Managed Care and Home- and Community-Based Services

January 26, 2022

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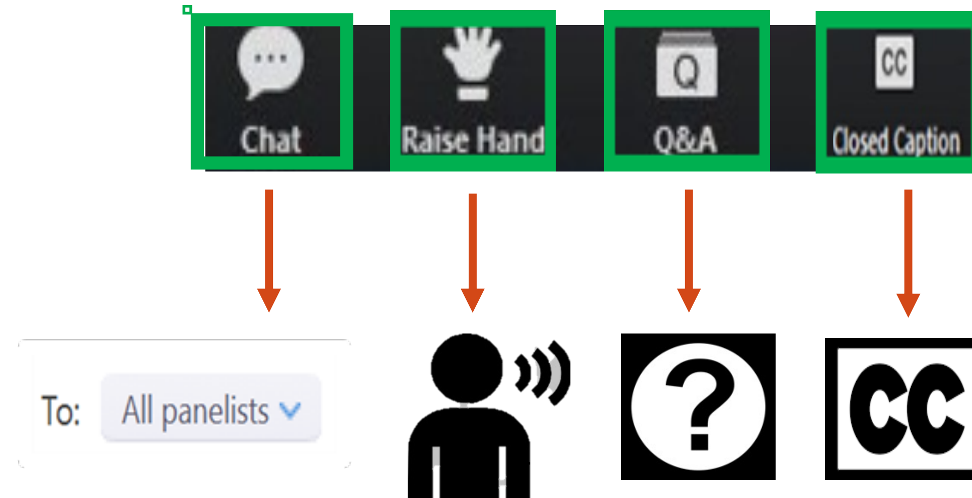

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Managed Care and
Home- and Community-
Based Services

Agenda and Objectives

- Describe Oneida Nation's journey from providing home- and community-based services (HCBS) based on a fee-for-service model to providing those services based on a managed-care model
- Summarize how 1915(b) waivers differ from 1915(c) waivers
- Identify unique problems with 1915(b) waivers that must be resolved during the transition from 1915© waivers
- Suggest strategies to ease the move into a 1915(b) environment

Beginning of HCBS

- In 1981, former President Ronald Reagan signed Public Law 97-35
  - Section 2176 of PL 97-35 established section 1915(c) of the Security Act (the Act), the Medicaid HCBS Waiver program
- Previously, Medicaid long-term care benefits were limited to:
  - Home health and personal care services
  - Institutional facilities (hospitals, nursing facilities, intermediate care facilities for persons with mental retardation)
- The HCBS legislation provided a way for states, for the first time, to offer additional services not otherwise available through their Medicaid programs to serve people in their own homes and communities, instead of institutions

HCBS in Wisconsin

- Since the early 1980s, Wisconsin had operated a 1915(c) HCBS program, known as the Community Options Program (COP), which was based on fee for service
- In the early- and mid-2010s, Wisconsin began to transition to managed care, operating as a 1915(b) waiver
- COP was phased out as of June 30, 2018, and Wisconsin transitioned into a managed-care program called Family Care

Oneida Nation

- Oneida Nation had operated COP since the early 1990s
- Based on fee for service
- Very concerned that the tribe was going to lose control of our services as a result of the move into managed care under 1915(b)
- Realized the importance of controlling case management services

1915 Waivers

States can waive certain Medicaid program requirements under HCBS waivers, including:

- **Statewideness** (Section 1902(a)(1))
  - Lets states target waivers to areas of the state where the need is greatest or where certain types of providers are available
- **Comparability of services** (Section 1902(a)(10)(b))
  - Lets states make waiver services available only to certain groups of people who are at risk of institutionalization
  - For example, states can use this authority to target services to elders, technology-dependent children, people with behavioral conditions, or people with intellectual disabilities, or on the basis of disease or condition, such as HIV/AIDS
- **Income and resource rules applicable in the community** (Section 1902(a)(10)(c)(i)(III))
  - Lets states provide Medicaid to people who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent
  - States can also use spousal impoverishment rules to determine financial eligibility for waiver services

1915(b) Authorities

- **Section 1915(b)(1): Mandated enrollment into managed care**
- Section 1915(b)(2): Central broker
- Section 1915(b)(3): Employ cost savings to furnish additional services
- **Section 1915(b)(4): Limit number and/or type of providers**

Tribal Members' Rights as Individuals

vs.

The Tribe's Rights as a Health Care Provider

- Under a 1915(b)(1) waiver, the individual can be forced to join a managed-care organization (MCO) if they want services
- The tribe does not lose its right to provide services without contracting to an MCO under 1915(b)(4) waivers

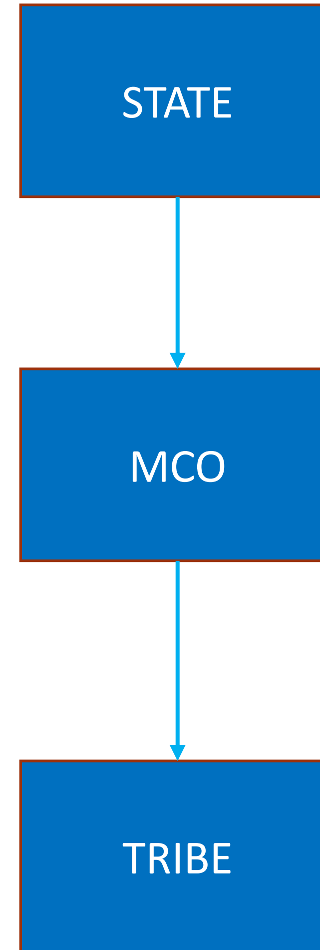
Tribal Options under 1915(b)

1. The MCO provides and controls all services without any tribal participation or involvement
2. Tribe creates its own MCO
3. The MCO provides and controls all services with tribal services being provided as a subcontracted service to the MCO
4. Negotiated agreement where the tribe has the option to control services

Typical Capitated System Relationships (under 1915(b) Waiver)

- Direct relationship between the state and the MCO
- The tribe has a contractual relationship with the MCO
- The tribe is a subcontractor of the MCO
  - This puts the MCO in control of all decision making, to include case-management functions
- This eliminates the government-to-government relationship

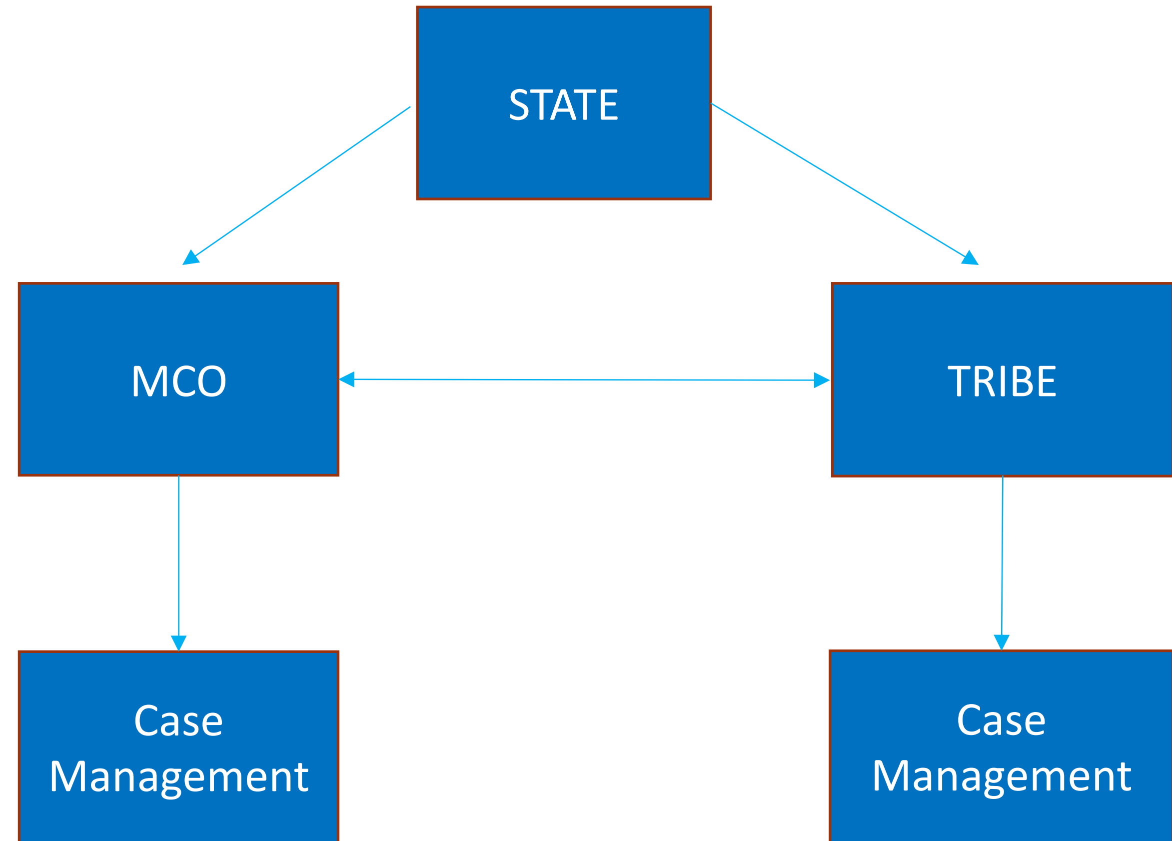
Typical Current Relationship



New Capitated System Relationships

- Direct relationship between the state and the MCO
- Direct relationship between the state and tribal health facility
  - This maintains the government-to-government relationship
- The tribe is not subordinated to the MCO
- An **AGREEMENT/Contract** relationship exists between the tribe and MCO
- The **AGREEMENT/Contract** defines how day to day operations work to include payment from the MCO and wraparound from the state

New Relationship



The Importance of Case/Care Management

- Case management is vital
  - Determines what services are authorized
  - How those services are provided
- If the tribe provides case management as a subcontractor, the MCO controls these functions
- If the tribe provides case management as a separate entity, the tribe controls these functions

MCO and State Concerns

- MCO is legally liable (enrolled member)
- Since the tribe will have control over some operations, how is liability addressed? Who has liability for what?
- MCO must be made whole financially

Need to Negotiate Jointly with State and MCO

- Information exchange between tribe and MCO
- Rate setting
- Billing/payment

What Rates Do You Get Paid?

- IHS has authorized but not funded LTSS
- Not a Medicare service
- Not a federally qualified health center (FQHC) service
- There is no federal payment level for LTSS
- Rates must be negotiated

Billing and Payment

Who Pays for Services Rendered?

- State pays the entire bill
- MCO pays initial bill, and the state pays wraparound
- MCO pays the entire bill to include wraparound

Is a Cost Report Required?

- It depends largely on what you can negotiate
- Depends, to a lesser extent, on method of payment
  - State pays the entire bill
  - MCO pays the entire bill
  - MCO pays initial bill, and the state pays wraparound
  - Is the health center an FQHC?

Problems We Encountered

State/Tribal Relationship

- State/tribal relationship and meaningful consultation

Communication

- Must be clear and concise
- Use a common lexicon/glossary

Education

- State staff may not know
- Tribal staff may not know
- MCOs may not know
- Staff turnover need to reeducate staff

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