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Medicaid Managed Care and the Rural Exception: A Review of Issues and Perspectives from the Field

Key Points:

- Nearly all states use managed care organizations (MCOs) to control costs and improve delivery of care for Medicaid beneficiaries. Making beneficiary enrollment in managed care mandatory, rather than optional, requires a waiver from Centers for Medicare & Medicaid Services (CMS). Regulations associated with the waiver process require that all beneficiaries have a choice of at least two MCOs. States may elect to seek a “rural exception” to the MCO choice requirement.
- State Offices of Rural Health (SORHs) reported participating in the decision process through stakeholder meetings.

INTRODUCTION

Over the past 20 years, states have increasingly used a managed care approach to control costs and improve delivery of care for Medicaid programs, with only Alaska and Wyoming retaining a fully fee-for-service Medicaid system. As of 2014, the most recent year for which data are available from the Centers for Medicare and Medicaid Services (CMS), 55.2 million Medicaid enrollees, or 77% of the 71.7 million total Medicaid population, were enrolled in some form of managed care.[1] A total of 43.4 million individuals, or 61% of the total, were enrolled in comprehensive managed care, i.e., care covering the spectrum of acute, primary, and specialty medical care through managed care organizations (MCOs). “Managed care” can also refer to primary care case management (PCCM), an arrangement in which primary care providers contract to serve as medical homes, coordinating beneficiaries’ care. The proportion of Medicaid enrollees in MCO versus PCCM arrangements varies by state, as does the total proportion of the Medicaid population covered by either or both of these arrangements.[2]

“Managed care” can also refer to capitated or other risk-sharing arrangements for providing financial access to specialty services, such as behavioral health or long-term services and supports for the disabled. These services are frequently not included in comprehensive medical managed care but are characterized as “carved out” of relevant plan contracts. Depending on individual state arrangements, a beneficiary might be covered by one managed care plan for medical services and a second managed care plan for behavioral health care.

To move Medicaid enrollees from fee-for-service to a managed care system, states have three options: amending their state Medicaid plan (Section 1932(a)), seeking a Section 1115 waiver or seeking a Section 1915 (a), (b) or (c) waiver. [3]

- Section 1115 demonstration waivers allow states to experiment with differing ways of ensuring that Medicaid and CHIP populations receive comprehensive medical care. These waivers are generally used for the general Medicaid population, i.e., persons who qualify for Medicaid but do not have special medical needs. Demonstration projects must be budget neutral (that is, not requiring additional Federal spending) and are required to be evaluated for effectiveness.
- Section 1915 (a) waivers allow states to offer managed care as an *option* for enrollees. This type of waiver does not appear to be in wide use at present.
- Section 1915 (b) and (c) waivers are used when a state wishes to make managed care enrollment mandatory for certain populations, such as dual-eligible (Medicare and Medicaid) beneficiaries or individuals with specific high-need conditions. States often have several 1915 waivers, each addressing a distinct population or specialized service.

Regardless of mechanism, states must ensure that MCOs meet minimum requirements for the waived population. Two of these requirements particularly affect rural populations: plan choice requirements and access standards. To examine the intersection of state Medicaid procedures with rural populations, we conducted a review of Medicaid waivers current as of September, 2017. This was supplemented with calls to State Offices of Rural Health (SORHs), state Medicaid offices, and other relevant stakeholders in an attempt to understand the process of waiver development. Results are presented in the sections that follow.

Technical Notes

State Medicaid waiver applications were accessed using the Medicaid.gov website and were analyzed between October 2016 and September 2017. **Only approved managed care (1115 and 1915(b) type) waivers were reviewed.**

Figure 2. Federal Regulations Pertaining to Rural Medicaid Beneficiary Choice of Managed Care Plans**§ 438.52 Choice of MCOs, PIHPs, PAHPs, and PCCMs.**

- (a) General rule. Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.
- (b) Exception for rural area residents.
 - (1) Under any of the following programs and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single MCO, PIHP, PAHP, or PCCM system:
 - (i) A program authorized by a plan amendment under section 1932(a) of the Act.
 - (ii) A waiver under section 1115 of the Act.
 - (iii) A waiver under section 1915(b) of the Act.
 - (2) A State that elects the option provided under paragraph (b)(1) of this section, must permit the beneficiary—
 - (i) To choose from at least two physicians or case managers; and
 - (ii) To obtain services from any other provider under any of the following circumstances:
 - (A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, PAHP, or PCCM network.
 - (B) The provider is not part of the network but is the main source of a service to the beneficiary, provided that—
 - (1) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network as other network providers of that type.
 - (2) If the provider chooses not to join the network or does not meet the necessary qualification requirements to join, the enrollee will be transitioned to a participating provider within 60 days (after being given an opportunity to select a provider who participates).
 - (C) The only plan or provider available to the beneficiary does not, because of moral or religious objections, provide the service the enrollee seeks.
 - (D) The beneficiary’s primary care provider or other provider determines that the beneficiary needs related services that would subject the beneficiary to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.
 - (E) The State determines that other circumstances warrant out-of-network treatment.
 - (3) As used in this paragraph (b), “rural area” is any county designated as “micro,” “rural,” or “County with Extreme Access Considerations (CEAC)” in the Medicare Advantage Health Services Delivery (HSD) Reference file for the applicable calendar year.
- (c) *Exception for certain health insuring organizations (HIOs).* The State may limit beneficiaries to a single HIO if—
 - (1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and
 - (2) The beneficiary who enrolls in the HIO has a choice of at least two primary care providers within the entity.
- (d) *Limitations on changes between primary care providers.* For an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of this section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under § 438.56(c).

Medicaid Directors on the Waiver Development Process

We were able to interview Medicaid directors in 17 states to obtain their perspectives on why the rural exemption was used (2 states) or why it was not sought (15) for one of more of the state managed care waivers. Among both rural-exception and no-exception states, the rationale turned on two key factors: number of potential managed care enrollees and number of potential managed care providers.

One state that sought the rural exception reported doing so because its large rural areas are sparsely populated:

“...we would have a few hundred members within a large geographical area.... We did not have enough critical mass of membership to support ...two plans.”

Most states reported basing their decision on managed care provider availability. The second responding state that sought a rural exception did so to guard against a future possibility that MCOs might withdraw from rural areas. Several states reported that there was no need for them to seek a rural exception, noting statewide availability of two or more managed care plans. Representative comments included:

“...we felt there was service availability statewide and it’s a statewide program.”

“because [we have] five MCOs ...anyone in the state can select from any of those. They [the MCOs] have to provide that service throughout the state.”

“Beneficiaries across the state may currently choose between one of two statewide Medicaid managed care organizations.”

Two states reported that they had not sought the rural exception for enrollee choice of MCO plan but instead did not make enrollment mandatory for beneficiaries in counties in the state that did not offer at least two plans.

“We have very active managed care plans, we have five plans and they are in almost every county. ...We only have one county ... that is not mandatory managed care, which means they have the choice of at least two plans.”

“The current Managed Care program exists [only] in counties along [a specific geographic] corridor that are close to metropolitan areas.”

Role of State Offices of Rural Health in Waiver Development

State Medicaid agencies are not required to confer with SORHs as part of the waiver development process. SORHs differ in size and administrative structure and may thus vary in their ability to provide data or other resources to contribute to an understanding of the needs of rural Medicaid beneficiaries. Given that SORHs, even when relatively small, may be uniquely placed to voice rural concerns, we inquired about SORH involvement when interviewing state contacts. Key findings are reported below. As noted earlier, given the small proportion of states interviewed, findings must be interpreted with caution.

Most SORH respondents noted that their state Medicaid agency convened multiple stakeholders through in-person sessions or review of proposed documents; SORHs were included in this group.

“They did have a series of public meetings as they were examining the final details of their adjusted 1115 waiver. I was included in the ... broad invitation list...[for] those stakeholder meetings that occurred across the state”

“I know we did have rural leaders at the table during these discussions, however, and I also participated in ... these two waiver processes and learning about them.”

“... what we do as the state office is we’ll comment back on ... whatever the state puts out in terms of options and weigh in with the rural point of view.”

One state Medicaid official did specifically report working with the SORH in one aspect of the waiver process:

“We certainly work with the office of rural health, but because we were taking that statewide approach we didn’t [involve the SORH] other than ... thinking through network adequacy standards.”

Some SORH contacts reported no input into discussions regarding beneficiary choice waivers. In some cases, interagency relationships in general may be somewhat strained. We were not able to ascertain how the needs of rural populations and providers were addressed in the situations described below.

“We were not involved in those decision making processes.”

“...we have very minimal interaction with our state department of human services ...we have not been asked to participate on any of their advisory committees, any groups that they’ve worked with ... it’s ... a difficult organization for us to access even when we have questions for them for instance regarding payments to rural health clinics and such.”

“...that [waiver] is all a political thing that is run through our state Medicaid office. Our rural health, primary care and rural health programs have no say and no input into that.”

Access Standards for Managed Care Organizations

“Access standards” for Medicaid MCOs cover a number of concepts, from the ratio of providers to beneficiaries through travel time. Under a CMS policy issued in 2016, all states must have access standards by the state fiscal year beginning on or after July 1, 2018.[3] At present, access standards for MCOs can address wait times before appointments, number of providers per enrollee, and travel/distance, at the discretion of individual states.

Based on data assembled by the Kaiser Family Foundation, as of 2013 no states had proposed standards for wait times for appointments or maximum enrollees per primary care provider that differentiated between rural and urban enrollees. Thirty-three (33) states had travel distance standards for primary care providers within a plan’s network; of these, 15 states had different standards for rural versus urban beneficiaries.[4] The 15 states with differing distance standards are not concentrated in a single area of the U.S., nor are they states with a high concentration of rural residents.

For urban populations, distance standards ranged from 6 miles (New Jersey) to 30 miles (several states); for rural populations, distance standards ranged from 15 miles (New Jersey) to 60 miles. Of note, two states (Nebraska and New Mexico) distinguished between rural (45 miles) and frontier (60 miles) areas.

Fewer states (16) had any time or distance standards for access to specialty care; of those, 5 set higher distance criteria for rural than for urban residents. CMS has not defined any travel maximums as part of these standards, although states must justify the “reasonableness” of their criteria.

CONCLUSIONS

The details of Medicaid administration vary from state to state; this variation is anticipated to increase with new flexibility provided by CMS (e.g., the addition of work requirements).[5] Based on interviews with 40 observers across 28 states, Medicaid agencies have previously solicited input from multiple stakeholders when developing current managed care requirements, including SORHs as well as provider groups. After waivers take effect, CMS rules require annual reports on spending and enrollment, and “periodic” evaluation of waiver outcomes.[6] These documents can be used by rural health advocates to ensure that rural beneficiaries benefit to the same extent as their urban counterparts from new funding arrangements.

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