

Medicaid and Public Health Partnership Learning Series

Population Health and Managed Care

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OVERVIEW

Some Medicaid and public health agencies are exploring new ways to partner to address mutual health priorities by leveraging the tools and mechanisms in Medicaid managed care. These approaches include holding plans financially accountable for performance on population health metrics and working with plans to implement performance improvement projects that meet both agencies' health outcome goals. Using a focus on population health improvement, states and Medicaid managed care plans are seeking to reward the value of care rather than the volume of services delivered. As states implement these value-based reforms, they will start to identify best practices to promote population health through managed care vehicles. This resource is intended to inform public health officials about some of the aspects of Medicaid managed care that are relevant when considering including an enhanced population health element in managed care. This resource will also prepare public health officials to discuss this issue with Medicaid officials.

OPPORTUNITIES FOR PUBLIC HEALTH

In order for public health and Medicaid agencies to incorporate population health metrics or other population health elements into managed care, it may be helpful to:

- Share public health data with the Medicaid agency to support an initial dialogue about mutual goals, a needs assessment, and possible return on investment for health plans and the Medicaid program. The more “Medicaid-specific” data, the better.
- Provide data analytic support to Medicaid to:
 - Help evaluate the feasibility and appropriateness of incorporating a population health element in managed care, including a metric that will hold plans accountable for their performance (for example, a metric that sets an HIV viral load threshold.)
 - Enable Medicaid to evaluate health plans’ progress on selected population health metrics and program impacts.
- Help Medicaid assess the impact of social determinants of health on mutual population health goals and help the state and managed care organizations (MCOs) identify approaches to tackle these key social determinants in managed care.
- Help the Medicaid agency and health plans design performance improvement projects and other approaches that will address mutual population health outcome goals, such as comprehensive diabetes management.

KEY ISSUES

The following are key issues to take into consideration when evaluating whether to include an enhanced population health focus in Medicaid managed care.

Managed Care Models

Medicaid programs typically deliver healthcare services through either a fee-for-service or a managed care model. In Medicaid managed care, states contract with private health plans (or MCOs) to deliver some or all healthcare services to Medicaid beneficiaries, which are individuals eligible for and enrolled in Medicaid coverage. Managed care arrangements are typically risk-based, meaning that the state pays a set fee—or a capitation rate—per enrollee to a private health plan for the delivery of specified services to that individual. The health plan is then responsible for contracting with and paying individual providers for the provision of care. There are often other payment schemes and incentive programs operating within this capitated system to promote certain outcomes or performance benchmarks.

Other managed care arrangements are not risk-based, such as primary care case management. In this type of managed care, a primary care provider receives a flat fee to coordinate care, but all other services are provided on a fee-for-service basis. That means that the provider receives a set payment when each covered service is delivered. (Additional information about different types of managed care programs is available in the June 2011 [Medicaid and CHIP Payment and Access Commission report](#).)

Each state may use a combination of managed care models and fee-for-service Medicaid to cover its populations. Historically, pregnant women and children have received services through managed care while individuals with disabilities or more complex care needs have been covered in fee-for-service Medicaid. However, this trend has shifted in recent years because of an ongoing movement toward managed care for more complex populations. (For information on the delivery models in your state and the populations they cover, visit your state Medicaid agency's [website](#).)

Across the spectrum of managed care, health plans in risk-based managed care programs are well-positioned to drive significant improvement in population health. This is partly because they are accountable for most, if not all, of a beneficiary's care and have more tools at their disposal to drive population health improvements.

It should be noted that there are limitations to managed care's capacity to drive population health outcomes. For example, the size of a population covered by a given plan may affect how feasible it is to hold the plan accountable for population health measures. Other limitations emerge related to the population of beneficiaries and benefit design, which are integral considerations for all health plans. An enhanced population health focus should not inadvertently encourage plans to select only healthy populations, nor cause it to be structured so tightly that it does not allow for innovation among plans in benefit design. Public health officials should recognize such limitations and challenges during conversations with Medicaid officials about managed care solutions.

Carve Outs

Generally, risk-based managed care plans are responsible for much of enrollees' healthcare, but managed care plans may not provide certain specialty services, such as pharmacy benefits or behavioral health services. This is called a "carve out." Providers that deliver carved out services may be paid a set fee by the state for those services, or the carved out services could be delivered through a specialty health plan or other approach.

It is important to understand which services are not under an MCO's purview when considering holding health plans accountable for a population health metric or pursuing other population health-focused requirements; a given metric may not be appropriate if plans are not responsible for services relevant to the metric. For example, if pharmacy benefits are carved out, an MCO may face significant barriers to influencing prescription drug compliance for individuals with cardiovascular disease. As a result, a measure that evaluates the percentage of patients with hypertension whose blood pressure is adequately controlled may not be the appropriate metric to use to hold that MCO financially accountable.

Pathways to Managed Care: Waivers and State Plan Amendments

To require Medicaid beneficiaries to enroll in managed care, a state must receive a waiver or amend its state plan. In general, a waiver allows Medicaid to make changes that are not in accordance with federal law while a state plan amendment (SPA) allows a state to make changes to its program within the construct of federal requirements.

- **Waivers:** There are a variety of waivers that states may use to implement managed care, and each waiver type has different requirements associated with it. States must dedicate significant time and resources to design a waiver and work with federal officials through the approval process. Although all waivers are time- and labor-intensive, Section 1115 waivers (pronounced "eleven fifteen waivers") are by far the most difficult, often taking multiple years to plan and receive approval. (More information on the waiver authorities used to operate managed care programs is available on [CMS' website](#).)
- **State plan amendments:** The SPA pathway may also be used to implement Medicaid managed care, but this pathway limits those populations that may be required by the state to enroll in managed care. An SPA, as inferred by the name, amends the Medicaid state plan, which is the contract between the state and CMS that runs the Medicaid program. The state plan specifies what optional program features the state has elected to include. A SPA is the least burdensome way for a state to amend its Medicaid program, but still requires significant time and effort to plan for and receive federal approval.

Understanding the types of managed care authorities a state may use is essential to inform a discussion with Medicaid officials on the appropriateness of holding health plans accountable for a stronger focus on population health. It may be more difficult under some managed care authorities to include a population health component; for example, the SPA approach to implement managed care allows for significant voluntary enrollment, including for children and youth with special healthcare needs. A measure that targets this population's health may be inappropriate because plans may not have the necessary leverage to drive improvement for them, or may encourage plans to try to enroll healthier individuals.

Managed Care Contracts

Managed care contracts are the agreements between states and health plans that specify how MCOs will deliver services to program enrollees. These contracts must be reviewed and approved by CMS, and they represent the primary vehicle by which states can hold plans accountable and drive improvement. Every three to five years, Medicaid agencies re-procure managed care plans through their states' usual procurement process, typically by issuing requests for proposals (RFP) that solicit health plans to serve Medicaid beneficiaries covered by the managed care program. RFPs outline the requirements that health plans would have to meet to serve beneficiaries, including the metrics they must achieve to receive full payments and, potentially, bonus payments. In order to promote innovation, states may also ask health plans to discuss in an RFP how they would address a given issue. In addition to the state's procurement process and rules, CMS also specifies some aspects of proposal review and selection.

States can hold health plans accountable for a population health metric or other enhanced population health focus through contracts with MCOs. As such, it is important to recognize that the timing for incorporating a stronger population health element is contingent on the contracting cycle. States may consider incorporating a population health metric to hold plans accountable when the state engages in contract re-procurement. In the RFP, states may choose to specify different levels of detail about how plans should address a population health issue. In some cases, states may ask health plans to propose their own approach to the issue, which can then be incorporated into the awarded contracts. States may do this to encourage MCOs to develop innovative methods of tackling key population health concerns.

Medicaid programs contract with multiple MCOs in every state. These contracts can vary in a number of ways, as can the means by which the plans deliver on their services. States must recognize and accommodate variety both within the contract and within plan approaches in these population health efforts.

Quality Metrics and Measurement

States that use managed care programs are required by federal law to ensure that the program delivers quality care. As part of this requirement, states must develop a written quality strategy. Health plans must also report on quality metrics selected by states, which often include measures from the Healthcare Effectiveness Data and Information Set, the Medicaid Child Core Set, the Medicaid Adult Core Set, and others. The quality measures states select signal the state's priorities for improvement and are an important driver of quality on the part of MCOs.

The quality information that MCOs report to states also provides key data that Medicaid and public health agencies can use to identify shared health outcome goals and assess which population health metrics may be appropriate to include in a contract. For example, if a state wishes to increase its vaccination rates, it may be appropriate to consider incorporating a population health metric related to immunizations into the subsequent health plan contract. Likewise, analyzing managed care quality data alongside public health data can support the development of plan performance benchmarks.

Performance Improvement Projects

Performance improvement projects (PIPs) are mandatory quality improvement initiatives that health plans must implement as part of their work to provide coverage for Medicaid beneficiaries. These projects must focus on both clinical and non-clinical aspects of care. States may lay out the number of PIPs each health plan must implement and may either select the topics or allow MCOs to select the topics. For example, a state may require an MCO to implement a PIP on increasing appropriate ADHD diagnosis and drug utilization. Regardless of which entity selects the quality improvement topic, MCOs have a degree of independence to implement PIPs that will drive quality improvement under the broad authority of their contracts. MCOs may also implement PIPs that reach beyond traditional healthcare interventions and address social determinants of health.

PIPs may provide another way for Medicaid to work with health plans to enhance its population health focus. If MCOs are being held accountable for a population health metric, they are likely to implement PIPs that will impact this issue. Alternatively, states may direct MCOs to develop PIPs that focus on the mutual population health outcome goals identified by Medicaid and the public health agency. For example, if both agencies are focused on targeting HIV, states could require MCOs to implement a PIP to achieve a target screening rate for individuals at risk for HIV.

Innovative Delivery in Managed Care

Medicaid plans have flexibility under their managed care contracts to provide certain services or supports that may otherwise not be covered under fee-for-service Medicaid. They can also use this flexibility to address social determinants of health that may be contributing to mutual population health concerns.

For instance, plans may use community health workers to deliver certain preventive services even though these workers may not be directly reimbursable under Medicaid. Plans are likely to exercise this flexibility when it will improve outcomes, contain healthcare costs, or achieve a given goal that the state has established. However, it is important to note that different plans will likely approach a given goal using different methods: while one plan may decide to use community health workers to provide low-level care coordination, others plans may find it more appropriate to use primary care providers to deliver this same service.

It is important to keep this type of flexibility in mind when thinking about the levers that managed care plans have at their disposal to improve population health. If an MCO is accountable for an enhanced focus on population health, the plan may use this flexibility to drive improvements that would not otherwise be possible in fee-for-service Medicaid. For example, if a state Medicaid agency determines that it is appropriate to hold a health plan accountable for a quality metric on the rate of adolescent tobacco screening and counseling, MCOs may then act on their own within the authority of their contract to conduct intensive consumer outreach to promote tobacco cessation.

RESOURCES

The following resources provide information on Medicaid managed care that may inform interagency partnerships to address mutual health priorities through managed care tools and mechanisms.

- **Report to the Congress: The Evolution of Managed Care in Medicaid**, MACPAC: the Medicaid and CHIP Payment and Access Commission. <https://www.macpac.gov/publication/>. *This document provides additional information on the different types of managed care programs.*
- **Managed Care**, Medicaid.gov. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>. *This report provides information on the authorities that states can use to operate managed care programs.*
- **Medicaid Enrollment in Comprehensive Risk-based Managed Care**, Kaiser Family Foundation. <http://kff.org/medicaid/state-indicator/medicaid-enrollment-in-comprehensive-risk-based-managed-care/>. *This resource provides state-by-state enrollment figures for risk-based managed care programs that cover most healthcare services.*
- **State Quality Strategies**, Medicaid.gov. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/state-quality-strategies.html>. *This report outlines the managed care quality strategies that states must develop in order to comply with federal regulations.*