NORC Medicaid Managed Care Organization (MCO) Learning Hub

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Medicaid MCO Authorities and Strategies for MCO Engagement

NORC at the University of Chicago
Speire Healthcare Strategies, LLC

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Medicaid MCO Learning Hub Partners

- **NORC is leading the project along with partner Speire Healthcare Strategies LLC**
- **Key Partners**
  - America's Health Insurance Plans
  - Association for Community Affiliated Plans
  - Community Catalyst
  - Families USA

Webinar Logistics

- All attendees will remain on listen-only mode
- Please send any questions for presenters using the chat box at the bottom – we'll have two Q&A breaks
- The slides can be accessed on our website here: https://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

John McCarthy

- Medicaid Director – Ohio 2011-2016
- Medicaid Director – DC Medicaid 2009-2010
- Policy Director, DC Medicaid 2006-2008
- Former NAMD Vice President
- Medicaid Consultant 1996-2006

Medicaid Managed Care Four Part Series

- Overview of Medicaid Managed Care
- Medicaid Managed Care Financing
- **Introduction to Medicaid Authorities**
- Strategies for MCO Engagement

Managed Care Authorities

Why Authorities are Important

- They provide the parameters on how a state can implement managed care
- They enable states to design unique programs
- States can use several different types of managed care to deliver services
- Not all managed care is health care services
- Not all managed care is risk bearing
- It is important to understand what a state can and cannot do under the laws and rules

Medicaid Managed Care Defined

CMS provides the definitions and parameters for state Medicaid managed care programs to be created and operationalized[1]

- Managed Care is a health care delivery system organized to manage cost, utilization, and quality.
- Managed care enables the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs)
- MCOs accept a set per member per month (capitation) payment for services provided to beneficiaries.
- Through MCO contracts states can potentially reduce Medicaid program costs and better manage utilization of health services.
- Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

[1]https://www.medicaid.gov/medicaid/managed-care/index.html

Medicaid Managed Care Authorities

States may implement a managed care delivery system using three types of federal authorities outlined in the Social Security Act:

- State plan authority - Section 1932(a)
- Waiver authority - Section 1915 (a) and (b)
- Waiver authority - Section 1115

Medicaid Managed Care Rules

CMS rules on managed care (Section 42 CFR 438), which have been recently revised:

- Define the program, participating organizations, functions, types of contracts, and financial requirements
- Provide guidance to states and MCOs on operating a managed care program.
- Serve as the basis for how states can implement managed care in their state

Medicaid Managed Care Rules – Key Definitions

Organizations

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract and is:

(1) A Federally qualified HMO that meets the advance directives requirements; or

(2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

(ii) Meets the solvency standards.

Medicaid Managed Care Rules – Key Definitions *(continued)*

Organizations *(continued)*

Prepaid ambulatory health plan (PAHP) means an entity that—

(1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP) means an entity that—

(1) Provides services to enrollees under contract with the State, and on the basis of capitation payments, or other payment arrangements that do not use State plan payment rates.

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

Medicaid Managed Care Rules – Key Definitions *(continued)*

Organizations *(continued)*

Health insuring organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries—

(1) Through payments to, or arrangements with, providers;

(2) Under a comprehensive risk contract with the State; and

(3) Meets the following criteria—

(i) First became operational prior to January 1, 1986; or

(ii) Is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985.

Medicaid Managed Care Rules – Key Definitions *(continued)*

Organizations *(continued)*

Primary care case management means a system under which:

(1) A primary care case manager (PCCM) contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries; or

(2) A PCCM entity contracts with the State to provide a defined set of functions.

Primary care case management entity (PCCM entity) means an organization that provides any of the following functions, in addition to primary care case management services, for the State:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.

(4) Provision of payments to FFS providers on behalf of the State.

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports systems/providers.

Medicaid Managed Care Rules – Key Definitions *(continued)*

Contract Types

Comprehensive risk contract means a risk contract between the State and an MCO that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

(1) Outpatient hospital services.

(2) Rural health clinic services.

(3) Federally Qualified Health Center (FQHC) services.

(4) Other laboratory and X-ray services.

(5) Nursing facility (NF) services.

(6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.

(7) Family planning services.

(8) Physician services.

(9) Home health services.

Nonrisk contract means a contract between the State and a PIHP or PAHP under which the contractor:

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits; and

(2) May be reimbursed by the State at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

Risk contract means a contract between the State a plan under which the contractor:

(1) Assumes risk for the cost of the services covered under the contract; and

(2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Medicaid Managed Care Rules – Key Definitions *(continued)*

Financial Provisions

- *Actuary* means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

- *Capitation payment* means a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Medicaid Managed Care Rules – Key Definitions *(continued)*

Actuarial Soundness

Capitation rates for plans must be reviewed and approved by CMS as actuarially sound. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the plan for the time period and the population covered under the terms of the contract. To be approved by CMS, capitation rates must:

- Have been developed in accordance with standards specified in rules and generally accepted actuarial principles and practices.
  - Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- Be appropriate for the populations to be covered and the services to be furnished under the contract.
- Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs.
- Be specific to payments for each rate cell under the contract.
- Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- Be certified by an actuary as meeting the applicable requirements of the rule.
- Meet any applicable special contract provisions.
- Be provided to CMS in a format and within a timeframe that meets requirements in the rule.
- Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard of at least 85 percent for the rate year.
  - They can be developed in such a way that plan would reasonably achieve a medical loss ratio standard greater than 85 percent as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

QUESTIONS?

Medicaid Managed Care Four Part Series

- Overview of Medicaid Managed Care
- Medicaid Managed Care Financing
- Introduction to Medicaid Authorities
- **Strategies for MCO Engagement**

Presenters

Tom Betlach

- Medicaid Director - AZ 2009-2019
- Medicaid Deputy Director 2002-2009
- AZ State Budget Director 1997-2002
- Former NAMD President & Vice President
- CBO Panel of Health Advisors

Session Focus

From the perspective of Medicaid agency leadership, the session focuses on:

- Shared goals of community-based organizations, states and the managed care organizations
- Effective strategies for community-based organizations to engage with states and managed care organizations

Serving the Community

CBOs in the Community

Community Based Organizations (CBOs) are uniquely positioned in communities to drive partnerships

- CBOs are embedded in the communities they serve directly engaging with Medicaid beneficiaries
- CBOs provide a range of services that meet many social determinants of health (SDOH) needs (e.g., housing, food, transportation, etc.)
- Many CBOs are equipped to meet the complex needs of the high-risk population they serve

Setting the Goals for Engagement

Partnerships between CBOs, states and managed care organizations are critical to serving beneficiaries' needs

- Identify the needs in the community that may be addressed through a collaboration with the state and Medicaid MCOs
- Determine the direct value to the beneficiary that can be derived through partnerships with MCOs
- Develop clear desired outcomes (e.g., greater capacity, improved access, broader services) for each targeted engagement
- Identify the opportunities/levers state leaders have
- Identify the various funding opportunities that may exist

MCO Engagement

State Priorities

Understanding a state's Medicaid landscape is critical for partnerships/contracts with Medicaid MCOs

- Each state has unique program priorities and regulatory environments
- Each state has different budgetary constraints
- Medicaid populations vary state to state
- Understanding the state's priorities and environment can better position you for potential engagement

Learning the landscape

Publicly available data can provide the state landscape

- Medicaid agency strategic plans (usually on the agency website)
- A state's MCO contracts lay out expectations of the MCOs, but may be difficult to identify because they are written into dense sets of requirements
- Request for proposals detail expectations states have for MCOs, including specific services
- Some states provide information in public meetings such as State Medicaid Advisory Committees
- Medicaid Director presentations at various venues are saved on state Medicaid websites

Understanding the State

Medicaid managed care programs are *NOT* homogeneous across states, know the landscape

- Do pre work to understand what services are included in or carved out of managed care, for example:
  - Mental health, substance abuse disorder services, or long-term services and supports may or may not be included.
  - Certain populations may be carved in or out
- Do not go into a meeting with the state or an MCO to pitch your post-acute care coordination program when the MCO only serves parent/care takers and babies in managed care

Getting Your Foot in the Door

- Meet with the Medicaid Director
  - Many Medicaid Directors meet frequently with vendors, CBOs, providers
  - If there is not an avenue into MCOs, ask for a brokered introduction to foster plan relationship
  - Never ask for a requirement that the MCOs must contract with your organization
    - Better approach is requesting your service or idea become a requirement in the contract or RFP and then compete for that work

Getting Your Foot in the Door *(continued)*

- Align your idea with the Medicaid agency's priorities
  - Develop value proposition, needs to be more than saving money
  - Convince MCO that your idea aligns with priorities
- Meet with MCO leadership
  - Work to get a meeting with decision makers
  - Use relationships with key provider partners who often have avenue to direct dialogue with MCOs
- Bring data that shows a clear return on investment (ROI)
  - Compile data from MCO's market first, but data from other markets is acceptable
  - Use largest possible data set (e.g., number of people), savings on 12 people is not as convincing as savings on 120 people or better 1,200 people
  - Cite objective analysis, gold standard is an ROI analysis from a third party that you did not pay to do the analysis

Potential Financing Approaches

Understanding Potential Funding Streams

- States may have established several different funding streams that CBOs may want to explore with MCOs
- Community Reinvestment – Some states require that MCOs reinvest a portion of profits into the community
- Administration – Some MCOs may be willing to invest limited administration dollars if there is the opportunity to generate a ROI
- 1115 waivers have resulted in a limited number of states receiving federal dollars to address SDOH through CBOs
- Foundations – Many MCOs have foundations that contribute resources to community efforts
- Service Dollars – while there are many challenges to transition to a Medicaid provider, areas like Long Term Services and Supports and Behavioral Health have broader definitions of services than traditional acute care
- Reserves – This is a challenging funding stream to leverage but there are examples where reserve dollars have been used in partnership with CBOs to address SDOH

Engagement on Value Based Payments (VBP)

- States are increasing expectations on MCOs to move from fee-for-service to value-based payments (VBP)
- VBP often provides additional flexibility for providers to address broader issues
- CBOs may be able to partner with MCOs and providers to bring value by addressing broader needs through these new payment model
- MCOs are often looking for VBP models that can be implemented to scale

Leveraging Dual Special Needs Plans

- More states are developing delivery system models that try to address the fragmentation of service delivery that dual eligible members face
- Many states have started requiring Medicaid MCOs to offer Medicare Dual Special Needs Plan (D-SNP)
- This would be a requirement in the Medicaid MCO contract and/or separate agreements states must have with D-SNPs
- Medicare offers another stream of funding that MCOs have available to serve certain populations
- Medicare is providing some greater flexibility on what this funding can be used for to address SDOH
- Additional information on the types of supplemental benefits can be found here in a resource from Avalere *https://avalere.com/insights/ma-enrollees-can-access-covid-19-supplemental-benefits-in-2021*

QUESTIONS?

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Webinars & Website

For more information about the Medicaid MCO Learning Hub, including accessing slides and presentation recordings from this webinar, please visit our website: https://www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

Past Webinar: **Introduction to Medicaid MCO Authorities and Strategies for MCO Partnerships**

- Slides, webinar recording, and Q&A from the first half of this webinar series, presented on 11/19/2020, can also be found on our website

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