

# The Medicaid Learning Collaborative

Medicaid is a critical player in the US Healthcare market and in maternal and reproductive health, yet can be confusing to navigate as a health service provider. In partnership with HealthTech4Medicaid and Manatt Health, Rhia Ventures created a six-session video series learning collaborative for reproductive and maternal health innovators with interest in entering or expanding their footprint in the Medicaid market. This document will serve as a highlight guide for each Learning Collaborative video.

## Medicaid — The Basics



Medicaid is a state and federal partnership that provides health coverage for low-income adults under age 65, children, pregnant people, elderly people, and people with disabilities.



State Medicaid programs are mandated to cover certain health services (ambulatory, inpatient, and long-term care) and may add services at their discretion (such as dental, substance use rehabilitation, pharmaceutical coverage).



The program is jointly funded by states and the federal government, and states act as program administrators. There is wide variation among the states with respect to covered populations, eligibility levels, and service delivery systems.

## Medicaid & COVID

**15.9%** Regulatory flexibilities, born out of the COVID-19 pandemic, have caused enrollment to surge. Enrollment in Medicaid and the Children's Health Insurance Plan (CHIP) grew by 15.9% in 2021.




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## Medicaid Expansion

- Medicaid expansion is critical for ensuring access to sexual, reproductive, and maternal health care. In March 2021, the American Rescue Plan established new financing opportunities for expansion, incentivizing the 12 remaining holdout states to expand their Medicaid programs.
- Most states expand Medicaid eligibility for pregnant people beyond the federal requirement.
- States have a lot of flexibility with Medicaid Family Planning in regard to eligibility and coverage. States that have expanded their programs tend to cover family planning. States that have not expanded their programs may have very low thresholds for eligibility.

## Funding for Medicaid Programs

- Paid for by a combination of state and federal funds.
- Federal Medicaid financing is divided into 3 buckets:
  -  Contributing a share of each state’s costs for beneficiary services at a fixed rate.
  -  Contributing a portion of each state’s administrative services.
  -  Additional payments to hospitals that primarily treat people on Medicaid.

## Medicaid Delivery Models

### TRADITIONAL

- Fee-for-service

### MANAGED CARE

- Risk-based Managed Care
- Primary Care Case Management

### OTHER

- Premium Assistance for Qualified Health Plans on the Marketplace
- Premium Assistance for Employer-Sponsored Insurance

## Extended Postpartum Coverage

Under the American Rescue Plan Act, states have a new option to extend Medicaid/CHIP postpartum coverage from 60 days to 12 months. States that adopt this option must provide full benefits to pregnant and postpartum individuals.

## Overview of the Medicaid Benefit Package

### MANDATORY

- Mandatory benefits include family planning, nurse-midwife services, inpatient and outpatient hospital services, and access to freestanding birth centers.
- Federal law requires states to cover a minimum level of mandatory benefits, but states may limit their amount, scope, or duration (e.g., number of visits).
- Benefits must be the same across the entire state.
- Additional mandatory benefits are covered for certain eligible groups such as pregnant people, children, the elderly, disabled people, low-income parents, adults in the Expansion program.
- Includes Family Planning, Nurse midwife Services, inpatient and outpatient hospital services, and access to freestanding birth centers.

### OPTIONAL

- Coverage of prescription drugs is optional but all states cover them

## Medicaid & Sexual, Reproductive, & Maternal Health Care

Medicaid provides access to essential sexual and reproductive health care, like contraception, testing and treatment for sexually transmitted infections (STI), wellness exams, family planning, maternity care, and life-saving cancer screenings.

Medicaid plays an extremely important role in reproductive and maternal health care.

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# 43%

In 2018, 43% of all US birth were covered by Medicaid.

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# 21%

**Black Americans**

# 22%

**Hispanic Americans**

About 21% of all Black Americans aged 15-44 and 22% of all Hispanic Americans aged 15-44 who were pregnant were enrolled in Medicaid when they gave birth.

## State of Play with the Current Administration



Early executive actions by the Biden Administration underscore its commitment to widespread coverage.



Coverage:

- **Medicaid:** Re-established coverage as the objective of the program; began the process of rescinding waivers that allowed states to impose work requirements.
- **Individual Market:** Called for rescission of Trump-era rules encouraging non-ACA-compliant plans; opened a COVID-19.gov special enrollment period, and provided additional navigator funding.



**Equity:** Issued an order to embed equity across federal policymaking and root out systemic racism; established the COVID-19 Health Equity Task Force



**Family Planning:** Directed HHS to consider changes to restrictions on use of federal Title X funds by family planning providers.



**Immigration:** Directed agencies to review rules and agency actions related to Trump-era policies that had a chilling effect on immigrants seeking access to health care.

Responding to the COVID-19 pandemic will dominate the health care agenda of both Congress and the Administration for the foreseeable future.

## Medicaid Covered Benefits

### ELIGIBILITY GROUP

- Benefits packages differ by eligibility group, and each eligibility group has different income requirements. For example, an “expansion” adult’s income eligibility level is 138% of the federal poverty level, and a pregnant person’s eligibility level could be 250% of it (depending on where the pregnant person lives).
- Each benefit package has minimum coverage requirements; states have flexibility to enhance coverage benefits for every group.
- Federal law requires states to cover a minimum level of “mandatory” benefits.
- States may limit the amount, scope, or duration of these benefits (e.g., number of visits covered).
- Within eligibility groups, benefits must be the same across the entire state.
- Certain groups are eligible for expanded benefits (like pediatric dental care, family planning, home health, etc.)

### PREGNANT PEOPLE

- States are mandated to provide coverage for pregnant people but have some flexibility in establishing income eligibility levels and covered benefits. States can make different choices about what to cover in a broad range of pregnancy-related support services and other non-hospital care offered to pregnant people.
- States are required to provide coverage to people with incomes up to 138% of the federal poverty level during pregnancy and 60 days postpartum (some states have extended this to 12 months postpartum!)
- Most states extend coverage to higher income levels (up to 250-380% of the federal poverty level)
- States are required to provide inpatient and outpatient medical care.
- Most states choose to cover basic prenatal services such as ultrasounds and vitamins, genetic testing, home visits, delivery in birth centers, postpartum visits, and breast pumps.
- Some states choose to cover childbirth and parenting classes, breastfeeding education, and lactation support.
- Very few states choose to cover doula and midwifery care.

### FAMILY PLANNING

- Expansion states are required to cover family planning. States may, but are not required to, provide separate family planning services to people who are enrolled in Medicaid.
- Expansion states must provide contraceptives, screening services, and counseling as a family planning benefit.
- States may use a Medicaid state plan amendment or 1115 waiver authority to provide a limited benefit package of family planning and related services to people otherwise ineligible for Medicaid.
- States have greater flexibility with respect to age, gender, income limit, family planning, and related services and supplies covered under 1115 waiver authority than under SPA authority.
- Often people who qualify for a family planning benefits package do not qualify for any other eligibility group (e.g., elderly, pregnant, disabled).

# Benefits Deep Dive



## MEDICAID COVERAGE OF CARE MANAGEMENT

Some states have strong requirements for Medicaid managed care or patient-centered care management to improve health outcomes for people with greater health care needs, including pregnant and postpartum people. Some states require that a percentage of care management be community-based and conducted in-person.

### State trends in medicaid managed care:

- Establish robust care management requirements for high-acuity populations which includes:
  - Conducting assessments of care needs
  - Developing and continually updating detailed care plans
- Performing health-risk stratification for early identification of physical and behavioral health needs
  - Providing targeted support during transitions in care



## LEVERAGING VALUE-ADDED AND IN-LIEU-OF SERVICES

Medicaid managed-care plans are obligated to cover case management and any other social support services that are built into the state’s benefit package and the MCO contract. MCOs may add additional services (not covered under the contract) in order to reduce costs and improve quality of care.

### In-Lieu-Of Services

are care services or settings that a plan substitutes for a similar service covered under the contract (e.g., preventative health, prenatal support, and assistance connecting other key community services “in lieu of” a typical prenatal visit).

- Such services qualify as covered services for rate setting.

### Value-Added Services

are extras, unrelated to contract services, and not part of the capitation rate (technology and innovation services are often in this category).

- States have assessed value-added services as part of their managed care program procurements and re-procurements. (Louisiana MCOs expanded dental services not covered by the state plan as a value-added service.)
- Plans may also provide value-added services when such services produce cost savings.



## SOCIAL DETERMINANTS OF HEALTH (SDOH) BENEFITS

**States are seeking to leverage federal Medicaid funding to invest in interventions that address social determinants of health. States are incentivizing or requiring Medicaid managed-care plan investment by:**

- Classifying certain social services as covered benefits under the state Medicaid plan
- Using value-based payment requirements to drive provider investment in social interventions
- Using incentives and withholdings to encourage plan investment in social interventions
- Integrating SDOH measures (location, income, education, etc.) in measurements of quality improvement performance
- Rewarding plans through higher rates for effective investments in social interventions
- Exploring use of value-added and “in lieu of” services

**Some states have established SDOH-related pilot programs through 1115 waivers. This is also an avenue for integrating tech innovation into care. Some examples:**

- “Healthy Opportunities”: a pilot addressing food, housing, transportation, and personal safety (NC)
- “Foundational Community Supports”: pilots of housing and employment support (WA)
- “Community Health Pilot Programs”: housing and home visit services (MD)
- Home Visit and Community Integration: pilot programs (IL)



## INEQUITIES IN TELEHEALTH ACCESS

The significant inequities in access to telehealth for Medicaid-eligible individuals and families are exacerbated for people who live in rural areas or subsidized housing or who are housing insecure, racial and ethnic minorities, older adults, those with limited health or tech literacy or limited English proficiency (LEP).

**Many of these inequities were highlighted during the COVID-19 pandemic.**

- **Broadband access:** Only 56% of low-income Americans have broadband at home. Across the US, households that have someone enrolled in Medicaid or with a disability are ~9% less likely to have access to broadband internet than or households without a Medicaid enrollee.

- **Language barriers:** The 25 million Americans who speak little English are disproportionately low-income. Medicaid and CHIP providers must ensure that LEP patients receive translation services in their spoken language, but only 15 states reimburse directly for such services.
- **Technology access:** Only 71% of low-income Americans owned a smartphone in 2019.
- **Awareness:** Before the pandemic, only 1/3 of Americans had ever used telehealth services.
- **Digital literacy:** Only 53% of low-income Americans have achieved a basic ability to navigate, evaluate, and communicate online.



## MEDICAID COVERAGE OF TELEHEALTH SERVICES

State programs have broad discretion to design their telehealth coverage, within federal guidelines. Most state programs expanded their coverage of telehealth services during the COVID-19 pandemic. Within the scope of their telehealth policies, states can define:

- Which in-person services to cover via telehealth service
- Which practitioners may deliver such service
- Which virtual care modalities (video, e-consult, phone, etc.) can be used
- Where in the state the service is covered (i.e. the originating site requirement)
- How the services will be reimbursed (States must submit a State Plan Amendment if telehealth services are reimbursed at a different rate than in-person services)



## COVERED BENEFITS AND ABORTION

- Coverage for abortion is increasingly limited by state and federal regulations.
- The Hyde Amendment restricts state programs' use of federal dollars to cover abortion care beyond rape, incest, or threat to the life of the pregnant person.
- 15 states use state-only funds to include abortion care in their covered benefits.



# Medicaid Financing



## MEDICAID DELIVERY MODELS

### TRADITIONAL

- Fee-for-service

### MANAGED CARE

- Risk-based Managed Care

### HYBRID APPROACH

- Provider/community-led managed care
- Multiple delivery systems, including managed care organizations, accountable care organizations, and FFS models



## FEE-FOR-SERVICE MODEL

- The state pays providers directly for each service (e.g., office visit, test, or procedure).
  - Each state's payment methodology for services is outlined in its State Plan (contingent on Federal approval).
  - States develop payment rates based on
    - Costs of providing services
    - Market rates of services paid by commercial payers
    - Percentages paid by Medicare for equivalent services
- Medicaid FFS payment rates are lower than in other markets (commercial, Medicare).
- Generally providers act independently of one another; there is little to no coordination of care.
- Providers do not bear any financial risk for provision of services.
- FFS payments are triggered by submission of a claim indicating that a service has been provided. Medicaid can reimburse for provider services, prescriptions, or durable medical equipment.

## FFS PROVIDER EXAMPLE

- To be enrolled as Medicaid providers, providers must apply to the state in which they intend to provide services.
  - Providers' enrollment applications are screened by states to verify that providers meet state and federal enrollment criteria (e.g., background checks, license verification).
- After completing an approved or authorized service, an enrolled provider submits a standardized claim electronically to the state Medicaid agency.
- Claims are subject to approved rates and a variety of data checks before payment is made to the provider.
- Claims provide a record of services provided using billing codes.
  - Physician and clinic services, for example, are commonly reported using Current Procedural Terminology (CPT) codes that are developed and maintained by the American Medical Association.
  - Federal statutes require that 90% of practitioner or shared health facility claims that require no follow-up be paid within 30 days, and 99% within 90 days.
  - Payment rates are determined by the state in accordance with its Medicaid plan.



## CAPITATED MANAGED CARE ACROSS THE COUNTRY

- 40 states use either managed care organizations (MCOs) only or MCOs in combination with primary-care case management (PCCM) models.
- The state contracts with MCOs, not direct service providers.
- MCOs accept a set “per member per month” (PMPM), or capitated, payment to cover Medicaid and other services for enrolled Medicaid beneficiaries.
  - In doing so, the MCO bears the financial risk for the provision and coverage of Medicaid services.
- PMPM rates are developed by state actuaries using a CMS-prescribed rate development methodology; CMS reviews and approves rates regularly.
- Consumers receive part or all of their Medicaid-covered services from MCO-contracted providers.
- Accountability for enrollees’ outcomes rests solely with the MCO; they monitor service utilization, coordinate service delivery, and monitor outcomes.

## MORE ON CAPITATED MANAGED CARE

- Capitation allows states to reduce—and predict—Medicaid program costs and better manage utilization of services.
- States determine covered benefits, as well as which populations are eligible to enroll.
- Plans can be comprehensive or non-comprehensive (“partial cap”).
  - Comprehensive plans cover the full range of benefits (e.g., mainstream Medicaid managed care plans in New York).
  - Non-comprehensive plans cover a subset of benefits (e.g., managed long-term care plans in New York).
- Improvements in MCO performance, health care quality, and health outcomes are key objectives of Medicaid managed care.



## NEW POPULATIONS AND BENEFITS IN MANAGED CARE

Medicaid traditionally served birthing people and children—a relatively young and healthy group.

### Expansion of care into new populations

States are increasingly enrolling higher-need and higher-cost beneficiaries

- Dual-eligible beneficiaries (e.g. a pregnant, disabled adult)
- Beneficiaries with severe mental illness
- Beneficiaries with substance-use disorders
- Beneficiaries with developmental disabilities

### New Benefits

States are “carving on” new benefits, such as

- Long-term services and support (LTSS)
- Permanent placement in nursing homes
- Hospice care
- Personal care services
- Home health services
- Auxiliary health services (dental, vision)
- Behavioral health services
- Pharmaceutical services
- School-based health center services



## GETTING PAID IN A MANAGED CARE ENVIRONMENT

- Payments vary in amount and complexity depending on the populations served, the benefit packages provided, and whether the plans are at risk for costs of services.
- States issue requests for proposals for procurement or re-procurement of managed care plans at state-specific schedules.
- States contract with MCOs to provide care; the contracts outline arrangements for payment to providers.
- States typically pay MCOs for risk-based care services through fixed periodic payments for a defined package of benefits. These capitation payments are typically made on a per-member, per-month basis.
- MCOs negotiate with providers to provide services either on a FFS basis or through a fixed periodic amount.
- To receive a payment in a managed care contract, providers need to identify which managed care plans have state contracts and become a contracted provider to a specific MCO.
  - This will require multiple contracts.



## EVOLUTION OF PRICING MODELS FOR DIGITAL HEALTH

### Models

- Free or freemium (advertising-based)
- One-time payment per member
- Licensing model
- Per member per month based on eligible users
- Per member per month based on actual users
- Outcomes-based and risk-sharing contracts (increasingly popular)

### General Pricing Structures

- Depends on outcomes and cost-savings potential
- For payers, generally in the \$60-250/month range for digital therapeutics, lower for others



## REIMBURSEMENT FOR REMOTE MONITORING: 25 STATE MEDICAID PROGRAMS COVER RPM

**New CPT codes for remote physiologic monitoring (RPM) may increase utilization of more digital health services and drive provider uptake**

- Existing RPM Codes: 99453, 99454, 99547, 99548
- Applicability: RPM, initial device set-up, patient education, device supply, treatment management services
- Examples: blood pressure, ECG, blood oxygen

**Potentially forthcoming CPT codes for remote therapeutic monitoring (RTM): 989X1, 989X2, 989X3, 989X4, 989X5**

- Applicability: RTM, initial set-up, patient education, device supply, and treatment management services
- *Note: RPM codes have a history of low uptake due to (1) onerous code-specific requirements for billing, (2) highly variable uptake by commercial payers, and (3) documentation requirements*



## STAKEHOLDER EVIDENCE REQUIREMENTS: BEST PRACTICES FOR GENERATING EVIDENCE

- Double-blinded randomized controlled trial
- Sufficiently powered sample size
- 12 months of data on clinical and financial outcomes
- Impact on total cost of care (ideally over a multi-year period)
- Sustained engagement or utilization
- Short-term return on investment (within 12 months)

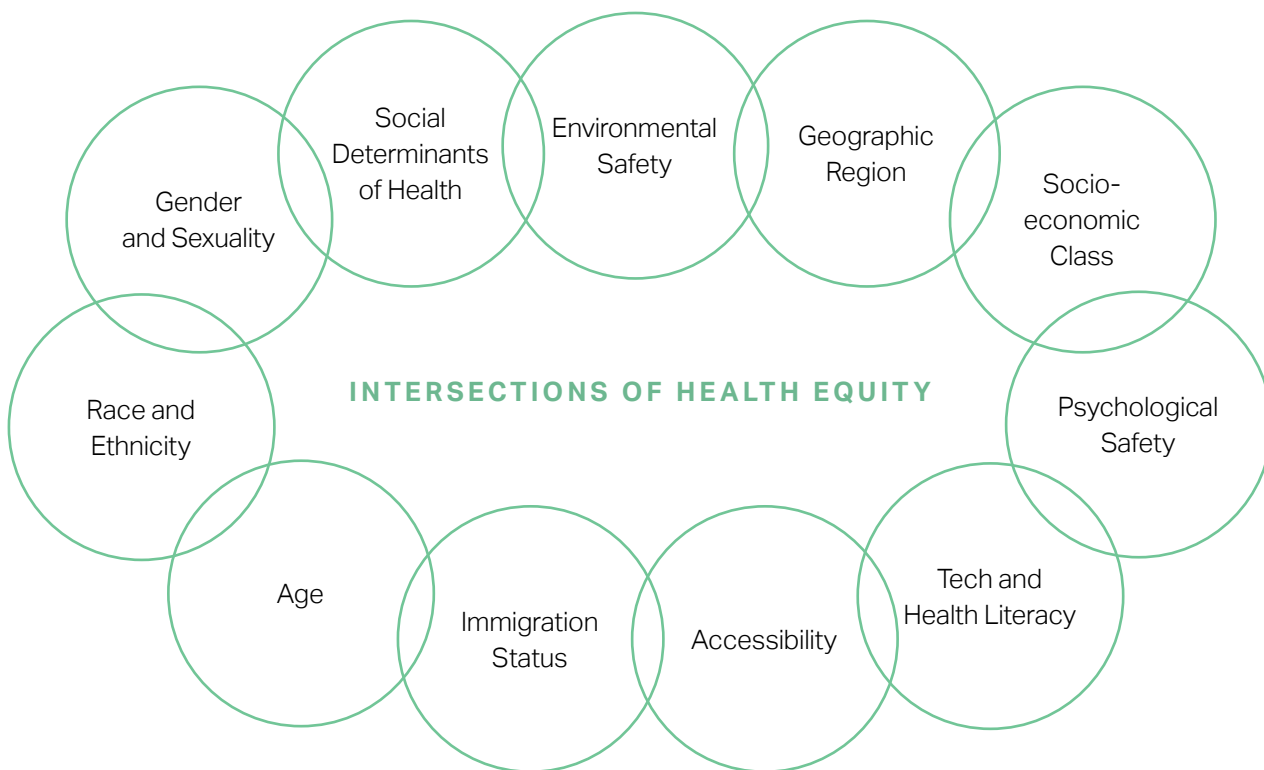
# Advancing Health Equity in Medicaid

## WHAT IS HEALTH EQUITY?

“ Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

– Robert Wood Johnson Foundation

In the context of reproductive and maternal health, health equity means safe, affordable, and comprehensive health care without barriers and autonomy over one’s reproductive health decisions. It requires grappling with and addressing the systemic inequities that exist in our healthcare systems and communities that lead to health disparities. This requires engaging across multiple sectors, assessing needs and resources, prioritizing and planning, evaluating social determinants of health, and implementing a plan to evaluate and sustain our actions.





## REPRODUCTIVE HEALTHCARE + MATERNAL HEALTH CARE IN MEDICAID

- 20% of women of reproductive age are insured through Medicaid.
- Medicaid is the largest payer of reproductive health care coverage, paying 75% of all public funds spent on family planning services.
- Medicaid covers prenatal care, delivery care, and other essential pregnancy care for 42% of people giving birth.
- 31% of Black women and 27% of Hispanic women ages 15–44 are enrolled in Medicaid, compared with 16% of White women.



## REPRODUCTIVE JUSTICE

- Reproductive Justice is the social movement rooted in the belief that all individuals and communities should have the resources and power they need to make their own decisions about their bodies, gender, sexualities, families, and lives.
- Reproductive justice is the right to maintain personal bodily autonomy, to have children, to not have children, and to parent children in safe and sustainable communities.
- The Reproductive Justice framework- developed by the organization SisterSong- incorporates an intersectional lens to examine the root causes of reproductive oppression leading to inequities.
- The Reproductive Justice framework works alongside the Reproductive Health framework—which focuses on health care and service delivery—and the Reproductive Rights framework—which supports access through policy and legislation.

## The Biden Administration's National Health Equity Efforts



### MEDICAID PAYMENT INITIATIVES TO IMPROVE MATERNAL HEALTH OUTCOMES

- Pregnant people in the US experience cesarean deliveries and early elective deliveries at higher than optimal rates.
  - The use of unnecessary interventions during delivery has significant implications for Medicaid, leading state Medicaid programs to implement payment initiatives to reduce unnecessary potentially harmful procedures and improve access to prenatal and postpartum care
- Payment options include:**
- Bundled payments
  - Blended payment rates
  - Reduced payment and nonpayment
  - Pay for performance
  - Medical homes



### EXECUTIVE ORDER ON ADVANCING RACIAL EQUITY AND SUPPORTING UNDERSERVED COMMUNITIES

The federal government is pursuing a comprehensive approach to advancing equity for all with specific emphasis on advancing civil rights, racial justice, and opportunity by

- Promoting equitable delivery of government benefits and opportunities
- Establishing working groups on equitable data
- Engaging with members of underserved communities
- Allocating federal resources to advance fairness and opportunity (e.g., the American Rescue Plan)
- Conducting an equity assessment in federal agencies



## INITIAL ACTIONS TO ADDRESS THE BLACK MATERNAL HEALTH CRISIS

### **Increased investment in reducing maternal mortality and morbidity**

- \$200 million to implement these four efforts:
  - Implicit bias training for medical providers
  - State pregnancy medical home programs
  - Bolstering maternal mortality review committees
  - Incorporating childhood development experts in pediatric offices with high shares of Medicaid and CHIP patients
- Providing an 18.7% funding increase to the Title X Family Planning Program
- Allocating \$6 billion for the critical Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

### **Approval of the first Medical section 1115 waiver**

- Extends postpartum coverage of Medicaid-eligible women beyond 60 days, for up to 12 months

### **Additional funding for maternal health care in rural areas**

- \$12 million in new awards for the Federal Office of Rural Health Policy's Rural Maternity and Obstetrics Management (RMOM) Program
- Develops models and implementation strategies to improve access and continuity of maternal obstetrics and outcomes in rural communities





## ADDITIONAL COMMITMENTS TO EQUITY

### Biden's Agenda for Women

- Improve economic security
- Expand access to health care and tackle health inequities
- Women's Health Protection Act
- Black Maternal Health Momnibus Act
- Equal Access to Abortion Coverage in Health Insurance (EACH)

### Biden's Plan to advance LGBTQ+ Equality

- Enact the Equality Act to guarantee LGBTQ+ individuals are protected under existing civil rights laws
- Empower federal agencies to be champions of equality by nominating and appointing federal officials and judges who identify as LGBTQ+
- Reverse the Transgender Military Service ban
- Reverse the Department of Defense policies that perpetuate stigmatization and discrimination against people living with HIV
- Provide additional Support for LGBTQ+ veterans and youth



## CMMI ACCOUNTABILITY FOR RACIAL EQUITY

The Center for Medicare and Medicaid Innovation's (CMMI) models to date have not routinely or sufficiently considered impact on racial equity.

### CMMI is moving to prioritize equity by:

- Considering potential impacts on equity in model design and development
- Developing feasible, consensus-driven metrics on equity of care provided
- Holding health systems, providers, and payers accountable for measuring quality of services

### CMMI can use various mechanisms to advance equity, including:

- Directly paying for performance on outcomes
- Requiring the collection and public reporting of data by race and ethnicity
- Requiring participating entities to create plans to reduce documented inequities
- Revisiting risk-adjustment methodologies to ensure that they are not disadvantaging entities that serve vulnerable populations
- Ensuring accountability, currently the central challenge of delivery system reform

- Value-based payment is a very popular approach, but it should be part of a comprehensive strategy that brings together a variety of mechanisms.
- CMMI has the opportunity to build on experience and demonstrate how to take healthcare delivery to a new level.



### MARSHALL PLAN FOR MOMS

- An initiative created out of the disproportionate economic and personal impact that COVID-19 has had on birthing people, resulting in employment loss and reduction, burnout, higher rates of postpartum depression, and increased mental load.
  - 2.3 million birthing people left the workforce in 2020.
  - Women of color are leaving the workforce at twice the rate of White women.
- Goals of the initiative are to make it possible for birthing people to be more supported in both career and parenting by
  - Making payments directly to birthing parents, who have had to replace their paid labor in the workforce with unpaid labor (parenting and homemaking)
  - Passing policies for paid family leave, affordable childcare, and pay equity and transparency
  - Establishing retraining programs to help women re-enter the workforce
  - Developing plans to safely re-open schools



### EQUITY-FOCUSED PAYMENT AND DELIVERY MODELS

- Several states are developing Medicaid health equity incentives as part of a broader effort to reform how health care is financed and organized in ways that are intended to improve population health, particularly in marginalized communities.
- Sexual, reproductive, and maternal health entrepreneurs have an important opportunity (and responsibility) to center equity in their companies, product, and healthcare enterprises and to improve health outcomes for their target audience.
- Future efforts can build on early policymaker progress, take action to develop bold and transformative plans to hold teams, customers, and healthcare systems accountable for health outcomes and reducing inequities, while working hand in hand with health equity and consumer health leaders to harness the current political moment for tangible, sustainable change.



## MULTIPLE DELIVERY SYSTEMS EXAMPLE: MASSACHUSETTS

**Massachusetts has multiple delivery systems, including managed care organizations (MCOs), accountable care organizations (ACOs), and fee for service (FFS).**

### Delivery System

**39%**

of members are enrolled in an MCO or ACO Partnership Plan.

**26%**

are enrolled in a primary care ACO or the state's primary care case management program.

**35%**

are enrolled in Medicaid FFS or specialized products for dual-eligibles.

- **MCOs:** States contract with two MCOs that provide comprehensive health coverage, including behavioral health services (planning to phase in long-term services and supports)
- **Three types of ACOs:**
  - MCO-Administered ACOs: provider-led entities with one or more MCOs to provide care coordination and management and take financial accountability for cost and quality for certain attributed MCO enrollees
  - ACO Partnership Plans: provider-led ACOs contracting with one MCO; accepts full capitation from MassHealth (Massachusetts Medicaid)
  - Primary Care ACOs: provider-led ACOs contracting directly with the state
- **Key Model Features:**
  - Flexibility for different delivery system models (plan and provider driven) at different levels of financial risk
  - Administrative complexity owing to multiple delivery system models
  - Significant responsibilities for investments in community-based providers for individuals with behavioral health and long-term services and support needs



## MASSACHUSETTS: IMPACT ON EQUITY

**Massachusetts is a leader in risk-adjusted, advanced, alternative Medicaid payment methodologies using social risk factors.**

### Delivery System Impacts

- MassHealth shifted most Medicaid financing into an ACO structure beginning in 2016, supported by a Medicaid section 1115 waiver.
- The MassHealth ACO program has a strong emphasis on social determinants of health (SDOH) and improving and integrating the delivery of behavioral health services. Behavioral health care in Massachusetts, like in many states, is siloed at the administrative, purchasing, and payment levels, resulting in significant barriers to access for consumers and inequitable health outcomes.

### ACO Model Features

- The state’s ACO program includes newly certified behavioral health community partners who work directly with ACOs to provide comprehensive care-management services for those with behavioral health needs.
- ACOS also contract with community-based social services organizations to deliver services such as housing and food. These organizations also conduct social needs screening, and ACOs are building and refining early implementation of SDOH interventions and operating protocols.
- ACOS access federal Medicaid waiver funding to provide these services.
- To assess costs and capitation rates, Massachusetts is using a methodology that it developed to risk-adjust on the basis of stability of housing status and a standardized “neighborhood stress score” using census data.



## PROVIDER/COMMUNITY-LED MANAGED CARE EXAMPLE: OREGON

### Delivery System

- Oregon has a provider/community-driven managed care system.
- Oregon contracts with 15 coordinated care organizations (CCOs) that serve the majority of the state’s Medicaid enrollees.
  - CCOs are MCOs that integrate physical, behavioral, and oral health while providing health-related services to address SDOH.

### Key Model Features

- Commercial managed care with a significant plan governance role for providers
- Full integration of services across physical, behavioral, and oral health in the CCO model
- Coverage and financing through managed care



## OREGON: IMPACT ON EQUITY

### Delivery System

- Oregon's broader Medicaid system reform efforts began in 2012 and centered on CCOs, to work collaboratively to improve health outcomes and reduce healthcare costs.
- In 2019, the Oregon Health Authority went through an extensive procurement process to secure the next iteration of CCOs (called CCO 2.0). Beginning in 2020, CCOs have been required to make investments in "health-related services" including SDOH and health equity initiatives. Oregon now directs CCOs to use administrative funds—margins after paying for covered benefits—to provide services related to SDOH (food vouchers, meal delivery, housing services, utilities, environmental remediation, education, etc.)
- Oregon also established an SDOH Health Equity Capacity-building Bonus Fund to reward CCOs that reach outcome-based milestones. CCS are also required to use traditional health workers, such as community health workers, as an integral component of their workforce.

### Key Model Features

- Oregon is the state furthest along in incentivizing providers based on equity performance, but it has had difficulty collecting demographic data on enrollees. Incentive measures based on administrative claims data are disaggregated by race, ethnicity, language, sex, and disability status, losing a critical step to build health equity measures.
- Oregon is beginning to designate certain incentive measures as equity measures. The first CCO health measure is Meaningful Language Access to Culturally Responsive Health Care Services, which was developed to measure access for people with limited English proficiency or who communicate in sign language.



## SPECTRUM OF EQUITY

### Internal Equity

- Self
- Leadership Team
- Governance
- Human Capital (including pay equity)
- Organizational Culture
- Internal Communications
- Business Development

### External Equity

- Sales
- Marketing/Branding
- Product Development
- External Communication



## EQUITY QUOTIENT (MEASURING EQUITY)

**Meant to measure internal equity through outcomes and hold leadership accountable to their stated equity commitments**

- Perceptions of internal equity often differ between senior leadership and staff
  - Internal equity discrepancies can have ripple effects to external equity factors, including health outcomes of patients
- Components of measuring internal equity
  - Safety
  - Respect
  - Value
  - Hiring, pay, and promotion
  - Culture