

Medicaid Authorities and Managed Care Organization (MCO) Engagement 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 Authorities and MCO Engagement webinar.

Medicaid Populations and Covered Services

How do you find out what the MCO carve outs are and what populations an MCO serves?

Each state has the authority to cover different populations and benefits through Managed Care. The Centers for Medicare and Medicaid Services (CMS) offers an overview of each state's Medicaid Managed Care program including populations and benefits covered on their website:

<https://www.medicaid.gov/medicaid/managed-care/profiles-program-features/index.html>

The Kaiser Family Foundation also offers an overview of the populations and benefits each state covers through Managed Care:

<https://www.kff.org/state-category/medicaid-chip/>

Medicaid Innovation

What states have been most innovative/outliers with their Medicaid model?

There is a lot of innovation happening in state Medicaid programs. A few innovative models are described below:

- Michigan – In 2015, Michigan received \$70 million from CMS' State Innovation Model initiative to test and implement a model of care centered around three core components:
 - "Population Health – It has Community Health Innovation Regions (CHIRs) that engage a broad range of stakeholders to identify and address factors that affect

resident's health such as housing, transportation, and food insecurity.

- Care Delivery – Encompasses a patient-centered medical home (PCMH) initiative and the promotion of alternative payment models which emphasize community linkages.
 - Technology – The state leverages its statewide infrastructure and related health information exchange initiatives to enable and support advances in population health and care delivery strategies".¹
- North Carolina – The state modified its Medicaid program to better identify and address social determinants of health (SDOH) needs through the following changes:
 - Created its own SDOH questionnaire to identify and assist members with unmet needs.
 - "Built a statewide resource platform, NCCARE360, to connect those with an identified need to community resources.
 - Incorporated SDOH strategies in its Medicaid 1115 waiver.
 - Developed the Healthy Opportunities pilot where CMS approved up to \$650 million to test the impact of providing SDOH interventions to high-need Medicaid members.
 - Supported the Community Health Worker (CHWs) Initiative where the CHW curriculum was standardized and a certification process was developed".²
 - New York – In 2014, CMS released \$99.9 million to support the implementation of

¹ https://www.michigan.gov/documents/mdhhs/SIM_Summary_Updated_October_2018_636963_7.pdf

² <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/about-healthy-opportunities>

NY's State Health Innovation Plan with three objectives:

- "80% of the population cared for under a value-based financial arrangement.
- 80% of the population receiving care within an Advanced Primary Care (APC) setting, with a systematic focus on prevention and coordinated behavioral health.
- Transparency over the cost and quality of care of the health care value chain, enabling informed choices".³

These objectives are achieved through the following initiatives:

- Formed NY's Medicaid Redesign Team responsible for identifying ways to serve Medicaid members more efficiently and effectively.
- The design and implementation of the NY Health Insurance Exchange.
- Improving the quality of primary care services to Medicaid members.
- Program elements and proposed investments in NY's waiver.
- Promote health at the community level through NY's Prevention Agenda, community schools and the Community Opportunity and Reinvestment initiative.
- Implement Electronic Health Records and put in place a statewide interoperable health information exchange and All-Payer Databases.
- Promote and implement value based insurance.⁴

- Oregon – Through an 1115 waiver, Oregon contracts with Coordinated Care Organizations (CCOs) which are given a fixed global budget to provide physical, oral, behavioral health and "health related services" to address social determinants of health for services not traditionally covered by Medicaid like housing.⁵

For additional information on state innovation across the country, CMS offers an overview of their State Innovation Models where they describe the different state opportunities they fund: <https://innovation.cms.gov/innovation-models/state-innovations>.

Can you give us a sense of how many states have community reinvestment opportunities or a few example states?

Several states have community reinvestment requirements. One example is the state of Arizona which serves individuals "with serious mental illness through Regional Behavioral Health Authorities that are required to reinvest 6% of their profits into the community. Some plans fund housing or food banks, while others fund competitive grant programs to finance community based organizations".⁶

Another example is Oregon with its Supporting Health for All through Reinvestment (SHARE) initiative which is geared towards SDOH investments like housing. During the first two years, CCOs allocate a portion of their profits from contract years 2020 and 2021 towards this initiative. The state of Oregon is in the process of developing a formula for each CCO to contribute to the SHARE fund in 2022.⁷

³ https://www.health.ny.gov/technology/innovation_plan_initiative/docs/executive_summary.pdf

⁴ Ibid.

⁵ https://www.michigan.gov/documents/mdhhs/SIM_Summary_Updated_October_2018_636963_7.pdf

⁶ <https://www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review>

⁷ <https://www.oregon.gov/oha/HPA/dsi-tc/Documents/SHARE-Initiative-Guidance-Document.pdf>

NY State which has its Community, Opportunity, Reinvestment (CORe) initiative designed as “a neighborhood-based community change model to address disparities in employment, public safety, education, health, and housing. CORe has three goals:

1. Align programs, policies, and funding across government organizations – both vertically (state-to-local) and horizontally (across state agencies) – to improve community outcomes.
2. Target efforts and investments at specific neighborhoods and outcomes.
3. Evaluate interventions and results.

CORe currently operates in two pilots: Albany and Newburgh⁸.

Medicaid Authorities

In a recent State Medicaid Director letter, CMS seemed to be discouraging the use of 1115 waivers to establish their various managed care programs, but rather to use the flexibilities of 1915(b) waivers. What is the reasoning behind this?

CMS has been discouraging the use of 1115 waivers among states who want to create innovation in their Medicaid Managed Care programs and pushing the use of flexibilities within other waiver authorities in a number of different areas. CMS is leaving 1115 waivers to be used where states want to try something experimental that has not been used before. States have been administering managed care programs for a long period of time, so managed care is no longer considered experimental; it is something known and used by the majority of states. Because of that, there are two other authorities CMS considers: both the 1915(a) and (b)

authorities and also the state plan authorities. CMS encourages states to use other authorities (e.g., state plan authority), as appropriate, to cover groups like kids and parents. States have to use the 1915(a) and (b) authorities if they are going to cover some of the more complex populations like the aged, blind, and disabled populations.

Another issue that surfaces when using the 1115 waiver authority is the requirement of a rationale for the 1115 demonstration. In 1115 waivers, states provide a rationale for the model (i.e., the change theory they are testing), which is followed by an evaluation to determine if the theory was correct. State Managed Care programs have been evaluated so extensively that CMS believes the 1115 authority should only be used if there is a credible new theory to explore. CMS wants a state to use one of the two other authorities so that states are you’re not going through the evaluation portion. Now, if there are other things the state wants to do outside of managed care that is where the 1115 authority often comes in and is needed.

What do you think are the trends in federal flexibilities that states are seeking via these waiver authorities with respect to Medicaid managed care organizations?

Only Tennessee currently uses the Prepaid Ambulatory Health Plan (PAHP) model for Pharmacy Benefits Management; Ohio is looking at the same model. In Ohio, the pharmacy benefit was carved into managed care; they are now looking to carve it out, but they did not want to go to just the old Fee-for-Service (FFS) model for various reasons. Instead, they are going to use the PAHP model. As a result we may see states consider this model, such as for 340b drug program pricing.

⁸ [https://www.ny.gov/community-opportunity-reinvestment-core-initiative/about-core#:~:text=Community%2C%20Opportunity%2C%20Reinvestment%20\(CORe,education%2C%20health%2C%20and%20housing](https://www.ny.gov/community-opportunity-reinvestment-core-initiative/about-core#:~:text=Community%2C%20Opportunity%2C%20Reinvestment%20(CORe,education%2C%20health%2C%20and%20housing).

Specifically for the 340b drug program, if you are in a FFS carve-out model, there are federal rules and law that specifically say how 340b entities can be paid and who gets the savings. Those same rules do not apply under managed care. Thus, a state could use the PAHP model, which would allow managed care entities to pay 340b entities differently. This is an example of how some of the authorities are currently being used differently.

Given concerns about structural racism and inequities in health built into our health care system, are there ways these authorities can be used by states to address health equity?

This is definitely a topic at the top of everyone's mind and these authorities in fact can be used to address inequities in the health care system. One example is the use of 1115 waiver authority to not only implement a state's managed care program, but also to implement other programs around managed care that address a specific inequity in the delivery of health care services (e.g., a program to address the recruitment of providers with different racial or ethnic backgrounds and to provide enhanced rates for those providers). States can also use other federal managed care authorities to move from a FFS program, where any certified provider can provide a given service, to a managed care program, where the state can define the providers that can participate in the program. Using this example, through a given state's managed care contract, the state can work with its managed care plan to specifically address the need to recruit, identify, and bring culturally competent providers into their networks. In addition, states could utilize their quality programs and performance requirements to incentivize advancements in health equity among their participating health plans.

MCO/CBO Partnership

We are a small community-based organization (CBO) interested in collaborating with the MCOs in our community. MCOs are complex organizations and we are not clear about who exactly to call to get started on a conversation. Can you provide thoughts on this?

Here are multiple ways that you can start a conversation with the MCO. One option is for CBOs to:

- Reach out directly to the MCOs in your community.
- Conduct background research to understand the MCOs operating in the market you serve and the status of current social determinants of health (SDOH) and health equity initiatives in your community.
- Identify key decision makers at each MCO and reach out to meet directly with these leaders. Use the meeting to understand priorities and any current or future community efforts and SDOH interventions the MCOs are pursuing.
- Identify the needs in the community that could be addressed by a collaboration with MCOs. Determine if a collaboration between your CBO and an MCO could lead to your CBO helping MCO members find stable housing or healthy food.
- Develop a value proposition for the MCO including how the member will benefit from collaboration with your CBO. What additional services will MCO members receive? How will these additional services benefit members? How will these additional services help the MCO deliver better care for members while reducing health care costs, such as reducing the number of avoidable Emergency Department visits or preventable hospitalizations? How does

your CBO envision these additional services to be covered?

- Develop a pitch for the MCO that clearly shows the return on investment (ROI) from the partnership you are proposing. To show the ROI, try compiling data from the MCO's market, using the largest possible number of people benefitting from the proposed services. An objective outside analysis from an independent third party demonstrating the ROI is always preferable, but sometimes difficult to obtain.

Another approach is to reach out to your state Medicaid agency directly to set up a meeting with representatives from the agency or with the Medicaid Director; they can inform you about state priorities, point CBOs in the right direction and help broker the conversation with MCOs.

For successful partnerships to develop between CBOs and MCOs, incentives must be aligned along with an in-depth commitment from the leadership of both organizations. The journey to develop a solid partnership is long and will require a lot of dialogue, with both parties educating each other on their different areas of expertise as they work together to formulate and implement a contract and develop the monitoring mechanisms that align incentives and hold both parties accountable.

We have heard our state and MCOs started to discuss value-based purchasing (VBP) for SDOH services. How do we engage in that conversation and how do we learn more about VBP and how it could apply to the services we provide?

In September 2020, CMS issued a [letter to State Medicaid Directors](#) emphasizing the importance of VBP and providing guidance for states and their partners to advance VBP. It will be important to start understanding the priorities for the State

Medicaid Agency by looking at the agency's strategic plan or Quality Strategy, which is usually in their website. Another way is to understand the VBP requirements the state Medicaid agency has for its Managed Care Organizations through the Managed Care request for proposals (RFP) and Managed Care contracts, which are also publicly available online. Sometimes, the State Medicaid Director provides information during specific public meetings like the Medicaid Advisory Committee or the other venues.

CBOs can always request a meeting with the State Medicaid Agency and its Director to ask for a brokered introduction to meet with health plans. Typically, it is not a good idea to ask the Medicaid Director to introduce a requirement for the MCOs to contract with your CBO. A better approach is to request that the type of services you provide become a requirement in the Managed Care contract or be included in the request for proposals (RFPs) to compete for that work.

We do not have much knowledge on how to make our programs fit into a value-based care model? How do we approach this? Can you please provide a webinar on value-based purchasing and community-based organizations?

To learn more about value-based care in the short term, CBOs can start a dialogue with other CBOs who have successfully partnered with MCOs in VBP arrangements which address SDOH issues. CBOs can also start to understand the different VBP opportunities in their states through their Medicaid program by reviewing the State Medicaid Agency's Quality Strategy as well as the state's Managed Care RFP and contract. CBOs can also reach out to MCOs in their communities to understand their priorities and start a dialogue about areas where both MCOs and CBOs interests are aligned for potential partnerships.

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

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