



Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Medicaid Learning Lab

Session 6: Medicaid Managed Care

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9-16-2021



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What We'll Cover in this Session

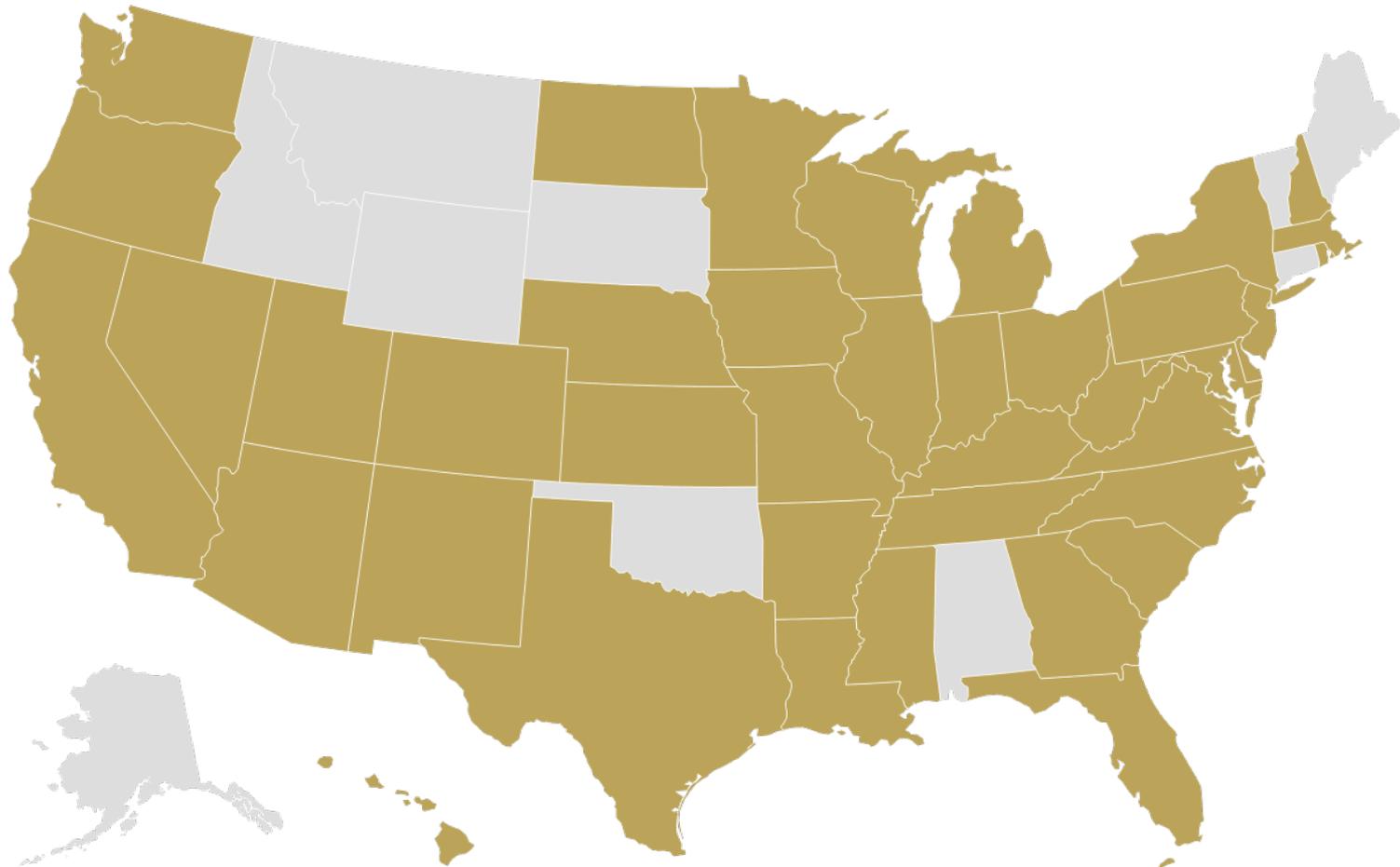
- ✓ Why do Medicaid MCOs Matter to Children, Pregnant Women, and Families?
- ✓ What are Medicaid MCOs?
- ✓ What are the Federal Rules for States Contracting with MCOs?
- ✓ How can States Hold MCOs Accountable for Access and Quality?
- ✓ How can Beneficiaries and Advocates Hold States and MCOs Accountable for Access and Quality?

What We Won't Cover in this Session

- X Managed Care in the Children's Health Insurance Program (CHIP)
- X Managed Long-Term Services and Supports (MLTSS)
- X Accountable Care Organizations (ACOs)
- X Behavioral Health Organizations (BHOs)
- X Social Determinants of Health (SDOH)
- X Value-Based Purchasing (VBPs)
- X And more!

Why do Medicaid MCOs Matter to Children, Pregnant Women, and Families?

- As of March 2021, **38.7 million children** were enrolled in Medicaid or CHIP.
- In 2019, Medicaid covered **41.8%** of all live births.
- Medicaid is a critically important program for children and families of color.
- **40 states and the District of Columbia** cover some or all of their beneficiaries through MCOs.
- In these states, MCOs' policies and performance determine **if and how** beneficiaries access care.



There are 40 Risk-Based Managed Care States (and DC)

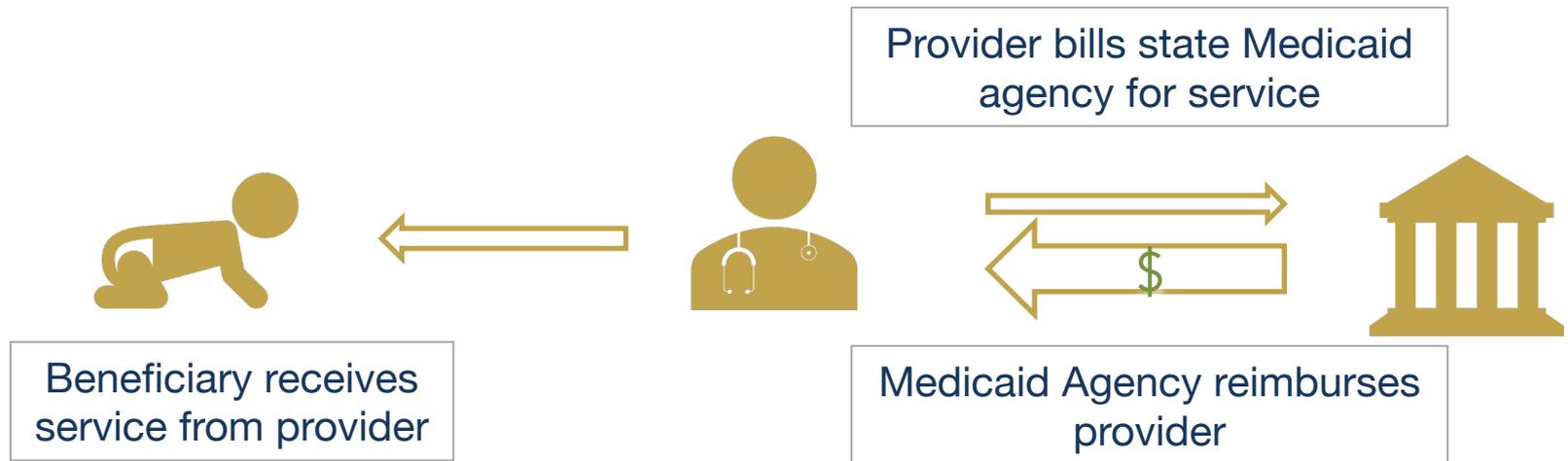


WHAT ARE MEDICAID MCOs?

Managed Care Organizations (MCOs) Defined

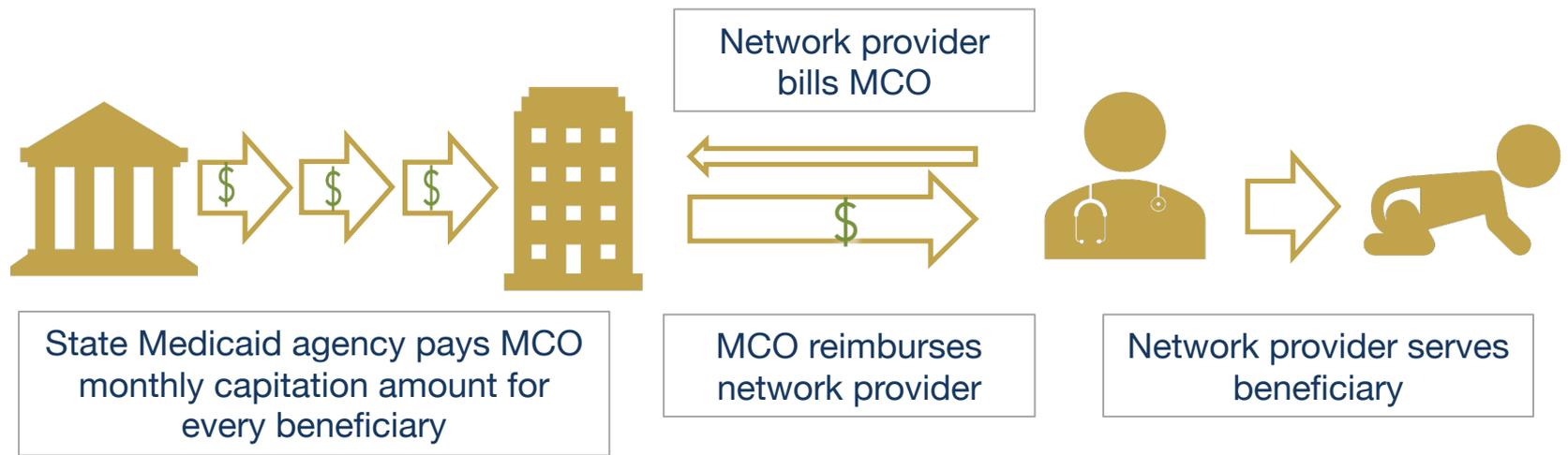
- An MCO is an entity that contracts with the state Medicaid agency on a risk basis to organize a network of providers to furnish covered services to beneficiaries who are enrolled.
- Under the risk contract, the MCO receives a monthly capitation payment (per member per month) from the state Medicaid agency for each Medicaid beneficiary enrolled.
- In exchange, the MCO agrees to ensure that its enrollees receive the services that are covered by the contract.
- The MCO receives the monthly capitation payment for each enrollee whether or not the enrollee uses services.

State Options for Delivering Medicaid Benefits: Fee-for-Service



Incentive: the more services the provider furnishes, the more revenue the provider receives.

State Options for Delivering Medicaid Benefits: Risk-Based Managed Care



Incentive: the less the MCO spends on services furnished by network providers, the more revenue the MCO has for administration and profits (within limits).

Capitation (PMPM) Rates: An Example

Actuarial Cell	Per Member Per Month Payment
Age <1	\$641
Age 1-20	\$282
Age 21+	\$377
Expansion Adults	\$531
SSIWO	\$1201
Duals	\$142

Rates for Arizona Care1st; effective October 1, 2021-September 30, 2022

Why States Contract with MCOs

- Improve budget predictability
 - Medicaid is 19.6% of state general fund spending (SFY 2020)
- Improve quality of care and outcomes for beneficiaries
- Outsource administrative responsibilities, such as:
 - Organizing provider networks
 - Paying network providers
 - Utilization management/prior authorization
 - Quality assurance

What does the MCO Market Look Like?

- The Congressional Budget Office projects that federal Medicaid managed care spending will increase from **\$234 billion to \$384 billion** over the next 10 years.
- There are **287 MCOs** as of July 2021.
- MCOs can be for-profit, nonprofit, or public.
- There are five dominant national companies (Aetna/CVS, Anthem, Centene, Molina, UnitedHealth) with:
 - 119 total subsidiaries
 - Geographic reach of 37 states
 - 37.5 million enrollees

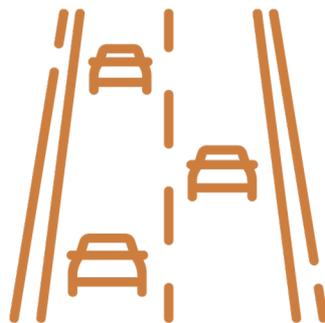




WHAT ARE THE FEDERAL RULES FOR STATES CONTRACTING WITH MCOs?

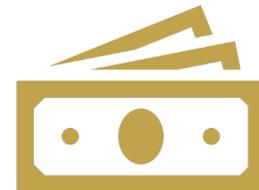
States Contract with MCOs within Federal Rules

- Federal rules at [42 C.F.R. Part 438](#) specify:
 - Requirements for risk contracts between State and MCOs
 - State Medicaid agency responsibilities
 - Standards for MCOs
 - External Quality Review of MCOs
 - Enrollee Rights and Protections
 - Program Integrity and Transparency Requirements
 - And more!



CMS is Responsible for Enforcing Compliance with Federal Rules

- Centers for Medicare & Medicaid Services (CMS) must approve:
 - ❑ Pathway to managed care
 - State Plan Amendment
 - Section 1115 Demonstration
 - Section 1915(b) Freedom-of-Choice Waiver
 - ❑ Risk contracts between state Medicaid agencies and MCOs
 - ❑ Capitation rates paid by state Medicaid agencies to MCOs



States Have Broad Discretion in Implementing Federal Rules

- Within what Federal rules specify, there is variation:
 - How many MCOs a state contracts with
 - What populations a state enrolls
 - What benefits a state contracts for
 - And more!
- Federal rules do not specify:
 - ✗ Procedures for procurement of MCOs
 - ✗ Methods for MCO payment of providers

If you've seen one state Medicaid managed care program, you've seen one state Medicaid managed care program.



HOW CAN STATES HOLD MCOs ACCOUNTABLE FOR ACCESS AND QUALITY?

Why Worry about Access and Quality in MCOs?

- Access and quality are fundamental to Medicaid coverage, whether the delivery system is fee-for-service or risk-based managed care.
- The incentive to reduce the amounts spent on services is inherent in capitation.
- Spending on services can be constrained by limiting provider networks, limiting reimbursement rates to network providers, and tightly managing provider claims.
- In the case of subsidiaries of publicly-held companies, MCOs answer to both the state Medicaid agency and investors.

How can States Monitor Access and Quality in an MCO?

- State Medicaid agency must monitor the performance of each MCO, including logs of enrollee grievances and appeals.
- State agency must contract with External Quality Review Organization (EQRO):
 - EQRO must be independent of both state agency and MCOs.
 - EQRO must validate adequacy of each MCO's network and report on quality metrics (e.g., well-child visits or developmental screening) identified by the state agency.
 - EQRO must produce and state agency must post EQRO Annual Technical Report which assesses the strengths and weaknesses of each MCO by April 30 every year.

What Levers are Available to State Medicaid Agencies to Improve Quality in MCOs?

- Initial procurement and reprocurement of contracting MCOs
- Provisions in risk contracts with MCOs:
 - Financial incentives/rewards for achieving improvements in quality metrics
 - Amounts withheld from capitation payments that are paid out when MCO meets quality metrics
 - Penalties for not meeting quality metrics, including: corrective action plans, suspension of default enrollment, fines

Pop Quiz

- Which of the following is NOT a Medicaid initialism?
 - ACO
 - BHO
 - EQRO
 - MCO
 - CHEERIO



HOW CAN BENEFICIARIES AND ADVOCATES HOLD STATES AND MCOs ACCOUNTABLE FOR PERFORMANCE?

Enrollee Choice

- States that require Medicaid beneficiaries to enroll in MCOs must offer them **a choice of at least two MCOs** in urban areas (they may limit rural beneficiaries to one).
- At initial enrollment, the beneficiary will have either an opt-in or opt-out choice among MCOs.
- If the beneficiary doesn't choose, they are enrolled into an MCO that the state selects (default enrollment).
- Beneficiaries may **disenroll without cause** within 90 days of initial enrollment and **once every 12 months**.
- Beneficiaries may disenroll for cause (including poor quality of care or lack of access to services) at any time.

Medical Care Advisory Committee

- [Federal rules](#) require every state to have a Medical Care Advisory Committee (MCAC) which includes providers, beneficiaries, and may include MCOs.
- MCACs may review:
 - MCO utilization and performance trends
 - State Quality Strategy ([required by Federal rules](#))
 - Metrics state is asking EQRO to validate
 - Performance incentives tied to capitation rates
- MCAC meetings are generally open to the public and minutes are often posted online.

Transparency Improvements

- In addition to the information required to be posted by Federal regulations, advocates can encourage the state Medicaid agency to post the following information *specific to each MCO*:
 - Total payments made by the state each year
 - Enrollment by eligibility group
 - Child and maternal quality metrics
 - EPSDT performance metrics
- Enrollment and metrics disaggregated by race and ethnicity



Example Child Health Dashboard



SFY20 Q3 SFY21 Q3

	SFY20 Q3	SFY21 Q3
Member Enrollment	225,565	235,816
Infancy < 1	12,723	10,208
Early Childhood 1 - 4	46,440	47,404
Middle Childhood 5 - 11	78,139	80,518
Adolescence 12 - 21	88,263	97,686
Well Child Exams (Preventive Visits)	38,491	38,064
Infancy < 1	13,480	3,356
Early Childhood 1 - 4	13,013	19,273
Middle Childhood 5 - 11	6,406	7,780
Adolescence 12 - 21	5,592	7,655
Lead Screenings	5,584	4,362
Infancy < 1	272	0
Early Childhood 1 - 4	4,945	3,739
Middle Childhood 5 - 11	324	592
Adolescence 12 - 21	43	31



SFY20 Q3 SFY21 Q3

	SFY20 Q3	SFY21 Q3
Member Enrollment	148,445	158,103
Infancy < 1	9,423	9,409
Early Childhood 1 - 4	29,589	31,562
Middle Childhood 5 - 11	51,077	52,767
Adolescence 12 - 21	58,356	64,365
Well Child Exams (Preventive Visits)	26,229	29,139
Infancy < 1	11,246	10,544
Early Childhood 1 - 4	7,354	8,877
Middle Childhood 5 - 11	4,062	4,991
Adolescence 12 - 21	3,567	4,727
Lead Screenings	2,881	3,146
Infancy < 1	72	74
Early Childhood 1 - 4	2,611	2,802
Middle Childhood 5 - 11	174	249
Adolescence 12 - 21	24	21

For Further Information

Kaiser Family Foundation, "10 Things to Know About Medicaid Managed Care," (October 2020), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>

Medicaid and CHIP Access and Payment Commission (MACPAC), "Managed Care," <https://www.macpac.gov/topics/managed-care/>

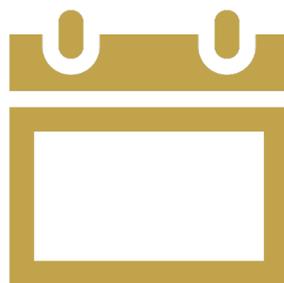
Commonwealth Fund, "Medicaid Managed Care Contract Analysis Database," <https://www.commonwealthfund.org/medicaid-managed-care-database#/>

National Health Law Program, "Addressing Health Equity in Medicaid Managed Care," (May 2021), <https://healthlaw.org/resource/addressing-health-equity-in-medicaid-managed-care/>

Georgetown Center for Children and Families, Managed Care Resource Page, <https://ccf.georgetown.edu/subtopic/managed-care/>

Medicaid Learning Lab Coming Attractions

- **October 21:** Section 1115 Waivers
Joan Alker, Leo Cuello, Allie Gardner
- **November 18:** Medicaid Eligibility Renewals
Tricia Brooks



Questions



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