



Providing Long Term Services and Supports in a Managed Care Delivery System

Enrollment Authorities and Rate Setting Techniques:

Strategies States May Employ to Offer Managed HCBS, CMS Review Processes and Quality Requirements

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Enrollment Authorities and Rate Setting Techniques: *Strategies States May Employ to Offer Long Term Services and Supports through a Managed Care Delivery System, CMS Review Processes and Quality Requirements*

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I. Purpose and Background

Why has CMS developed this technical assistance document?

A growing number of States are interested in delivering managed home and community based services (HCBS) – also called long term services and support (LTSS)- through their Medicaid program. Specifically, these States are interested in the budget predictability, a shared approach to quality, and capitalization on the successes that can occur when individuals have comprehensive managed care that includes long term supports and services that delay or substitute for more costly institutional care. States are interested in using managed care as a tool in their efforts toward deinstitutionalization. With carefully constructed contract incentives, States can effectively tip the institutional bias toward community, rather than institutional setting. Additionally, some States are identifying the potential for rich data sources and quality outcome measurement as a potential benefit in a managed care environment with carefully constructed contact language.

Historically, the authorities that have enabled the provision of HCBS or LTSS in a managed care setting have been a combination of waivers under sections 1915(b) and 1915(c), or a demonstration under section 1115. In addition to describing these more frequently utilized authorities, this paper will provide information on other authorities States may consider using to accomplish their goals.

Many States currently employ successful strategies to ensure strong care coordination, linkages and quality within stand-alone, fee-for-service 1915(c) HCBS waivers. While recognizing that States use case management entities, organized health care delivery systems¹ (OHCDs) and other techniques to achieve seamless service delivery, this paper

¹ State Medicaid Director Letter, December 20, 1993 and Section 1915(c) Home and Community Based Services Instructions, Technical Guide and Review Criteria, pp 260-262. January 2008.

will focus on Medicaid managed care authorities that can be used independently or in concurrent operation with a 1915(c) waiver to implement a managed care delivery system.

How will this document be helpful to States, Stakeholders and CMS staff alike?

This document intends to provide information about current policy guidance for States interested in using a managed care delivery system for home and community based services. It is incumbent upon States to comply with all applicable federal requirements in the Social Security Act and the Code of Federal Regulations for operating waivers and State Plans as they relate to requirements for managed care, eligibility, home and community based services, and any other requirements pertaining to the State's specific proposal. This paper will identify those important areas and provide some practical guidance for using these authorities.

It is important to clarify at the outset of this document that the topic of this paper refers to the delivery of home and community based services (HCBS), not specifically home and community based *waivers authorized by section 1915(c) of the Act*. This distinction is important because, while section 1915(c) HCBS waivers are a prominent vehicle for the delivery of home and community based services, they are not the only mechanism available to States to provide HCBS.

II. Enrollment Authorities

In Medicaid, there are certain authorities that a State may utilize to enroll individuals into managed care, henceforth referred to as 'enrollment authorities'. Some of these authorities allow States to have mandatory enrollment, while others require voluntary enrollment, with potential differences for the groups of individuals to be served. The following section provides a brief overview of the most frequently utilized enrollment authorities for managed care and a brief description of the CMS review and approval process. Each of the managed care enrollment

authorities is covered by the regulations governing managed care at 42 CFR 438. Included in those regulations is the requirement that enrollees have a choice of managed care entities where enrollment is mandatory. Below is a discussion of the most frequently used enrollment authorities when States are offering long term services and support in a managed care delivery system.

While the enrollment authorities enable the use of a managed care service delivery arrangement, they do not, typically, by themselves, contain services. Most frequently, these authorities will be utilized to ‘manage’ the State plan services available within the State. In some instances, the enrollment authority may be operated concurrently with a 1915(c) waiver to enable individuals who gain their Medicaid eligibility through the 1915(c) waiver to receive their services through the managed care model as well.

When a 1915(c) waiver runs **concurrently** with a managed care enrollment authority, the following principles apply:

1. The State operates a 1915(c) HCBS waiver, and individuals are eligible to receive services (meeting all applicable programmatic and targeting requirements of the waiver);
2. HCBS waiver services are then delivered through a managed care contract, as described in 42 CFR 438;
3. Individuals are enrolled in both the 1915(c) waiver AND in the managed care enrollment authority; and
4. Use of managed care contracts require one of the types of authorities described below.

(See Attachment A for an At A Glance Reference Tool)

SECTION 1915(a) of the Social Security Act

Section 1915(a) permits the State to enter into a voluntary contract with an entity to provide State plan services. Section 1915(a) authority provides a vehicle for voluntary enrollment into capitated managed care otherwise unavailable to States providing HCBS

on a fee-for-service basis. A State may design a contract that serves particular geographic regions of the State, or that provides a uniquely designed service package for particular populations without being in violation of state-wideness, comparability or freedom of choice requirements in section 1902. Under section 1915(a), the State may not limit the number of qualified providers who may serve as the contracting entity (PAHP, PIHP or MCO). In addition, section 1915(a) authority is entirely voluntary, meaning that the individuals must elect to receive services through this mechanism.

As section 1915(a) conveys no additional authority beyond the ability to enter into voluntary contracts, a State may employ two strategies (or a combination thereof) to provide HCBS under a managed care contract using the section 1915(a) authority:

HCBS may be included in a stand-alone 1915(a) contract when there is an approved 1915(c) waiver or 1915(i) State plan amendment in the same geographic region of the State that contains the same services and would be available to the same population as those proposed in the 1915(a) contract.

CMS may consider the inclusion of HCBS in a stand-alone 1915(a) contract in those cases where the State operates an approved section 1915(c) waiver or 1915(i) State plan benefit within the State for the same population served through the contract, in the same geographic region as the contract, containing the same services offered through the contract, and the costs of such services may be included in contract payments. These HCBS services would be expressly contained in the managed care contract, and the individual need not be enrolled in a section 1915(c) HCBS waiver or be receiving services through 1915(i) HCBS as a State Plan Option. Because this is a voluntary vehicle, an individual must be able to have the option to receive the services through another Medicaid approved authority in the State (i.e., State plan or HCBS waiver).

The “217 Group”: Without a *concurrent* 1915(c) waiver, the State cannot cover the individuals eligible for Medicaid by virtue of section 1902(a)(10)(A)(ii)(VI) and regulations at 42 CFR §435.217. *Concurrence* with the 1915(c) waiver

means that individuals receiving services under the 1915(a) contract must simultaneously be enrolled in the section 1915(c) waiver. Concurrent waivers are available for States to use at their election. When the 1915(a) contract will operate concurrently with the section 1915(c) waiver, the section 1915(c) waiver must be approved simultaneously with or prior to the implementation of the contract.

Services not expressly contained in the approved section 1915(c) waiver or in the section 1915(i) State plan amendment for which payment is made under the contract, may be provided as 'in lieu of' services (see "Rate Setting Techniques") at the State's election.

CMS Approval Process:

When there is a stand-alone 1915(a) contract, the State submits the contract to the appropriate CMS Regional Office for approval. If the contract includes HCBS explicitly or is likely to provide for HCBS as 'in lieu of' services (i.e., includes institutional services in the capitation rate and the actuarial calculation reveals an adjustment for anticipated alternative services), the Regional Office will consult with its CMS Central Office analyst for HCBS. CMS recommends that the State submit the contract at least 60 days prior to the desired contract effective date to ensure no delay in implementation or loss of Federal Financial Participation (FFP). CMS encourages States to submit draft versions of new contracts as early as 120 days prior to implementation so that any concerns about meeting Federal requirements are resolved prior to the contract effective date.

If the section 1915(a) contract will operate concurrently with a section 1915(c) HCBS waiver, the process noted above will apply along with the concurrent review process required for the review and approval of the 1915(c) waiver application (see attachment A: Standard Operating Procedures for the Review and Approval of 1915(c) Waiver Applications).

Section 1932(a) State Plan Amendment Authority

This section of the Act enables States to implement mandatory managed care for certain populations, such as families and most children, on a statewide basis or in limited geographic areas without a waiver. As with the section 1915(a) authority, States can implement these programs without regard to Medicaid “freedom of choice,” “comparability of services,” or “statewideness” requirements. This authority must be voluntary for certain children with special needs, for individuals dually eligible for Medicare and Medicaid, and for American Indians unless Indian Health Service, Tribal, or Urban Indian providers are available to them as managed care entities

The benefit of using a section 1932(a) authority is that States may selectively contract with a PCCM or an MCO as long as in non-rural areas, a choice of at least two entities is provided. For details on the rural exception, see section 1932(a) (3) (B).

CMS Approval Process:

The State submits a State Plan Amendment formally to CMS for review. After submission a 90-day review period begins. CMS may formally request additional information (RAI), stopping the 90-day clock. When the State responds to the RAI, one more 90-day review period begins.

If the State uses section 1932(a) to deliver health services in a managed care delivery system, a managed care contract is required. The State must submit the contract to the appropriate CMS Regional Office for approval. If the managed care contract includes HCBS explicitly, or is likely to provide for HCBS as in lieu of” services (i.e., includes institutional services in the capitation rate and the actuarial calculation reveals an adjustment for anticipated alternative services), the Regional Office will consult with the CMS Central Office analyst for HCBS. CMS recommends that the State submit the contract at least 60 days prior to the desired contract effective date to ensure no delay in implementation or loss of Federal Financial Participation (FFP). CMS encourages States to submit draft versions of new contracts as early as 120 days prior to implementation so that concerns about meeting Federal requirements are resolved prior to the contract effective date.

Section 1915(b) Waivers

This section of the Act provides the Secretary authority to grant waivers that permit States to make mandatory the enrollment of beneficiaries in Medicaid managed care plans, use locality as a central broker, deliver additional services generated through savings and restrict providers using selective contracting. Under this authority, CMS can waive many requirements in section 1902 of the Act. Section 1915(b) waivers allow States to restrict freedom of choice for any Medicaid groups..

A section 1915(b) waiver program cannot restrict beneficiary access to medically necessary quality services , and the waiver must be cost-effective. States may use the CMS Section 1915(b) waiver preprint and submit the application for review. An independent assessment is required after each of the first two waiver periods. Section 1915(b) waiver programs are approved for up to 2-year periods, and States may submit renewal applications to continue these programs.

There are two significant differences between section 1915(b) authority and sections 1915(a) or 1932(a). First, under 1915(b), States may require enrollment of dually eligible Medicaid and Medicare beneficiaries and other aged, blind, or disabled populations into managed care. Second, section 1915(b) waivers provide the opportunity for States to offer to enrollees additional services paid for through savings achieved under the waiver, measured at the inception of the waiver against services the State provides through its regular State plan. In order to provide these section 1915(b)(3) services, CMS must approve a State's request for authority under subsection 1915(b)(3) in conjunction with either subsection 1915(b)(1) and/or (b)(4).

CMS Approval Process:

The State submits a waiver application formally to CMS for review. A Federal review team that includes staff from the Office of Management and Budget and may include staff from the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) are assigned to the waiver and a 90-day review period begins. CMS may formally request additional information (RAI), stopping the 90-day clock. When the State responds to the RAI, a second 90-day

review period begins. Section 1915(b) waivers should begin at the beginning of a quarter (January, April, July, October).

If the State uses section 1915(b) to deliver services using a managed care delivery system, a managed care contract is required. The State must submit the contract to the appropriate CMS Regional Office for approval. If the managed care contract includes HCBS, or is likely to provide for HCBS as 'in lieu of' services (i.e., includes institutional services in the capitation rate and the actuarial calculation reveals an adjustment for anticipated alternative services), the Regional Office will consult with the CMS Central Office analyst for HCBS. CMS recommends that the State submit the contract at least 60 days prior to the desired contract effective date to ensure no delay in implementation or loss of Federal Financial Participation (FFP). CMS encourages States to submit draft versions of new contracts as early as 120 days prior to implementation so any concerns about meeting Federal requirements are resolved prior to the proposed contract effective date.

Concurrent Section 1915(b)/(c) Waivers

States may opt to concurrently utilize section 1915(b) and 1915(c) waivers to provide a continuum of services to disabled and elderly populations. When both authorities are used, the State uses the 1915(b) authority to mandate enrollment in a Medicaid managed care plan and limit freedom of choice and/or selectively contract with providers, and uses the 1915(c) authority to target eligibility for the program and provide home and community-based services. By using both authorities, States can provide long-term services and supports in a managed care environment. Additionally, they could use section 1915(b) authority to use a limited pool of providers.

In addition to providing traditional long-term services and supports available through the State plan (e.g. home health, personal care, and rehabilitative services,) States may include non-State plan home and community-based services (e.g. homemaker services, adult day health services, and respite care) in their managed care programs' capitation rate for individuals eligible for the 1915(c) waivers. States may also include hcbs in their section 1915(b) waivers as Section 1915(b)(3) services.

States can implement concurrent sections 1915(b) and 1915(c) waivers as long as all Federal requirements for both programs are met. When submitting applications for concurrent 1915(b)/(c) programs, States must submit a separate application for each waiver authority and satisfy all of the applicable requirements, e.g. States must demonstrate *cost neutrality* in the 1915(c) waiver and *cost effectiveness* in the 1915(b) waiver. States must also comply with the separate reporting requirements for each waiver. Because waivers are approved for different time periods, renewal requests may be submitted at different points in time.

Meeting these separate requirements can be a potential barrier for States that want to provide home and community based services through a managed care delivery system. However, the ability to develop an innovative, *mandatory* managed care program that integrates home and community-based services with traditional State plan services is appealing enough to some States to outweigh the potential challenges.

CMS Approval Process:

When a State submits a separate section 1915(b) and 1915(c) waiver application to CMS for review a 90-day review period begins and each waiver is evaluated against the review criteria for the applicable governing authority. CMS may formally request additional information (RAI), stopping the 90-day clock. When the State responds to the RAI, a second 90-day review period begins. The Federal review team will review the application for Section 1915(b) waiver.

If the State uses sections 1915(b)/1915(c) concurrent waiver authorities to deliver health services through a managed care delivery system, a managed care contract is required. The State must submit the contract to the appropriate CMS Regional Office for approval. If the managed care contract includes HCBS, or is likely to provide for HCBS as 'in lieu of' services (i.e., includes institutional services in the capitation rate and the actuarial calculation reveals an adjustment for anticipated alternative services), the Regional Office will consult with the CMS Central Office analyst for HCBS. CMS recommends that the State submit the contract at least 60 days prior to the desired contract effective date to ensure no delay in implementation or loss of Federal Financial Participation (FFP). CMS encourages States to submit draft versions of new contracts as

early as 120 days prior to implementation so concerns about meeting Federal requirements are resolved prior to the proposed contract effective date.

Section 1115 Demonstration Programs

This section of the Social Security Act (the Act) provides the Secretary broad authority to approve projects that test policy innovations likely to assist in promoting the objectives of the Medicaid program. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some States expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. Projects are generally approved to operate for a five-year period, and States may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral". There is no standardized format to apply for a section 1115 demonstration, but the application must be submitted by the single State Medicaid agency.

States often work collaboratively with CMS from the concept phase to further develop the proposal. CMS encourages States to meet their programmatic goals using other waiver or State plan authorities, since the innovation and budget neutrality requirements for these demonstration projects are difficult to meet. Section 1115 demonstrations require a formal evaluation.

Section 1115 demonstrations are not generally viewed as a vehicle for smaller scope managed HCBS arrangements because of the other authorities available for this purpose.

CMS Approval Process:

CMS works collaboratively with States from the concept phase through the program development. There is no statutory review period for these demonstrations. CMS

works closely with its Federal partners, including the Office of Management and Budget, to review the 1115 demonstration submissions.

If the State uses section 1115 demonstration authority to deliver health services in a managed care delivery system, a managed care contract is required. The State must submit the contract to the appropriate CMS Regional Office for approval in accordance with the Standard Terms and Conditions of section 1115.

While concurrent sections 1915(b)/1915(c) authorities were described above, any of the managed care enrollment authorities may be operated concurrently with a section 1915(c). It is also noteworthy that many 1115s that deliver managed long term care or represent system reform initiatives subsume HCBS waivers or matriculate HCBS services into the broader demonstration.

In addition to the enrollment authorities contained heretofore, regulations at 42 CFR §438.6(e) provide additional information regarding services that may be covered in a contract with an MCO, PIHP or a PAHP. A contract may cover services for enrollees that are in addition to those covered under the State plan, although the cost of these services cannot be included when determining the payment rates. An example may be a service which may not be Medicaid reimbursable, but for which the State has elected to utilize State general funds only to pay for the service.

III. Capitation, Rate Setting and HCBS

All capitated contracts, regardless of the enrollment authority utilized by the State, must adhere to the contracting requirements set forth in 42 CFR §438.6. There are options and strategies allowable within those regulations that a State may employ to structure its contracts and its commensurate rates to achieve particular objectives.

Services comprising the capitation rate must be included and approved in the State Plan, approved under section 1915(b) (3) authority, or approved under section 1115. Please note that this may include services authorized under sections 1902(a), 1915(i) and 1915(c) when approved and covered under the State Plan under these authorities.

Rate Setting and Authority for HCBS under sections 1915(c), 1915(i), 1115

When establishing capitation rates for services for which there is explicit coverage authority, the State must adhere to the regulations at 42 CFR §438.6. Specifically, the capitation rates must be actuarially sound, and be developed in accordance with generally accepted actuarial principles and practices, are appropriate for the populations to be covered, are appropriate for the services to be furnished under the contract, and have been certified by actuaries. When setting these rates, the State must base the rates on utilization and cost data that are derived from the Medicaid population, or if not, are adjusted to make them comparable to the Medicaid population. In addition, the State must make adjustments to smooth² data and to account for a number of factors, including medical trend inflation, plan administration (subject to certain limits). Finally, the rate cells should be specific to enrolled populations by eligibility category, age, gender, locality/region, and risk adjustments based on diagnosis or health status.

² Data smoothing techniques are used to eliminate "noise" and extract real trends and patterns.

For many of the HCBS services that may be included expressly in a contract, this data may be available from comparable populations served through existing HCBS waivers, or certain State plan services.

Rate Setting and Authority for HCBS under 1915(b) (3)

Section 1915(b) (3) enables States to provide health-related services in addition to those in the approved State plan to beneficiaries participating in 1915(b) freedom of choice waivers. The cost of these services must come from savings measured against the cost of State plan services before the inception of the waiver. Section 1915(b)(3) HCBS may be included in the capitation rate, or treated as a separate capitation payment. The State must have a process in place to summarize its section 1915(b)(3) expenditures each year. Section 1915(b)(3) services must meet all other applicable requirements described by CMS.

Rate Setting and 'In Lieu Of' Services

A State might encourage a managed care plan that chooses to provide more cost-effective services 'in lieu of' (or as a substitute for) more costly contracted State plan services. The State may not require the beneficiary to accept HCBS 'in lieu of' State plan-covered services and cannot require the managed care plan to provide them. However, the State may include modifications in the rate development process to account for the expected cost and utilization of 'in lieu of' services as a proxy for the cost of approved State plan services in a contract.

This rate-setting technique may be used in any capitated contract. CMS expects the use of such a rate-setting technique to be described in the rate methodology documentation from the actuary.

Although a State cannot require ‘in lieu of’ services, CMS encourages a State to include permissive language in the contract with the managed care plan if the State chooses to utilize such a rate-setting technique in its capitation methodology.

Example: A State builds a capitation rate including payment for ICF/MR services. The plan (PIHP or MCO, depending on the other State Plan services included in the capitation rate) may offer individuals substitute services in lieu of the ICF/MR service services. The actuary may assign a cost and anticipated utilization to these in lieu of services and adjust the capitation rate accordingly. When a State uses encounter data to set subsequent years’ rates, encounters reflecting ‘in lieu of’ services can be included as long as the State can identify the State plan services they replace and the State’s actuary can price the service appropriately.

Because ‘in lieu of’ services are intended to be a cost effective substitute for State plan services included in the capitation payment, the managed care plan and the State must be able to demonstrate both the State plan service being replaced and the efficacy of the ‘in lieu of’ service. In instances where questions arise regarding the relationship between the ‘in lieu of’ service and the State plan service replaced, or the cost effectiveness of the ‘in lieu of service’ CMS may require supporting documentation, including a line-by-line justification showing the ‘in lieu of’ services and the service replaced, along with the cost impact of the substitution.

Examples of language that have been included in contracts addressing this issue:

Example 1: Definition: Substitute Health Services means those services an MCO has used as a replacement for or ‘in lieu of’ a service covered under this Contract because the MCO has determined: (1) the MCO reimbursement for the Substitute Health Service is less than the MCO reimbursement for the Covered Service would have been, had the Covered Service been provided; and (2) that

the health status of and quality of life for the Enrollee is expected to be the same or better using the Substitute Health Service as it would be using the Covered Service.

Example 2: Substitute Health Services Permitted. To the extent consistent with State statute, the MCO shall have the right, in its discretion, to pay for or provide if such services are, in the judgment of the MCO, medically appropriate and cost-effective. Substitute Health Services submitted as encounter data will be considered in calculations of MCO costs.

HCBS services may be provided as “in lieu of” or substitute health services through a contract authorized under 1915(a). In this case, there is no section 1915(c) waiver necessary. Again, it is important to note that without a concurrent 1915(c) waiver, there is no provision to serve individuals who become eligible for Medicaid by virtue of the regulations at 42 CFR 435.217.

Other Rate Setting Considerations:

Below are a few rate setting techniques commonly used in managed care contracts. These techniques can help to spread the financial risk for costs of individuals with special health care needs or provide financial incentives for meeting specified targets in quality or service delivery. The following are strategies that States may employ in the construction of their contracts, within limitations and guidance set forth in 42 CFR 438.6(c).

Risk Sharing Arrangements

When States are designing their contracts, they may wish to consider risk sharing arrangements. Two frequently utilized strategies include ‘risk corridors’, and ‘stop-loss limits,’ and ‘reinsurance’. These contract provisions may be included.

A risk corridor means a risk sharing mechanism in which States and contractors share in both profits and losses under the contract outside of a predetermined threshold

amount, so that after the initial corridor in which the contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits. This tool is sometimes used in the early stages of a managed care program with populations for whom there is no managed care experience as a protection for both the State and the plan against unanticipated losses or gains. The sharing of cost overruns is limited to (1) the amount the State would have paid on a fee for service basis for services actually provided, or (2) a specific limit specified in the contract between the State and the MCO in accordance with section 438.6(c)(5)(ii) of the regulations.

Under a stop-loss limit, the State and its contractor agree to a limit on the amount of potential financial losses a managed care entity may incur under its contract. This limit may be established in terms of aggregate costs or per member costs for a specified time period. The State pays for costs in excess of the limit through FFS. If the State agrees to a stop-loss limit, it must adjust capitation rates to account for the projected additional FFS costs it will incur as a result of this arrangement.

Reinsurance is a risk sharing method like a stop-loss limit, but one that is purchased from a private corporation as opposed to being part of the agreement with the State. This arrangement would not have an impact on the rate setting process, since the State will incur no additional costs under the contract regardless of the plan's experience.

Incentive Arrangements

Incentive arrangements may be used by the State in the development of contracts to provide for a payment mechanism under which a contractor may receive additional funds over and above the capitation rates paid for meeting targets specified in the contract. Such incentives, if crafted carefully, can provide a unique opportunity for States to encourage comprehensive community based services for individuals, who without the supports would require institutional placements. Section 438.6(c) (5) (iii) and (iv) of the regulations contains specific rules that govern incentive arrangements, including the requirement that they be for a fixed period of time and necessary for specified activities and targets, and limit total payments to no more than 105% of the

capitation payments, or portion thereof, attributable to the services covered by the incentive arrangement. (This is a very long sentence and a bit hard to follow.)

In addition to the information contained in this document, CMS recommends that individuals interested in pursuing managed care programs serving individuals dually-eligible for Medicare and Medicaid refer to the information available on the following website:

http://www.cms.hhs.gov/IntegratedCareInt/2_Integrated_Care_Roadmap.asp#TopOfPage

IV. Quality Requirements

Safeguards, Assurances and Contract Requirements

To the extent that a managed care contract includes HCBS otherwise authorized under section 1915(c) and section 1915(i) of the Act, CMS may require States to include safeguards within the contract and in State initiated assurance documents akin to those statutory assurances required for section 1915(c) HCBS waivers if those requirements cannot be satisfactorily addressed under the quality and oversight requirements set forth in 42 CFR 438. Depending upon the type of managed care contract (MCO, PIHP or PAHP), which is determined by the scope of services and the payment arrangement under the contract, some or all of the requirements contained in 42 CFR 438 may apply, including (but not limited to):

438.6 Contract Requirements

438.8 Provisions that apply to PIHPs and PAHPs

Notably contract requirements, information requirements, enrollee rights and protection provisions (also noted below), quality assessment and performance improvement provisions, grievance system provisions, etc.

Subpart B – State Responsibilities

This Subpart includes provisions governing choice of managed care entity, enrollment and disenrollment, and State oversight of programs.

Subpart C – Enrollee Rights and Protections

This Subpart includes beneficiary protections on marketing, emergency services, plan solvency and liability for payment.

Subpart D – Quality Assessment and Performance Improvement Subpart D describes Quality Assessment and Performance Improvement and sets forth the requirement that each State with MCOs and PIHPs providing Medicaid services must publish and have approved by CMS a State Quality strategy. Many States published their Quality Strategies in 2004, but have redrafted them as circumstances of their programs require. CMS reviews State Quality strategies for Part D compliance and for the soundness of quality methods. Comments are sent to the State and CMS approval is contingent upon compliance. CMS has additional requirements for State Quality Improvement Strategies related to home and community based services programs (that is, a continuous quality improvement strategy applied to assurances).

Subpart E – External Quality Review

Subpart E of the regulation requires States to conduct an annual survey of the quality of care provided by MCOs or PIHPs. Most States hire an External Quality Review Organization (EQRO) to conduct the annual review. The EQRO annual reports must contain data on validation of performance measures (usually HEDIS by NCQA), validation of performance improvement projects (selected by the State or MCOs)

and, over a 3-year period, a full review of the compliance with the rules on access, structure and operation, and QA/PI regulations contained in Part D.

Subpart F – Grievance System

Subpart F includes the rule governing beneficiary appeals rights and procedures.

Subpart H – Certifications and Program Integrity

Subpart H describes the required certification of data submitted by managed care entities and the prohibition of certain entities from participation.

Subpart I – Sanctions

This Subpart includes the types of sanctions States may impose for certain specified violations and includes provisions for temporary management and plan termination.

Subpart J – Conditions for Federal Financial Participation

Subpart J includes the requirements for MCO contract approval prior to FFP, costs under risk and nonrisk contracts, and requirements that apply to enrollment brokers.

Quality Requirements when a Section 1915(c) HCBS Waiver is Operated Concurrently with a Managed Care Enrollment Authority:

When a State operates a 1915(c) waiver *concurrently* with any of the enrollment authorities described above, the State is expected to have, at a minimum, systems in place to measure and improve its performance in meeting the waiver assurances that are set forth in 42 CFR §441.301 and §441.302. These assurances address important dimensions of waiver quality, including assuring that service plans are designed to meet the needs of waiver participants and that there

are effective systems in place to monitor participant health and welfare. CMS recognizes that the design of the Quality Improvement Strategy will vary depending on the nature of the waiver target population, the services offered, and the waiver’s relationship to other public programs.

CMS recognizes the administrative burden presented to States when more than one Medicaid authority is used, e.g. concurrent sections 1915(b) and (c) waiver authorities. We also recognize sufficient similarities within the quality requirements of the different authorities described in this paper to streamline and reduce that administrative burden. For example, a Quality Improvement Strategy (QIS) for purposes of meeting the requirements of section 1915(c) waivers can also meet the quality requirements for section 1915(b) waivers, when appropriately designed. In the QIS for a managed HCBS system, CMS would expect States to describe their process for continuous quality improvement, and to include, at a minimum, methods for discovering identified problem areas, addressing or remediating those problems for specific members, and making system-wide improvements in the delivery of managed home and community based services to all members. Incorporation of evidence-based practices, valid performance measures, and use of appropriate representative sampling techniques and stratification strategies are essential elements of the QIS. CMS would also expect States to address in its QIS the quality assurances that are fundamental to Medicaid HCBS, including level of care, service plan, qualified providers, health and welfare, and financial and administrative accountability.

“At-A-Glance” Guide to Medicaid Authorities for Integrated Programs

Authority	Description	Key Flexibilities and/or Limitations
Section 1915(a) Exception to State Plan Requirements for Voluntary Managed Care	Used to authorize voluntary managed care programs on a statewide basis or in limited geographic areas implemented through CMS Regional Office approval of the managed care contract.	<ul style="list-style-type: none"> • No waiver or State plan required. • <i>No mandatory enrollment or selective contracting.</i> • <i>States may use MCOs, PIHPs, or PAHPs</i>
Section 1932(a) State Plan Amendment Authority	State plan authority for mandatory and voluntary managed care programs on a statewide basis or in limited geographic areas. States may choose to include dual eligibles as part of a broader managed care program	<ul style="list-style-type: none"> • Permanent State plan authority and no “cost effectiveness” test. • Allows for selective contracting. • <i>No mandatory enrollment of dual eligibles; but dual eligibles may voluntarily</i>

	authorized under Section 1932(a).	<p><i>enroll.</i></p> <ul style="list-style-type: none"> • <i>States may use MCOs or PCCMs.</i>
Section 1915(b) Waivers	<p>Up to two-year, renewable waiver authority for mandatory enrollment in managed care and/or selective contracting with providers on a statewide basis or in limited geographic areas.</p> <p>1915(b) waivers must demonstrate their access, quality and cost-effectiveness.</p>	<ul style="list-style-type: none"> • Allows mandatory enrollment of dual eligibles. • May provide additional, health-related services through 1915(b) (3). • <i>States may use MCOs, PIHPs, PAHPs, PCCM</i>
Section 1915(c) Home and Community Based Services (HCBS) Waivers	<p>Waiver authority that permits States to provide long-term care services delivered in community settings as an alternative to institutional settings.</p> <p>1915(c) waivers must be “cost neutral” and are renewable for 5 years after the initial, 3-year approval period.</p>	<ul style="list-style-type: none"> • <i>Cannot waive “freedom of choice”</i>
Concurrent 1915(a)/(c) Authority	Used to implement a voluntary managed care program that includes HCBS services in the managed care contract, when it is necessary for the State to ensure that individuals receiving	<ul style="list-style-type: none"> • <i>Cannot waive “freedom of choice” or selectively contract with managed care providers.</i>

	services through the (a) are simultaneously enrolled in the (c) waiver.	
Concurrent 1915(b)/(c) Authorities	<p>Used to implement a mandatory managed care program that includes HCBS waiver services in the managed care contract. The 1915(c) waiver allows a State to target eligibility and provide the HCBS services. The 1915(b) then allows a State to mandate enrollment in managed care plans that provide these HCBS services.</p> <p>States must apply for each waiver authority separately and comply with the statutory and regulatory requirements of each.</p>	<ul style="list-style-type: none"> • Allows for selective contracting with managed care plans. • <i>Requires administration of two separate, concurrent waivers with separate reporting requirements.</i>
Section 1915(i) Home and Community Based Services State Plan Option	<p>States can amend their State plans to offer HCBS as a State plan optional benefit effective January 1, 2007.</p> <p>Section 1915(i) services may be included in capitation rates when a State elects to provide home and community based services through managed care delivery systems.</p>	<ul style="list-style-type: none"> • No level of care requirement • Cannot expand eligibility • Income cannot exceed 150% of the Federal Poverty Level (FPL) • States must establish needs-based criteria • Can waive statewideness • Can limit the number of participants • Cannot waive comparability

		<ul style="list-style-type: none"> • No renewal needed • No cost neutrality requirement
<p>Section 1115 Demonstrations</p>	<p>Broad authority at the discretion of the Secretary to approve projects that test policy innovations likely to further the objectives of the Medicaid program.</p>	<ul style="list-style-type: none"> • Provide most flexibility to waive provisions in Section 1902. • <i>Must be budget neutral.</i> • <i>Approval at the discretion of HHS and subject to Federal/State negotiations.</i>