Influencing Medicaid Managed Care and Other Payer Contracts

Musings from a Former
State Medicaid Director

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Presentation Overview

- Understanding the key priorities of Medicaid agencies and their managed care organizations (MCOs)
  - How can associations frame safety nets needs to align with those objectives?
- How best to engage Medicaid programs and their MCOs
  - Hint: Build strong relationships; focus on data and not anecdotes.

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Understanding the Medicaid Environment

- Some Obvious Observations:
  - Medicaid is one of biggest expenditures in every state's budget
    - Typically second only to K-12 education
    - Tremendous pressure on state Medicaid agencies to reduce cost growth
  - Average tenure of Medicaid director is between 2-3 years. Why so short?
    - As Medicaid becomes bigger part of state budget, more political and harder to stay in job cross parties
    - It's a hard, demanding job – everyone wants something from you, and you have very little to give

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What are Key Priorities for the Medicaid Agency?

- Highest priorities for all states:
  - Stay within budget
  - Reduce cost growth
  - Keep the trains running
  - Stay out of the news
- Other key priorities:
  - Implement key priorities of the Governor and/or Secretary
    - In some states the Medicaid director will get to set the priorities but that varies tremendously by state.
  - Implement legislative mandates
    - Required to do some things that do not otherwise align with Medicaid agency's priorities

Hot Policy Issues in State Medicaid Programs

- Addressing the opioid crisis
  - Expanding SUD treatment, including MAT
- Payment and Delivery System Reform
  - Pay for value not volume
  - Integration of Physical and Behavioral Health
  - Pharmacy costs
- Population Health
  - Better use of data in identifying gaps in care
  - Focus on social determinants of health
- Medicaid work requirements

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Hot Policy Issues in Medicaid Managed Care

- Great overlap with general priorities– most states have some form of managed care and implement most policies through their plans
- Many states spent last few years coming into compliance with Medicaid Managed Care rule
  - Network adequacy requirements
  - Quality strategy
- Purchasing behavioral health services
  - More states including BH within same plan as acute services
  - Need to ensure that managed as a whole within the plan

How States Develop Managed Care Procurements

	Task	Timing
Phase I	Strategic planning	6-12 months prior to procurement release
Phase II	Procurement development	As soon as strategic planning underway
Phase III	Bidder selection	Provide bidders with sufficient time to respond (ideally 6 weeks minimum); expect to need 4-5 weeks to review bids
Phase IV	Contract management	Ongoing!

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How Can You Influence Managed Care Procurements?

- Most states seek significant stakeholder feedback in advance of releasing a procurement
  - Provide overview of what planning
  - Obtain feedback on priority areas
    - e.g., LA – released RFI prior to procurement
- Some states release draft procurements before final procurement is released
- Vendor selection
  - Occasionally states include provider and/or consumer representative on the review committee
  - May ask for references specifically from provider and/or consumer
  - If not asked, need to wait and see outcome; any other attempts to influence may void entire process
  - As a whole, states are seeing more procurement protests

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Is there Opportunity to Influence Medicaid Managed Care Contracts Post-Procurement?

- States routinely amend managed care contracts
  - Typically amended annually to update rates
  - Often update/modify performance measures through contract amendment
  - Other policy changes can be included within amendments – as long as within the scope of the initial procurement
- States also can direct policy through sub-regulatory methods
  - Supplement Medicaid managed care manuals
  - Policy letters

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Consider How to Frame Your Priorities to Align with State Priorities

- State Medicaid programs have little bandwidth to touch anything outside of its own priorities
  - Where is the there overlap between your priorities and the state's?
  - How can an FQHC help state address priority issues?
    - What can you do with existing resources?
    - Where do you need investment to support state priorities?
- Each Medicaid program is unique; what works in one state won't necessarily work in another

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State Priority: Behavioral Health and SDOH

- Addressing the opioid crisis
  - In MA: Many FQHCs function as office-based opioid treatment (OBOTs) providers and support state's need for increased access to MAT
- Strengthening the behavioral health system
  - Important partnerships between FQHCs and CMHCs
    - Delta Center Initiative
  - FQHCs providing increasing BH for mild to moderate
  - FQHCs often key to state activities to integrate physical and behavioral health care
- Increased focus on Social Determinants of Health
  - Plays to FQHC strengths and experience in serving its core patients
    - What data do you have to show how you have worked to address SDOH?
    - Where is it most important for a state to focus?

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FQHC Involvement in Payment and Delivery System Reform

- How can an FQHC participate in new payment and delivery system reform initiatives
  - States focused on moving from volume to value
  - How does it impact the PPS rates? Willingness to take on risk?
- Leading state examples:
  - FQHCs as Lead Partners within ACO models
    - MN: Federally Qualified Urban Health Network (FUHN)
      - group of 10 FQHCs within the Minneapolis /St. Paul area to create a virtual ACO as part of MN's Integrated Health Partnership
    - RI: Accountable Entities
      - 3 of 5 are FQHC-based
      - Focused on integration of BH and SDOH
    - MA: Community Care Cooperative; other ACOs with FQHC leads
  - OR: Alternative Payment and Advance Care Model (APCM)
    - Willing FQHCs entered into APM agreement
    - Global budget with financial risk

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When Have a Specific Ask of Medicaid Agency: Keep request simple and reasonable

- Understand where state agency has flexibility and where it doesn't
  - States typically don't have more money to spend
    - If have a solution that requires funds, show how will bring savings in short/long run or how improves quality.
  - Rates are always an issue – and very hard to solve
    - See from state's perspective – some see FQHC rates as high relative to other primary care providers b/c of PPS

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Bring a Solution; Not a Problem

- Don't just come in with a problem; propose a solution
  - Example: Barriers to BH integration.
    - State Medicaid program historically allowed only to bill for one service per day. FQHC presents case to state that this impacts ability to provide integrated physical and BH services.
  - Use data to illustrate what the problem is that you are trying to solve – impact to member and to FQHC. Use data to show:
    - impact to patients who need to return for second service due to billing barrier; may not come back for second appointment (track this data)
    - loss of revenue to FQHC if provide same day service
    - potential savings from decreased ED or other services by not providing services same day
  - Find allies who can help make the argument

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How Best to Engage Medicaid Agencies

- Associations and FQHC leaders should work to build long term relationships with Medicaid agencies.
  - See Medicaid agency as a partner
    - Similar missions: to serve the underserved
  - Focus on them always, not just when you need/want something
  - Get to know not just the Medicaid director but key program leadership
  - Participate in state working groups to show dedicated to the Medicaid program and its population

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Partnership Principles (From Joe Parks)

DO

- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interest
- Reveal anything helpful
- Take one for the team

DON'T

- Talk about your needs first
- Expect to get something
- Limit assistance to a project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps

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Influencing MCOs/BHOs and Other Contracting Entities

- Many of the same principles apply
  - Create an ongoing relationship with plans
  - Be a team player
  - Consider where priorities align
  - Propose solutions
  - MCOs may not have flexibility with rates (since their PMPM is typically based on state FFS rate)
  - Be clear about what you are asking for and how it helps the plan
    - Focus on providing right BH services will likely lead to reduction in overall cost of a member
    - Provide data where available

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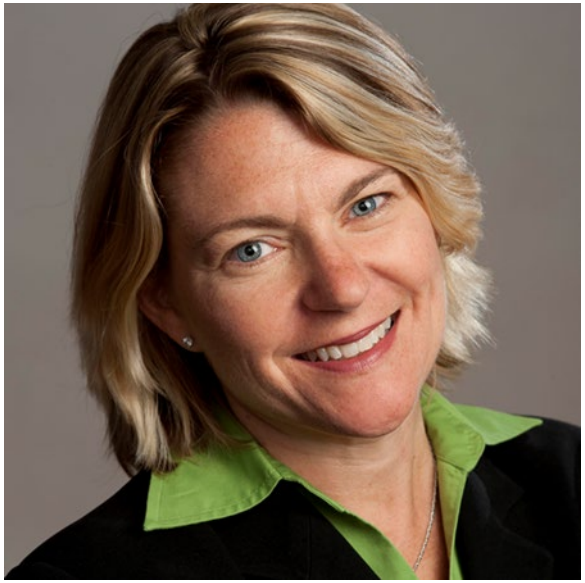
Key Components to Influence (1 of 2)

- What services are within managed care?
  - BH Carve in/out
  - Pharmacy
  - How do monitor spend on BH?
- Network Adequacy
  - What are related workforce issues and where do need capacity?
  - How can plans help to support building of capacity and training?
- Quality measures
  - Process vs. outcomes
  - Standardized vs. home grown
  - Performance target; incentive for improvement over baseline

Key Components to Influence (2 of 2)

- Data
  - What data will be made available to BH providers? How often?
  - How to address privacy concerns?
  - What TA is available?
- VBP approach
  - Required vs. Flexible?
  - How are BH providers involved?
  - What is included within TCOC?
  - How is "value" defined?
  - How does attribution work?
  - What TA is available?

Questions? Comments? Discussion?



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Thank you!

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