Untangling the Medicaid Maze: Managed Care and its Implications on Home Care & Recent Federal Updates

Welcome

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AGENDA

- Managed Care Overview and Implications
- Regulations and NY Considerations
- Other Factors Impacting Medicaid

Managed Care

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RECAP OF CORE MEDICAID POLICIES

- Once a person comes into Medicaid, they have access to all services that the state covers and are medically necessary
- Services must be statewide, comparable, delivered with reasonable promptness, and allow individuals to choose providers
- States can define the “amount, duration and scope” of services to reasonably achieve their purpose

MANAGED CARE: FEDERAL RULES

Unlike in HCBS/LTSS, CMS has established uniform regulations for managed care in Medicaid (42 CFR Part 438)

Some key requirements:

- CMS must give ***prior approval*** to managed care contracts (§438.806)
- Contracts must be ***actuarially sound*** (§438.4)
- States must establish ***network adequacy*** standards (§438.68)
- **Marketing restrictions**, including bans on cold-calling and state approval of all materials (§438.104)
- MLTSS plans must operate a ***member advisory committee*** (§438.110)
- All plans must calculate and publicly report ***medical loss ratios (MLRs)*** (§438.8)
  - States may, but are not required to, establish a mandatory MLR standard
  - If implemented, the standard must be at least 85%

MANAGED CARE: PROGRAM OVERSIGHT

42 C.F.R. §438.66: State Monitoring Requirements	
• Must perform "readiness review" prior to any MCO beginning operations • Must provide annual reports on the operation of each managed care program, including:	
Financial performance of plan, including MLR	Encounter data reporting by each plan
Enrollment and service area expansion (if applicable)	Modifications to benefits covered
Grievance, appeals, and State fair hearings	Availability and accessibility of covered services, including network adequacy standards.
Evaluation of performance on quality measures	Results of any sanctions or corrective action plans
Activities and performance of the beneficiary support system	Any other factors in the delivery of LTSS not otherwise addressed.

ADDITIONAL CMS REQUIREMENTS FOR MLTSS

In 2013, CMS issued guidance for states with MLTSS programs*

Many of these elements were incorporated into regulation in the 2016 Managed Care rule**

Key elements include:

Adequate Planning	Stakeholder Engagement
Enhanced Provision of Home and Community Based Services	Alignment of Payment Structures and Goals
Support for Beneficiaries	Person-centered Processes
Comprehensive, Integrated Service Package	Qualified Providers
Participant Protections	Quality

*https://www.medicaid.gov/Medicaid/downloads/1115-and-1915b-mltss-guidance.pdf

**https://www.medicaid.gov/Medicaid/downloads/strengthening-the-delivery-of-managed-long-term-services-and-supports-fact-sheet.pdf

MANAGED CARE IMPLICATIONS FOR PROVIDERS

Single Point of Contracting	Multiple Plans
State Fee Schedule	Negotiated Rates
HCBS Case Management	Managed Care Service Coordination

Higher provider administrative costs	Mixed results on reimbursements
Payment/billing challenges	Delayed authorizations
Increased HCBS utilization / Decreased nursing home utilization	Scale/volume are increasingly important

https://aspe.hhs.gov/sites/default/files/private/pdf/73196/3LTSStrans.pdf

CURRENT ISSUE IN MANAGED CARE: MCO TAX

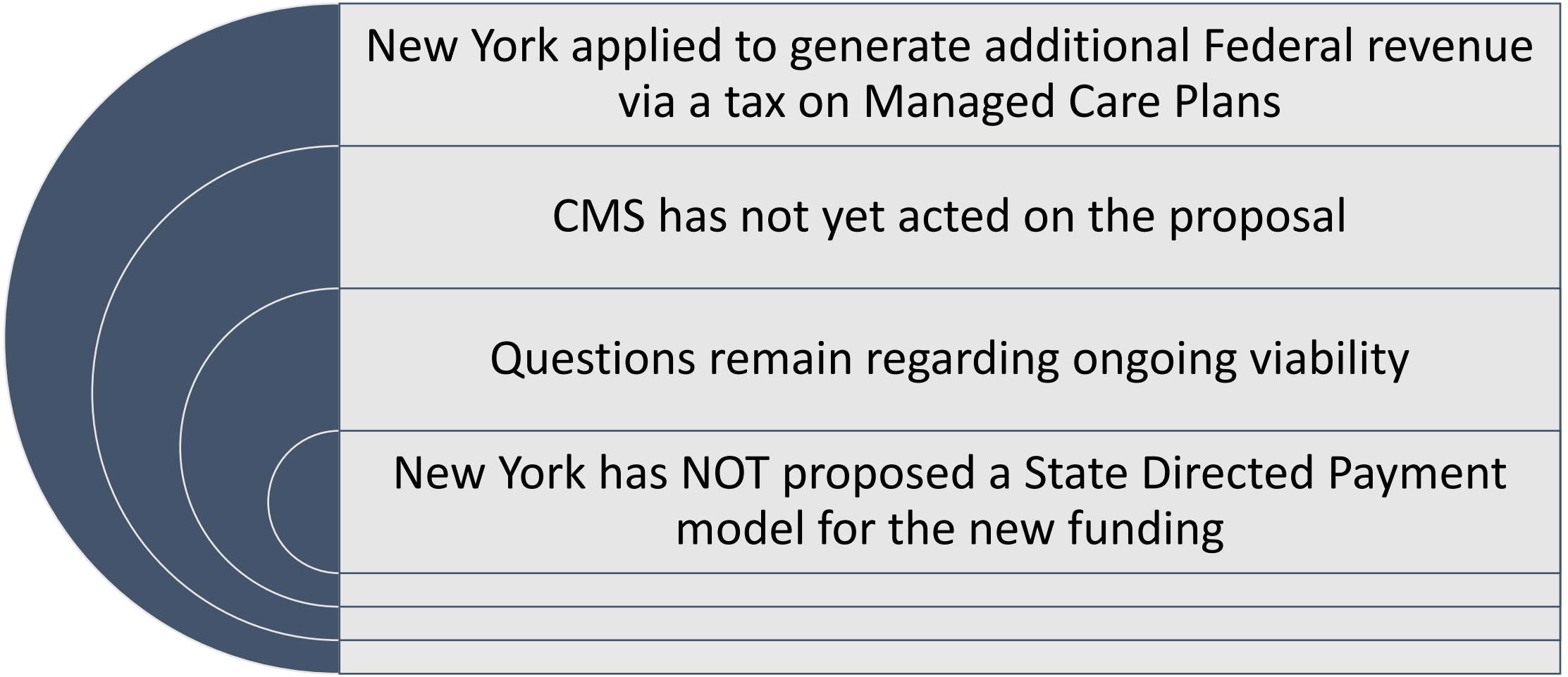
Federal Law Allows States to Tax Health Care Entities and Use the Funds as Medicaid State Share

- Must be an "allowable class" of providers
- Must be Broad-Based/Uniform/ Redistributive
- Must not include "hold harmless"
- Must be limited to 6% of Gross Provider Revenue

This is a Controversial Part of Medicaid Law and Policy

- Many Federal Regulations
- Federal Legislation
- Lawsuits

CURRENT ISSUE IN MANAGED CARE: MCO TAX



WHAT IF MANAGED CARE WENT AWAY?

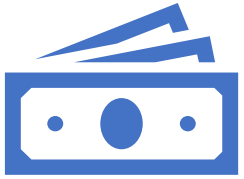
Process

State legislation would be necessary to terminate Managed Care

State would submit a waiver amendment

State and plans would need to establish transition plan to move individuals back into fee-for service

Each provider would need to establish Medicaid provider agreement with state and accept state-established payment rate



Potential Positives

Single point of contracting

Fewer prior authorization “roadblocks”

Consistent payment rate transparently established by state

Potential Negatives

Lack of actuarial soundness requirements -> stagnant payments

Less flexibility in service delivery

State bureaucracy can be challenging

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New Federal Rules

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MANAGED CARE REQUIREMENTS

Appointment Wait Time Standards

- Outpatient mental health and substance use disorder:
  - 10 business days;
- Primary care:
  - 15 days;
- Obstetrics and gynecology:
  - 15 days
- Additional state-defined service:
  - No Federal maximum.
  - Defined using an "evidence-based" approach

"Secret Shopper" Surveys

- Require states to contract with an independent entity to verify compliance
  - Would attempt to schedule as though it were a Medicaid participant
- Applies to same 4 services as wait time requirements
- Used to monitor wait time and provider directories

Experience of Care Surveys

- Require States to conduct an annual enrollee experience survey
- Does not prescribe the tool – examples such as CAHPS surveys
- Results used to monitor and improve managed care performance
- Encourages but not requires provider surveys

MANAGED CARE PAYMENT ANALYSIS

The plan must compare aggregate payment amounts to what Medicare would have paid for the same services for:	Primary care
	OB/GYN
	Mental health
	Substance use disorder services
Health plan must compare aggregate payment amounts to what Medicaid fee-for-service would have paid:	Homemaker
	Home Health Aide
	Personal Care

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MANAGED CARE QUALITY RATING SYSTEM

Three specific parts of the MCO quality strategy:

- Mandatory measures
- Rating methodology
- Website display requirements

Goal is help individuals make MCO choices by improving:

- Availability
- Understandability
- Usability

HCBS PAYMENT ADEQUACY

Would require states to "assure" that at least 80% of all Medicaid payments, including but not limited to base payments and supplemental payments, be spent on compensation to direct care workers

Limited scope of services:

- Homemaker;
- Home Health Aide; and
- Personal Care.

Applied to following parts of Medicaid:

- 1915(c)
- 1915(i)
- 1915(j)
- 1915(k)
- 1115

NOT applied to 1905(a) [State plan].

Becomes effective 6 years after the publication of the final rule → July 9, 2030

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REPORTING/MONITORING

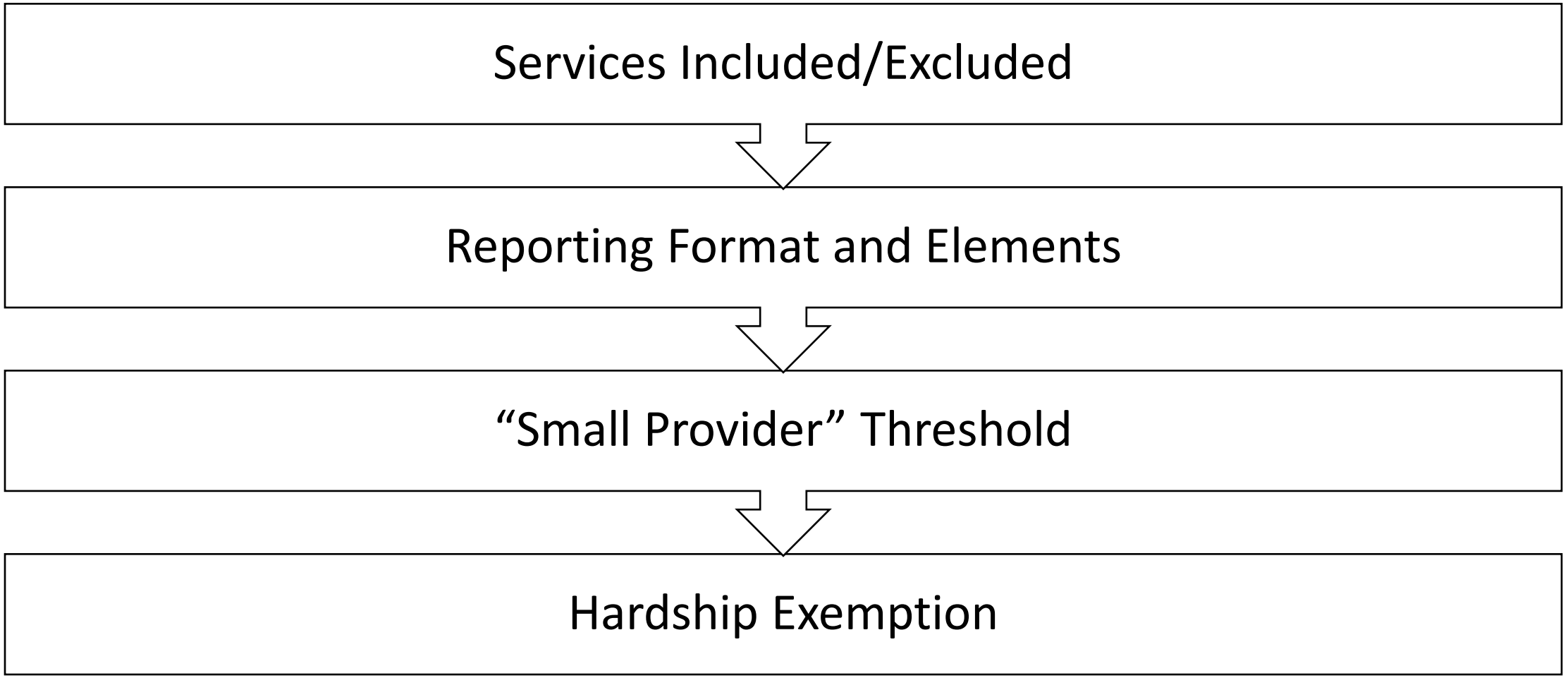
States must report annually on the percent of payments for homemaker, home health aide, personal care, and habilitation spent on compensation for direct care workers

- Separate reports for each service category
- Separate report on self-directed services for each category
- Separate report on facility-based services

Effective 4 years after issuance of final rule

- 3 years after the issuance, states must report on readiness/ability to track

KEY STATE DECISION POINTS



Other Issues

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OTHER ISSUES: END OF ENHANCED FEDERAL FUNDING

Families First Coronavirus Relief Act:

- 6.2% increase from 2020 – March 31, 2023
- 5% April 1, 2023 – June 30, 2023
- 2.5% July 1, 2023 – September 30, 2023
- 1.5% October 1, 2023 – December 31, 2023
- Normal FMAP January 1, 2024
  - New York: 50%

American Rescue Plan Act:

- 10% FMAP increase to HCBS services only
- In effect April 1, 2021 – March 31, 2022
- States could "spend down" the accumulated funding until March 2024, with option to request 1-year extension until March 2025
- New York: $5.5 billion of total spending planned - $2.8 billion spent

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OTHER ISSUES: ELECTIONS AND MEDICAID

What happens with a Dem sweep?

- Continue to push for higher pay/larger worker rights
- Push for higher FMAP
- Expanded eligibility

What happens if Republicans sweep?

- No 80-20
- Broader overhaul and limits on Medicaid spending

What happens with split government?

- R white house:
  - Repeal many regulations
  - Seek to expand 1115 authority
- D white house
  - Largely status quo

Thank You

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