Chapter 1:

Streamlining Medicaid Managed Care Authority

Streamlining Medicaid Managed Care Authority

Recommendations

1.1 Congress should amend Section 1932(a)(2) to allow states to require all beneficiaries to enroll in Medicaid managed care programs under state plan authority.

1.2 Congress should extend approval and renewal periods for all Section 1915(b) waivers from two to five years.

1.3 Congress should revise Section 1915(c) waiver authority to permit Section 1915(c) waivers to waive freedom of choice and selective contracting.

Key Points

- Managed care is now the dominant delivery system in Medicaid; the share of beneficiaries enrolled in any form of managed care grew from 58 percent in 2002 to 80 percent in 2015.
- Three legal authorities can be used to mandate enrollment in a Medicaid managed care program: Section 1115 waiver authority, Section 1915(b) waiver authority, and Section 1932 state plan authority. These authorities differ in several ways, including scope, who can be required to enroll in managed care, initial approval and renewal time periods, and reporting requirements. Many states operate more than one managed care program, often under multiple authorities or through multiple waivers.
- Federal regulations define beneficiary protections and oversight standards required of state Medicaid agencies and managed care organizations, and these apply across all authorities.
- It is the Commission's view that allowing states a more streamlined mechanism to select managed care as their delivery system and to require beneficiaries to enroll in such systems is appropriate at this time, based on the following:
  - the numbers and types of beneficiaries already enrolled in such systems and their experiences;
  - the value of managed care in promoting effective integration and coordination of care;
  - the current federal regulatory framework and the protections and assurances it provides;
  - the accountability of states to their own constituents and beneficiaries; and
  - the need for states to direct limited resources to activities with proven direct impact on plan performance, beneficiary experience, and costs.
- The Commission also recognizes that requirements and standards alone are not sufficient; the process and resources for oversight must also be in place at the federal and state levels. When resources are limited, vulnerable groups may be overlooked. In addition, states may differ in their ability to successfully implement and oversee managed care programs.

CHAPTER 1: Streamlining Medicaid Managed Care Authority

States' use of managed care to administer the Medicaid program has increased substantially over the years. The share of Medicaid beneficiaries enrolled in any form of managed care grew from 58 percent in 2002 to 80 percent in 2015 (CMS 2016a, CMS 2013). The share of Medicaid beneficiaries enrolled in comprehensive managed care was nearly 65 percent in 2015 (MACPAC 2017a). Medicaid managed care program design has also evolved over this time, serving new groups of enrollees (e.g., low-income adults not eligible on the basis of disability) and covering new services, such as long-term services and supports.

The authorities that states can use to implement managed care in Medicaid have also evolved over time. For many years, Section 1115 of the Social Security Act (the Act) provided the only authority by which states could require individuals to enroll in managed care (P.L. 87-543). In 1981, Congress enacted specific program waiver authority under Section 1915(b) of the Act to implement mandatory managed care (OBRA 1981, P.L. 97-35). Then in 1997, the Balanced Budget Act (BBA, P.L. 105-33) created a new state plan option for managed care available under Section 1932.[1]

In light of the increasing use of and experience with managed care across states, populations and services, CMS issued a broad update to its regulatory framework for such delivery systems in 2016. The standards for states and plans with respect to network adequacy, rate development, quality assurance and performance monitoring, and beneficiary protections in enrollment, disenrollment, grievances and appeals, apply to states and plans regardless of the authority used to implement the managed care program. The changes made in 2016 also placed new requirements on managed care programs that deliver long-term services and supports.

In early 2017, the Commission began an inquiry to consider whether there might be ways to streamline Medicaid managed care authorities, with the goal of reducing administrative burdens for states making delivery system choices while continuing to ensure adequate beneficiary protections. These are goals shared by states and the federal government (CMS 2017a, CMS 2017b). After reviewing current law, the current regulatory framework, and how states have structured their managed care programs and sought federal approvals, the Commission recommends three statutory changes that would streamline managed care authority in three different ways. Specifically:

- Congress should amend Section 1932(a)(2) to allow states to require all beneficiaries to enroll in Medicaid managed care programs under state plan authority.
- Congress should extend approval and renewal periods for all Section 1915(b) waivers from two to five years.
- Congress should revise Section 1915(c) waiver authority to permit Section 1915(c) waivers to waive freedom of choice and selective contracting.

These recommendations should not be considered to be a package. That is, the adoption of any one of the recommendations does not require the adoption of the others.

It is Commission's view that allowing states a more streamlined mechanism to select managed care as their delivery system and to require beneficiaries to enroll in such systems is appropriate at this time, based on the number and types of beneficiaries already enrolled in such systems and their experiences; the value of managed care in promoting effective integration and coordination of care; the current federal regulatory framework and the protections and assurances it provides; the accountability of states to their own constituents

and beneficiaries; and the need for states to direct limited resources to activities with proven direct impact on plan performance, beneficiary experience, and costs. The Commission also recognizes that requirements and standards alone are not sufficient; the process and resources for oversight must also be in place at the federal and state levels. When resources are limited, vulnerable groups may be overlooked. In addition, states may differ in their ability to successfully implement and oversee managed care programs. These concerns will be the focus of the Commission's continuing work on Medicaid managed care.

The chapter begins by describing the current requirements and standards for states to implement Medicaid managed care programs. Next, it provides an overview of the authorities under which states can administer Medicaid managed care programs, including a comparison of those authorities. The chapter then describes three approaches to streamlining Medicaid managed care authorities, and concludes with the Commission's recommendations and its rationale for adopting them.

History of Medicaid Managed Care

The authorities that states can use to implement managed care in Medicaid have evolved over time (Box 1-1). For many years, Section 1115 was the principal authority states used to require individuals to enroll in managed care.

In the 1960s, some states began enrolling Medicaid beneficiaries in managed care programs on a pilot basis, and Medicaid managed care continued to grow in the 1970s. However, concerns were raised that plans did not provide needed care or took advantage of capitated payments by enrolling only people who rarely used care (GAO 1995). Congress passed the Health Maintenance Organization Act of 1973 (HMO Act, P.L. 93-222), which established certain requirements for health maintenance organizations (HMOs). Congress added certain requirements in the Health Maintenance Organization Amendments of 1976 (HMOA, P.L. 94-460), which amended the definition of an HMO to coordinate with the Health Maintenance Organization Act of 1973 (P.L. 93-222). The HMOA mandated that that at least 50 percent of a Medicaid-participating managed care organization's membership be non-Medicaid, non-Medicare enrollees, known as the 50/50 rule. HMOA also established certain requirements for Medicaid managed care organizations, such as standards affecting mandatory health services, and open enrollment periods.

States' use of Medicaid managed care continued to grow. In 1981, Congress enacted specific program waiver authority under Section 1915(b) to implement mandatory managed care, and changed the 50/50 rule to require that at least 25 percent of a plan's total enrollment be private insurance enrollees (the 75/25 rule). Then in 1997, BBA created a new state plan option for managed care available under Section 1932. The BBA also rescinded the 75/25 rule, which greatly expanded the market for managed care and led to more rapid growth in Medicaid.

The regulatory framework governing Medicaid managed care has also evolved over time. In the early days of Medicaid managed care, many of the requirements for states and plans were specified in the terms and conditions of waivers. As states and the federal government acquired more experience, many of these requirements were codified in federal statute. The Centers for Medicare & Medicaid Services (CMS) promulgated the first Medicaid managed care rule in 2001 after the state plan option was added to statute. The Medicaid managed care rules were substantially revised in 2016.

BOX 1-1. History of Medicaid Managed Care Authorities

1962	The Public Welfare Amendments of 1962 (P.L. 87-543) establish Section 1115, which gives broad authority to the Secretary of the U.S. Department of Health and Human Services (the Secretary) to waive compliance with any of the requirements of a number of sections of the Social Security Act for any experimental, pilot, or demonstration project.
1965	Medicaid is enacted as Title XIX of the Social Security Act (P.L. 89-97).
1968	California's Medicaid program begins contracting with comprehensive risk-based managed care plans on a pilot basis (GAO 1995).
1970s	States expand enrollment in Medicaid managed care plans during the 1970s. Controversies arise around marketing practice ethics, network adequacy, delivery system quality, and plan financial stability (Freund and Hurley 1995).
1973	The Health Maintenance Organization Act of 1973 (HMO Act of 1973, P.L. 93-222) establishes requirements for health maintenance organizations (HMOs).
1976	The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) is enacted. • Amends the definition of HMO in the Social Security Act to align with the definition in the HMO Act of 1973. • Redefines basic health services as referring to mandatory Medicaid services. • Requires entities seeking risk-based contracts under Medicaid to meet federal HMO requirements. • Prohibits payments to organizations providing inpatient hospital services or any other mandated Medicaid services on a prepaid risk basis that are not qualified as an HMO.
1981	The Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) is enacted. • Establishes Section 1915(b) freedom-of-choice waivers to allow states to pursue mandatory managed care enrollment of certain Medicaid populations. • Requires Medicaid capitation payments to be actuarially sound.
1997	The Balanced Budget Act of 1997 (BBA, P.L. 105-33) is enacted. • Amends Title XIX by adding Section 1932, which permits states to mandate Medicaid managed care enrollment for most beneficiaries without obtaining a Section 1115 or Section 1915(b) waiver. • Requires states to develop and implement a quality assessment and improvement strategy that does the following: ensures coverage of emergency services, creates a system to address complaints, demonstrates adequate capacity and services, and meets certain quality standards. • Calls for independent performance reviews of Medicaid managed care organizations.

Overview of Medicaid Managed Care Authorities

Depending upon their policy goals and the design of their programs, states can implement managed care under multiple federal authorities. Many states operate more than one managed care program, often under multiple authorities or through multiple waivers. The requirements for states and plans are the same regardless of authority, as discussed later in this chapter.

Below we describe the three authorities used by states to mandate managed care enrollment and differences in key structural features.

Section 1115 waiver authority

Section 1115 waiver authority allows states to test an experimental, pilot, or demonstration project likely to assist in promoting the objectives of Medicaid. This was once the primary authority available to states to implement managed care, and states have used it to waive comparability and statewideness requirements related to eligibility, benefits, service delivery, and payment methods used by the state to administer the managed care program.

Twenty-two states implement managed care under Section 1115 waiver authority, as of June 2017. Many of these waivers are complex and used to achieve policy goals beyond managed care. For example, many states have implemented delivery system reform programs, provided enhanced behavioral health services, or introduced managed long-term services and supports (MLTSS) programs.

Application process. States use a CMS-provided template to describe their program: who will be covered, what services and care will be provided under the waiver, and how they will be provided.[2] There is no preprinted application. There is no time frame for approval and the process is often characterized by lengthy negotiations. Most Section 1115 waivers can be approved for up to five years.[3]

Budget neutrality. Many states implement managed care under Section 1115 waivers to finance other program changes. Under Section 1115 authority, states can apply savings generated from the managed care portions (and other portions) of their demonstrations to request federal matching funds for costs that are not otherwise matchable (CNOM) under the state plan, making the demonstration budget neutral (§1115(a)(2) of the Act). These CNOM expenditures have been used to finance coverage expansions to populations that are not otherwise eligible for Medicaid, additional payments to providers, such as uncompensated care pools or delivery system reform incentive payments, and additional payments to states.

Although many states using Section 1115 authority could operate their managed care programs under Section 1915(b) authority, doing so would limit the ability of states to use managed care savings to support additional spending under Section 1115 expenditure authority. Budget neutrality savings can accumulate over the course of the demonstration; that is, states may carry these savings forward for many years, subject to CMS approval. For example, Hawaii's Section 1115 demonstration to implement managed care was first approved in 1993, and the state continues to use savings attributed to implementing managed care to fund its uncompensated care pool today: the state carried forward more than $2 billion in managed care savings in its 2014 waiver renewal (CMS 2015a).

Transparency requirements. States must provide a public notice and comment period of at least 30 days for Section 1115 waiver proposals, and inform the public by describing the program and its goals, eligibility requirements, an estimate of changes in annual enrollment and expenditures, and the research goal of a proposed waiver. States are also required to consult federally recognized American Indian tribes located within state boundaries and to solicit advice from Indian health providers.

Eligible populations. States can require all Medicaid beneficiaries to enroll in managed care under approved Section 1115 waivers.

Monitoring and reporting. States must submit quarterly reports, which typically provide data on enrollment and information about grievances and other issues arising during the previous quarter. In addition, states must submit annual reports that describe the progress of their demonstration. According to federal regulations, several elements must be included in annual reports:

- early findings about the impact of the demonstration in meeting its objectives, including the effect of the demonstration on insurance coverage, the health care delivery system, and beneficiary outcomes;
- a summary of grievances, appeals, and any feedback received from stakeholders during post-award public forums; and,
- information on various operational aspects of the demonstration, such as the number of people enrolled, the financial performance of the demonstration, and any state legislative developments that may impact the demonstration (42 CFR 431.428).

In addition, CMS requires some states to submit other monitoring reports related to specific components of their demonstration. For example, Indiana is required to submit quarterly data on enrollee use of health savings accounts, and Texas is required to submit annual reports on payments to hospitals under its uncompensated care pool (CMS 2018, 2017d).

Evaluation. Section 1115 waivers typically have evaluation requirements. States must submit an evaluation design plan that describes the intended policy goal and how they will determine whether the waiver has been successful in achieving this goal, including evaluation methods and data sources. After an evaluation is completed by the state and approved by CMS, the evaluation must be posted publicly, either on the CMS website or the state's website.

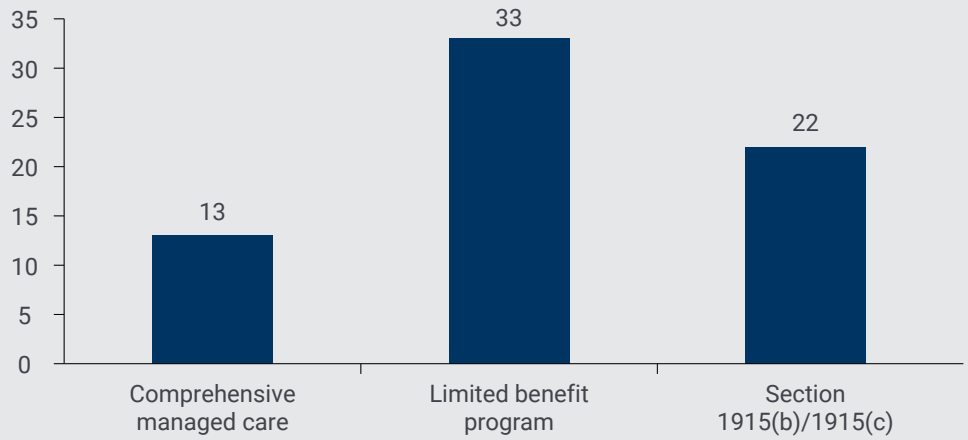
Section 1915(b) waiver authority

Section 1915(b) waiver authority, enacted in 1981as part of OBRA 1981, allows CMS and states to waive state plan requirements under Section 1902 of the Act as necessary to achieve one of four managed care program goals:

- **1915(b)(1)—primary care case management (PCCM) or specialty service arrangement.** This authority allows states to mandate enrollment in a managed care plan or PCCM program. Under both models, freedom of choice must be waived to limit the providers through whom enrollees access services.
- **1915(b)(2)—locality as a central broker.** A state may allow a county or a local government to serve as a broker to help Medicaid enrollees choose among PCCMs or competing managed care plans.
- **1915(b)(3)—sharing of cost savings with enrollees.** This authority allows a state to share the savings resulting from a managed care program with enrollees (by providing additional services) resulting from the use of more cost-effective care.
- **1915(b)(4)—restriction to specified providers.** States may use waivers to limit the number or type of providers who can provide specific Medicaid services—for example, for disease management or transportation. 1915(b)(4) applies to selective contracting by states that pay providers on a fee-for-service (FFS) basis. Freedom of choice cannot be restricted for providers of family planning services and supplies.

Section 1915(b) waivers are often referred to as freedom-of-choice waivers because the program designs limit the enrollee's choice of health care providers to those participating in the waiver (§ 1902(a)(23)(A) of the Act). In other words, Section 1915(b) waivers allow states to mandate enrollment in restricted networks (e.g., a PCCM program or

FIGURE 1-1. Number of Section 1915(b) Waivers, by Type, 2017



Notes: States can use a Section 1915(b) waiver to achieve multiple policy goals, and therefore a waiver may be included in multiple categories in this chart. For example, South Carolina uses a Section 1915(b) waiver to require that pregnant women enroll in comprehensive managed care and to provide prenatal and maternity services to these beneficiaries; this waiver is included in both comprehensive managed care and limited benefit program categories above. The Section 1915(b)/1915(c) program category includes all types of Section 1915(b) authority, including selective contracting under Section 1915(b)(4). There are four MLTSS programs operated using Section 1915(b) waivers in conjunction with 1915(c) waivers.

Source: MACPAC analysis of active Section 1915(b) waiver applications as of October 2017.

an MCO). Section 1915(b) waivers are now used primarily to achieve the following goals:

- to implement comprehensive managed care by requiring beneficiaries to receive services from a managed care plan;[4]
- to create a program that provides a limited set of benefits or services to beneficiaries;[5] or
- to establish a home- and community-based services (HCBS) program in conjunction with Section 1915(c) authority (Figure 1-1).

Application process. States seeking Section 1915(b) waivers complete a preprinted application describing the nature and scope of the proposed waiver and submit it to CMS for approval. Once a waiver application is submitted, the Secretary of the U.S. Department of Health and Human Services (the Secretary) has 90 days to make an approval decision. However, the Secretary (or CMS, operating under the Secretary's delegated authority) can stop the 90-day review period (known as stopping the clock) by writing to request additional information from the state. Once the state submits the requested information, a new 90-day period begins (42 CFR 430.25).

Section 1915(b) waivers are initially approved for two years (or up to five years if individuals dually eligible for Medicaid and Medicare are included) and can be renewed for two-year periods after the initial waiver term (42 CFR 430.25(h)(ii)).[6]

On November 6, 2017, CMS notified states of its intent to make process improvements that improve transparency and efficiency and reduce burden associated with waiver applications. For example, CMS intends to conduct an introductory discussion with states within 15 days of a Section 1915(b) waiver application submission, in which CMS and states can review the intent of the waiver, timelines, and any incomplete information. CMS also intends to make toolkits and other resources available to

states to improve the waiver application process (CMS 2017b).

Cost-effectiveness requirement. States must provide enrollment and financial documentation to demonstrate that the proposed waiver is cost-effective and efficient (42 CFR 431.55(A), 42 CFR 413.55(b)(2)(i)).

Transparency requirements. States must consult federally recognized American Indian tribes located within state boundaries and solicit advice from Indian health providers.

Eligible populations. States can require all Medicaid beneficiaries to enroll in managed care under approved Section 1915(b) waivers.

Monitoring and reporting. Section 1915(b) monitoring, although not formally codified in regulation, is generally carried out by requiring CMS approval for managed care contracting and rate-setting activity, and by specifying in the waiver's terms and conditions the reports or other information that must be submitted to CMS by the state. While reporting requirements vary by waiver type and program, states may be required to complete quarterly and annual reporting on waiver activity. These reports can include elements such as:

- enrollment and disenrollment information;
- beneficiary complaints and grievances;
- waiver spending data;
- consumer satisfaction data (e.g., results from annual Consumer Assessment of Health Care Providers and Systems surveys);
- state quality monitoring activities under the waiver, such as external quality review;
- provider enrollment and termination data; and
- network information (e.g., provider-to-enrollee ratios, number of providers).

Evaluation. States must contract with an independent entity to assess waiver performance during the first two years of operation and following the first renewal period. Independent assessments must address beneficiary access to services, quality of care, and cost-effectiveness of the waiver.

Use of Section 1915(b) in combination with Section 1915(c) HCBS waivers. Although states have the option of offering HCBS under state plan authority, Section 1915(c) waivers allow states to limit the number of individuals who can receive these services. In addition, states can use Section 1915(c) authority to waive statewideness and comparability for services provided under the waiver (that is, provide services to waiver enrollees that may not be covered or are limited under the state plan). Forty-seven states and the District of Columbia use Section 1915(c) waivers, primarily to offer HCBS to limited groups of enrollees meeting level-of-care requirements—that is, enrollees who would require institutionalization in the absence of HCBS (42 CFR 1915(c)(1)).[7]

States typically establish an HCBS waiver through Section 1915(c) authority and use Section 1915(b) authority to selectively contract with an entity to administer the program and to mandatorily enroll certain populations.[8] This is because Section 1915(c) waivers do not provide authority for states to waive beneficiaries' freedom of choice or mandatorily enroll these groups. The state must apply for each waiver separately, and meet separate statutory, regulatory, and reporting requirements established under the Act for each waiver. For example, Virginia provides HCBS to individuals who meet the nursing facility, specialized care facility, or hospital level of care under a combined Section 1915(b)-1915(c) waiver. The state designed the program, including the benefit package, through a Section 1915(c) waiver, and mandates enrollment in a managed care plan through a Section 1915(b) waiver (CMS 2017e, 2017f).

Section 1932 state plan authority

In 1997, the BBA created a new state plan option for managed care available under Section 1932. Under this authority, states may implement mandatory managed care for all Medicaid enrollees except individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs, including children eligible for Medicaid on the basis of disability or involvement with the child welfare system, or children receiving Supplemental Security Income (SSI).[9] States must generally give enrollees a choice of managed care entities. State plan authority to operate a managed care program does not expire and does not require renewal.

Application process. State Medicaid agencies must submit a preprinted state plan amendment (SPA) to CMS for approval. Like Section 1915(b) waivers, the Secretary has 90 days to make an approval decision, and can stop the clock by requesting additional information. The SPA must describe the proposed managed care plan in similar detail as would be required in a Section 1915(b) waiver application. For example, states must describe which beneficiaries will be enrolled in managed care, the process and requirements for enrollment and disenrollment, the access standards and requirements, and consumer protections such as grievance and appeals processes and limitations around marketing and outreach.

Fiscal impact. States must include a fiscal impact statement in its SPA application that estimates the effect of the SPA on federal spending. Unlike waivers, SPAs are not required to meet budget neutrality or cost-effectiveness requirements.

Transparency requirements. Generally, federal public notice requirements apply to SPAs only when states plan significant changes in payment methods and standards (42 CFR 447.205). The state plan must document public involvement in the design and implementation of the managed care program (42 CFR 438.50(b)(4)). Notwithstanding federal requirements, states may have their own public notice requirements. Transmittals and SPA approvals are posted to the CMS website.

Eligible populations. States can require most beneficiaries, including pregnant women, adults eligible on the basis of disability, and low-income children and families, to enroll in managed care under state plan authority. Section 1932 may not be used to mandatorily enroll members of the following populations: individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of disability or involvement with the child welfare system, or children receiving SSI) (§ 1932(a)(2)). However, states can enroll individual members of these groups in a managed care program on a voluntary basis.

Monitoring and reporting. As with Section 1915(b) waivers, most monitoring and reporting of managed care under state plan authority is carried out through contract and rate-setting review and external quality review reporting.

Evaluation. Section 1932 SPAs do not include an evaluation requirement.

Comparing Managed Care Authorities

States have flexibility to design a Medicaid managed care program that reflects their policy goals and to select the authority under which to administer that program. As noted above, these authorities have different application processes and requirements, such as reporting or evaluation requirements. For example, a state might choose to implement managed care under Section 1915(b) authority or state plan authority because the application process is more predictable than the Section 1115 waiver application process. Both Section 1915(b) and state plan authority processes feature a preprinted application, and CMS is required to respond to submissions within

90 days (Table 1-1). On the other hand, a state may prefer a Section 1115 waiver to make use of budget neutrality provisions in order to finance other Medicaid policy goals.

Some of the key similarities and differences between these authorities are described below.

Similarities among managed care authorities

States use Section 1915(b), Section 1115, and state plan authority to implement similar programs, even though the underlying requirements for the three authorities may vary. For example, to enroll children and families in a Medicaid managed care program, Pennsylvania uses a Section 1915(b) waiver, Arizona uses a Section 1115 waiver, and the District of Columbia uses Section 1932 state plan authority (CMS 2017h, 2016b, 2010). The structure of these programs are similar, in that they use comprehensive risk-based managed care plans to provide Medicaid coverage to children and families. States have used different authorities to implement MLTSS programs and non-emergency medical transportation programs as well.[10]

Requirements on states and plans apply consistently regardless of authority. Standards and requirements are tied to the type of program (e.g., comprehensive managed care or primary care case management), rather than the authority under

TABLE 1-1. Comparison of Medicaid Managed Care Authorities, by Issue

Issue	Section 1115	Section 1915(b)	Section 1932 state plan
Application process; time to approval	Use of CMS template encouraged; no required time frame for approval	Use of CMS preprinted form recommended; 90-day clock	Use of CMS preprinted form required; 90-day clock
Approval and renewal periods	Up to five years	Two years (up to five if dually eligible individuals are included)	Indefinite approval period; renewal not required
Financial requirements	Budget neutrality	Cost effective	Fiscal impact statement
Transparency requirements	30 day public notice and comment period; tribal consultation	No additional requirements; tribal consultation	No additional requirements; tribal consultation
Eligible populations	Any beneficiary	Any beneficiary	Certain populations are exempt
Monitoring and reporting requirements	Quarterly and annual reports (requirements vary based on STCs)	No additional requirements	No additional requirements
Evaluation requirements	States must submit evaluation design plan, and complete an evaluation at the end of the demonstration	Independent assessment required after initial two-year approval and first renewal	None required
Managed care requirements	Managed care standards and requirements, including oversight, are same under managed care regulation		

Note: STCs are special terms and conditions.

Source: For Section 1115: 42 CFR 438.400, CMS 2017g. For Section 1915(b): CMS 2012a, 2012b. For Section 1932 state plan: MACPAC 2017b.

which it is implemented. Similarly, state and federal oversight responsibilities also are similar.

Although states cannot mandatorily enroll certain vulnerable populations in managed care without a waiver, the waivers themselves currently do not provide special protections for these groups. Beneficiary protections are established in statute and regulation and apply across all authorities. Some of these beneficiary protections include:

- **Access standards.** States are required to develop and enforce network adequacy standards, including time and distance requirements, and must assure CMS that providers for contracted plans have the capacity to meet the needs of Medicaid beneficiaries. Time and distance standards will also be required for LTSS providers, with alternate standards for those who travel to enrollees.
- **Monitoring standards.** States are required to establish a monitoring system for all managed care programs. These plans must address several areas, including: enrollee materials and customer services, marketing, medical management, availability and accessibility of services, provider oversight including network adequacy and provider capacity, and quality improvement.
- **State quality strategy.** States must establish a quality strategy and require the Medicaid MCOs they contract with to report data in support of the quality strategy. The quality strategy focuses on many areas that relate to all Medicaid populations, but must include mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs and those receiving LTSS.
- **Care coordination.** Managed care plans must ensure that beneficiaries have an ongoing source of care appropriate to their needs, including primary and specialty care. In addition, plans must coordinate services between care settings and must coordinate plan services with services provided outside of the plan, including services provided by other plans, by FFS Medicaid, and by community and social support organizations. States must also develop a transition policy that ensures that beneficiaries have access to services without which they would experience serious detriment to their health. This transition requirement covers transitions from FFS to managed care and from one plan to another. Beyond these standards, states must identify beneficiaries who need LTSS and beneficiaries with special health care needs, and identify any ongoing special conditions in beneficiaries that require a course of treatment or regular care monitoring.
- **Communication.** Medicaid regulation requires that managed care plans and states make information accessible and available to all beneficiaries, including the populations exempted from mandatory Medicaid managed care. There are requirements around language and cultural competency. Plans may use electronic communication, including email, text, and website postings. Plans are required to publish and routinely update provider directories, including website and physical accessibility information.
- **Enrollment broker and choice-counseling requirements.** States must establish an independent beneficiary support system to provide enrollment choice counseling and assist enrollees post-enrollment.[11] There are also standards around enrollment communication to mandatory and optional managed care beneficiaries. If states use passive enrollment, then enrollment brokers must consider beneficiaries' current source of care.
- **Grievances and appeals.** Medicaid managed care plans must establish a process for beneficiaries to submit grievances and appeal benefit determinations. Managed care plans

must perform one level of internal appeal before enrollees proceed to a state fair hearing. Other standards for grievances and appeals include plan communication to the beneficiary, time frames, recordkeeping, and continuation of benefits while a state fair hearing is pending.

Although there are no population-specific oversight requirements in the statute, Section 1932(b)(5) requires that MCOs have the capacity to provide access to care for the entire population expected to be enrolled (which would include any specific populations), and Section 1932(c)(1) requires that states have procedures for monitoring and evaluating the quality and appropriateness of care and services for the full spectrum of populations enrolled in managed care. That is, instead of naming specific subpopulations, the statute requires MCOs and states to address the needs of all enrolled populations.

Differences among managed care authorities

There are several key differences among these authorities. To determine which authority best meets their needs, states weigh the differences with the policy goals.

Scope of authority. These authorities exist along a spectrum where, on the one hand, state plan authority allows a state to implement a discrete program within Medicaid rules and requirements (generally, those outlined in Section 1902), and on the other hand, Section 1115 waivers provide broad flexibility to waive statutory requirements. In practice, this means that states generally use Section 1115 waiver authority to implement broad program changes, in which comprehensive managed care is one component of a larger waiver. For example, New Jersey uses Section 1115 waiver authority to enroll some beneficiaries in managed care, but also to implement MLTSS and a delivery system reform incentive program. The scope of Section 1915(b) waivers and state plan authority are more limited relative to authority provided to states under Section 1115.

Mandatory enrollment in managed care. These authorities differ in terms of who can be required to enroll in Medicaid managed care. As noted above, under state plan authority states can require almost all beneficiaries to enroll in Medicaid managed care, with the exception of individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of disability or involvement with the child welfare system, or children receiving SSI). States can, however, require these excepted populations to enroll in managed care under Section 1915(b) authority and Section 1115 authority. For example, Kentucky mandates managed care enrollment for low-income parents and children, individuals with disabilities, individuals dually eligible for Medicaid and Medicare, and children eligible for Medicaid on the basis of involvement with the child welfare system under a Section 1915(b) waiver (CMS 2015e).

Initial approval and renewal time periods. Medicaid managed care programs can be authorized for different periods of time, depending on the authority used to implement the program and who is enrolled. SPAs are not required to be renewed, so managed care programs implemented under such authority can be implemented indefinitely. Section 1115 waivers can be approved for initial and renewal periods of up to five years, or longer in certain limited circumstances. Section 1915(b) waivers can be approved for initial and renewal periods of two years, or for periods of up to five years if the waiver includes dually eligible individuals.

Administrative burden associated with implementing programs under each authority. Because of the variation in scope, the administrative burden and expertise required to exercise each authority varies. Each authority varies in terms of the application requirements and process, how long they are approved for, and the reporting requirements associated with each authority.[12] For

example, each authority requires a different budget or financial test; states provide a budget estimate with a state plan amendment, but must meet a cost effectiveness test under Section 1915(b) authority and a budget neutrality test under Section 1115 authority. These financial tests generally require specialized resources to complete.

Streamlining Managed Care Authorities

Given the available authorities and the evolution of managed care in Medicaid, Medicaid managed care authorities should be streamlined to make it easier for states to administer managed care without affecting protections for beneficiaries. Since the inception of managed care in Medicaid, states and the federal government have gained more experience in administering these programs to meet the diverse needs of Medicaid beneficiaries, including subgroups with complex or high needs for care. Managed care standards and requirements are tied to the type of program a state administers, rather than the authority under which the program is administered. In light of this evolution, there are three areas in which Medicaid managed care could be streamlined.

Mandatory managed care enrollment

Under current law, states cannot require the following beneficiaries to enroll in comprehensive managed care programs except with a waiver: individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of disability or involvement with the child welfare system, or children receiving SSI).[13] This policy reflects concerns common two decades ago that managed care arrangements for these groups should be entered into under special conditions; that is, waivers were seen as necessary to ensure adequate oversight that the needs of these beneficiaries were met.

Enrollment of these populations in comprehensive Medicaid managed care is now commonplace

BOX 1-2. Medicaid Managed Care Coverage for Dually Eligible Beneficiaries

Many dually eligible beneficiaries are enrolled in both a comprehensive Medicaid managed care plan for most medical services and a limited-benefit plan that provides oral health, behavioral health (including mental health and substance use services), long-term services and supports, or transportation services. For full-benefit dually eligible beneficiaries, comprehensive Medicaid managed care plans must cover:

- Medicare premiums and cost sharing;
- acute care services in excess of Medicare coverage limits; and
- Medicaid services not covered by Medicare, such as behavioral health care, oral health care, vision and hearing services, home- and community-based services described in the Medicaid state plan, and non-emergent medical transportation.

There is considerable variation across states in the optional Medicaid services covered. This variation results in different benefits for dually eligible beneficiaries depending on where they live (MACPAC 2016).

(Figure 1-2). This includes 27 percent of American Indian and Alaska Native Medicaid beneficiaries (about 235,000 beneficiaries); 62 percent of children enrolled in Medicaid based on a determination of a disability (about 829,000 beneficiaries); and 44 percent of children eligible for Medicaid on the basis of involvement in the child welfare system (about 406,000 beneficiaries) (MACPAC 2018).

About 16 percent of Medicaid beneficiaries (about 1.8 million) who were dually eligible for Medicaid and Medicare were enrolled in comprehensive Medicaid managed care in fiscal year 2013, including over half of dually eligible beneficiaries enrolled in comprehensive managed care in Arizona, Hawaii, Minnesota, New Jersey, and Tennessee (MACPAC 2018). Seven states mandated partial-

TABLE 1-2. Mandatory or Excluded Enrollment in Section 1915(b) Comprehensive Managed Care Waivers, by State and Population, 2015

State	Individuals dually eligible for Medicaid and Medicare	Children with special health care needs	American Indian or Alaska Native	Children eligible on the basis of involvement with the child welfare system
Total states mandating enrollment	**5**	**8**	**6**	**8**
Indiana	Not found	Not found	Voluntary	Voluntary
Iowa	Mandatory	Mandatory	Voluntary	Mandatory
Kentucky	Mandatory	Mandatory	Excluded	Mandatory
Michigan (comprehensive health care program)	Voluntary	Voluntary	Voluntary	Mandatory
Missouri	Not found	Mandatory	Mandatory	Mandatory
Nebraska	Mandatory	Mandatory	Mandatory	Mandatory
New Hampshire[1]	Mandatory	Mandatory	Mandatory	Mandatory
North Dakota[2]	Not found	Not found	Mandatory	Mandatory
Pennsylvania	Mandatory	Mandatory	Mandatory	Not found
Virginia	Not found	Mandatory	Excluded	Mandatory
West Virginia	Not found	Mandatory	Mandatory	Excluded

Notes: Individuals dually eligible for Medicaid and Medicare includes individuals who are eligible for Medicare and either (1) they are eligible to receive all state Medicaid benefits or (2) the Medicaid agency pays only for Medicare premiums and cost sharing. This table excludes South Carolina's Enhanced Prenatal and Postpartum Home Visitation Pilot Project and Managed Care program, which allows South Carolina to require pregnant women to enroll in comprehensive managed care under Section 1915(b) authority.

[1] New Hampshire operates a comprehensive managed care program for most populations under Section 1932 state plan authority and uses Section 1915(b) authority to require populations explicitly exempted under Section 1932 authority to enroll in Medicaid managed care.
[2] North Dakota enrolls the new adult group made eligible by the Medicaid expansion in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) in Medicaid managed care under Section 1915(b) waiver authority. Individuals dually eligible for Medicaid and Medicare are by definition exempt from this waiver.

Source: CMS 2016a, 2016c, 2015f.

benefit dual-eligible enrollment in comprehensive Medicaid managed care plans in 2015 (CMS 2016a). Together, the two programs provide a comprehensive set of benefits, although coverage may vary by state (Box 1-2).

Currently, 5 of the 11 states that administer a comprehensive managed care program under Section 1915(b) authority require at least one of these populations to enroll in managed care (Table 1-2). Few states explicitly exclude these populations from enrollment in managed care.

States may opt to mandate managed care enrollment for beneficiaries with complex health needs for a variety of reasons, including:

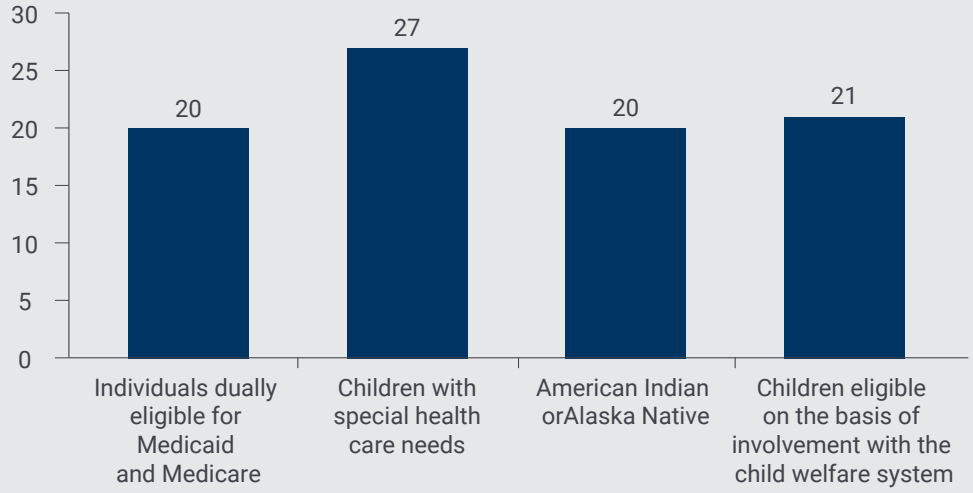
- the state has developed a robust Medicaid managed care delivery system, and has few FFS providers;
- moving to managed care may slow the rate of growth in program spending or provide more predictable cost growth; and
- managed care offers improvements in care management and coordination relative to FFS.

Historically, waivers were also viewed as necessary because they were used to ensure that beneficiaries had access to benefit packages that met their needs. Some were concerned that Medicaid managed care plans had financial incentives to limit benefits, either by excluding benefits from coverage or by imposing benefit limits, and that managed care coverage would differ substantially from coverage available under FFS.

Today, however, benefits available under Section 1915(b) programs are generally the same as those available under the state plan. In their waiver applications, states indicate what benefits are available, but they are not required to provide information on utilization management tools, such as benefit limits or prior authorization requirements.

Requiring waivers to mandatorily enroll these populations increases administrative burden for states and CMS in three ways. First, states must

FIGURE 1-2. Number of States That Require Medicaid Managed Care Enrollment, by Population, 2015



Notes: Individuals dually eligible for Medicaid and Medicare includes individuals who are eligible for Medicare and either (1) they are eligible to receive all state Medicaid benefits or (2) the Medicaid agency pays only for Medicare premiums and cost sharing.

Source: CMS 2016a.

complete the application process, and renew their programs every two to five years (depending on the authority and populations enrolled). Second, these applications require states to meet cost effectiveness or budget neutrality requirements. CMS and states must devote resources to each of these tasks. Finally, many states are operating managed care programs under multiple authorities. For example, New Hampshire mandates managed care enrollment for most state beneficiaries under Section 1932 state plan authority and has a Section 1915(b) waiver for the explicit purpose of mandating managed care enrollment for populations exempted under Section 1932. This increases administrative burden because a state would have to submit a SPA and an amendment to its Section 1915(b) waiver to make any coverage changes.

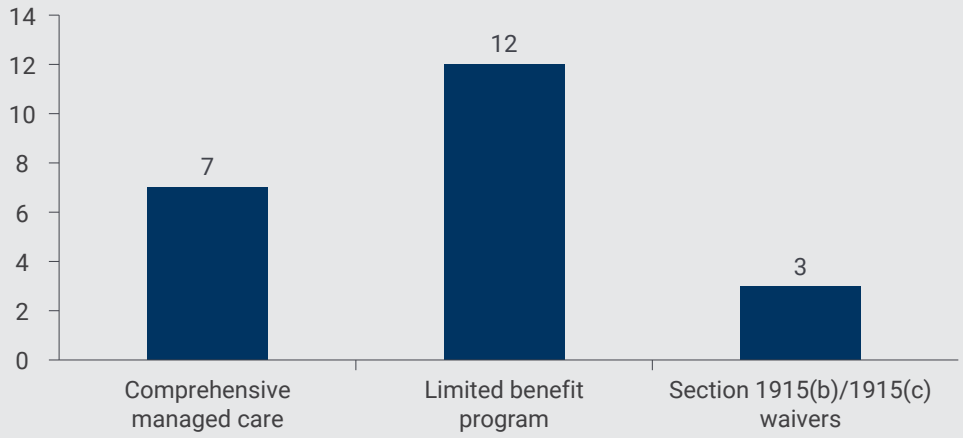
Section 1915(b) waiver approval periods

The two-year authorization period for Section 1915(b) waivers is shorter than for the other authorities: Section 1115 waivers can be approved for up to five years (or longer in certain circumstances) and state plan authority does not expire.

The short authorization period increases the administrative burden for states operating Medicaid managed care programs under Section 1915(b) waivers relative to other authorities. For example, Pennsylvania has operated most of its comprehensive managed care program under a Section 1915(b) program since 1996. Since then, the state has submitted nine renewal applications to continue to offer comprehensive managed care (CMS 2016b). Pennsylvania is not alone; Missouri and Virginia have operated comprehensive Medicaid managed care programs under Section 1915(b) waivers since the 1990s, renewing their programs multiple times (CMS 2017e, 2017i).

Other Medicaid waiver authorities can be approved for longer time periods. For example, any waiver that includes individuals dually eligible for Medicaid and Medicare can be approved for up to five years. These include Section 1115 waivers, demonstrations implemented by the CMS Federal Coordinated Health Care Office, and Section 1915(b) waivers that include dually eligible individuals. CMS may approve routine, successful,

FIGURE 1-3. Section 1915(b) Waivers with Two-Year Approval Periods, by Type, 2017



Source: MACPAC analysis of active Section 1915(b) waiver applications as of October 2017.

non-complex Section 1115(a) waivers extensions for up to 10 years (CMS 2017a).

Twenty-two of the 64 Section 1915(b) waivers that were active as of October 2017 were approved for two-year periods (Figure 1-3). Forty Section 1915(b) waivers were authorized for more than two years, including 36 approved for five-year periods.

Concurrent Section 1915(b) and Section 1915(c) waivers

States use Section 1915(b) waivers to deliver HCBS authorized separately under Section 1915(c) authority through a managed care delivery system. Section 1915(c) waivers allow states to limit the number of individuals who can receive these services. In addition, states can use Section 1915(c) authority to waive statewideness and comparability of those services. States use Section 1915(b) authority in conjunction with Section 1915(c) authority to waive freedom of choice or to selectively contract with an entity to administer the program. States must apply for each waiver separately and meet separate reporting requirements established in each waiver's special terms and conditions.

Commission Recommendations for Streamlining Medicaid Managed Care Authorities

In this report, the Commission makes three recommendations to streamline Medicaid managed care authorities. Although much of the Commission's conversation focused on recommendation 1.1, the two other recommendations focus on streamlining other features of existing waivers. These should not be considered to be a package of recommendations; that is, the adoption of any one of the recommendations does not require the adoption of the others. In addition, it is important to note that these recommendations, if adopted, would not eliminate use of Section 1915(b) waivers altogether as states seek Section 1915(b) waiver authority for purposes other than mandatory enrollment in managed care plans. For example, many states seek Section 1915(b) waiver authority to implement limited benefit plans.[14]

Recommendation 1.1

Congress should amend Section 1932(a)(2) to allow states to require all beneficiaries to enroll in Medicaid managed care programs under state plan authority.

Rationale

This recommendation would allow states to require any or all categories of Medicaid beneficiaries to enroll in managed care programs under state plan authority, including individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of disability or involvement with the child welfare system, or children receiving SSI).

Under current law, states that want to require these beneficiaries to enroll in managed care programs must seek waiver authority. To do so, states must complete a waiver application and apply for renewal of such programs every two years (or five, if the waiver includes individuals dually eligible for Medicaid and Medicare). As well, states must comply with mandatory quarterly and annual reporting requirements in addition to the monitoring requirements established in managed care regulations.

Medicaid beneficiaries in groups exempt from mandatory enrollment under state plan authority typically have complex health needs that require attention to provider networks and coordination across providers and settings.

At a time when the regulatory framework for states to monitor plans and for CMS to provide oversight was less developed than now, waivers provided a structure and process to ensure accountability of managed care organizations, states, and the federal government for covering the needs of complex populations. Today, states and plans are experienced in serving these populations under managed care and the standards and oversight requirements are the same across all authorities.

The Commission had a robust discussion about whether the process of applying for and renewing waivers provides additional protections for the populations with complex health needs, with some Commissioners noting the importance of public input in a state's decision to implement Medicaid managed care and in the program's design. Commissioners also noted that many important beneficiary protections are described in regulation, rather than statute, and thus may be easier to change.

Commissioners noted that the statute requires MCOs and states to address the needs of all enrolled populations. States must document the process used to involve the public in design and implementation, and states must ensure ongoing public involvement even when such programs are implemented under the state plan. Several Commissioners noted that beneficiary advocate groups play an important role in state decisions about how managed care is implemented and administered, regardless of whether that happens in the context of a SPA or a waiver application. Commissioners also noted that the recommendation rests on the existence of the current regulatory framework that provides important beneficiary protections. Moreover, it is desirable to have a legal framework that spells out responsibilities for states and plans as well as oversight mechanisms at the state and federal level that applies regardless of the individual authorities.

The Commission's discussion of beneficiary protections raised questions about the extent to which states and the federal government provide adequate oversight of Medicaid managed care programs. The current legal framework creates obligations for states and MCOs to ensure that beneficiaries receive care appropriate to their needs. In practice, states and MCOs have varying levels of capacity and competency that affect implementation and oversight of managed care. In the months ahead, the Commission will continue to explore oversight and administration of Medicaid managed care to better understand factors that affect the care beneficiaries receive, such as program structure and design.

It is the Commission's view that the current legal framework for Medicaid managed care includes detailed requirements for states and Medicaid MCOs that help ensure that Medicaid managed plans meet the complex health needs of individuals dually eligible for Medicaid and Medicare, American Indians and Alaska Natives, and children with special health care needs (including children eligible for Medicaid on the basis of disability or involvement with the child welfare system, or children receiving SSI). These standards and requirements have been codified over time and reflect state and federal experience in providing Medicaid coverage to all populations through managed care. In addition, states and plans have obligations that are specific to the populations enrolled in their managed care programs. For example, states must develop network adequacy standards that ensure that Medicaid beneficiaries have access to needed care, including primary care providers and other specialists. Managed care plans must ensure that beneficiaries have an ongoing source of care that is appropriate to their needs and must coordinate services between settings as well as with services provided outside the managed care plan. States and plans must ensure that beneficiary communication is accessible and available to all populations, including requirements around language and cultural competency. In addition, states are required to develop not only a monitoring program that addresses many of these obligations and other aspects of the beneficiary experience in managed care, but also a state quality strategy

that assesses the quality and appropriateness of the care furnished to enrollees on an ongoing basis. Thus, the regulatory framework now in place extends to all Medicaid beneficiaries, including those with complex health needs, regardless of which authority the state uses to enroll beneficiaries in managed care.

This recommendation would streamline program management, allowing states that administer managed care under multiple authorities to consolidate their programs under a single authority, without changes to beneficiary protection or oversight. It would reduce the administrative burden associated with waiver renewals and the burden associated with waiver reporting requirements. By reducing this burden, states could redirect staff efforts toward other priorities, such as program oversight and contract management.

It is the Commission's view that, given all the considerations delineated above, states should be able to seek federal approval for mandatory enrollment of all populations through state plan authority. The recommendation assumes continuation of the essential elements of the current regulatory framework for Medicaid managed care.

Implications

Federal spending. The Congressional Budget Office has estimated that this recommendation will not affect federal Medicaid spending.

States. The implication of this recommendation varies for each state, depending on how the state operates its managed care program. Some states may prefer to maintain their current managed care arrangements. For example, a state may choose to continue to operate comprehensive managed care under Section 1115 waiver authority to preserve budget neutrality savings.

On the other hand, this recommendation could simplify administration for some states. Some states operate a single comprehensive managed care program under different authorities. For example, a state may use Section 1915(b) waiver authority to require dually eligible individuals, American Indian and Alaska Natives, and children with special health care needs in managed care and use Section 1932 state plan authority to require all other beneficiaries to enroll in managed care. States could consolidate their program under state plan authority, and would not be required to seek renewals or complete waiver-required quarterly and annual reporting requirements. States may continue to seek Section 1915(b) waivers for other reasons. For example, states may seek authority to selectively contract with prepaid inpatient health plans, prepaid ambulatory health plans, or other entities to establish a limited benefit program under Section 1915(b) authority.

This recommendation would have no effect on states choosing to initiate a managed care program. States choose to implement mandatory managed care for a number of reasons, including promoting care management and coordination; providing greater control and predictability over Medicaid spending; and improving program accountability for performance, access, and quality. Moreover, states must meet a number of requirements to initiate a managed care program regardless of the authority under which it is implemented. For example, states must meet public input requirements in implementation and design, and contract review, which includes an assessment of the MCO's financial ability to provide coverage for Medicaid beneficiaries. This recommendation does not affect a state's decision to initiate a managed care program, but rather is intended to address the efficiency and administrative burden associated with that decision.

Enrollees. The effect of this recommendation on enrollees will vary, depending on which state they live in. Many dually eligible enrollees, American Indians and Alaska Natives, and children with special health care needs are already enrolled in comprehensive Medicaid managed care plans, either voluntarily or by state mandate under a waiver. The recommendation provides states with

another option under which to enroll beneficiaries in managed care.

Plans and providers. This recommendation is not likely to have a direct effect on Medicaid MCOs or Medicaid providers.

Recommendation 1.2

Congress should extend approval and renewal periods for all Section 1915(b) waivers from two to five years.

Rationale

This recommendation would simplify program management for states and for CMS. The two-year authorization period for Section 1915(b) waivers is shorter than the other authorities: Section 1115 waivers can be approved for up to five years and state plan authority does not expire. Extending the approval period would allow states to operate their Section 1915(b) waiver programs for a longer period of time without having to complete the renewal process. Reducing the burden associated with renewal applications could allow states and the federal government to focus their efforts on managing and monitoring waivers. There is also a precedent for a longer approval period: Section 1915(b) waivers that include individuals dually eligible for Medicaid and Medicare can be approved for up to five years.

This recommendation would not affect CMS' responsibility for reviewing managed care contracts or capitation rate determinations every year, which may or may not be aligned with the two-year approval period. Requirements for states to establish a monitoring program and any periodic reporting requirements would still be in place for states.

Implications

Federal spending. The Congressional Budget Office has estimated that this recommendation will not affect federal Medicaid spending.

States. This recommendation would simplify waiver administration and reduce administrative burden of renewal applications for states that operate Section 1915(b) waivers.

Enrollees. This recommendation is not likely to affect waiver enrollees because states can submit amendments to a waiver at any time during waiver implementation.

Plans and providers. Extending approval periods for Section 1915(b) waivers would ensure that plans and providers currently participating in a Section 1915(b) waiver could continue to provide services to waiver enrollees without disruption.

Recommendation 1.3

Congress should revise Section 1915(c) waiver authority to permit Section 1915(c) waivers to waive freedom of choice and selective contracting.

Rationale

Under current law, states must complete two separate waiver applications to operate a single HCBS waiver program if the state selectively contracts with a single entity to operate the program or if the state wishes to waive statewideness or comparability. Each waiver (§§ 1915(b) and 1915(c)) has separate reporting requirements. Moreover, the separate waiver authorities may not always be aligned in terms of their timing; waivers may have different effective dates or different due dates for quarterly and annual reports.

This recommendation would add the two Section 1915(b) authorities that are not already included in the Section 1915(c) authority (as noted above, two other Section 1915(b) authorities, statewideness and comparability, are already also included in Section 1915(c) authority). States interested in operating a home- and community-based program under Section 1915 authority would be required to complete a single application or renewal. This recommendation would simplify reporting requirements for states by requiring one set of quarterly and annual reports rather than multiple

sets. This recommendation also calls for CMS to consolidate program rules such that beneficiaries retain the protections currently assured under both waivers. For example, states would be required to detail how they would help ensure beneficiary access to timely care and how they would measure and maintain quality of care, as well as how their managed care plans would be marketed to beneficiaries. In addition, CMS can use regulatory authority put in place under managed care rules to require states to operate a monitoring system to mitigate access and quality concerns associated with limiting beneficiaries' choice of providers.

Implementation of this recommendation would result in simplified program administration for states and the federal government. Section 1915(b) and Section 1915(c) waivers are a key approach to delivering HCBS to Medicaid beneficiaries with complex health needs. The assurances made by states regarding beneficiary rights and protections are a vital part of these waiver authorities. On the other hand, requiring separate waivers to operate a single program increases complexity and reduces states' administrative capacity, limiting states' ability to manage the program or pursue other Medicaid program priorities.

This recommendation does not preclude states' ability to pursue home- and community-based programs under Section 1115 waiver authority. Rather, there are distinct features of each waiver authority that allow states to pursue different policy goals. For example, states may view the application process for Section 1915 waivers as more predictable given the 90-day time frame for CMS response. On the other hand, states may seek Section 1115 authority to finance other program changes. This recommendation maintains both waiver options to preserve states' flexibility to design programs that address the needs of their beneficiaries.

Implications

Federal spending. The Congressional Budget Office has estimated that this recommendation will not affect federal Medicaid spending.

States. This recommendation would simplify waiver administration and reduce administrative burden of renewal applications for states that operate concurrent Section 1915(b) and Section 1915(c) waivers.

Enrollees. Simplifying the application process could create incentive for some states to pursue home- and community-based programs. However, it is more likely that permitting states to waive freedom of choice and selective contracting under Section 1915(c) waivers would not have a direct effect on Medicaid enrollees. Moreover, this recommendation calls for CMS to consolidate all program rules without reducing or eliminating assurances of access and quality made under each authority.

Plans and providers. Permitting states to waive freedom of choice and selective contracting under Section 1915(c) waivers would not have a direct effect on Medicaid managed care plans or health care providers.

Endnotes

[1] This chapter focuses on authorities used to mandate managed care enrollment for Medicaid beneficiaries. States can implement a voluntary managed care program under a Section 1915(a) waiver by executing a contract with companies that the state has procured using a competitive procurement process. These voluntary managed care programs under Section 1915(a) waivers are beyond the scope of this chapter and its recommendations.

[2] CMS has indicated that it plans to review the Section 1115 waiver application process to reduce the administrative burden for states. Specifically, CMS plans to revise and simplify the application template, work with states to develop a timeline for the approval process, and apply several strategies for each waiver's special terms and conditions (CMS 2017a).

[3] Some waivers may be extended for periods of 10 years. CMS indicated that it will approve routine, successful, non-complex Section 1115(a) waiver extensions for up to 10 years (CMS 2017a). In December 2017, CMS approved the Mississippi family planning waiver for 10 years (CMS 2017c).

[4] For this paper, a comprehensive managed care program is defined as an arrangement in which a state contracts with a managed care plan to provide all acute, primary, and specialty medical services, and plans that cover long-term services and supports are included under this definition.

[5] States use Section 1915(b) waivers to create a specialized or targeted program. Some states seek waivers to provide a certain benefit or array of services to beneficiaries through a state-developed network of specialty providers because no other network exists, or through selective contracting. For example, Colorado and California contract with behavioral health organizations to provide behavioral and mental health services to beneficiaries across each state (CMS 2015b, 2015c). In Alabama, the state contracts with 14 administrative entities throughout the state to provide maternity services to beneficiaries (CMS 2015d). In other circumstances, states selectively contract with an organization because there is only one option with which to contract. As of December 1, 2017, 22 states have 33 approved Section 1915(b) waivers that allow states to operate specialized programs.

[6] Section 2601 of the Patient Protection and Affordable Care Act (P.L. 111-148, as amended) authorized CMS to approve Section 1915(b) waivers that include individuals dually eligible for Medicaid and Medicare for up to five years. This provision aligned waivers' approval periods with the approval periods available under demonstrations and initiatives implemented by the Federal Coordinated Health Care Office at CMS.

[7] The three states without a Section 1915(c) waiver (Arizona, Rhode Island, and Vermont) use their Section 1115 waivers to accomplish the same goals. Some states have implemented separate waivers for different populations under both authorities.

[8] States can establish HCBS programs under other Medicaid authorities as well. For example, two states (Kansas and New Jersey) use Section 1115 waiver authority in conjunction with Section 1915(c) waivers.

[9] In this chapter, children eligible for Medicaid on the basis of involvement with the child welfare system are defined as children receiving foster care or adoption assistance under Part E of Title IV of the Act, and children in foster care or otherwise in an out-of-home placement.

[10] For example, compare Illinois, which uses Section 1932 state plan authority and a Section 1915(b) waiver to implement an MLTSS program, with New Jersey, which uses a Section 1115 waiver to implement an MLTSS program.

[11] Choice counseling is a service for Medicaid beneficiaries that provides them with unbiased information about their options for managed care plans and providers and answers related questions.

[12] Section 1115 waivers generally require quarterly and annual reporting, including monitoring calls with CMS. These requirements are outlined in the STCs of each waiver. Reporting requirements for Section 1915(b) waivers and Section 1932 state plan authority vary in terms of timelines and reporting formats, but content is the same as outlined in statute and regulations.

[13] Different types of dually eligible beneficiaries receive different levels of Medicaid assistance. Partial benefit dually eligible beneficiaries qualify for Medicaid under mandatory pathways referred to as Medicare Savings Programs (MSPs), and receive assistance with payment of both Medicare premiums and cost sharing. People who qualify for the full range of services offered by state Medicaid programs under separate non-MSP pathways are referred to as full-benefit dually eligible beneficiaries.

[14] Some states seek Section 1915(b) waiver authority to selectively contract with prepaid inpatient health plans, prepaid ambulatory health plans, or other entities in order to establish a limited benefit plan.

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Commission Vote on Recommendations

In its authorizing language in the Social Security Act (42 U.S.C. 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendations included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendations on streamlining Medicaid managed care authorities. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on Recommendation 1.1 on January 26, 2018. The Commission voted on Recommendation 1.2 and Recommendation 1.3 on December 14, 2017.

Streamlining Medicaid Managed Care Authority

1.1 Congress should amend Section 1932(a)(2) to allow states to require all beneficiaries to enroll in Medicaid managed care programs under state plan authority.

Yes:	Burwell, Carter, Cerise, Cruz, Douglas, George, Gordon, Gorton, Milligan, Szilagyi, Thompson, Weil
Abstain:	Gold, Scanlon
Not Present:	Davis, Lampkin, Retchin

12	Yes
2	Abstain
3	Not Present

1.2 Congress should extend approval and renewal periods for all Section 1915(b) waivers from two to five years.

Yes:	Burwell, Carter, Cerise, Davis, Douglas, George, Gold, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil
Not Present:	Cruz

16	Yes
1	Not Present

1.3 Congress should revise Section 1915(c) waiver authority to permit Section 1915(c) waivers to waive freedom of choice and selective contracting.

Yes:	Burwell, Carter, Cerise, Davis, Douglas, George, Gold, Gordon, Gorton, Lampkin, Milligan, Retchin, Scanlon, Szilagyi, Thompson, Weil
Not Present:	Cruz

16	Yes
1	Not Present