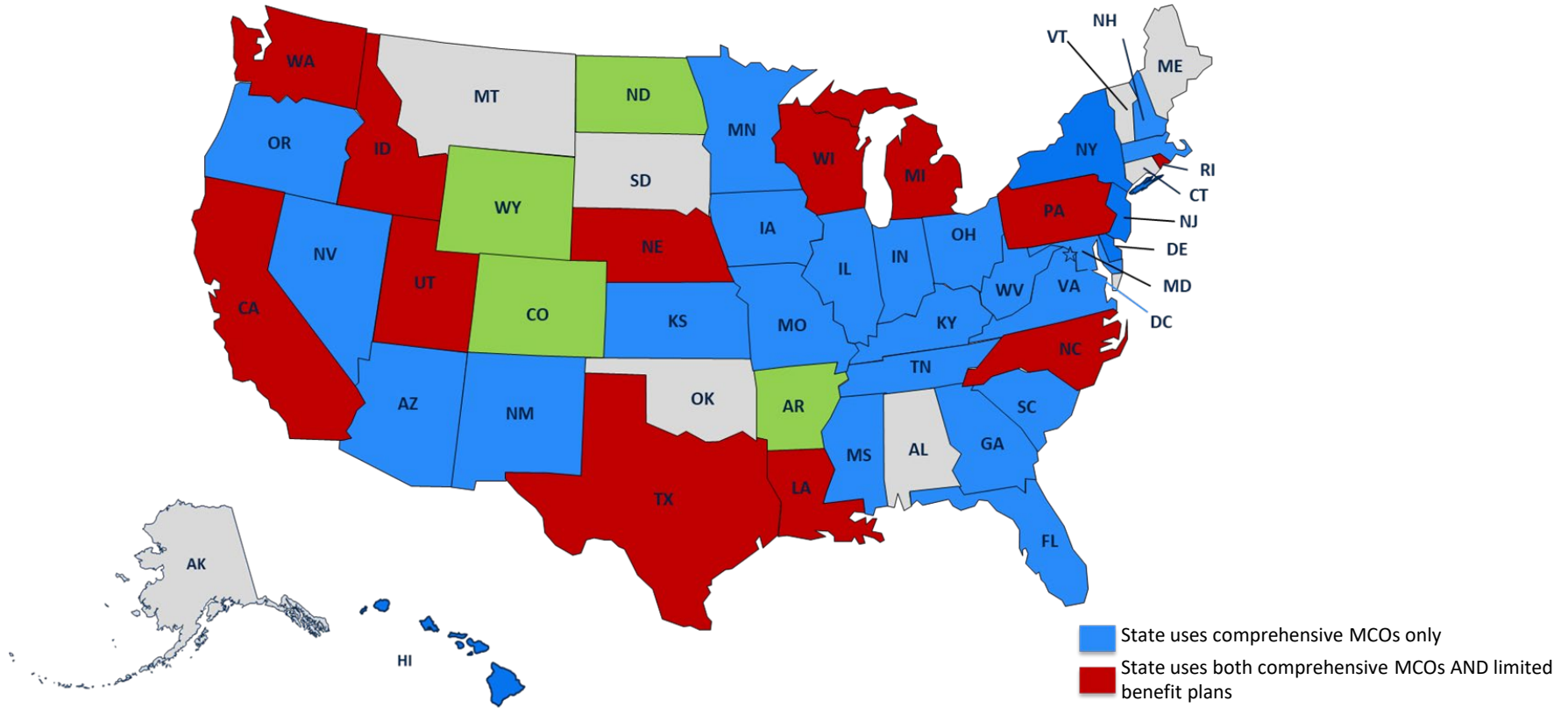
# Medicaid Managed Care

Managed care is the predominant delivery system for Medicaid beneficiaries

- 42 states deliver some or all Medicaid benefits through either comprehensive or limited benefit health plans
- Capitated health plan payments represented 46% of all Medicaid expenditures in 2015 (up from 17% in 2003)

Source: Source: 2017 CMS Medicaid Managed Care Enrollment Report; 2016 Actuarial Report on the Financial Outlook for Medicaid

# Medicaid Managed Care Penetration - 2019



Source: CMS 2017 Medicaid Managed Care Enrollment Report and NASUAD data

# How does a state implement managed care?

## Get approval from CMS!

- The 'default' delivery system in Medicaid is fee-for-service (FFS)
  - The state contracts directly with health care providers and pays them (typically) a fee for every covered service they provide to Medicaid beneficiaries
- For states to use health plans to deliver Medicaid services, CMS must provide multiple approvals

# How does a state implement managed care?

- Medicaid managed care programs must follow – at a minimum – Federal regulations at 42 CFR Part 438
- First promulgated in 2001; revised in 2016
- CMS currently reviewing comments to proposed changes in 2018
- Includes requirements for both states and managed care plans



# Type of Plans

# Types of Managed Care Plans

- The type of managed care plan depends on what services are covered under the managed care contract
- Medicaid programs must provide the following services (called mandatory benefits):

Hospital services

Nursing Facility Services

Home health services

Physician services

Clinic services

Laboratory and X-ray services

Family planning services

Transportation to medical care

# Types of Managed Care Plans

- Medicaid programs MAY provide the following services (called optional benefits):

Prescription Drugs

PT/OT/ST

Optometry services

Dental Services

Chiropractic services

Private duty nursing services

Personal Care

Hospice

Case management

HCBS Services \*

- Most states provide most of these optional services (typical exceptions: dental and chiropractic)

\* HCBS will be addressed later in this presentation

# Types of Managed Care Plans

- If a health plan delivers inpatient services as well as at least three of the mandatory benefits, the plan is considered comprehensive and is called a managed care organization (MCO)
- If a health plan delivers inpatient services and less than three mandatory benefits or any optional benefits, the plan is considered to offer limited benefits and is called a prepaid inpatient health plan (PIHP)

# Types of Managed Care Plans

- If a health plan does not cover inpatient services and provides less than three mandatory benefits or any optional benefits, the plan is considered to offer limited benefits and is called a prepaid ambulatory health plan (PAHP)
- See example below:

MCO	PIHP	PAHP
Hospital	Hospital	Dental
Physician	Physician	
Lab/Radiology/Home Health	Laboratory	
Prescriptions	Mental Health/SUD	
Mental Health/SUD		

# Managed Care Authorities

# How can a state implement managed care?

- States decide how to structure their managed care program by determining:
  - Who will enroll (eligibility groups);
  - What services will be provided by the plans; and
  - Where will it operate (geographic reach)
- CMS provides technical assistance and directs states to the Federal authority that will accommodate their program design

# Managed Care Authorities

The Social Security Act (which authorizes the Medicaid program) provides four different ways under which states may operate managed care programs (numbers below reference sections of the SSA):

- 1915(a) - Voluntary Program
- 1932(a) - State Plan Amendment
- 1915(b) - Managed Care Waiver
- 1115(a) - Research & Demonstration Project



# §1915(a) Voluntary Program Features

- Managed care enrollment is voluntary – beneficiaries must have option to receive services FFS
- State must contract with any qualified, willing provider
- Self-implementing upon approval of managed care contract by CMS
- No ‘cost’ test
- Approval is not time-limited

# §1915(a) Voluntary Program

- About 15 1915(a) programs in country
- Over half enroll elderly and/or disabled beneficiaries and include HCBS services
  - CO
  - DC
  - MA (Senior Care Options)
  - MN (MN Senior Health Options)
  - WI

# §1932(a) State Plan Amendment Features

- States must submit SPA form to CMS
- State can require most beneficiaries to get services from health plans (or primary care case manager)
- State can operate managed care only in certain areas
- State can limit the number of health plans it contracts with
- State can allow health plans to provide different benefits to enrollees
- Certain populations **can't be required to enroll** - Dual eligibles, AI/AN, and special needs children
- No 'cost' test and approval is not time-limited
- CMS must approve managed care contract and payment rates

# §1932(a) State Plan Amendment

- 20 States operate one or more managed care programs through this authority
- They are split between small regional programs and large statewide programs
- States with large statewide programs include:

DC	Georgia
Illinois	Louisiana
Mississippi	Nevada
Ohio	South Carolina
Washington	Wisconsin

# §1915(b) Managed Care Waiver Features

- States must submit a waiver application to CMS
- State can require **all Medicaid beneficiaries** to enroll in health plans
- State can operate managed care only in certain areas
- State can limit the number of health plans it contracts with
- State must show that waiver is “cost effective” over the waiver period
- Waiver approval lasts two years; state must apply to ‘renew’ within 90 days of expiration date
- CMS must approve managed care contracts and payment rates

# §1915(b) Managed Care Waiver

- About 14 states operate managed care through this authority
- A few provide limited benefits (primarily mental health) and the others are large statewide and comprehensive programs
- States with large statewide programs include:

Florida	Kentucky
Iowa	Michigan
Missouri	Nebraska
North Carolina	Pennsylvania
Utah	Virginia

# §1115 Research & Demonstration Project Features

- Must assist in promoting the objectives of the Medicaid or CHIP statute, as determined by the Secretary
- Provides waivers from statutory and regulatory requirements not available under SPAs or 1915(b) waivers
- Allows states to receive Federal match for activities not otherwise considered medical assistance
- In wide use since mid-1990s, esp. to expand coverage to childless adults

# §1115 Research & Demonstration Project Features

- States must submit a demonstration application to CMS
- State must show that demonstration is “budget neutral” over the demonstration period
- Demonstration approval is generally for five years at initial approval and for three years at a time thereafter
- CMS must approve managed care contracts and payment rates



# §1115 Research & Demonstration Projects

- Less than 20 states operate managed care through this authority
- All are large statewide programs

Arizona	California	Delaware
Hawaii	Kansas	Maryland
Massachusetts	Minnesota	New Jersey
New Mexico	New York	Oregon
Rhode Island	Tennessee	Texas

# State Requirements

# When CMS approves....then what?

- State has to select the managed care plans that they will contract with
  - Typically done through competitive procurement, although some states take ‘any qualified plan’
  - If procurement, state must develop RFP
  - Review bids and make selection
- State has to write the MCO contract
  - State administrative code/legislation, etc.
  - CMS has ~ 40 pages of Federal requirements for MCO contracts
  - Some are more than 500 pages

NOTE: Most states take these steps concurrently with seeking CMS approval

# When CMS approves.....then what?

- State has to set the rates that the managed care plans will be paid
  - MCOs are paid a set amount each month for each Medicaid consumer they enroll (a PMPM amount)
  - CMS has specific requirements for how those are calculated
- CMS must review and approve both the MCO contract and rates
- Federal funds are not available to the state without both being approved

NOTE: Most states take these steps concurrently with seeking CMS approval

# When CMS approves.....then what?

- State has to educate/inform Medicaid consumers about the changes coming
  - Public meetings, website, mailings, provider communication
- State has to ensure that MCOs are operationally ready to serve Medicaid consumers
  - Readiness reviews of all systems and processes – claims, enrollment, encounter data, medical management, quality
- State has to ensure that its staff have the requisite skills and knowledge to provide appropriate oversight of MCOs

NOTE: Most states take these steps concurrently with seeking CMS approval

# MCO Requirements

# MCO Requirements

Managed care plans are required to:

- Have sufficient providers to ensure access to services (network approved and monitored by state)
- Coordinate care for members who have special needs
- Measure and report to state on quality of care
- Provide access to member services (by phone/web/email)
- Authorize (when appropriate) and pay providers timely for services

# MCO Requirements

Managed care plans are required to:

- Have an appeal process for disagreements on service access
- Spend at least 85% of their payments from the state on services/quality activities
- Implement activities to minimize fraud, waste and abuse



# Managed Long-Term Services and Supports

# Managed Long-Term Services and Supports

- MLTSS is a delivery system that uses managed care plans (MCOs or PIHPs) to deliver long-term services and supports (LTSS) to Medicaid beneficiaries
- LTSS includes both institutional services (nursing homes/ICF-I/DD) as well as home and community-based services (personal care, meals, adult day programs, employment, etc.)
- Most HCBS require §1915(c) waivers from CMS, but some HCBS can be offered through state plan authority

# Managed Long-Term Services and Supports

- If HCBS is offered by a state through a §1915(c) waiver, the state must get both (c) waiver approval **as well as** a managed care authority approval.
- These are called **concurrent authorities**
- Some states have been able to use §1115 demonstration authority to both cover services as well as mandate managed care enrollment

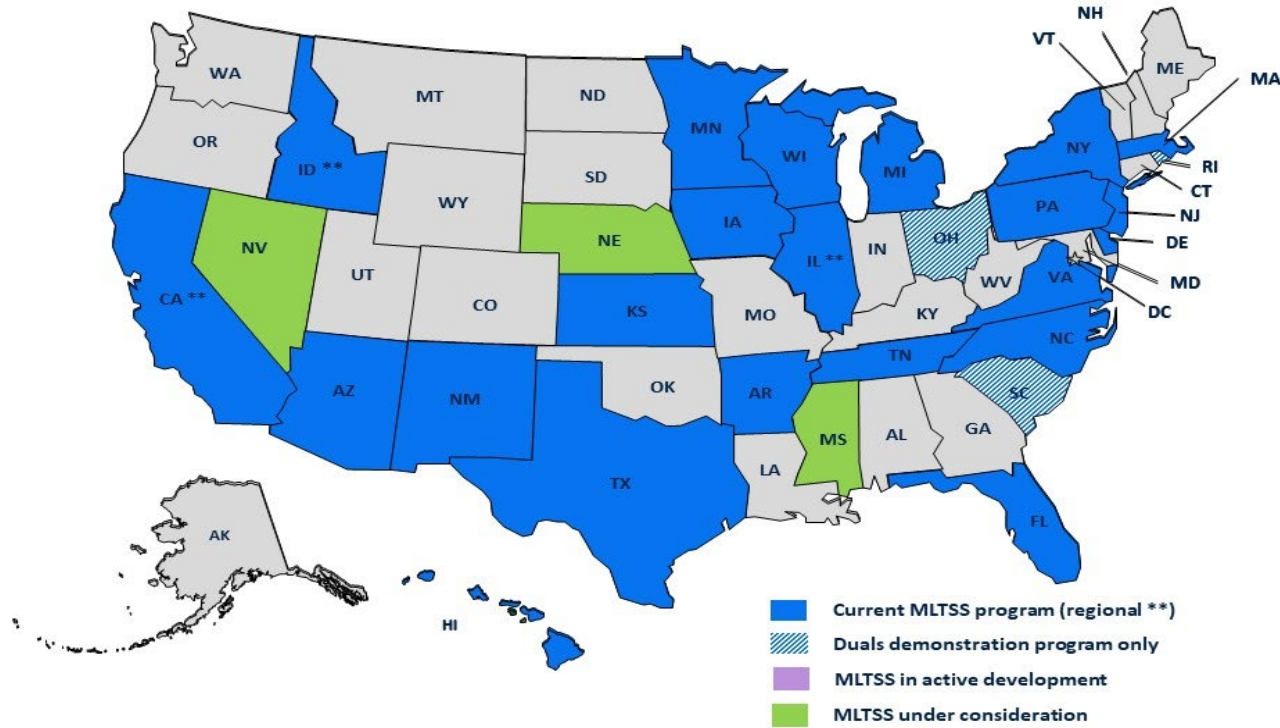
# Concurrent Authorities

- CMS has approved the following types of concurrent waivers:

1915(b)/(c) waivers	1915(b)/(c)/(i) waivers
1915(b)/(i) waivers	1932(a)/(c) waivers
1115(a)/1915(c) waivers	

- 14 States operate MLTSS programs using concurrent authorities including FL, IL, IA, KS, MA, MI, OH, and WI
- The remaining states use §1115 demonstrations to operate MLTSS programs, including AZ, CA, DE, KS, NM, NY, and TN.

# MLTSS Programs – August 2019



Note: VT is included in CMS' list of MLTSS states

# Why do states implement MLTSS?

## Accountability

- State can drive performance through contracting with few entities
- Eliminates state need to 'run' insurance company

## Access

- Reduce HCBS waiting lists
- Increased use of primary and preventive care

## System Balance

- Increase HCBS options (consistent with consumer desire)
- Plans have incentive to divert NF admissions
- Support for individual choice and self-direction

## Innovation and Quality

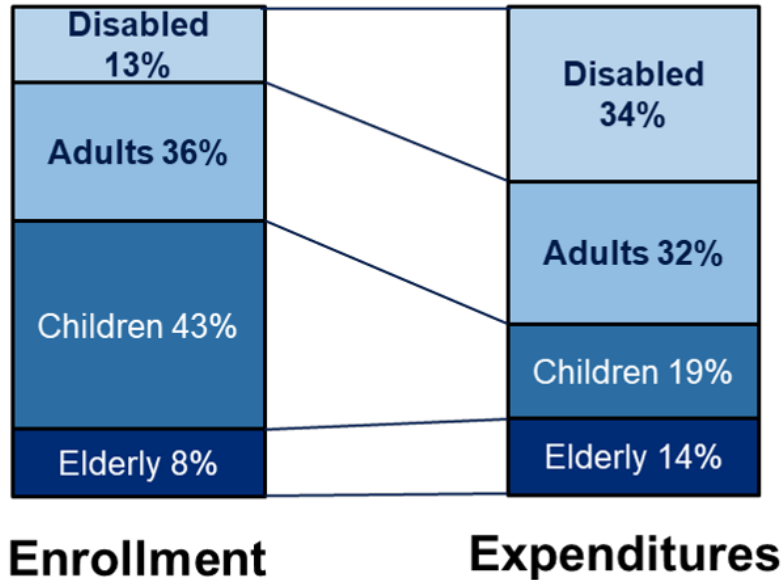
- Shift to person-centered, integrated care and services
- Plans have more flexibility to deliver services
- Can better measure health and quality of life outcomes

## Budget Predictability

- Capitation minimizes unanticipated spending
- May slow growth in per-person costs

# Why do states implement MLTSS?

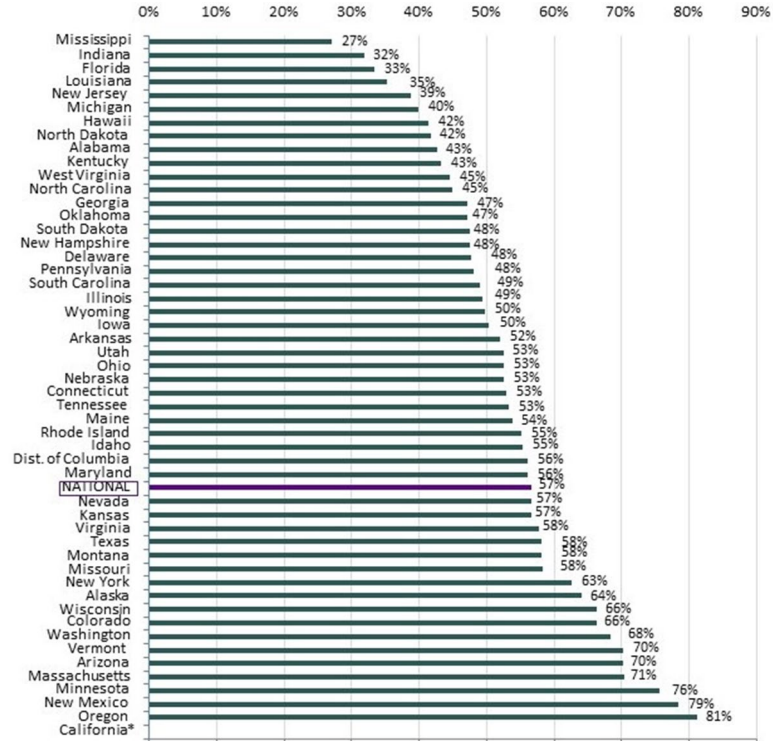
**Nearly half of Medicaid spending is for the elderly and people with disabilities, FY2015**



Source: Center for Budget and Policy Priorities

# Why do states implement MLTSS?

HCBS Expenditures as % of all Medicaid LTSS Expenditures, FFY 2016



National  
Avg -  
57%

Source: IBM Watson Health, June 2018

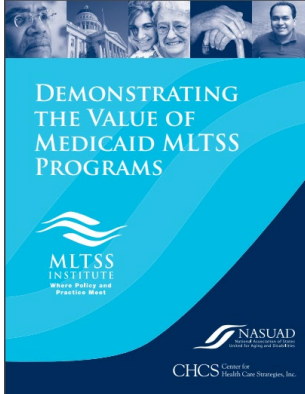


# Unique Requirements for MLTSS Programs

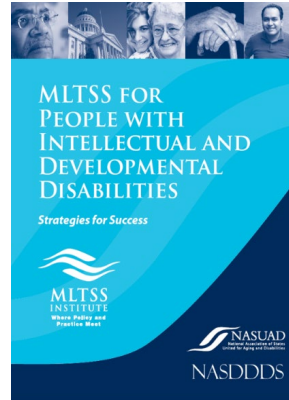
- 2016 Final Managed Care regulations established new MLTSS program requirements for both states and plans
- Echoes 2013 CMS guidance on MLTSS programs
- Includes:
  - Mandated continuity of care period
  - Network adequacy standards
  - Beneficiary support system
  - MLTSS-specific quality measures
  - Disenrollment right for NF network termination

# ADvancing States' MLTSS work

- MLTSS Institute
  - Provide intensive technical assistance to states
  - Bring thought leaders together to discuss policy issues
  - Publish research papers (<http://www.nasuad.org/initiatives/managed-long-term-services-and-supports/resources>)



May 2017



May 2018



April 2019

# ADvancing States' MLTSS work

- The State Medicaid Integration Tracker: a bi-monthly publication that highlights LTSS activities, including MLTSS, dual eligible programs and other integrated care activities in the states
  - <http://www.advancingstates.org/initiatives/tracking-state-activity/state-medicaid-integration-tracker>



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