HUB ANALYSIS   December 2020

Medicaid Managed Care Organization (MCO) Overview and Financing Webinar: *Questions & Answers*

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The NORC Medicaid Managed Care Organization (MCO) Learning Hub shares timely and relevant resources to support Medicaid MCOs and other stakeholders in improving the health of their members and increasing advancements in health equity and health care transformation. We encourage you to share your experiences with us and welcome your feedback on future MCO Learning Hub work to better serve your needs. To start the conversation or join our distribution list, please email us at MCOLearningHub@norc.org.

Through our early discussions with various organizations, we have learned that, among some stakeholders, there is an interest in learning more about the basics of the Medicaid program and Medicaid managed care. This first webinar provided an overview of Medicaid managed care, including the use of Medicaid managed care across states and state contracting strategies, as well as cost growth, rate setting and the use of managed care reserves. The following are questions and answers from this first webinar series.

The second webinar in this series covered Medicaid managed care federal authorities, and how these authorities are both defined and used by managed care plans, as well as promising approaches and strategies for community-based organizations to partner with Medicaid managed care plans. The webinar took place on Thursday, December 3rd at 3pm EST and the slides, recording, and Q&A can be found on the Medicaid MCO Learning Hub's website.

Questions & Answers

Please see below for questions and answers from the Medicaid MCO Overview and Financing webinar.

General Q&A

What age is considered aged vs. newly eligible adults?

Generally, individuals are considered in the "aged" or "elderly" category when they are 65 or older and could potentially meet Medicare eligibility.

Newly eligible adults usually refers to the new eligibility group in the ACA that expanded eligibility to individuals age 19 to 64 who do not have children age 17 or younger. There are people within this group who may have qualified for Medicaid previous to the ACA under one of the disability categories.

Managed Care vs. Fee-for-Service

What are the main differences between Managed Care and Fee-for-Service (FFS)?

State Medicaid programs have different ways in which their members can receive Medicaid services:

1. Fee-for-Service (FFS) – In this model, members can access Medicaid services from any provider accepting new Medicaid patients and the provider receives payment directly from the state. The state sets FFS payment rates for the various providers based on the level of services rendered to members.

2. Managed Care – The state contracts with health plans that offer health education and care management services to help members navigate the health care system and coordinate their needs. Members in Managed Care can only receive care from providers contracted by the health plan they are enrolled in. The state reimburses health plans based on a capitated, fixed amount per member per month, for a predetermined set of services.

States have the authority to select which services are delivered through Managed Care vs. FFS and usually there are certain services that are carved-out of Managed Care.

What type of populations are usually enrolled in Managed Care?

Most state Medicaid agencies currently deliver care through managed care organizations (MCOs) for some or most of their Medicaid populations; each state is different and makes decisions about populations or benefits covered through Managed Care based on their specific circumstances.

 "The majority of Medicaid enrollees, largely non-disabled children and adults under age 65, are in managed care plans, but just over half of Medicaid benefit spending is in managed care. The enrollment of high-cost populations, such as people with disabilities, in managed care has been more limited than for lower-cost populations. In addition, coverage of certain high-cost services (e.g., nursing home and other long-term services and supports) may be excluded from managed care contracts, although such arrangements are growing in number." [1]

MCOs & States

Why would a state want to operate their Medicaid program under an MCO?

There are many reasons why a state would want to operate their Medicaid program under Managed Care:

a) More flexibility in service delivery and more administrative capabilities - Managed Care has greater flexibility in service delivery than FFS including a more robust network of providers that serve Medicaid members and more capabilities in the administration of Medicaid services including better technology to engage with members and providers.

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[1] https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/#:~:text=Under%20the%20FFS%20model%2C%20the,person%20enrolled%20in%20the%20plan.&text=However%2C%20the%20majority%20of%20Medicaid%20spending%20still%20occurs%20under%20FFS%20arrangements.

b) Opportunities for more enhanced member engagement - Managed care also offers different mechanisms to engage with Medicaid members through targeted outreach, education, disease management, and care management programs to help members navigate the health care system and better manage their health.

c) More financial stability and cost containment- Another advantage of Managed Care is that it helps contain the financial risk associated with delivering services on FFS basis and to provide greater budget predictability to state Medicaid agencies.

d) Better alignment with state goals and objectives – Through Managed Care, the state Medicaid agency can coordinate the delivery of services with health plans and their providers to align them with the state goals and objectives like enhancing access to care or improving the quality of services.

e) Drive more value – Managed Care can help the state to drive more value in their Medicaid programs by containing costs and ensuring a high quality of services for members.

Why would a state not want to operate their Medicaid program under an MCO?

States may also decide to limit Managed Care in their Medicaid programs; the following states have a small to minimal Managed Care presence in Medicaid: Connecticut, Alaska, and Wyoming.

One reason a state may not use managed care is that there are not enough lives to spread risk. That is often the case in very small or rural states.

Another reason is that the state may conclude they have the resources to develop appropriate care management, disease management, and performance improvement programs to manage the care of the Medicaid population themselves rather than through a MCO. Connecticut for example delivers Medicaid services directly on a FFS basis and contracts with administrative services organizations to conduct basic functions previously conducted by health plans like case management, claims management, and member outreach and education.[2]

Another reason may be related to political push-back from certain stakeholder groups to moving to managed care. For example, while managed care is more generally accepted for acute care, in some states there is less agreement to move to managed care for long-term services and supports.

Which states require MCOs to use a specific tool to conduct care planning? Which states set minimum standards and definitions for "care coordinators" and member "care plans"? How can one find out which tools are used?

Per section 42 CFR 438.208 of the federal Medicaid Managed Care rule, Medicaid MCOs are required to (1) ensure that each enrollee has an ongoing source of care and a person or entity designated as primarily responsible for coordinating the services accessed by the enrollee; (2) coordinate the services the MCO furnishes to the enrollee; (3) conduct an initial screening of each enrollee member within 90 days of enrollment; (4) share with the state and other MCOs the results of any identification and assessment of the member's needs. In addition, MCOs are required to complete an assessment of individuals with special health care needs and develop a treatment or service plan for these

2 https://www.cga.ct.gov/2015/rpt/pdf/2015-R-0010.pdf

individuals that is reviewed and updated at least annually. [3]

State Medicaid agencies have the authority to define their own care management standards and requirements for MCOs in order to meet these federal requirements while addressing the health care needs of Medicaid members. States can define who should conduct care coordination services as well as the elements or the tool MCOs must use when conducting care planning. These requirements are defined in the contracts between the State Medicaid agency and the MCO. The National Academy for State and Health Policy (NASHP) developed in 2013 an overview of different states' care management requirements for complex populations which may have evolved over time. [4] [5]

Depending on each state's contract requirements, MCOs may use their own proprietary care plan tool that complies with the regulations and requirements defined by the state Medicaid agency for the population they are serving. Additionally, care planning requirements are usually more stringent for the population receiving long-term care services and supports (LTSS) as this population have more health and care coordination needs.

As a result, care planning tools or questionnaires may look very different depending on the state, the population served, and the MCO serving Medicaid members.

With that said, there are some standard care plan templates or tools used by MCOs: AHRQ has developed its "whole-person transitional care

planning tool"[6] and Aging Care has guidelines to develop a care plan for the elderly. [7]

MCOs Rates & Payment

Is there information on share of MCO-provider contracts that are Fee-For-Service based vs. capitation-based, or even shifting toward value based payment? Perhaps nationally, or by state, and by type of health care service and provider?

Information on the share of MCO provider contracts that are FFS vs. capitated is usually considered proprietary by the health plans and it is difficult to obtain even at a state-specific level. Nationally, the Learning Action Network (LAN) determined that in 2018 "35.8% of US health care payments, representing approximately 226.5 million Americans and 77% of the covered population, flowed through Alternative Payment Models which accounted for 23.3% of Medicaid payments". [8]

Additionally, the Institute for Medicaid Innovation issued its second survey of Medicaid MCOs and found that "82% of health plans implemented value based purchasing arrangements with primary care providers, while very few established similar arrangements with behavioral health providers, dentists, home and community-based service providers and long-term care facilities". [9]

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[3] https://www.law.cornell.edu/cfr/text/42/438.208
[4] For an introduction to Medicaid care management best practices, check:
https://www.chcs.org/media/Introduction_to_Medicaid_Care_Management_013013.pdf
AHRQ also has issued guidance on how to design and implement Medicaid disease and care management programs:
https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/hcbs/medicaidmgmt/mm1.html
[5] https://www.nashp.org/policy-chronic-and-complex-populations-care-coordination/
[6] https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.ahrq.gov%2Fsites%2Fdefault%2Ffiles%2Fwysiwyg%2Fprofession
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[7] https://www.agingcare.com/Articles/how-to-create-a-care-plan-195526.htm
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[9] https://www.hcinnovationgroup.com/policy-value-based-care/medicare-medicaid/news/21106922/survey-medicaid-mcos-focus-valuebased-
purchasing-efforts-on-primary-care

Are capitated payments adjusted for the risk of the population or based on the comorbidities of patients in the MCO?

State Medicaid agencies adjust payment rates to Medicaid MCOs based on the risk of the population they serve, since some MCOs may serve members with greater health needs and incur higher costs, than other MCOs. While Medicaid agencies can and do use a variety of risk adjustment methods, states most commonly use the Chronic Illness and Disability Payment System (CDPS) methodology. CDPS is a risk-adjustment methodology specifically designed to take into account the profile and conditions of the Medicaid population. The CDPS adjustments are used by state Medicaid agencies at the health plan specific level to account for a higher number of disabled members or members with chronic conditions; the states then adjust the rates based on that member composition.[10]

What about rates? Many MCOs pay providers less than FFS.

Health plans typically negotiate reimbursement rates with providers and the rates are similar to the state Medicaid agency's fee-for-service (FFS) rates. Sometimes health plans pay higher rates than FFS to incentivize providers to join their network, especially for example, in areas where there is a shortage of providers. Sometimes state Medicaid agencies require health plans, through special contracting requirements, to pay providers at least at the FFS rates. In this case, MCOs cannot pay less than FFS; although if this requirement is absent, then MCOs could pay less than Medicaid FFS for a specific service.

It's also important to note that state Medicaid agencies are required to ensure Medicaid members receive adequate access to Medicaid covered services. For example, if a MCO pays dental providers less than FFS rates, fewer dentists may choose to be part of that MCO and those MCO members would likely experience issues accessing dental care. State Medicaid agencies regularly monitor complaints and grievances from managed care members to ensure they have adequate access to Medicaid services.

Can states set a floor for the rates MCOs pay providers to deliver care?

Per 42 CFR § 438.6 (c)(1)(iii)(A), state Medicaid agencies can "adopt a minimum fee schedule for network providers that provide a specific service under contract". States can set floors in terms of the rates MCOs pay to providers - for example a state can set a floor in terms of what MCOs pay to nursing facilities. The managed care rule does allow states to dictate a floor for reimbursement purposes. In Tennessee, for example, there is a floor and a ceiling that plans can pay hospitals. If a floor is put in place, the state has to ensure the MCO rates allow the plans to cover at least the "floor" rates.

Health Disparities and Social Determinants of Health (SDOH)

What role can managed care have in reducing health disparities?

As the entities delivering care to Medicaid members, MCOs play a significant role in reducing health disparities. State Medicaid agencies are introducing contract requirements and sometimes incentives and value based purchasing initiatives for MCOs to reduce health disparities. MCOs in turn are developing specific health disparity reduction programs with their providers in-network to meet

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[10] https://www.soa.org/globalassets/assets/files/e-business/pd/events/2019/health-meeting/pd-2019-06-health-session-077.pdf

these requirements. [11] [12] [13]

Health plans are increasingly implementing interventions to reduce health disparities particularly in the area of SDOH and largely focused on ensuring stable housing or reducing food insecurity. MMCO Learning Hub resources on MCO's role in combatting homelessness and food insecurity provide additional information and resources on these topics. There is a lot of work to be done at the state and the health plan levels to move the needle on health disparities, but we are gradually seeing more states and health plans moving in this direction.

Are there any current pilots or projects to point to as evidence of successful partnership between CBOs and MCOs to meet Medicaid member SDOH needs?

One example of a successful model is Circle the City, a non-profit, federally qualified health center (FQHC) focused on providing quality health care to people experiencing homelessness in Maricopa County, Arizona.

Circle the City works with eight different health plans; for example, UnitedHealthcare provided Circle the City with a three-year, million-dollar grant, from 2017-2019, to establish a standardized program model for medical respite care. A Centers for Medicare & Medicaid (CMS) study released in late 2017 found that respite care helps decrease ER visits and hospital admissions, which saves the health care system overall, and insurance plans specifically, a great deal of money. In addition, Circle the City case managers and UnitedHealth coordinators work together with housing entities to find housing for patients.

Circle the City also works with at least two health plans on a navigator program to intercept patients who are experiencing homelessness when they are ready to be discharged, assess their need for respite care, and present Circle the City services and the benefits of respite care. Circle the City's designation as an FQHC allows them, from a payment perspective, to charge for the work they do and receive reimbursement via the prospective payment system (PPS).

The MMCO Learning Hub will also soon be profiling other successful CBO and Medicaid managed care partnerships to meet Medicaid member SDOH needs.

Please describe how SDOH strategies are paid for and where or how they may evolve.

There are many ways in which SDOH strategies can be paid through Medicaid. State Medicaid agencies are increasingly including requirements in MCO contracts for health plans to develop strategies to address SDOH, which the state will then reimburse by paying health plans a higher administrative rate. A few states are also conducting risk-adjustment based on SDOH (as compared to risk-adjusting based on medical conditions) and then providing a higher reimbursement rate to MCOs that have populations with greater SDOH needs. More frequently state Medicaid agencies incentivize health plans to develop successful strategies to address SDOH issues through value based purchasing (VBP) arrangements. State Medicaid agencies usually define the requirements, identify SDOH measures and establish targets and incentives for health plans through risk-sharing mechanisms like shared savings and advanced payment methodology models.

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[11] https://www.shvs.org/wp-content/uploads/2020/06/SHVS-MCO-Contract-Language-Health-Disparities.pdf
[12] https://www.chcs.org/media/Addressing-SDOH-Medicaid-Contracts-1115-Demonstrations-121118.pdf
[13] https://www.nashp.org/wp-content/uploads/2018/08/Social-Determinants-of-Health-in-Medicaid-Contracts-plus-CT-12_6_2018.pdf

Moving forward, it is expected that more state Medicaid agencies will partner with MCOs and CBOs through VBP initiatives that share upside and downside risk with clearly defined SDOH measures and targets. The number of state Medicaid agencies risk-adjusting for SDOH is expected to continue to increase.

ABOUT NORC MEDICAID MCO LEARNING HUB

The key goal of the NORC Medicaid MCO Learning Hub is to serve as a source of information, expertise, and best practices to support managed care organizations in moving forward with system reform. NORC and its partner organizations identify, develop, and disseminate promising approaches and emerging opportunities for MCOs to improve the physical health, behavioral health, and social needs of their members.

Your ideas and opinions are important to us. We welcome your feedback on future Medicaid MCO Learning Hub work or programs you are working on to better serve your needs. To start the conversation, please contact the senior staff listed here:

www.norc.org/Research/Projects/Pages/medicaid-managed-care-organization-learning-hub.aspx

Acknowledgements

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