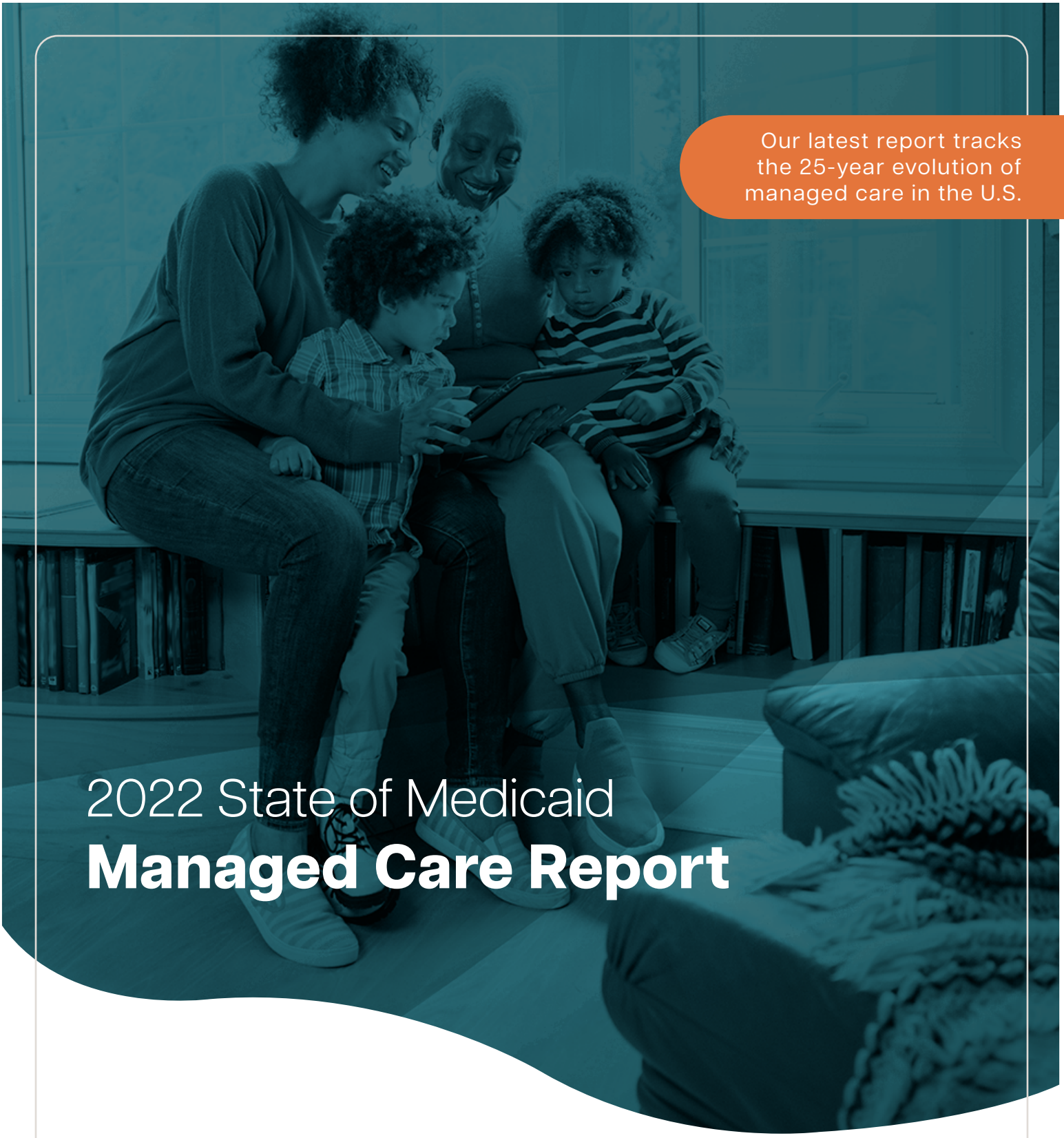


Our latest report tracks the 25-year evolution of managed care in the U.S.

2022 State of Medicaid
Managed Care Report

A collaboration between

sellers dorsey

mhpa
Medicaid Health Plans of America

ACAP
Association for Community Affiliated Plans

CONTENTS

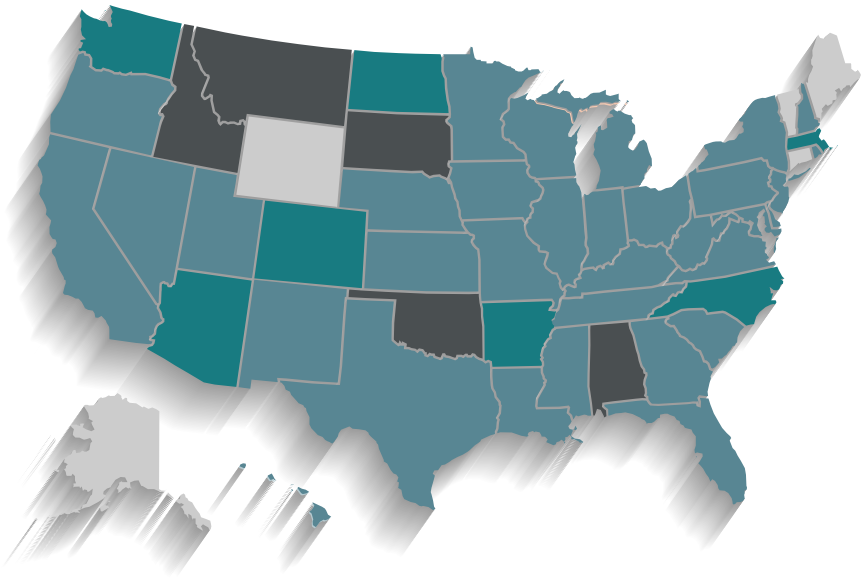
EXECUTIVE SUMMARY

While in 2022 managed care is the predominant delivery system states use for delivering Medicaid services, this has not always been the case. Twenty-five years ago, prior to the passage of the Balanced Budget Act of 1997 (BBA), the federal statutory and regulatory framework for Medicaid made it difficult for states to implement new and expand existing managed care programs, which resulted in a primarily fee-for-service delivery system. This system had few mechanisms to encourage improvements in the quality of care, while at the same time rewarding providers for delivering volume over value. Changes at the federal level, beginning with passage of the BBA, allowed states to expand their use of managed care delivery systems, which has in turn facilitated new partnerships between states and the managed care industry. The growing role of managed care organizations (MCOs) as state partners in the delivery of Medicaid services has led to improved access, increased services, and program innovation, as MCOs have competed for members and state contracts by offering tailored packages of value-added services, maximizing performance on quality measures, and investing in the local communities in which they do business. The result of these 25 years of experience and evolution is a Medicaid program that is not just a state and federal partnership, as it is often described, but a partnership between the federal government, state governments, and private industry, in which all three parties have collaborated to push each other to improve and further advance the goals of the Medicaid program.

This report traces the evolution of Medicaid managed care since the 1997 passage of BBA, which transformed the regulatory framework for managed care and provided the context in which the modern Medicaid managed care sector came into being. In **Section 1**, we provide an overview of the state of the Medicaid managed care industry today, focusing on key figures related to enrollment, market share, and spending. In **Section 2**, we describe the history of federal regulation related to Medicaid managed care, recounting key changes from the BBA of 1997 through the more recent Centers for Medicare & Medicaid Services (CMS) managed care regulations of 2020. In **Section 3**, we profile six states (Arizona, California, Florida, New Jersey, North Carolina, and Texas) and highlight their effective approaches to managed programs. In **Section 4**, we profile six MCOs (Aetna Better Health of Florida, AlohaCare of Hawaii, AmeriHealth Caritas of North Carolina, Banner Health of Arizona, Molina of Illinois, and Texas Children's Health Plan of Texas) and describe their innovations and successes in their respective state markets. Finally, in **Section 5**, we provide an overview of some of the outcomes stemming from Medicaid managed care, as documented in states' program evaluations and other public reporting.

SECTION 1

State of the Managed Care Industry



40 states (plus Washington DC) Use the Managed Care Delivery System

- FFS
- MCO and PCCM
- MCO
- PCCM

MCO Enrollment

CLICK HERE for more details on MCO Enrollment

Total Medicaid/ Managed Care Spending

CLICK HERE for more details on Total Medicaid/ Managed Care Spending

SECTION 2

Evolution of Federal Oversight 1997–Present

> "The BBA signaled that Medicaid managed care was here to stay – states no longer had to apply for a waiver. And this freed health plans to make long-term investments in their communities and focus exclusively on serving people with low incomes, if they chose to do so."
>
> – Margaret A. Murray, CEO, Association for Community Affiliated Plans

Balanced Budget Act of 1997

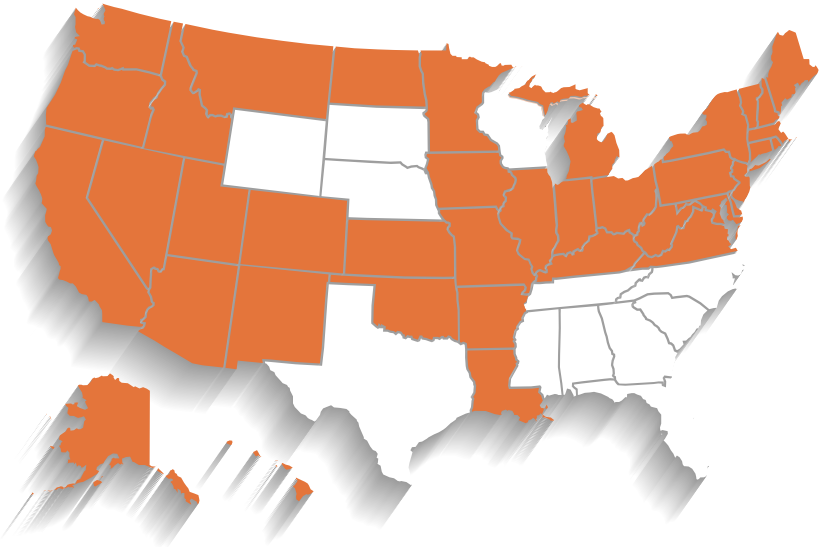
The passage of the Balance Budget Act of 1997 (BBA 1997) (P.L, 105-33) was a critical milestone in developing the modern framework for Medicaid managed care. Prior to 1997, states were permitted to implement managed care and mandate enrollment only under waiver authority, using either 1115 or 1915(b) waivers, and 38 states had implemented one or more risk-based managed care programs.[1] Under these authorities, only one-third of Medicaid beneficiaries were enrolled with a MCO[2], of which another third of beneficiaries were enrolled in a non-risk primary care case management (PCCM) arrangement. However, these authorities brought with them key limitations, including the requirement that waivers be reauthorized by the Centers for Medicare & Medicaid Services (CMS) on a regular cadence. Further limiting states' abilities to implement managed care was the 75/25 rule, which required Medicaid beneficiaries to make up no more than 75% of the membership of an MCO. While Congress passed legislation waiving the 75/25 rule for some MCOs, and CMS had discretion to waive the rule under 1115 demonstration waivers, the rule sharply limited managed care growth until its repeal under BBA 1997.

In addition to eliminating the 75/25 rule, BBA 1997 also created a state plan option under Section 1932 of the Social Security Act (the Act) for states to implement Medicaid managed care, allowing states to mandate enrollment for most eligibility groups (except dual eligibles, American Indians, and children with special health care needs) without obtaining a waiver. States were permitted to mandate beneficiaries to choose between at least two MCOs in urban areas and mandate enrollment in a single MCO in non-urban areas. This provided flexibility to states to operate managed care programs permanently without first seeking CMS approval for waiver renewals, easing administrative burden.

Recognizing the high financial stakes associated with expanding Medicaid managed care, BBA 1997 also bolstered state procurement and contracting standards. The Act required states to adopt conflict of interest standards for MCO contracting that are as effective as federal standards. The Act also applied similar standards to state staff involved in the procurement and management of other large Medicaid contracts, such as an enrollment broker or claims administrator.

At the same time, BBA 1997 put in place many of the regulatory guardrails of the modern managed care system. The Act required states implementing managed care under Section 1932 to contract with a "qualified independent entity" to conduct an annual external review of MCOs that must be made available to the public. This requirement formed the basis for today's state external quality review organizations (EQROs). The Act also required states implementing managed care to develop quality improvement strategies, including standards for access to care. In addition, the Act put in place numerous other beneficiary protections related to MCO marketing, balance billing, disenrollment protections, requirements for information sharing, grievance and appeals and prohibitions on physician "gag" rules.

"The Balanced Budget Act of 1997 was a critical milestone in developing the modern framework for Medicaid Managed Care."



As of November 4, 2022

39 states have expanded Medicaid coverage

EXPANDED **NOT ADOPTED**

Patient Protection and Affordable Care Act of 2010

The 2010 passage of the Affordable Care Act (ACA) provided additional opportunities to expand and increase the use of managed care within the Medicaid program, most notably through a significant expansion of eligibility for adults. Newly eligible adults covered through the Medicaid expansion are required to receive an Alternative Benefit Package, which is measured against the benefits offered through the second lowest cost silver-tier plan offered on the Exchange.[3] This requirement was an attempt to align Medicaid more closely with commercial coverage and modernize Medicaid benefit design. Although Medicaid expansion was made optional in 2012 resulting from *National Federation of Independent Business v. Sebelius,* 39 states and the District of Columbia have elected to expand coverage under the ACA, which has resulted in more than 20 million individuals, mostly adults, receiving Medicaid coverage, most of whom are served through managed care.[4]

Other important ACA changes impacting Medicaid managed care were the alignment of the minimum eligibility threshold for children in Medicaid at 133% of the federal poverty limit, which resulted in some states shifting some children from the Children's Health Insurance Program (CHIP) to Medicaid; and process changes to streamline Medicaid enrollment, which some analysts have recognized as contributing to increased Medicaid enrollment even in non-expansion states.[5]

CMS Managed Care Rule (2016)

In April 2016, CMS finalized the most significant rewrite to its regulations governing Medicaid managed care in more than 10 years. CMS intended the revisions to strengthen federal oversight and beneficiary protections while aligning expectations for Medicaid managed care with those of other major sources of coverage, such as Qualified Health Plans, also known as Marketplace plans. While most provisions of the rule became effective in July 2017, CMS provided for phased implementation on many key provisions over the next several managed care contract years.

The rule contains numerous provisions to enhance beneficiary supports and member experience, including:

1. Requiring MCOs to provide updated provider directories and formulary information to members
2. Requiring states to ensure information provided to members is easily accessible
3. Requiring states to provide members a 90-day period to change plans if they use a passive enrollment process
4. Strengthening access to care requirements by requiring states to establish time and distance standards across 11 provider types

The rule aligns requirements around MCO appeals and state fair hearings by allowing managed care members to continue receiving services pending the disposition of an appeal, but also requires members to exhaust the MCO appeals process before they may request a state fair hearing. Finally, the rule requires states to develop and maintain a written managed care quality strategy and authorizes CMS to develop a quality rating system for Medicaid and CHIP.

The rule also places new guardrails around managed care spending, establishing a minimum medical loss ratio (MLR) standard of 85% for Medicaid MCOs, which is the same standard used for Medicare Advantage, and requiring states to set capitation rates to achieve an 85% MLR. States are permitted, but not required, to establish a remittance requirement for plans that do not meet the minimum MLR under this regulation. The rule also establishes new parameters around directed payment programs in managed care, allowing states to direct MCO expenditures only based on the utilization, delivery of services to enrollees covered under the contract, or the quality and outcomes of services, thereby phasing out pass-through payments.

Importantly, recognizing the continued adoption of managed long-term services and supports (MLTSS), the rule for the first time outlined specific requirements related to MLTSS, signaling CMS's increasing interest in oversight of this rapidly growing delivery system. The 2016 managed care rule explicitly requires MLTSS plans to comply with home-and community-based services (HCBS) settings and person-centered planning requirements set forth in the 2014 rule related to HCBS settings. It also requires states to identify and assess individuals receiving long-term services and supports (LTSS) and establish stakeholder advisory groups for MLTSS programs. The rule also strengthens disenrollment protections for MLTSS members, requires states to establish both access standards for LTSS and an independent beneficiary support system for individuals receiving LTSS.

Other key provisions of the 2016 managed care rule include new requirements for the coverage of facility-based services that would otherwise be precluded by the institutions for mental disease exclusion, allowing states to pay for inpatient psychiatric or inpatient substance use disorder (SUD) services for no more than 15 days in a month as an "in lieu of" service; strengthening program integrity by requiring all providers, including providers only delivering services in managed care, to enroll in their state's Medicaid program; and strengthening requirements around the validity and timeliness of MCO encounter data.[6]

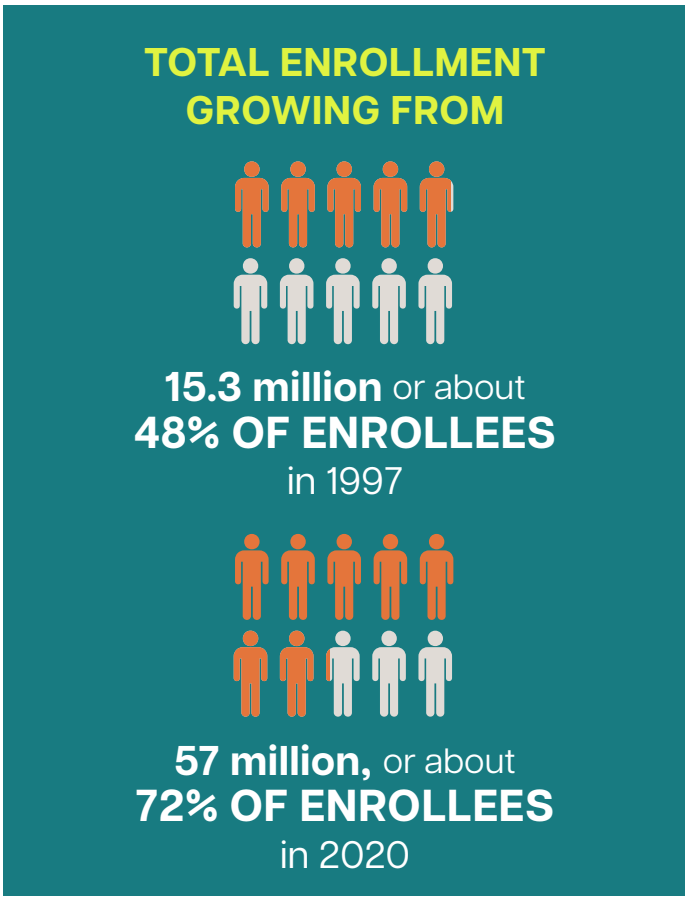
CMS Managed Care Rule (2020)

A CMS rule finalized in November 2020 offered more revisions to the regulatory framework for Medicaid managed care, although less sweeping than the changes made in 2016. Key changes in the 2020 CMS final rule include provisions that relax requirements of the 2016 rule and provide additional flexibility for states, such as allowing states to choose quantitative access standards other than time and distance, relaxing requirements around accessibility of written MCO materials and provider directories. The rule allows states to shorten the timeframe for members to request an appeal and allows members to request an appeal orally with no written follow-up. The rule also strengthens program integrity by requiring MCO encounter data to include both allowed and paid amounts.

Perhaps the most significant changes in the 2020 managed care rule are related to capitation rates. The rule allows states to establish capitation rate cell ranges, rather than one set rate per cell and allows states to adjust capitation rates +/- 1.5% within a rating period without CMS approval. At the same time, the rule prohibits states from varying capitation rates by eligibility group based on available federal financial participation. Finally, the rule incentivizes states efforts around value-based care by allowing multi-year approvals of directed payment programs that are tied to value-based purchasing (VBP).

Impact

The cumulative result of these federal legislative and regulatory changes has been to facilitate a framework that allows for the continued growth of Medicaid managed care as the dominant delivery system within the Medicaid program.



While changes in the statutory and regulatory framework for Medicaid managed care have opened new markets and made it easier for states to leverage managed care arrangements for increasingly complex eligibility groups, Congress and CMS have at the same time put in place additional provisions around access and quality, ensuring states take a thoughtful and considered approach to managed care implementation and oversight. The managed care growth in enrollment kicked off by BBA 1997 has been matched by growth in transparency and accountability, as well as improvements in program outcomes, which we will discuss in Section 5.

What Comes Next

In August 2022, CMS released proposed rules establishing mandatory annual reporting for the Core Set of Children's Health Care Quality Measures for Medicaid CHIP, the behavioral health measures on the Core Set of Adult Health Care Quality Measures for Medicaid, and the Core Sets of Health Home Quality Measures for Medicaid. Many states already require MCOs to report on these measures, as will be discussed in Section 4, and many states leverage Core Set and other measures as part of capitation withhold arrangements to reward improved outcomes.

CMS has also indicated through the Unified Regulatory Agenda it is developing additional rules related to managed care, tentatively scheduled to be released in April 2023. New rules would provide additional parameters on states' use of In Lieu of Services or Settings (ILOS) and state directed payments under Medicaid managed care contracts, as well as other policy and reporting changes to ensure the efficient operation of state managed care delivery systems and access to care for Medicaid managed care enrollees.

SECTION 3

State Managed Care Program Design

In this section, we profile six states (Arizona, California, Florida, New Jersey, North Carolina, and Texas) and highlight their approaches to managed care program design. The states selected represent a mix of states that have long-standing managed care programs, such as Arizona, as well as states that implemented managed care more recently, such as North Carolina. The profiles are based on research that included a review of publicly available documents, such as managed care contracts and provider manuals, as well as interviews with current and former state Medicaid staff.

Topics covered in each profile include:

Program History

Value-Based Purchasing

Procurement History and Approach

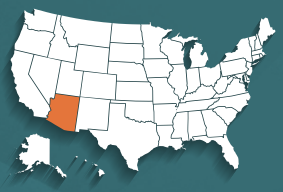
Quality Management

Medical Loss Ratio and Administrative caps

Social Determinants of Health and Health Equity

Capitation Withholds

ARIZONA



> "What I've really learned is the importance of managed care organizations as stakeholders. Our job is to partner with them to advance the program and ensure that we're providing quality care and containing costs and giving them a seat at the table at the very onset of those discussions."
>
> —Jami Snyder, Director of AHCCCS

Background

Arizona has a unique place in the nation's history of Medicaid as it was the last state to create a Medicaid program in 1982. In holding out on the creation of a Medicaid program, Arizona state officials argued that the benefit of federal dollars was outweighed by the burden of federal Medicaid requirements, and therefore the state maintained a county-operated and funded system of care. In 1980, the state legislature imposed strict limits on the counties ability to raise property taxes, which caused fiscal turmoil in many counties, and county officials began campaigning for a state Medicaid program to relieve the financial burdens. In 1981, the state legislature enacted a prepaid, competitively bid medical program, the Arizona Health Care Cost Containment System (AHCCCS), as the state Medicaid program. However, AHCCCS was different in three ways from what was permissible under a traditional Medicaid program at the time.

1. AHCCCS required all beneficiaries to enroll in a competitively bid managed care system
2. The program did not cover institutional or community-based long-term care (LTC) services
3. It also did not cover behavioral health services

Notably, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which requires states to cover behavioral health and state plan long-term services and supports for children, did not become a requirement until 1989. At the time of AHCCCS' inception, all other states' Medicaid programs primarily employed a fee-for-service (FFS) model apart from some pilot programs, making Arizona's program the first systematic use of a managed care delivery system in Medicaid.[8,9,10]

Arizona officials requested federal permission under a Section 1115 demonstration waiver to operate AHCCCS in 1982. Under this demonstration, Arizona would operate a statewide managed care system that only covered acute care services and 90 days of post-hospital skilled nursing facility coverage. The Reagan Administration was eager to demonstrate its support for state flexibility and therefore granted the request, which waived many applicable federal requirements of the time, allowing AHCCCS to be funded through county, state, and federal funds and for the waiver to allow a unique public-private partnership to operate its managed care model. Arizona hired a private contractor, the MCAUTO Systems Group, to administer the program. Many issues arose with the initial implementation of AHCCCS under the predecessor state agency, including MCAUTO being inexperienced, administrative gaps, fiscal and organizational capacity of health plans, inadequate provider networks, and beneficiary resentment over managed care. In 1984, federal regulators threatened to revoke the 1115 waiver, so the state terminated the relationship with MCAUTO and created a state agency that solved many of the initial issues.[11,12] Since, Arizona has been largely regarded as a national model for managed care. In 1989, the state added LTC to its benefit package under the requirement that it was delivered through managed care. In the early 1990s, the state did the same with behavioral health care. In 2015, AHCCCS integrated behavioral health services into three Regional Behavioral Health Authorities (RBHA) for members with Serious Mental Illness (SMI).[13,14]

AHCCCS has gradually moved from fragmented health care delivery to a fully integrated system that integrates physical and behavioral health. On October 1, 2018, AHCCCS created the AHCCCS Complete Care (ACC) Program which provide Medicaid physical and behavioral health covered benefits for most adults and children enrolled.

There are seven ACC health plans that operate regionally across the state:

- ☑ Arizona Complete Health
- ☑ Banner University
- ☑ Care1st
- ☑ Health Choice Arizona
- ☑ Molina Complete Care
- ☑ Mercy Care
- ☑ UnitedHealthcare Community Plan

While Regional Behavioral Health Authorities (RBHAs) traditionally provided behavioral health care services to members, in 2018 the ACC plans began to provide these services. However, ACC plans do not deliver services to members with SMI determination, as those members continue to receive integrated services from the ACC-affiliated RBHAs: Arizona Complete Health, Health Choice Arizona, and Mercy Care. RBHAs also continue to service members with developmental disabilities who are enrolled with the Department of Economic Services/Division of Developmental Disabilities, as well as foster care children.[15,16,17]

While physical and behavioral health has been integrated under the ACC, AHCCCS separately administers LTC through the Arizona Long Term Care System (ALTCS). ALTCS provides services to individuals 65 or older, or who have a disability, and who require a nursing facility level of care.

These services are provided in an institutional setting or in an HCBS setting through three regional plans:

1. Banner University
2. Mercy Care
3. United Healthcare Community Plan

Through a contract with AHCCCS, the Department of Economic Stability/The Department of Developmental Disabilities (DES/DDD) offers physical and behavioral services, Children's Rehabilitative Services (CRS), and limited LTSS coverage to enrollees who are eligible for ALTCS. Mercy Care and UnitedHealthcare Community Plan currently provide the DES/DDD health plans.[18,19]

Before 1992, there was minimal competition for AHCCCS health plan contracts since the largest plans were county sponsored, and any other plans were provider sponsored. In 1992, however, Inter-Group became the first commercial health plan to win an AHCCCS contract. By 1994, AHCCCS plans reported significant profits, and competition for contracts skyrocketed with 21 health plans submitting bids that year. During this time, state officials reported that plans submitting bids with low capitation rates were often successful.

Since its inception, AHCCCS has worked to integrate programs and reshape models to provide the best possible care. In 2013, AHCCCS streamlined all children enrolled in the acute care program with rehabilitative conditions under one Children's Rehabilitative Services (CRS) contractor. In August 2021, AHCCCS released a Competitive Contract Expansion (CCE) request for proposals (RFP) to expand the current ACC contracts to include responsibilities with a RBHA (ACC-RBHA). Arizona Complete Health, Care1st, and Mercy Care were awarded the ACC-RBHA contracts and implemented on October 1, 2022.[20,21] On October 14, 2022, CMS approved the extension of the AHCCCS 1115 waiver demonstration. The renewal preserves and builds on existing programs by approving innovative practices that enhance health outcomes. Two new initiatives, the Targeted Investments 2.0 program and the Housing and Health Opportunities (H2O) program, demonstrate the state's commitment to addressing social determinants of health and health-related social needs through the coverage of extensive and various services.

Medical Loss Ratio/ Administrative Caps

Starting in 2017, Arizona has included MLR reporting requirements in its health plan contracts. All AHCCCS health plans must submit MLR reports in compliance with the 2016 CMS guidance. MLR reporting for all AHCCCS plans are due annually, five months following the contract year, and must meet the 85% federal minimum. Any retroactive changes to capitation rates after the contract year end will be incorporated into the calculation. All plans are required to comply with all AHCCCS Financial Reporting Guide requirements. Plans must additionally submit unaudited financial information for the plan, as well as unaudited financial information of any entity with a controlling interest in the plan. These requirements have been the same through the most recent available contracts AHCCCS executed with its health plans.[22,23,24]

Withholds and Value-Based Purchasing

In 2013, AHCCCS began developing several Value-Based Purchasing (VBP) initiatives to further encourage acute health plans' quality improvement efforts, as well as improved health outcomes and cost savings. In 2015, AHCCCS required MCOs to make a specific percentage of provider payments through approved VBP arrangements. AHCCCS VBP includes a variety of initiatives for payment reform including differential adjusted payments (DAP), directed payments, performance-based payments (PBP), and alternative payment models (APM).[25,26]

APMs reward providers for providing high quality and cost-efficient care.[27] In 2017, AHCCCS implemented the APM Initiative – Withhold and Quality Measure Performance (QMP). The APM-QMP arrangement withholds 1% of an MCO's capitation; some or all the withheld amount is repaid to the MCO for performance on selected quality measures. This payment is dependent on the MCO meeting minimum requirements, by performance measure, based on the results of the Combined Performance Score and cannot exceed 100% of the MCO's withhold.[28,29]

1% of the plans' capitation rates will be withheld and returned based on plans' performance on quality measures such as[30,31]:

- Well-child Visits
- Emergency Department Utilization
- Children's Dental Visits
- 30-day Hospital Readmissions

Quality Management

AHCCCS established its Quality Strategy in 2003 in accordance with the federal regulatory requirements. It has been revised throughout the years to drive innovative approaches to beneficiary care and quality improvements. Notably, the Quality Strategy has shifted emphasis from process measurements to comprehensive outcome-based measurements and delivery system design. The Quality Strategy collects input from stakeholders and members regarding the direction and recommendations. The state publicly records its quality measures and collects and publishes Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. There are minimum performance standards on various quality measures such as immunization rates, well-child visits, diabetes care, and hospital utilization and readmissions. If a plan does not meet a minimum standard, it must submit a corrective action plan and may be subject to a financial sanction. In the most recent Quality Strategy report from July 2021, acute care health plans are required to enter shared savings arrangements equal to 5% or more of their contracted payments to health care providers.

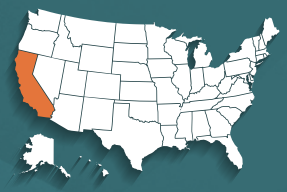
Social Determinants of Health/Health Equity

In 2019, AHCCCS launched the Whole Person Care Initiative (WPCI) to identify and address social risk factors that impact members' health outcomes. WPCI focuses on providing support for transitional housing and individuals experiencing homelessness, leveraging non-medical transportation services to support a member's access to community services, reducing social isolation for members in LTC, and screening members to address social risk factors of health. In 2021, AHCCCS began implementing the Closed-Loop Referral System (CLRS). The CLRS is a critical component of WPCI that allows providers to screen for members' social risk factors and refer them to community organizations and resources for assistance.[32,33]

In July 2020, the Health Equity Committee was established and tasked with developing strategies to ensure health equity for AHCCCS beneficiaries. The committee is responsible for understanding health disparities among members and creating policy changes and supporting the implementation of strategies for equitable services. The committee continues to work towards interventions aimed at eliminating health disparities in the state.[34]

The October 2022 approval of AHCCCS' 1115 waiver extension allows for the implementation of the new H2O initiative. The H2O program permits Arizona to provide coverage of services that directly address health-related social needs (HRSN). These services include short term post-transition housing for up to six months, including associated utility assistance, housing supports, pre-tenancy and tenancy services, and medically necessary home modifications. Additionally, the services include case management, outreach, education, and infrastructure investments and will be provided to individuals experiencing homelessness or life transitions who meet specific clinical and social risk criteria. The approval of this initiative is a novel provision as Medicaid funding towards room and board has historically been prohibited.[35,36,37]

CALIFORNIA



> "California excels at driving innovation. The state has engaged in a full redesign of its Medicaid program called California Advancing and Innovating Medi-Cal (CalAIM). CalAIM is focused on standardizing California's Medi-Cal delivery system statewide across the various components of its delivery system – managed care, fee-for-service, mental health, SUD, HCBS, etc."
>
> –Mari Cantwell, Managing Director, Sellers Dorsey, and Former California Medicaid Director and Sarah Brooks, Director, Sellers Dorsey, and Former Deputy Director of Health Care Delivery Systems for California

Background

California first established Medi-Cal managed care plans (MCPs) in 1973 and was the first state to pilot Medicaid managed care. At the time, California operated both Prepaid Health Plans (PHPs) and Primary Care Case Management (PCCM) models. Since the initial managed care pilot in 1973, California has expanded its managed care offerings and evolved over time due to changes in both state and federal policy.

1997
Medi-Cal expanded access to family planning services

1998
Created the state's CHIP program, Healthy Families

2000
The state extended Medi-Cal to families with incomes at or below 100% federal poverty level

2004
HCBS coverage was expanded resulting from SB 1104, legislation designed to ensure and measure delivery of services and program integrity

2010
A Section 1115 demonstration waiver, "California Bridge to Reform Demonstration," was approved by CMS, which was designed to strengthen the state's health care safety net and prepare infrastructure for Medicaid expansion

2012
California authorized the transition of children from Healthy Families to Medi-Cal and expanded managed care to rural counties

2014
California opted to expand Medicaid eligibility to childless adults under the provisions of the ACA. This decision significantly impacted the number of people eligible for Medi-Cal, driving the number of Medi-Cal managed care beneficiaries to more than 10 million.

Today, Medi-Cal managed care covers most acute, primary, and specialty care, mild to moderate mental health services, and some LTC services. Specialty behavioral health services and pharmacy services are provided as a carve-out. California has always utilized a county-based or regional managed care model, meaning the state maintains different contracting methodologies for specific county or geographical areas, a unique feature of the Medi-Cal managed care program. Over the years, California continued to expand into additional counties, with close to 85% of the state's Medicaid population being enrolled in Medi-Cal MCPs.[40,41]

Procurement

Today, California's managed care program is the largest in the country, with more than 11.7 million beneficiaries enrolled. California operated exclusively under a Section 1915(b) waiver until 2010 when California put it under a Section 1115 demonstration waiver. In January 2022, the program was reauthorized under both Section 1115 and 1915(b) waiver authorities.

Medi-Cal is currently undergoing a multi-year redesign to complete the transformation to California Advancing and Innovating Medi-Cal (CalAIM). This is the state's long-term

commitment to transform and strengthen the Medi-Cal program, offering beneficiaries a more equitable, coordinated, and person-centered approach to maximizing both their health and lives.[42] This change allows all elements of Medi-Cal to be streamlined into a program that is standardized and simplified. To do so, the **California Department of Health Care Services (DHCS) developed the following three goals[43]:**

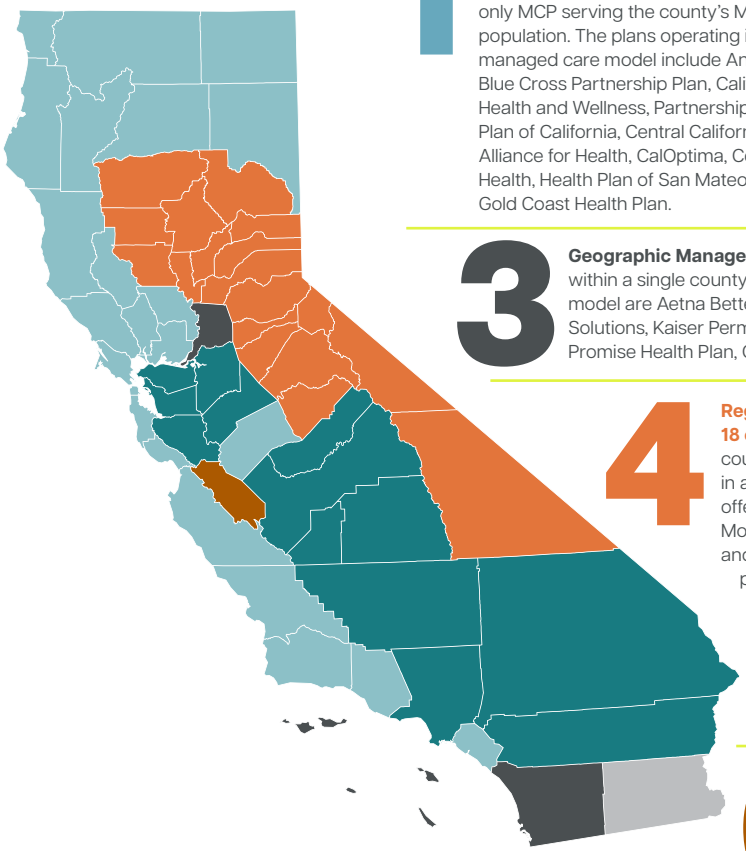
1. Identify and manage comprehensive needs through whole person care approaches and social drivers of health.
2. Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, program modernization, and payment reform.
3. Make Medi-Cal a more consistent and seamless system for enrollees to navigate by reducing complexity and increasing flexibility.

The CalAIM contract is scheduled to become effective on January 1, 2024.

Previously, MCP procurements were structured in two ways: 1) a Request for Proposal (RFP) by which health plans are competitively assessed and the most qualified are selected; or 2) a Request for Application (RFA) by which any qualified health plan may be selected by the state.[44] The state released an RFP in January 2022, with responses due April 11, 2022. The state released a Notice of Intent to Award (NOIA) statement in August 2022, announcing it is awarding five-year Medicaid contracts to Molina

As of October 2022, the state operates six different managed care models in the 58 counties.

The different models are as follows:[46,47]



1 County Organized Health System (COHS) – 22 counties: The managed care health plan, run by the county, is the only MCP serving the county's Medi-Cal population. The plans operating in this managed care model include Anthem Blue Cross Partnership Plan, California Health and Wellness, Partnership Health Plan of California, Central California Alliance for Health, CalOptima, CenCal Health, Health Plan of San Mateo, and Gold Coast Health Plan.

2 Two-Plan Model – 14 counties: In counties operating the two-plan model, DHCS contracts with a county-organized plan called the Local Initiative (a PHP) and a commercial plan for the delivery of Medi-Cal managed care services in the county. The plans operating in this managed care model include Alameda Alliance for Health, Anthem Blue Cross Partnership Plan, Contra Costa Health Plan, CalViva Health, Health Net Community Solutions, Kern Family Health Care, AIDS Healthcare Foundation, L.A. Care Health Plan, SCAN Health Plan, Inland Empire Health Plan, Molina Healthcare of California Partner Plan, San Francisco Health Plan, Health Plan of San Joaquin, and Santa Clara Family Health Plan.

3 Geographic Managed Care (GMC) – 2 counties: DHCS contracts with multiple commercial health plans within a single county and serves clearly defined geographic areas. Plans operating in this managed care model are Aetna Better Health of California, Anthem Blue Cross Partnership Plan, Health Net Community Solutions, Kaiser Permanente, Molina Healthcare of California Partnership Plan, Blue Shield of California Promise Health Plan, Community Health Group Partnership Plan, and United Healthcare Community Plan.

4 Regional Expansion/Rural Model – 18 counties: This is a model in which rural counties that have chosen not to participate in a COHS model or Two-Plan model can offer Medi-Cal managed care. The Regional Model was developed for rural expansion and is made up of two commercial health plans serving two or more contiguous counties in the designated expansion region. The plans operating in this managed care model are Anthem Blue Cross Partnership Plan, California Health and Wellness, and Kaiser Permanente.

5 Imperial Model – 1 county: The Imperial Model was derived from the Regional Expansion model to serve rural expansion needs. Like the Regional Expansion model, there are two commercial plans that contract with DHCS to serve beneficiaries. The plans operating in this managed care model are California Health and Wellness and Molina Healthcare of California Partnership Plan.

6 San Benito (Voluntary) Model – 1 county: The San Benito Model was also derived from the Regional Expansion model to serve rural expansion needs. In the San Benito model, there is one commercial plan that contracts with DHCS. Beneficiaries can choose to participate in managed care or fee-for-service Medi-Cal. The plan operating in this managed care model is Anthem Blue Cross Partnership Plan.

Healthcare, Centene subsidiary Health Net, and Elevance Health's Anthem Blue Cross Partnership plan, all of which already held Medicaid contracts in the state.[45] There are changes that will happen due to managed care procurement and other policies around MCP model changes. The state will also be issuing direct contracts to Kaiser in select geographic regions as defined by the state, with Kaiser not having to go through the procurement process. The state is seeking amendments to the CalAIM 1915(b) and 1115 waivers for authority to effectuate the MCP model changes and direct contracts with Kaiser.

Medical Loss Ratio/ Administrative Caps

Prior to the enactment of federal requirements around MLR reporting, California established MLR regulations exclusively for the Adult Expansion Medicaid population. MLR calculations were to be performed as outlined in federal guidelines and reported on year over year. MCPs were required to expend a minimum of 85% of net capitation payments on allowed medical expenses in each county. If MCOs did not meet the minimum threshold, they were required to return the difference between the 85% and actual allowed medical expenses incurred for that county to the state. Contractors had the opportunity to dispute a determination through an appeals process defined by DHCS.[48] California's recently CMS-approved Section 1915(b) managed care waiver special terms and conditions (STCs) contains updated managed care MLR requirements. MCPs still must report on MLR, but the new requirements in the STCs are much more extensive and include remittance requirements equivalent to those located in 42 CFR § 438.8(j).[49]

Withholds and Value-Based Purchasing, Quality Management

California has continued to require Medicaid MCPs to submit audited HEDIS and CAHPS data. The state then compares the plans' results with the state and national average and publishes the results.[50,51] MCPs must report annually on a set of measures known as the managed care accountability sets (MCAS), which includes a subset of HEDIS measures. On most measures, plans are required to meet or exceed a minimum performance level (MPL) set by the state. When plans fall short of the MPL on a measure, they must submit a plan-do-study-act cycle submission or perform an alternative quality improvement project as directed by DHCS. For plans that have multiple measures below the MPL the state may require a corrective action plan that includes additional performance improvement projects. California has no capitation withholds in place, but the state has the authority to impose financial penalties, auto-assignment withholds, or sanctions on MCPs that fail to meet required MPLs.

In 2012, California designed a quality strategy that was modeled after the nationally recognized Triple Aim Initiative. The activities outlined in this plan aimed to deliver more effective, efficient, and affordable care or advance disease prevention in the state overall. California's most recent comprehensive quality strategy, released in February 2022, continues this mission and outlines quality goals in response to federal managed care requirements.[52]

California has several managed care-related incentive and value-based purchasing programs within Medi-Cal, including primary care, specialty care, inpatient care, resource utilization, behavioral health, housing and homelessness, care for high-cost and/or high-need populations, prenatal and postpartum care, chronic disease management, and early childhood prevention.

These programs include:[53-59]

- Directed Payments Quality Incentive Pool program (2017)
- CalAIM Incentive Payment Program
- Student Behavioral Health Incentive Program
- Proposition 56 Value-Based Payment Program
- Behavioral Health Incentive Program
- Housing and Homelessness Incentive Program
- Other Value-Based Payment Programs

The appropriations for these programs are funded with federal dollars and from various sources for the non-federal share including the state General Fund, Proposition 56 tobacco tax funds, and Intergovernmental Transfer funds (IGTs). Most of these are allocated as part of the state budget process.

Social Determinants of Health/Health Equity

California has made explicit efforts towards improving health equity. These efforts include relationships between departments and the governor's support for driving health care goals, data collection, and measures for hospital performance improvement programs. The newly CMS-approved CalAIM Section 1915(b) and 1115 waivers both have a health equity framing. The design of the program continues the state's intention to align the program into a system that is standardized, simplified, and focused on helping enrollees live healthier lives. In the 2024 MCP contract, there is a large section dedicated to health equity related provisions. Each MCP must contractually include and complete the following[60] *(please note that these provisions are subject to change or update since original release date):*

- Designate a Chief Health Equity Officer that has the authority to design and implement policies that ensure health equity is prioritized and addressed
- Create a Quality Improvement and Health Equity Transformation Program (QIHETP) as well as a Quality Improvement and Health Equity Committee (QIHEC) that includes participation of providers
- Develop and submit an annual QIHETP Plan that provides a comprehensive assessment of all QI and health equity activities undertaken
- Publicly report on MCP health equity activities
- Develop Population Health Management interventions designed to address social drivers of health, reduce disparities in health outcomes experienced by different subpopulations of members, and work towards achieving health equity by developing equity focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services
- Ensure all MCP, subcontractor, downstream subcontractor, and network provider staff receive mandatory diversity, equity and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) annually
- Perform, oversee, and report on Quality and Health Equity Performance Measures
- Be accountable for all QI and Health Equity functions and responsibilities that are delegated to Subcontractors and any Downstream Subcontractors
- Achieve, maintain, and oversee subcontractors' NCQA Health Equity Accreditation no later than January 1, 2026 (MCP must start process to achieve this no later than January 1, 2023) and complete additional NCQA accreditation programs as directed by DHCS.
- Community Advisory Committee (CAC) must provide input and advice on health equity
- Ensure all services are delivered in a culturally and linguistically competent manner that promotes health equity for all members

The CalAIM Incentive Payment Program supports the implementation and expansion of Enhanced Care Management and Community Supports by incentivizing MCPs, in accordance with 42 CFR §438.6(b), to drive MCP delivery system investment in provider capacity and delivery system infrastructure; bridge current silos across physical and behavioral health care service delivery; reduce health disparities and promote health equity; achieve improvements in quality performance; and encourage take-up of Community Supports.[61]

In January 2022, California implemented its Community Supports Program, which offers services through an ILOS structure. California's MCPs were given the option to provide 14 different types of community supports. All MCPs currently operating in the state opted to offer at least one as an ILOS. These ILOS all focus on the social determinants of health (SDOH) and/or health equity, wrap-around services that are not traditionally offered under the Medicaid program. The CalAIM community support ILOS program options are as follows: Housing Transition/Navigation, Housing Deposits, Housing Tenancy and Sustaining Services, Short-Term Post-Hospitalization Housing, Recuperative Care (Medical Respite), Respite Services, Day Habilitation Programs, Nursing Facility Transition/Diversion, Community Transition Services/Nursing Facility Transitions to a Home, Personal Care and Homemaker Services, Environmental Accessibility Adaptations, Medically-Supportive Food/Meals/Medically-Tailored Meals, Sobering Centers, and Asthma Remediation.[62]

FLORIDA

> "Our SMMC program provides strong contractual compliance levers that would include both liquidated damages and sanctions and we routinely apply these through continuous monitoring. The [SMMC] program has goal-focused penalties and incentives that are applied, and they are completely transparent to the public, so they are aware if the plans reach [those standards] or if they don't reach [the standards]."
>
> –Thomas Wallace, Deputy Secretary, Division of Medicaid at AHCA

Background

Florida has had a Medicaid managed care program since 2006. Then, most families and children (TANF-level individuals), pregnant women, and aged, blind, or disabled (ABD) individuals were enrolled in the Florida Medicaid Pilot program (formerly called Florida Medicaid Reform) that was authorized under an 1115 demonstration. The Pilot was initially only available in two counties in 2006, then expanded to three more counties in 2007, and finally expanded statewide in December 2011 and renamed the State Medicaid Managed Care (SMMC) program.[63]

SMMC plans cover all mandatory acute, primary and specialty services. Before 2011, SMMC could offer customized benefit packages and reduced cost sharing, however, that flexibility in benefits plans became more restricted after 2011. Enrollment was mandatory for most populations receiving full Medicaid benefits, including ABD individuals, TANF-level individuals, full dual eligible beneficiaries, and children in foster care. Individuals with LTSS needs that qualify for an institutional level-of-care (ILOC) received their acute and primary care services from SMMC plans and long-term care (LTC) services from an LTC managed care program. The program, formerly known as Nursing Home Diversion, was authorized under 1915(b)/(c) waivers.[64]

In 2013, Florida received CMS approval to transition nearly all its Medicaid beneficiaries and services into managed care, as well as make managed care enrollment mandatory on a statewide basis. The only groups who remain exempt from managed care enrollment are individuals eligible to receive family planning services, individuals eligible through breast and cervical cancer programs, individuals who are eligible for emergency Medicaid for aliens, and children receiving services in a prescribed pediatric extended care center. SMMC was reorganized to contain two separate managed care components: LTC Managed Care program and Managed Medical Assistance (MMA) program. The LTC Managed Care program was brought under the management of SMMC and continues to provide LTSS to individuals with ILOC needs. The MMA program was created to provide comprehensive (acute, primary, and LTSS) services to all beneficiaries. The rollout of the new SMMC program occurred in phases by regions over 2013 and 2014 with both programs having been fully implemented by August 2014. As of 2022, there are 10 plans in the SMMC program (all of them are in the MMA program while seven are in the LTC program).[65]

- Aetna Better Health of Florida
- AmeriHealth Caritas Florida
- Vivida
- Children's Medical Services Network
- Florida Community Care
- Humana Medical Plan
- Molina Healthcare of Florida
- Community Care Plan
- Simply Healthcare Plans, Inc.
- Sunshine State Health Plan
- United Healthcare of Florida

Medical Loss Ratio/ Administrative Caps

Florida did not initially have an MLR established for its plans. After the 2016 Managed Care Rule was implemented, the Agency for Health Care Administration (AHCA, Florida Medicaid) amended the SMMC plan contracts for both MMA and LTC programs to add a minimum MLR of at least 85%, varying by plans and by year, under the Achieved Savings Rebate (ASR) program. The ASR program started in 2018 and is authorized under F.S. 409.967(3). The program acts as an incentive for proper use of state funds by mandating SMMC plans to refund a portion of their income to AHCA if they do not spend a specified amount on medical care.

The ASR program monitors plans' premium revenues, medical and administrative costs, and income or losses in a uniform manner. The actuarially sound maximum amount for administrative costs is calculated by the actuary developing the capitation rates as part of the rate setting process. SMMC plans are required to submit quarterly and annual unaudited ASR Financial Reports, and an annual financial statement audit conducted by an independent certified public accountant. AHCA validates each plan's ASR report. The ASR amount is established by determining pretax income as a percentage of pretax revenues and applying the following income ratios:

1. 100% of plan net income that is less than or equal to 5% of revenue shall be retained by the plan.
2. 50% of plan net income between 5%–10% of revenue shall be retained by the plan, and the other 50% refunded to AHCA.
3. 100% of plan net income greater than 10% of revenue shall be refunded to AHCA.

In the most recently available data from fiscal year 2020, eight plans had profits that exceeded a certain percentage of revenue (thereby achieving savings for the overall program). These plans paid an estimated total rebate of $218 million to AHCA. In the year prior, only a single plan achieved savings and paid an estimated $128 million rebate to AHCA, though it should be noted that this performance period partially overlapped with the initial months of the COVID-19 pandemic.

Withholds[67]

The ASR program is also tied to plan performance – when a plan exceeds AHCA-defined quality measures (referred to in the next section) in the reporting period, it may retain up to an additional 1% of revenue. Plans can continue to retain an additional 1% revenue each subsequent reporting year if they maintain a high score in their quality metrics. The state has made no changes to the ASR program ever since its introduction into the managed care contracts.

Quality Measurement[68]

Under the ASR program, AHCA has established HEDIS performance measures for MMA and LTC plans across six groups: Mental Health and Substance Abuse, Well-Child, Other Preventive Care, Prenatal/Perinatal, Diabetes, and Other Chronic and Acute Care. AHCA has assigned each performance measure a point value (0-6) that correlates to the NCQA HEDIS National Means and Percentiles. SMMC plans must achieve a group score of four or higher for each of the six performance measure groups to be able to retain an additional 1% revenue. LTC plans further have additional performance measures that they need to surpass a specified threshold to be able to retain an additional 1% revenue. These measures include additional HEDIS measures (Care for Older Adults and Call Answer Timeliness) as well as AHCA-defined measures, and some performance metrics (Face-To-Face Encounters, Case Manager Training, Timeliness of Services).

Value-based Purchasing / Alternative Payment Models[69]

The State of Florida does not require SMMC plans to set targets for payments made through APMs, have incentives or penalties for meeting or failing to meet APMs, or require plans to develop VBP strategy within state-specific guidelines. The state of Florida does require MCOs to participate in a state directed VBP initiative and has a limited strategy to embrace value-based payment.

Social Determinants of Health/Health Equity

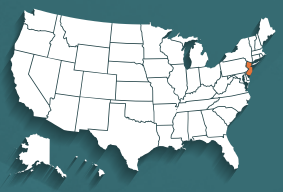
In late 2019, the state of Florida started to incorporate SDOH initiatives into its managed care contracts through the housing assistance pilot program authorized under

the state's 1115 waiver demonstration.[70] The pilot, known as the Behavioral Health and Supportive Housing Assistance Pilot Program, provides flexible services, including temporary housing assistance, for individuals with SMI or SUD through managed care. Participating MMA and/or specialty plans are required to screen enrollees for social needs, behavioral health needs, and behavioral health risk factors to provide eligible individuals with referrals to social services, specifically to the pilot program. However, the pilot program is not available to all beneficiaries in the state as MCOs need to apply and must be qualified to receive additional capitation for pilot services. To be qualified, AHCA requires that plans must:

- Provide transitional housing services, tenancy sustaining services, mobile crisis management, self-help/peer support, and a one-time payment for moving expenses to eligible individuals.
- Have the capability to provide housing assistance through agreements with housing providers and have strong community partnerships with local housing coalitions

Currently, only select MCOs (Aetna, Magellan, Simply, and Staywell) provide pilot services as expanded benefits in two Medicaid regions (Region 5 and 7).

NEW JERSEY



> "To serve people the best way possible, we believe it is important to strike a balance. Accountability for compliance and outcomes is essential for ensuring MCOs are delivering on critical commitments in the contract. But we also need to support an innovative partnership to continue to improve our program and address emerging issues together. We think this is the sweet spot where we get the most out of our relationships with managed care organizations."
>
> —Jennifer Langer-Jacobs, New Jersey Medicaid Director

Background

The New Jersey Medical Assistance and Health Services Act of 1968 established a program of medical assistance and services for eligible individuals within the state. In 1970, New Jersey created its Medicaid program, NJ FamilyCare, which is administered through the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) and provides services for low-income residents. The program has grown incrementally through the years to include various age and eligibility groups.[72,73]

Throughout the early 1990s, Medicaid spending in New Jersey outpaced the national average. This increased spending was intentional as the state pursued disproportionate share hospital (DSH) federal matching funds to cover existing programs previously funded in different ways. Medicaid spending in the state slowed from 1992 to 1995, and in 1995 New Jersey began moving Medicaid beneficiaries into statewide managed care. New Jersey's Medicaid program was expanded to cover all children from families with incomes of up to 133% of the federal poverty level, while KidCare provides coverage to children in families with incomes between 133% and 200% of the federal poverty level. State officials saw that fully capitated managed care was a way to save money while improving care and services for beneficiaries, increasing access to physicians, and increasing physician salaries. Shortly after, in 2000, the state expanded the program by adding parents and some childless adults under NJ FamilyCare.

By 2011, nearly 80% of Medicaid enrollees were enrolled in managed care under NJ FamilyCare.

That same year, the state sought CMS approval of a Section 1115 demonstration waiver to consolidate Medicaid and CHIP under a single authority. This integrated primary, acute, behavioral health care, and long-term services and supports; established a federally funded Supports Program that provides a wide array of services to individuals with intellectual or developmental disabilities who are living at home with their families; advanced MLTSS by increasing utilization of home and community based services for seniors and individuals with disabilities, instead of nursing facility or other institutional care; and increased community-based services for children who are diagnosed with developmental disabilities and mental illness. The new demonstration combined the previously existing programs, including two 1915(b) managed care waiver programs, four 1915(c) HCBS waivers, and Title XIX Medicaid and Title XXI CHIP Section 1115 demonstrations. In October 2012, CMS granted federal approval of the 1115 demonstration waiver and the state expanded existing managed care programs to include institutional long-term services and supports, behavioral health services, and home and community-based services. The waiver authorized the MLTSS program, which officially began in 2014.[74,75,76,77,78,79] It was amended in subsequent years to include the adult expansion group authorized under the ACA, and to expand eligibility and benefits for individuals with developmental disabilities.[80]

With the New Jersey Comprehensive 1115 Demonstration waiver, nearly all Medicaid and CHIP beneficiaries in the state are now required to receive benefits through managed care. Limitations include individuals in a Program of All-inclusive Care for the Elderly (PACE) program, and some individuals who were receiving

long-term institutional care at the launch of MLTSS. More than 95% of NJ FamilyCare's enrollees are enrolled in one of the state's MCOs: Aetna Better Health, Amerigroup New Jersey, Horizon NJ Health, UnitedHealthcare Community Plan, or WellCare. Since the implementation of the New Jersey Comprehensive Demonstration, the state's notable accomplishments include a significant rebalancing from institutional care to home and community-based care, strong performances on quality measures, streamlining administrative supports, establishing an integrated behavioral health delivery system, and significant increase in enrollment in managed care with an all-time high of 2.02 million enrollees in January 2022.[83]

Historically, New Jersey allowed any willing MCO to contract with the state. Since implementing the 1115 demonstration waiver has set MCO contract operating standards and monthly base capitation rates. Any health plan that meets the standards, accepts the rates, and agrees to operate statewide in all 21 counties may participate.[84]

The New Jersey managed care market has remained stable and historically maintained an average of four to five plans. The most recent change occurred in 2014, when MCO Healthfirst exited the New Jersey market and its members were acquired by WellCare, which entered the New Jersey market at that time.[85]

- Aetna Better Health of New Jersey
- Amerigroup New Jersey
- Horizon NJ Health
- UnitedHealthcare Community Plan of New Jersey
- Wellcare of New Jersey

Medical Loss Ratio/ Administrative Caps

New Jersey began incorporating MLR reporting requirements into its health plan contracts in 2017. The Department of Health Services selected the federal minimum medical loss ratio of 85% of adjusted premiums from non-MLTSS premium groups and 90% of adjusted premiums paid in all form for MLTSS premium groups. Health plans must provide annual reporting for the state fiscal year (SFY) based on six months of claim run-out following the end of the most recently concluded SFY and must include a separation of MLTSS and non-MLTSS. If a plan fails to maintain the required capitation group specific minimum MLR, it must remit funds to the Department in full as an interim settlement and submit revised MLR reports to the Department within 90 days.[86]

Withholds

New Jersey uses encounter data completeness benchmarks to identify potentially underreported encounter areas with MCOs. Contractually, the benchmarks reflect the minimum acceptable number of services reported in the service month and are subject to revision to ensure accurate reflection of minimum reporting expectations. If an MCO fails to meet a category of service or encounter group monthly benchmarks without providing an acceptable explanation, it is subject to a withhold of a portion of the capitation. The amount withheld for failing to achieve a monthly benchmark is dependent on the ratio of approved encounters to the benchmark for that category of encounter group combination. However, the amount withheld from a MCO will not exceed a total of 2% of the capitation paid for the reporting month. The rate of approved encounters will be recalculated monthly and the withhold amount may be released back to the MCO in whole or in part based on its improvements towards attaining the benchmarks.[87]

Value-Based Purchasing

In 2014, the Medicaid Innovation Accelerator Program (IAP), led by the Center for Medicaid and CHIP Services, launched to provide state Medicaid agencies with resources and technical support to expedite delivery system reform innovation. IAP assisted New Jersey with designing and implementing Value-Based Payment (VBP) approaches.[88]

In February 2019, the Department of Human Services launched a new Office of Medicaid Innovation to improve the quality, delivery, and cost of the Medicaid program within the state. The Office leads the work on value-based payment and purchasing strategies and focuses on areas of potential innovation.[89]

New Jersey Medicaid has an HCBS VBP program where plans are awarded for high performance related to MLTSS delivery. The goal for this VBP program is to encourage MCOs to better document the frequency, type, scope, and duration of HCBS in member service plans, and

produce more timely, accurate, and valid claims reporting for the HCBS in the service plans. The VBP initiative was developed as a result of the 2019 EQRO report, which incorporated MLTSS performance measures from the HCBS care management audit. The top three performing health plans are awarded a one-year sliding-scale bonus performance payment based upon data collected by the State's External Quality Review Organization (EQRO).[90,91]

In August 2022, NJ FamilyCare launched the Perinatal Episode of Care, a three-year pilot program that will test a new alternative payment model statewide. The goal of the pilot is to improve the quality of perinatal care delivered to New Jersey's Medicaid and CHIP beneficiaries. The pilot is a voluntary model for NJ FamilyCare providers and providers must commit to participate in order to receive financial incentives. All participating providers must be contracted with at least one of the five MCOs in New Jersey. Additionally, participating providers must be able to submit professional claims and receive reimbursement for obstetrical care.

Providers who participate will be assessed on five quality metrics:

- Prenatal Depression Screening
- Gestational Diabetes Screening
- Delivery Mode
- Postpartum visits within three weeks of discharge, and neonatal visit within five days of discharge

Providers are then eligible to receive any of three different financial incentives:

- Shared Savings
- High Performance Bonus
- SUD Participation Incentive

The pilot hopes to tie incentives to improvements in quality and cost of maternity-related care.[92,93]

Quality Management

New Jersey incorporated quality performance and improvement into its 1115 demonstration waiver. Under the demonstration, the state began to develop managed care quality strategies that included measures addressing long-term services and supports. Today, an external quality review is conducted annually and includes an assessment of all MCO operations, performance measure (PM) validation, performance improvement projects (PIPs), DMAHS encounter data validation, a focused quality study, CAHPS survey, Core Medicaid care management (CM) audits, and MLTSS CM Audits.[94,95,96]

The 2021 Nurture NJ strategic plan includes 9 action areas:

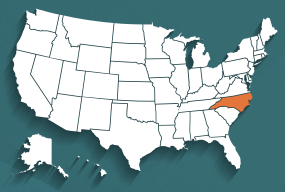
1. Build racial equity infrastructure and capacity
2. Support community infrastructures for power-building and consistent engagement in decision-making
3. Engage multiple sectors to achieve collective impact on health
4. Shift ideology and mindsets to increase support for transformative action
5. Strengthen and expand public policy to support conditions for health in New Jersey
6. Generate and more widely disseminate data and information for improved decision-making
7. Change institutional structures to accommodate innovation and transformative actions
8. Address the SDOH
9. Improve the quality of care and service delivery to individuals[97]

Social Determinants of Health/Health Equity

New Jersey has taken various approaches to addressing the intersection of health inequity and maternal and infant mortality for decades. In 2019, the First Lady Tammy Murphy launched Nurture NJ as a statewide initiative to address and reduce maternal and infant mortality and morbidity, as well as ensure equity in care. Nurture NJ is a muti-agency initiative that includes the Department of Human Services and the Medicaid program.

The newly launched Perinatal Episodes of Care pilot is also a part of the maternal health reforms of Nurture NJ. The Nurture NJ strategic plan recommended the Department of Human Services institute perinatal episodes of care contractual requirements for MCOs in order to ensure coordination of services and safeguards. Starting in January 2021, reimbursement of prenatal care for the pregnant member became contingent on the completion of a Perinatal Risk Assessment (PRA). Completion of the PRA is a reimbursable service that serves as a uniform screening tool. The PRA helps obstetrical providers in identifying the member's medical and social needs, supports NJ's Medicaid MCOs in pregnancy risk stratification, and facilitates referrals for community-based resources.[98] In February 2022, DMAHS applied to CMS for the renewal of the 1115 New Jersey FamilyCare Comprehensive Demonstration. The 1115 demonstration waiver is set to include new approaches to addressing the SDOH, especially with respect to health and expand health equity analyses to support better access and outcomes for communities of color, people with disabilities, and other marginalized groups.[99]

NORTH CAROLINA



> "We have data that suggests that we have increased the number of primary care providers participating in the Medicaid programs by 12% [after transitioning to managed care]. Similarly, we've increased the number of non-emergency medical transportation trips for beneficiaries."
>
> –Jay Ludlam, Assistant Secretary for Medicaid, and Melanie Bush, COO at NC Department of Health and Human Services

Background

In 2021, North Carolina became the most recent state to implement Medicaid managed care. Since 1991, the state has provided Medicaid coverage under a PCCM delivery system called Carolina ACCESS, which provided primary care practices a nominal PMPM fee to coordinate patient care. In 1998, the state started an enhanced care case management program called Community Care of North Carolina (CCNC). CCNC was composed of 14 provider networks across the state that received PMPM payments to provide case management and lead data analysis and quality improvement initiatives for participating primary care practices.[100] In 2015, the state legislature passed a law directing the Department of Health and Human Services (DHHS) to shift the Medicaid and CHIP programs from an FFS and PCCM delivery system to risk-based managed care.[101] In 2018, Governor Roy Cooper (D), announced DHHS's plan for Medicaid transformation that included integration of medical and mental health care and proposed a Section 1115 demonstration waiver to address SDOH.[102] However, a budget impasse in the state legislature in November 2019 postponed Medicaid transformation until February 2020, and the COVID-19 pandemic resulted in further delays.[103] State lawmakers passed the DHHS budget in June 2020, which included an official launch date for Medicaid transformation of July 1, 2021.[104]

The managed care program, known as NC Medicaid Managed Care, covers most families and children who meet financial eligibility requirements, pregnant women, CHIP beneficiaries, and ABD individuals not receiving Medicare. NC Medicaid Managed Care includes two plan types: Standard Plans and Tailored Plans. The Standard Plans cover physical health, pharmacy, care coordination, and basic behavioral health services, while the Tailored Plans cover all the Standard Plan benefits plus enhanced behavioral health, I/DD, and traumatic brain injury services. Standard Plans have been in operation since July 2021 and tailored plans are slated to launch in April 2023. NC Medicaid Managed Care has five PHPs, or MCOs, providing Standard Plan benefits. Four of the five plans are statewide, while Carolina Complete Health is only available in some regions.[105]

- ☑ AmeriHealth Caritas
- ☑ Carolina Complete Health (Centene)
- ☑ Healthy Blue (BCBS)
- ☑ United Healthcare Community Plan
- ☑ WellCare (Centene)

Medical Loss Ratio/ Administrative Caps[106]

PHPs are required to calculate and report aggregate MLR annually on two bases: CMS-defined MLR and Department-defined MLR. The CMS-defined MLR for an MLR reporting year is defined as the ratio of the numerator and denominator. The numerator is the sum of the PHP's incurred claims, expenditures for activities that

improve health care quality, and the lesser of expenditures for fraud reduction activities or fraud reduction recoveries. The denominator equals the PHP's adjusted premium revenue. The Department-defined MLR is defined as the ratio of the numerator and denominator and they are calculated in the same way as the CMS-defined MLR however, with some adjustments:

Numerator:

- PHPs are permitted to include expenses made for voluntary contributions to health-related resources that align with the DHHS Quality Strategy.
- PHPs are not allowed to include expenses on required additional directed payments to providers that are reimbursed by DHHS separate from the prospective PMPM capitation and maternity event payments.
- PHPs are not allowed to include expenses on provider payments that violate the Payment Limitations as required in the contract.

Denominator:

- Payments (along with any associated taxes and fees) made by DHHS to reimburse for additional directed payments to providers cannot be included.

The minimum MLR threshold in aggregate across all contracted PHPs is 88%. The minimum MLR thresholds for each rating group are: 89.1% for ABD, 88.7% for TANF newborn (<1), 85.7% for TANF children (1-20), 88% for TANF adults (21+), and 91.9% for maternity event. If the PHP's Department-defined MLR is less than the minimum MLR threshold, the PHP is required do one of the following:

- **Remit to DHHS a rebate equal to the denominator of the Department-defined MLR multiplied by the difference between the minimum MLR threshold and the Department defined MLR.**
- **Contribute to health-related resources targeted towards high-impact initiatives that improve health outcomes and the cost-effective delivery of care within the regions it serves.**
- **Contribute to initiatives that advance public health and health equity in alignment with the DHHS Quality Strategy, subject to approval by DHHS.**
- **Do a combination of the above, with amounts for each subject to review and approval by DHHS.**

Withholds/Value-Based Purchasing[107]

While DHHS does not have any withholds in place for PHPs currently, beginning in Contract Year 3, DHHS may implement withhold measures based on quality measures used to administer a PHP quality withhold or incentive program. DHHS plans to include a performance-based incentive system financed through a withhold as part of the program design. The withhold program will begin on January 1, 2023, at the earliest.

DHHS defines VBP arrangements as payment arrangements between PHPs and providers that fall within Levels 2-4 of the multi-payer Health Care Payment – Learning and Action Network (HCP-LAN) APM framework.[108] The PHP is required to submit an updated VBP/APM Strategy to DHHS on an annual basis. By the end of Year 2 of the PHP operations, DHHS requires the portion of each PHP's medical expenditures allocated as VBP arrangements will either increase by 20% or represent at least 50% of total medical expenditures. In Contract Year 3, DHHS may use PHP-submitted HCP-LAN assessments to implement withholds associated with VBP penetration. PHPs are permitted to develop Physician Incentive Plans outside of the VBP and Pregnancy Management Program requirements, provided that any such physician incentive plans are related to the aims and goals set forth in the DHHS Quality Strategy. PHPs shall submit all Physician Incentive Plans as part of the PHP VBP/APM Strategy to DHHS for review and approval prior to PHP implementation of such incentives.

Quality Management[109]

PHPs are required to submit a Quality Assessment and Performance Improvement (QAPI) plan that focuses on health outcomes and health care process measures and aligns with the NC Medicaid Quality Strategy and the state's QAPI plan. PHPs are required to submit an annual QAPI plan.

PHPs are required to annually report a set of 23 quality and administrative measures to DHHS. These include a select set of adult and child core measures, measures required for accreditation, and a select set of additional measures, including administrative measures aligned with key Department interventions.

Social Determinants/Health Equity[110]

To support DHHS' Health Equity goals, PHPs are required to establish and maintain a Health Equity Council that reports to the plan CEO. The council should be reflective of the PHP's diverse population and is tasked in identifying, analyzing, and addressing health disparities; addressing stakeholder representation and engagement improvements; improving staff diversity; and examining existing policies that can be amended to improve health equity and reduce health disparities.

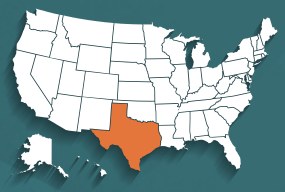
PHPs are also required to develop a Member Engagement and Marketing Plan for Historically Marginalized Populations for review by DHHS. PHPs are also required to submit the following policies for DHHS approval that will specifically acknowledge how the PHP is addressing health equity and incorporating health equity into their external and internal policies:

- Network Access Plan
- Provider Training Plans
- VBP/APM Strategy
- Opioid Misuse Prevention Program
- Care Management Strategy
- Local Community Collaboration Plan
- Provider Support Plan

A PHP can be awarded a preference in auto-assignment if it voluntarily contributes at least 0.1% of its annual capitation revenue in a region to health-related resources or health equity initiative as approved by DHHS.

DHHS has also launched initiatives addressing SDOH. Under an 1115 waiver demonstration, the state started a pilot program, Healthy Opportunities, which is a comprehensive program that provides select evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety to high-needs Medicaid enrollees via managed care. The pilot operates in 33 of the 100 counties in North Carolina. All MCOs operating in those regions are required to participate and are responsible for allocating pilot program funds to social service organizations and integrating those services into their health care delivery through care management entities.[111]

TEXAS



> "We approached our MCOs as partners from the beginning. We helped them understand expectations. We didn't just put expectations in a handbook and a contract and then followed up later. We spent considerable time on rollouts. We spent considerable time with stakeholders and advocates collectively. We were partners with them along the way."
>
> –Gary Jessee, Senior Vice President, Sellers Dorsey, and Former Deputy Executive Commissioner for Medical and Social Services, Texas

Background

Texas first launched managed care as a four-county pilot program, LoneSTAR, in 1993. In 1995, the state expanded the program to seven counties and rebranded the program STAR (State of Texas Access Reform). STAR has since incrementally expanded to cover 13 service areas across all 254 Texas counties. The program covers acute care, primary care services, behavioral health services, and prescription drugs for qualifying pregnant individuals, families, and children. All managed care service areas have at least two MCOs from which members can choose; each MCO offers value-added services so that members may choose a plan that best suits their needs.

In the years since launching STAR, Texas launched four additional product lines:

- **STAR+PLUS,** which launched in 1997, serves qualifying individuals with a disability, individuals aged 65 and older, individuals who are dually eligible for Medicare and Medicaid, and individuals with breast or cervical cancer.
- **CHIP,** which serves qualifying children and pregnant individuals in households that earn too much to qualify for traditional Medicaid.
- **STAR Kids,** which launched statewide in 2016, serves qualifying individuals with a disability aged 20 and younger; and
- **STAR Health,** implemented statewide in 2008, serves qualifying individuals in the foster care system and young adults previously in foster care.

In 2011, a transformative year in Texas Medicaid's history, the state received approval for its 1115 demonstration waiver, which authorized the expansion of STAR and STAR+PLUS to just under half of all Texas counties. The program expansions marked the beginning of an incremental approach to carving populations and services into managed care and the end of the state's Primary Care Case Management program, which had operated in rural counties since 2005. Texas launched expanded STAR statewide in 2013, during which the program carved-in pharmacy services. The same year, the Texas legislature directed the state Medicaid program to develop a performance-based payment system in a long-term transition to outcome-based care. In 2014, STAR integrated targeted case management and mental health rehabilitative services into its managed care benefit package. In subsequent years, the state carved nursing facility services into managed care and implemented the STAR Kids program, moving one of the largest remaining FFS populations into managed care.

Texas currently contracts with 16 MCOs through statewide and regional agreements to provide care under its five managed care product lines. The state contracts with a mix of nine local MCOs (Community Health Choice, Cook Children's Health Plan, Dell Children's Health Plan, Driscoll Health Plan, El Paso Health, FirstCare, Parkland Community Health Plan, RightCare, Texas Children's Health Plan) and seven national (Aetna, Amerigroup, Blue Cross Blue Shield, Community First Health Plans, Molina, Superior, and UnitedHealthcare) health plans for the provision of managed care services. Texas engages in a competitive bidding process to secure plans for each of its programs; the state is currently accepting proposals for its STAR+PLUS program. As of 2020, more than 95% of Texas Medicaid enrollees were enrolled in an MCO.

- Aetna Better Health of Texas
- Amerigroup Texas
- Blue Cross Blue Shield of Texas
- Community First Health Plans
- Community Health Choice
- Cook Children's Health Plan
- Dell Children's Health Plan
- Driscoll Health Plan
- El Paso First Premier Plan
- FirstCare
- Molina Healthcare of Texas
- Parkland Community Health Plan
- RightCare from Scott & White Health Plan
- Superior HealthPlan
- Texas Children's Health Plan
- UnitedHealthcare Community Plan of Texas

Medical Loss Ratio/ Administrative Caps

Texas does not have a minimum MLR requirement. Instead, Texas Medicaid's managed care contract provides a cap on administrative expenses that an MCO may deduct from revenue for the purposes of determining income subject to an Experience Rebate. The administrative cap neither affects the MCO's Financial Statistical Report (FSR) nor prohibits the MCO from incurring administrative expenses above the cap, but it requires that administrative expenses above the limit be counted as Net Income for the purposes of calculating an Experience Rebate. The Experience Rebate acts as a graduated cap on the amount of profit an MCO can retain after taxes and other expenses. The Experience Rebate, coupled with the administrative cap and the FSR, serves to monitor administrative costs and keep MCO spending within state-defined targets.

Withholds and Value-Based Purchasing

In 2011, Texas State Senate Bill 7 established a value-based payment program for hospitals and managed care plans, allowing them to receive quality reports in advance of payment adjustments made to the state. The state included a contract provision in its 2012 Medicaid managed care procurement process requiring MCOs to risk 4% of premiums, an annual statewide total of $640 million, based on the outcomes of performance measures. Texas Medicaid later split the 4% contract risk provision between three plan-specific HEDIS measures and three Potentially Preventable Events (PPEs). A retrospective study of STAR, STAR+PLUS, and CHIP enrollment files found that the three managed care PPEs, Potentially Preventable Admissions (PPAs), Potentially Preventable Readmissions (PPRs), and Potential Preventable Emergency Department Visits (PPV), decreased more than expected, with PPAs decreasing the most at approximately 21% more than expected.

The 2013 Texas legislature directed Texas Medicaid to develop a performance-based payment system that rewards improved health outcomes. As of 2018, Texas MCOs became contractually obligated to transition volume-based provider payment methodologies to quality-based alternative payment models, increasing year-over-year percentages of provider payments linked to measures of quality or efficiency. Starting in 2018, the MCOs were required to have at least 25% of provider payments in an APM framework, with 10% of all payment arrangements in a risk based APM. By 2021, MCOs were required to increase provider payments arrangements in any type of APM framework to 50%, with 25% of all payment arrangements in a risk based APM.

Texas Medicaid imposed a 3% quality withhold under its mandatory Pay 4 Quality (P4Q) program starting in FY 2018, meaning health plans that fail to meet their at-risk measures can lose up to 3% of their capitation rate. The P4Q program replaced a previous quality withhold program with a different risk and measurement structure. The at-risk measures in place for 2022 and 2023 include Potentially Preventable Emergency Room Visits (STAR+PLUS, STAR, STAR Kids, and CHIP), Potentially Preventable Admissions (STAR), Potentially Preventable Readmissions (STAR+PLUS), Prenatal and Postpartum Care (STAR), Diabetes Control (STAR+PLUS), Cervical Cancer Screening (STAR+PLUS), Weight Assessment and Related Counseling (CHIP), Follow-up After Hospitalization for Mental Illness (STAR+PLUS, STAR Kids), Childhood Immunization Status Combination 10 (STAR, CHIP), Follow-up Care for Children Prescribed ADHD Medication

(STAR), Getting Specialized Services Composite (STAR Kids), and Assistance with Care Coordination (STAR Kids). Texas suspended the P4Q program in 2020 and 2021 due to the COVID-19 pandemic.

Quality Management

Federal statute dictates that Texas Medicaid review, update, and publicize its quality strategy every three years, as well as contract with an external quality review organization (EQRO) to help shape its quality strategy. Texas Medicaid has contracted with the University of Florida's Institute for Child Health Policy (ICHP) as its EQRO since 2002. The state uses a blend of state-developed measures and standard national measures to gauge quality performance. The EQRO evaluates Annual Quality of Care Administrative and Hybrid HEDIS and AHRQ Measures Data Tables, annual MCO Level PPE Reports for PPAs, Potentially PPRs, PPVs, PPCs and Potentially Preventable Services (PPSs), and annual MCO Report Cards Surveys using the National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®), Agency for Healthcare Research and Quality Pediatric Quality Indicators /Prevention Quality Indicators, 3M Software for Potentially Preventable Events, Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys, National Core Indicators-Aging and Disabilities (NCI-AD), and CMS Core Sets of Adult and Child Health Care Quality Measures.

Health Equity

The Texas Medicaid managed care contract encourages MCOs to "implement intervention strategies to avoid disparities in the delivery of Health Care Services to diverse populations and provide services in a culturally competent manner," but there is no contractual obligation to provide services through a health equity lens. Accordingly, innovation in the provision of care related to social drivers of health has largely occurred at the discretion of individual MCOs.

In 2019, Texas MCOs, in partnership with federal and state-based non-governmental organizations, launched the Texas Managed Care Organization Social Determinants of Health Learning Collaborative. The Collaborative develops evidence-based strategies for MCOs in Texas and beyond to better serve populations whose health is impacted by social factors.

SECTION 4

MCO Operations

In this section, we profile six MCOs (Aetna Better Health of Florida, AlohaCare of Hawaii, AmeriHealth Caritas of North Carolina, Banner Health of Arizona, Molina of Illinois, and Texas Children's Health Plan of Texas) and describe their evolution and footprint within the state's Medicaid program along with innovations and successes in their respective state markets. The profiles are based on research that included a review of publicly available documents, such as MCO websites and member handbooks, as well as interviews with key MCO staff. Topics covered in each profile include value-added and in lieu of services, strategic partnerships, innovations, and community reinvestments.

Topics covered in each profile include:

Innovation

Strategic Partnerships

Member Handbooks

MCO Websites

Interviews with Key MCO Staff

Community Reinvestment

Value Added and In Lieu of Services

AETNA BETTER HEALTH - FLORIDA

> "Since before the pandemic, we've been setting up a partnership with Feeding South Florida. It started with the Feeding Futures School Pantry program which sets up a school food bank run by students where we offer nutritional services. The whole program is structured not only around the provision of fresh food and shelf stable food to students and their families, but also engaging in those conversations around nutrition, how do you get this food, and how do you prepare this food, all with a cultural sensitivity."
>
> – Jennifer Sweet, CEO, Aetna Better Health of Florida

Aetna Inc. is a health insurance company founded in 1853. In its nearly 170 years of operation, the company has developed, and provides managed care health plans across consumer-direct health insurance, employer-sponsored insurance, Medicare, Medicaid, CHIP, Marketplace Exchange, LTSS, behavioral health, dental, and pharmacy benefit management services. Aetna Better Health is Aetna's Medicaid managed care brand and is available across 16 states, including Florida.

Aetna Better Health of Florida provides a full range of physical health, pharmacy, care coordination, and behavioral health services across three regions (6, 7, and 11) in the state.

Aetna Better Health of Florida also serves the CHIP population statewide, managing 47% of the state's Florida Healthy Kids membership.

Aetna Better Health, referred to onwards as the Plan, was operating in Florida on a county-by-county application basis when the legislature approved the move to SMMC. The Agency rolled the program out in 2014. The Plan has worked towards delivering high quality outcomes, improving member satisfaction, and building a more integrated whole person model of care in the State.

As of August 2022, Aetna Better Health of Florida serves approximately 189,035 members in the MMA program and 4,993 members in the LTC program, nearly 4.8% and 4% of the respective programs' populations.[130]

Regarding value-added services (VAS), also referred to as "expanded benefits" in Florida, the Plan provides a comprehensive range of 36 VAS that include prenatal/postpartum services, doula services, hearing and vision benefits for adults, OTC drugs coverage, housing assistance, and more. These VAS are selected by the Plan from a designated list of approximately 50 VAS that the state compiled from all plans contracted under the SMMC program. While these VAS are covered by most plans in the state, the Plan differentiates its VAS offerings by incorporating them into its Whole Person Care (WPC) model. The Plan intends to be more purposeful with its VAS, aligning them with its care management programs or members' needs and conditions. An example of this "strategic package" is providing members with diabetes with remote monitoring devices (like glucometers) and food and nutrition benefits to supplement their diabetes care management program. This WPC-focused VAS packages are intended to be member-centric, driving health outcomes that are beneficial to members' particular conditions.

In Florida, the Plan offers 16 medically appropriate, cost-effective substitutions for services covered by the state. The focus of these in-lieu-of services (ILOS) in Florida are entirely behavioral health driven and includes Crisis Stabilization and Partial Hospitalization Programs, both in lieu of Inpatient Psychiatric Care and a variety of SUD programs in lieu of Inpatient Detox Hospital Care. The ILOS fill the gaps in coverage in behavioral health

services, better support members' needs, and ensure access to the most appropriate level of care. The Plan works with providers to offer these ILOS by engaging in provider outreach and awareness to drive utilization of the Plan's ILOS offerings.

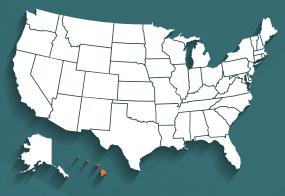
The Plan has established strategic partnerships at the local, state, and national levels to advance its goal of improving member health and well-being in Florida and across other state programs. First among these relationships is the Plan's collaboration with CVS Health. Aetna Inc. was acquired by CVS Health in 2018. Given CVS' large retail footprint, geographic accessibility, and high consumer trust, the Plan actively promotes CVS health services for Medicaid members, like primary care walk-ins via Minute Clinics and HealthHUBs.

In addition, CVS invests in affordable housing developments across many states, and with the CVS relationship, the Plan now participates in site selection and affordability planning on Florida projects. Since 2020, CVS has invested $23 million across 14 communities in Florida to construct and refurbish more than 5,500 affordable dwelling units (ADUs), which are specifically designed for individuals experiencing homelessness, survivors of domestic violence, persons with disability, and youth aging out of foster care – all populations typically served by Medicaid.

Furthermore, many of these ADUs provide residential services, health services, and/or employment support services. The Plan has actively built provider and community partnerships to address many of its members' needs, with a strong focus on behavioral health care programs and benefits. Historically, the Plan subcontracted the management of its behavioral health benefits. However, the Plan made key strategic hires, investments, and connections in the provider community and now fully manages behavioral health benefits for Plan members. This move gives the Plan greater control, creativity, and innovation in the behavioral health space, especially in applying the Plan's philosophy of delivering member-centric WPC.

In every step of building these varied partnerships, implementing innovative care models, and covering expanded and in-lieu-of benefits, the Plan has focused on addressing SDOH and health inequity with its community-based partners. To this end, the Plan has deployed a "social team," which embeds themselves in the community strategically to collaborate with people, organizations, and systems to ensure capacity and sustainability of social care programs and supports. The Plan has developed a community resource database that identifies social care programs, connecting members needing identified resources, tracking those member referrals, and ensuring the receipt of resources. This database is a closed loop system that monitors and reports to the Plan and its providers on the delivery and effectiveness of these benefits. Concerning food security, the Plan has donated $350,000 in financial support to Florida food banks since the start of the pandemic. The Plan, in partnership with Feeding South Florida has undertaken two key partnerships in recent years: the Feeding Future School Pantry Program that creates student-run school food banks as well as provide nutritional services to students and their families; and the Mobile Food FARMacy, a mobile healthy foods distribution aligned to a diabetes-stabilization nutritional program for its members. The latter program will also be expanded to Jacksonville and Tampa.

ALOHACARE – HAWAI'I



"AlohaCare was founded on the idea of whole-person care. Being a health center-founded plan, the design was community centric, with a focus on members' mental, physical, and spiritual health. Addressing the social determinants of health is the best way to engage with the populations we serve."

–Francoise Culley-Trotman, CEO, and Paula Arcena, Executive Vice President, External Affairs at AlohaCare

AlohaCare is a community-led, non-profit health plan that was founded in 1994 by Hawai'i's community health centers. AlohaCare is the only health plan in the state that is dedicated to serving only those eligible for Hawaii QUEST Integration (Medicaid) and Medicare programs. Today, AlohaCare operates statewide, across the islands, and served 83,929 members as of June 2022.

AlohaCare has always opted to utilize value-added services (VAS) as the plan's philosophy focuses on whole-person care. Because community health centers founded the plan, there has always been a focus on meeting the members' needs and considering the members' mental, physical, and spiritual health. AlohaCare believes addressing social determinants of health is key to engaging with their members. The most significant VAS that AlohaCare offers is Ke Aloha Mau, its newly launched, culturally responsive service that targets a member's mental, spiritual, and physical health. Traditional Native Hawaiian practices have played a vital role in the local culture, and AlohaCare honors that heritage. Ke Aloha Mau allows AlohaCare to meet members where they are, empowering their health journeys. Practitioners are located across the islands, even in remote and rural areas where providers travel to deliver services. AlohaCare is working to provide care more easily and accessibly by working with cultural advisors. This benefit took a while to develop but became effective in January 2022. These services are available for all eligible members between the ages of 12 and 64 who live within the service area. These are person-centered services that address cultural disparities and provide a bridge between traditional Western medicine and Native Hawaiian health. These services include:

- **Ho'oponopono:** brings balance in relationships and reduces discord by resolving spiritual, emotional, behavioral, and/or physical conflict
- **'Ai Pono:** a traditional Native Hawaiian nutrient rich diet
- **Lomilomi:** the traditional form of Native Hawaiian physiology using massage and stretch to align the mind and spirit
- **Hula:** a traditional form of physical movement to align health in a whole person perspective

VAS are a key piece of AlohaCare's approach to caring for the people of Hawai'i. Dental services is another service the plan opted to provide to address the services needed for adult members. Recently, Hawai'i decided to include preventive and restorative dental coverage in the state plan beginning in January 2023. As a result, the value-added dental services provided by AlohaCare are no longer necessary. By reviewing data and utilization of services, AlohaCare can adjust and provide services that will benefit the most enrollees.

AlohaCare offers several alternative services for medically appropriate benefits. AlohaCare has partnered with a medical respite home solution, Tutu Bert's, to reduce the number of days a houseless person is waitlisted for a bed in an acute facility. Tutu Bert's provides clean, safe spaces or homes and allows for contracted home-based providers to provide any additional recovery services. One of the homes provides a sober living environment that allows for outpatient recovery services for individuals with SUD. Additionally, AlohaCare has connected with hospice providers to develop and implement a palliative care program that provides supportive services to

members with complex chronic conditions who are not in stable situations. Providers offer emotional, physical, spiritual, and behavioral health support services while working closely with the member, their primary care provider, and any other specialists to address the member's whole-person needs. The benefit will provide for 180 days of services per benefit year.

AlohaCare's partnership with the University of Hawai'i Medical School helps prepare new physicians to better meet the needs of their patients with a greater understanding of the local population and practices, Hawai'i's healthcare system, and the role of a Managed Care Medicaid insurer like AlohaCare. The health plan's medical director designed and developed the curriculum which covers the principles of population health, SDOH, the role of government and public policy, quality, and care coordination. This program launched in the summer of 2022 and revealed the potential for medical students to learn more about the important role they play in improving community health and care delivery.

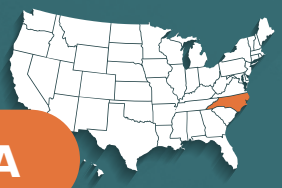
AlohaCare also has a strategic partnership with the Hawai'i Department of Education (DOE) to support the significant number of Hawai'i adult Medicaid enrollees who have not completed their high school education. By paying for program and test fees and supplies, AlohaCare aims to give its members an opportunity to overcome the cost barrier to education. AlohaCare is committed to supporting Medicaid beneficiaries through education to empower them to improve health literacy and engage in their own health goals. Strategic partnerships are an ongoing effort for AlohaCare that is constantly evolving, and the insurer is making a concerted effort to listen and engage with its partners about a variety of issues while seeking innovative solutions.

One of AlohaCare's core principles is that its own expertise is not always enough, and it needs the skill and wisdom of Hawai'i's community-based organizations (CBOs) to complement and expand its efforts. As trusted pillars in the community, CBO leaders and their staff serve as critical links because they speak the languages of Hawai'i's diverse communities and understand the challenges they face. AlohaCare's community investment program has been retooled under the new name Imua Loa program, which means to go forward in good health and well-being in the Hawaiian language. In 2021, AlohaCare expended over $800,000 to fund organizations and initiatives that improve access to quality medical and social care for Hawai'i's Medicaid populations.

In January 2021, AlohaCare launched its Social Determinant of Health transformation plan and strategy for 2021 – 2026. AlohaCare identified three trends that impact the health of its members:

- A high prevalence of potentially preventable chronic medical conditions
- Behavioral health conditions
- SDOH such as housing, food, and financial insecurity

In addition to being one of the founding members of the Association for Community Affiliated Plans (ACAP) Center for SDOH Innovation, one of the most significant ways AlohaCare is working to address the SDOH needs of its members is through the Unite Hawai'i initiative. Unite Hawai'i is a coordinated care network of health and social service providers working together to address social factors affecting people's well-being and improve health in the communities. It is powered by the Unite Us technology platform. Unite Us built local coordinated care networks to connect community providers via the platform, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities. Unite Us is a national company, but the keys to the success of the program are the networks of Hawaii community providers and the Community Network Advisory Board (C-NAB). C-NAB is made up of community network providers that represent various service types and currently include the Hawai'i Foodbank, Domestic Violence Action Center (DVAC), Hawaii Children's Action Network, Hawai'i Alliance of Nonprofit Organizations (HANO), Papa Ola Lokahi, Hawaii Primary Care Association (HPCA), and Partners in Care. Through Unite Hawaii, AlohaCare connects members to health and social care, giving members access to more than 133 active organizations with 239 programs.



AMERIHEALTH CARITAS – NORTH CAROLINA

> "Not only do we have a physical presence across the state across the six regions in North Carolina, we have a physical presence in each of those regions, as we establish these Wellness and Opportunities Centers to serve as a community hub. We're able to offer information on benefits for members like health screenings and community education. If we think about GED training or job placement, we have computer labs. We run seminars or sessions on resume building at each one of our centers in North Carolina."
>
> –Heidi Chan, Market President, and Rebecca Engelman, Executive Vice President, Medicaid Markets, at AmeriHealth Caritas

AmeriHealth Caritas has been operational for nearly 40 years with managed care health plans across Medicare, Medicaid, CHIP, Health Insurance Marketplace®, LTSS, behavioral health, and pharmacy benefit management services. Currently, AmeriHealth Caritas serves approximately five million members across 12 states and the District of Columbia.[134]

AmeriHealth Caritas North Carolina, which began serving members in July 2021, is a PHP that offers a standard benefit plan to North Carolina Medicaid beneficiaries. AmeriHealth Caritas North Carolina operates statewide and coordinates a full range of physical health, pharmacy, care coordination, and basic behavioral health services. As of September 2022, AmeriHealth Caritas North Carolina serves approximately 314,830 members, covering nearly 18% of the state's managed care population.[135]

In its relatively brief time in the North Carolina Medicaid Managed Care program (since July 2021), AmeriHealth Caritas North Carolina, referred onwards as the Plan, has implemented various initiatives to support and empower its members in the state. Relying on its expertise and experience in operating quality, award-winning managed care health plans in other states and markets, AmeriHealth Caritas Family of Companies has adopted and evolved its managed care functions and services to match the needs of its members within North Carolina. In the context of VAS, the Plan offers VAS in North Carolina like what it offers in other states, including GED support (Mission GED Program) and referrals for safe and affordable housing. However, the Plan goes further by taking a state-specific approach to adding more VAS by considering North Carolina's health priorities, disparities, and demographics, like mortality and morbidity, to better align its VAS to member needs. An example is the Plan's recent addition of a breast pump program in response to the formula shortage in the state and other parts of the country.

Presently, the three most utilized VAS in North Carolina are:

- CARE Card Program: members can earn dollars in a reloadable reward card for completing healthy activities such as getting preventive health screenings, immunizations, and child/adult wellness visits. Members can then use the card to purchase groceries and over-the-counter health items.
- Adult Vision Program: adults (ages 21-64) receive an additional pair of glasses and one extra eye exam every two years, in addition to the traditional North Carolina Medicaid (NC Medicaid) benefit.
- WW (formerly Weight Watchers) membership.

In North Carolina, the Plan offers two medically appropriate, cost-effective substitutions for services covered by NC Medicaid. The Plan offers these ILOS to fill the gaps in coverage in behavioral health services to better support members' needs as well as get them access to the most appropriate level of care. These ILOS are:

- Institutions for Mental Diseases (IMD) care for mental health services for members ages 22-64 as an alternative placement for acute psychiatric care in other

covered settings. IMD is an acute residential service for adult members who need mental health inpatient services, due to imminent risk of harm to self or others.

- Behavioral Health Urgent Care (BHUC) as an alternative to a community hospital emergency department. BHUC is a designated service for individuals four years or older who are experiencing a behavioral health crisis related to a SUD, mental health disorder, and/or Intellectual and Developmental Disabilities (I/DD) diagnosis or any combination of the above.

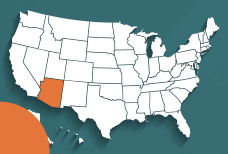
In addition to accommodating services according to member needs and state priorities, the Plan has established strategic partnerships and community engagements at the local, state, and national levels to advance its goal on improving member health and well-being in North Carolina. The Plan has partnered with NCCare360, a statewide coordinated care network that connects Plan members to local community resources and services and provides a feedback loop on the outcome of those connections. Furthermore, the Plan has established five regional Wellness and Opportunity Centers across the state to directly provide members with access to social services and supports. These Centers provide services that include nutrition, physical activity, and financial literacy classes as well as job search help. The Plan will also be adding a mobile Wellness and Opportunity Center in late 2023.

Partnerships and community reinvestments like these are part of AmeriHealth Caritas' Next Generation Model of Care, a whole person, integrated care management model that is focused on addressing members' economic and social disparities beyond just the delivery of medical care. AmeriHealth Caritas implemented this model in 2018 and adopted it in North Carolina at its start. The Plan uses an Integrated Care Team (ICT) model, which consists of a nurse, social worker, community health worker, and a care connector who serve as a direct support system for the members. The ICT has support from additional Plan resources, including pharmacists, doctors, and SDOH coordinators that assist members in getting connected to housing, employment, and other community-based resources.

The Plan's work in addressing SDOH is complemented by North Carolina's Health Opportunities Pilot, a 1115 waiver demonstration program focused on addressing housing, food, transportation, and interpersonal safety issues for high-needs Medicaid enrollees. However, unlike the Pilot program that is limited to a certain number of counties, the Plan applies its ICT Model statewide.

Looking to the future, AmeriHealth Caritas Family of Companies has plans to further embed its community-based services with hyper-local health programs afforded through its investment in and partnership with Wider Circle, a neighborhood-based health organization that establishes local peer-to-peer social networks. These networks connect members to various resources and aid, including helping individuals schedule doctor's appointments and directing them to local food pantries.

BANNER UNIVERSITY HEALTH PLAN – ARIZONA



> "Since 2018 we've really focused our community reinvestment on addressing social determinants of health. Factually, 70 to 80% of health outcomes are driven by addressing social determinants of health needs, so we must tackle that first and then get folks into clinical intervention. In the last two years, we've funded close to 50 programs totaling over $3 million of community-based reinvestments in grants across the whole domain, from education and awareness to food insecurity to housing and so on and so forth."
>
> –James Stringham, CEO, Banner Health

Banner – University Health Plan (B – UHP) is an MCO, a subsidiary of Banner Health, and has an affiliate agreement with the University of Arizona. B – UHP is the longest serving Medicaid managed care plan in the state since AHCCCS' inception in 1985. B – UHP has a long history serving different parts of the state, different regions, and having different partnerships in its nearly 40 years of operation. Today, it covers Central and Southern Arizona with over 300,000 members. B – UHP owns and operates: Banner – University Family Care (B – UFC/ACC), an AHCCCS Complete Care plan; Banner – University Family Care (B – UFC/ALTCS), an Arizona Long Term Care plan; and Banner – University Care Advantage (B – UCA), a Medicare Advantage Dual Special Needs Plan (D-SNP).

B – UHP has always strived for continued ways to expand and build upon VAS to best serve its members. The MCO examines how to best use its partnerships to reach its diverse and rural communities, including its tribal nations. B – UHP works closely with its community health workers known as promotoras, other community health worker partners, and the College of Public Health in order to create foundational relationships that work together. Additionally, the plan has dedicated senior staff positions that focus solely on race and equity within the state as well as 13 different neighborhood advisory councils with dedicated staff who are continuously learning about the health inequities and challenges within those communities. B – UHP's approach with VAS has always been to start small and then build once data on outcomes has been collected and evaluated. B – UHP believes one of the major benefits to being a not-for-profit entity is the ability to reinvest net income into the community and stay nimble around making decisions around allocating resources for VAS.

Starting in 2018, all contractors in Arizona are required to reinvest 6% of their net profits into community reinvestment. All AHCCCS managed care plans must submit a plan detailing its anticipated community reinvestment activities, including expected beneficiaries and how they will benefit, within 60 days of the start of the contract year.[137] While a lot of reinvestment funding goes towards value-added or alternative services, it has also historically been used for community reinvestment, uncompensated care, or charity care – with a focus on addressing SDOH. One of the largest examples of recent community reinvestment comes from a collaborative effort from AHCCCS to address the housing crisis in the state. In 2020, all the AHCCCS health plans came together under a state-led initiative and committed collectively to reinvest up to half of their community reinvestment dollars to a fund called Home Matters to Arizona.[138]

The fund aggregates those dollars to create a pool of funding, which can then be increased by additional outside funds. Today, AHCCCS has raised more than $30 million as an entity. Home Matter to Arizona has an application-based process for developers seeking funding, and the applications are reviewed through a health care lens. The goal is to fund the building of affordable housing that strategically addresses SDOH and provides opportunities for AHCCCS members. The Home Matters to Arizona initiative demonstrates how aligned strategy and thoughtful collaboration can achieve success throughout

communities and improve members' lives. Additionally, B – UHP has a stove-to-table program, which provides hot meals to Latino adults in subsidized housing. It has funded a health navigator program through a peer run organization to promote health and system navigation, and it has a second chance program for peer mentorship for women transitioning out of correctional facilities.

As a community-based organization, B – UHP described its strong focus on strategic partnerships. Since its inception, the plan has had a 30-year affiliation with the University of Arizona, which has sparked additional partnerships in the Banner University Medical Group and various medical centers. In our interview, this was highlighted as particularly helpful during the COVID-19 pandemic when there were shortages of behavioral health appointments. B – UHP worked with the University to create a psychiatry for non-psychiatrists' program with a fully developed curriculum and trained primary care and nurse practitioners on how to treat individuals with low to moderate behavioral health issues.

Through a 50/50 joint partnership with Quest Laboratories, B – UHP was able to get efficient COVID-19 testing, raise public awareness, and spread education through lab portals.

The plan also helped fund and launch Pyx Health, a social isolation technology company that is now being used by Medicaid agencies across the nation. However, B – UHP remains the highest utilizer of Pyx Health with more than 5,000 B – UHP members currently using the technology. In the LTC space, B – UHP partners with Rovicare, an organization that helps the transition, care coordination, and digital streamlining of referrals to home and community-based providers. This partnership has helped B – UHP track gaps in its network and create an efficient process.

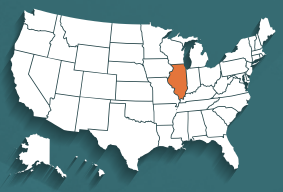
In August 2021, B – UHP and Blaze Advisors partnered with community-based behavioral health, primary care, and social services providers to develop the Integral Health Network of Southern Arizona. The new network is designed to improve access and lower costs for individuals with complex behavioral health needs in Central and Southern Arizona. At the onset of the pandemic, B – UHP recognized there were challenges with this population gaining access to care. It developed a task force to begin solving the issue and from February 2021 to December 2021, collected data on 200 cohort members leveraging a University of Washington collaborative care model. These 200 members were chosen for their high emergency room and cost utilization.

B – UHP found that when providers actively sought out these members, there was a 65% reduction in emergency room utilization, 73% reduction in inpatient, and 75% of the members saw their primary care physicians when none of them had previously.

Furthermore, 26% moved into temporary housing and 32% received regular counseling. These data and findings led to the creation of the new behavioral health led clinically integrated network, which focuses on a much broader population of membership that have high behavioral health needs and either high or low physical health needs and are not engaged yet in primary care services.

B – UHP staff relayed its strong commitment to addressing SDOH and health equity for its members at both an organizational and plan level. In response to the COVID-19 pandemic, B – UHP leadership focused on how to approach the crisis through national and community collaborations. B – UHP is a founding member of the ACAP Center for Social Determinants of Health Innovation and participates in the race and equity collaborative led by ACAP as well. Additionally, the plan has a race and equity division with senior staff leads that focus on criminal justice, veterans, the Native American population and housing. At a larger Banner Health organizational level, there has been the creation of a VP of Health Equity role that partners with B – UHP to develop programs, education, and awareness for staff and providers. B – UHP believes while organizational changes are important in focusing in on health equity and social determinants, it is the actual dedication of each staff member to analyze data and implement positive changes in the community and through neighborhood councils that will ultimately make a difference.

MOLINA HEALTHCARE – ILLINOIS



> "When vaccines were first made available, we made over 50,000 outbound calls to assist Molina members in finding locations to get their COVID-19 vaccinations. We also provided education to members who were a little more hesitant about getting their vaccination."
>
> –Matthew Wolf, Plan President, Molina Healthcare of Illinois

Molina Healthcare was established in 1980 with just one Long Beach medical clinic that provided primary care to Medicaid patients. By 1994, Molina Healthcare of California was licensed as the first managed care program, followed in 1997 by Molina Healthcare of Utah and Molina Healthcare of Michigan.[139] Today, Molina Healthcare offers Medicaid, Medicare, and health exchange plans in 19 states as well as managed health care information systems for state governments.[140]

In 2012, Molina Healthcare of Illinois was selected by the Illinois Department of Healthcare and Family Services to serve members in Central Illinois under the Medicare-Medicaid Alignment Initiative (MMAI).[141] Molina Healthcare of Illinois provides Medicaid HealthChoice, MMAI (MMP Duals), and MLTSS services to all 102 counties in the state and coordinates a full range of medical, dental, vision, behavioral health, and pharmacy benefits for its members. HealthChoice Illinois, the state's managed care program for the 3.2 million residents enrolled in Medicaid, includes families and children, Affordable Care Act expansion adults, adults with disabilities, dual-eligible adult, those receiving long-term services and supports (LTSS) in an institutional care setting or through an HCBS waiver, special-needs children and more.[142] As of August 2022, Molina Healthcare of Illinois serves 333,387 HealthChoice members in Illinois.[143]

At the onset of the pandemic, Molina Healthcare of Illinois quickly added two VAS to aid its members. The plan provided telehealth services, available 24/7.

Additionally, the plan offered $100 gift cards as an incentive for individuals to get vaccinated. While these services were implemented in response to the pandemic, Molina Healthcare of Illinois has many long-standing VAS available to its members. These include extra dental visits for adults, upgraded frames and lenses as part of vision services, and transportation to and from the pharmacy so members can obtain needed prescriptions, thereby possibly preventing unnecessary emergency room visits. Molina Healthcare of Illinois also offers many value-added member incentives on the quality side. These include providing care packages for expecting mothers to encourage prenatal and preventative visits.

Additionally, as recently as 2020, the plan offered free blood pressure cuffs to help members monitor high blood pressure at home and unlimited test strips for diabetic members.

While the pandemic presented many challenges, it also created opportunities for strategic partnerships. Molina Healthcare of Illinois partnered with Clark Resources, a minority-owned business out of Pennsylvania, to assist members in finding locations to obtain their COVID-19 vaccines. The partnership has since expanded to include educating members about quality visit gaps, as well as assisting with scheduling appointments for health-risk screenings and preventative exams. In July 2022, Clark Resources opened its first office in Illinois, located in the same building as Molina, bringing new jobs to the community and making it a partnership that not only benefits Molina members but also the state.

With support from the Illinois Department of Healthcare and Family Services (HFS), through the withhold reinvestment program, Molina Healthcare of Illinois has been able to pilot many innovative programs. Throughout the pandemic, Molina Healthcare provided drive-through food giveaways and free laundry days. In partnership with the YMCA, Molina Healthcare offered MolinaCares community closets across the state to provide access to essential hygiene goods and clothes for parents and children. In partnership with the Chicago Housing Authority, Molina Healthcare donated over 150 Chromebooks for students learning remotely.

In 2021 and 2022, the plan implemented the MolinaCares Scholarship Program, awarding 20 scholarships worth $10,000 each to students in low-income communities or low-income households.

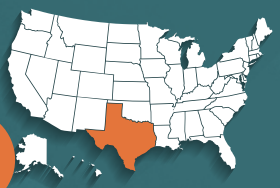
YEAR 1 In the first year of implementation, the program focused on how students navigated the challenges of the pandemic. Applicants were required to provide proof of COVID-19 vaccination, income verification, and current college enrollment.

YEAR 2 In the second year of the program, students were asked to demonstrate how they improved their communities through volunteer service.

Additionally, the plan supported the creation of a hydroponic garden in Englewood, a food insecure area in Chicago. The garden produces food 10 months a year, in addition to providing a green space for the community and a space for local artists to display their designs.

Looking ahead, Molina Healthcare of Illinois continues to focus on community, health equity, and SDOH.

TEXAS CHILDREN'S HEALTH PLAN – TEXAS



"I think strategic partnerships are a place for MCOs to focus. We are increasingly asked to do a lot for members, and we can't do it all. I think it's important for us to recognize that and to try and determine where and how to create a strategic partnership strategy. And I think that's where FindHelp really came in handy. It's not the answer to everything, but it can help us get some data to determine where we have community-based organizations or other partners in the community who are really valued."

–Natalie Burns, Director of Population Health, Texas Children's Health Plan

Texas Children's Health Plan, founded in 1996, is a health maintenance organization (HMO) covering children, teens, pregnant women, and adults in Houston and the surrounding area. The HMO was founded by Texas Children's Hospital, a hospital system headquartered in Houston, which maintains current ownership of the plan. Texas Children's Health Plan serves CHIP and STAR beneficiaries in 20 counties and STAR Kids beneficiaries in 53 counties with a network of over 4,300 doctors, 6,800 specialists, and 118 hospitals.[144]

In the 2011 round of Texas MCO re-procurement, Texas Children's Health Plan's new contract expanded its STAR product service area from 9 to 20 counties. The 2011 contracting period also expanded the plan's CHIP perinate benefits to provide prenatal care for the children of low-income women who do not qualify for Medicaid.[145] In 2016, the Texas Health and Human Services commission selected Texas Children's Health Plan for inclusion in the STAR Kids program, which allowed the plan to provide health coverage to children and youth with special health care needs.

Texas Children's Health Plan's inclusion in STAR Kids expanded the plan's service area from 20 to 54 counties, bringing approximately 40,000 new members and 400 new personnel under the plan.[146]

Texas Children's Health Plan was accredited by the National Committee for Quality Assurance (NCQA) in 2013.[147]

In Texas, MCOs may change their VAS once per fiscal year, beginning September 1.[148] Texas Children's Health Plan changed its VAS offerings, known as the Healthy Rewards Program, on September 1, 2022. The Healthy Rewards Program provides VAS related to pregnancy, physical activity, transportation, dental care, vision care, nurse hotline resources, education, diabetes management, cervical cancer screenings, and mental health hospitalization.[149] On September 1, 2022, the plan altered its basic baby care and childbirth classes, offered new incentives for prenatal and postpartum care visits, discontinued its kidney function test benefit for diabetes management, discontinued its minimum GPA and GED incentives, established a separate wellness visit benefit for individuals aged 18-21, added sports clinic types at which members may register for no cost, and reduced the time frame in which rewards can be claimed from the duration of the eligible year to up to 30 days after the end of the eligible year.[150]

Texas Children's Health Plan offers a web-based "Family Resources" tool to help staff, members and non-members navigate social services that improve food security, financial security, housing security, and other social drivers of health. "Family Resources" is powered by FindHelp, a social services network formally known as Aunt Bertha. Texas Children's Health Plan staff use the tool to help their members access the services they need in real time. Members and non-members can also independently access the tool through a Texas Children's

branded web portal. Upon entering their zip code in the portal, users receive a list of all resources related to social drivers of health in their geographic relation, including assistance related to food, housing, goods, transportation, health, wellness, finance, education, legal matters, and education.[151] Texas Children's Health Plan partnered with Project SEARCH, a community reinvestment program for individuals with intellectual and developmental disabilities, when the plan expanded to include STAR Kids members in 2016. Project SEARCH provides employability training to STAR Kids members through three 10-week (30 week) internships with the health plan, setting participants up for improved SDOH through promoting employability and eventual financial independence.[152] Texas Children's Health Plan collaborates with local school districts and the Texas Workforce Commission to further support employment opportunities for Project SEARCH participants. Texas Children's Health Plan has employed 60 STAR Kids member interns at the health plan since the launch of Project SEARCH, and the organization has plans to expand the program to more participants in the coming years.[153]

SECTION 5

Outcomes

> "They say a cynic is someone who knows the cost of everything and the value of nothing. Managed care is the only delivery system – the only one – where Medicaid outcomes are routinely measured and reported. How else do you know what you're getting in return for your investment in Medicaid?"
>
> – Margaret A. Murray, CEO, Association for Community Affiliated Plans

> "Medicaid has always been a 50 state experiment, and one thing we now know for sure is that Managed Care is the most effective means to improve access and quality while controlling costs."
>
> – Craig Kennedy, President and CEO, Medicaid Health Plans of America (MHPA)

Trends

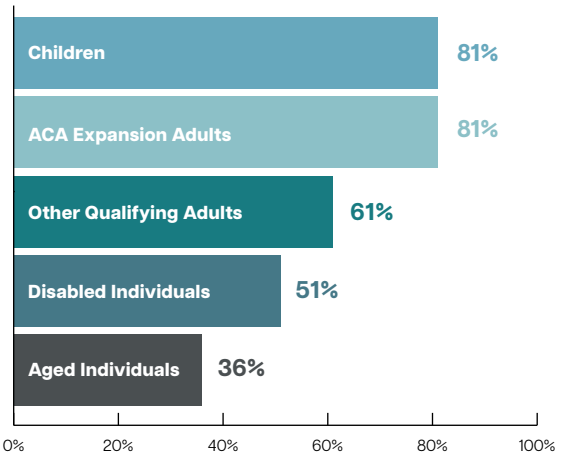
From 1991 to 2000, managed care enrollment increased from 2.7 million individuals (9.5% of all Medicaid beneficiaries) to 18.8 million individuals (55.8% of all Medicaid beneficiaries). By 2000, 14 states had over 75% of their Medicaid population enrolled in managed care, and approximately four-fifths of managed care enrollees received services under a capitated, risk-based model. By 2011, 49 million individuals were enrolled in managed care, and 47% of all Medicaid beneficiaries were enrolled in a comprehensive risk-based program. By 2019, just under 54 million individuals, or close to 70% of all Medicaid beneficiaries, were enrolled in a comprehensive risk-based managed care program, reflecting a nationwide adoption of more risk-based plans in Medicaid. About 90% of today's Medicaid beneficiaries are enrolled in some form of managed care.[154]

In 2000, 556 managed care plans were in operation nationwide, the majority of which were full-risk plans.[155] As of 2014, states contracted with approximately 600 MCOs.[156] By 2022, state Medicaid programs contracted with 282 MCOs, representing a shift to larger, nationwide payors taking a greater share of the managed care market, as well as a consolidation of local and regional plans. Six firms account for more than half of all Medicaid managed care enrollment. At the same time, plans associated with safety net providers accounted for 40% of enrollment in 2021.[157]

State Medicaid programs have the authority to contractually carve-in or carve-out behavioral health services, LTSS, pharmacy benefits, and dental benefits from their managed care programs. In the past decade, states have trended towards carving-in more of these services into managed care programs. However, a growing number of states are opting to carve-out pharmacy benefits: California, New York, and Ohio intend to join five other states in carving out their pharmacy benefits from managed care by 2022.[158]

Managed care's initial expansion in the mid-1990s focused on children, their parents, and populations with relatively predictable and low-cost health care needs. With the growing maturation of managed care oversight and payment systems, states have incrementally incorporated children with special health care needs, individuals dually eligible for Medicare and Medicaid, and adults with physical and developmental disabilities into their managed care lines of business. States incorporating special populations under managed care found opportunities for improved care coordination and cost savings for these groups with more complex health care needs. With the passage of the ACA in 2010, states also began gradually incorporating childless adults into their managed care plans.[159]

Individuals Receiving Medicaid Benefits Enrolled in a Comprehensive Managed Care Program in 2019[160]



The Families First Coronavirus Response Act (FFCRA), which provides states a 6.2 percentage point increase in Federal Medical Assistance Percentage (FMAP) funding for the duration of the COVID-19 Public Health Emergency (PHE) declaration, also requires states to meet maintenance of effort requirements by preventing Medicaid eligibility redeterminations while the declaration is in place. Given the current outlook of the COVID-19 pandemic, the PHE declaration is expected to expire in early 2023. From February 2020 through June 2022, Medicaid enrollment grew by an estimated 18.2 million individuals to its highest ever enrollment, topping 89 million.[161] An estimated 18 million Medicaid beneficiaries, the overwhelming majority of whom are enrolled in a managed care program, are expected to lose Medicaid coverage when the PHE declaration ends. HHS is working with states to mitigate the likelihood of unnecessary coverage losses, but a downturn in managed care enrollment is highly likely despite these efforts.[162] MCOs are at risk of lost revenue as enrollment numbers wane, but they may act to mitigate coverage losses by proactively updating beneficiary contact information and outreach to members who may lose coverage for procedural reasons. Additionally, managed care plans with multiple lines of business may work to transition their former Medicaid members into ACA Marketplace coverage plans.[163]

Managed Care and Cost Savings

The potential for cost savings under a managed care delivery system, as compared to an FFS system, has been analyzed and debated by state and federal policymakers and stakeholders since states implemented the first Medicaid managed care programs. Just as each state's Medicaid program is local and unique, so, too, are each state's Medicaid managed care program, with varying programmatic, quality, and financial requirements, as well as different accountability structures. Varying payment models among states, the degree to which states require their Medicaid populations enroll in managed care, and the amount of high-cost patients enrolled in a state's managed care program led to significant variation in cost savings on a state-by-state basis.[164] States have implemented managed care in vastly different ways, ranging from complete carve-ins of services and populations to incremental approaches to expansion over the course of many years.

Nevertheless, there are clear conclusions to draw 25 years into the era of modern Medicaid managed care. The first is that some level of cost savings, and importantly, cost predictability, is built into the managed care model, which establishes cost containment guardrails for Medicaid programs. State payments to MCOs are required by federal law to be actuarially sound. The payment rates are upfront, fixed costs approved by CMS in 12-month increments, leading to increased predictability in the state budgeting process.[165] CMS requires state spending on Section 1115 demonstration waivers, the demonstration program through which many states operate their managed care programs, be "budget neutral." Section 1115 budget neutrality requirements dictate that states may not exceed the projected costs they expect would occur if their 1115 demonstration waiver were not in place. If the state 1115 waiver spending is below the projected cost of what would have been spent if the waiver were not in place, the state may spend the difference, considered "savings," on services or members not otherwise covered by Medicaid.[166] States have continued to use 1115 demonstration waiver authorities to operate and expand their delivery of managed care services with anticipated and continued savings generated that enable them to cover additional populations and services that would not otherwise be covered absent the savings generated within the program. Likewise, states using the 1915(b) waiver authority as a vehicle for managed care must apply for waiver approval through preprint forms with cost effectiveness guardrails. Specifically, the preprint application requires states to demonstrate their 1915(b) waiver will result in expenditures lower or equal to that of projected spending if the waiver were not in place.[167] CMS must review and approve states' documentation related to budget neutrality or cost effectiveness prior to implementation of a managed care program and must also approve extension and renewal applications. In practice, we observe CMS generally approves such applications, showing states are demonstrating to CMS that their managed care programs contain costs.

In short, managed care authorities require states to hold themselves and their contracted MCOs accountable to cost containment standards that are simply not applicable to an FFS delivery system. Along with these higher standards come reporting and evaluation requirements to test and examine what is working and what needs improvement.

Arizona

Arizona has the unique distinction of being the first state in the country to operate under a statewide managed care 1115 demonstration waiver and is the only state to have done so since the inception of its Medicaid program. AHCCCS reports that its health care delivery system design is essential in eliminating barriers to care while containing costs.[168] **The state's interim evaluation report for its 1115 waiver concluded that MCO efforts to contain costs had saved the state in excess of $9 billion over the four fiscal years from 2017 through 2020.[169]**

In 2018, AHCCCS fully integrated physical and behavioral health managed care contracts, which allowed for reduced fragmentation and improved service delivery to its members. Since, AHCCCS, in partnership with its managed care plans, has continued to pursue long-term strategies that improve health outcomes while simultaneously bending the curve of rising health care costs. One of the agency's current goals is to focus on payment modernization by leveraging the managed care model to move the Arizona health care system toward greater value-based health care adoption, while also developing and implementing initiatives such as electronic prescribing, care coordination and integration, and a health care payment learning and action network (LAN).[170]

California

According to the California Department of Health Care Services (DHCS), Medi-Cal managed care provides high quality, accessible, and cost-effective health care through managed care delivery systems.[171] Managed care plans in the state provide the most cost-effective use of health care resources, while also improving health care access and ensuring quality of care. California has started the process of implementing the full redesign of the Medi-Cal program called California Advancing and Innovating Medi-Cal (CalAIM). This will allow the state to standardize care across the various components of the delivery system, which allows coordinated and equitable access to services that address physical, behavioral, developmental, dental, and LTC needs.[172] One of the three primary goals of CalAIM is to improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.[173] Additionally, California is focused on increasing coverage for all Californians, especially populations in which no federal reimbursement exists, such as individuals without documentation. Through the Medi-Cal managed care program, the state has continued to partner with regional plans across its different delivery models to produce savings that allow it to cover more enrollees while developing and implementing more innovative services. The Medi-Cal population is the largest in the country, and as such, maintains the largest budget. While this is the case, **spending across all enrollee groups is lower than the national average.**

Florida

In August 2011, Florida submitted an amendment request to CMS for its 1115 demonstration that would permit the state to establish and implement the MMA program and broadly restructure the state Medicaid delivery system into the SMMC program without increasing costs. CMS approved the waiver in June 2013, and the MMA program was fully implemented and operational in all regions by August 2014. Florida's transition to SMMC program did not come without challenges. Expanding and restructuring its managed care program to the entire state in a span of a few months was a significant accomplishment for the Agency. However, in its competitive procurement of nationally accredited managed care plans with broad networks, expansive benefits packages, and top-quality scores, the MMA program yielded meaningful positive results in its first year (FY 2014-15). There were significant declines in service utilization compared to the pre-MMA period for inpatient stays, outpatient visits, emergency department visits, and professional (physician) visits. Additionally, the statewide weighted mean of 17 of the 26 HEDIS measures (65%) improved, while seven measures (27%) remained the same after MMA implementation. **More importantly, per member per month (PMPM) costs adjusted for age, race, gender, and Chronic Illness and Disability Payment System (CDPS) scores (case-mix) for MMA services were 32.9% lower for comprehensive plans (serving both LTC and MMA enrollees) compared to PMPM costs for enrollees who are in separate LTC and MMA plans ($206 PMPM comprehensive vs. $306 PMPM separate).** In its second round of the SMMC program (2018-2023), the state has established strict goals of managing costs while also maintaining high quality and efficiency of care. In its evaluation design, the state has aimed for its per-enrollee cost by eligibility group in MMA plans to be no greater than pre-MMA implementation. The state has also applied these cost maintenance/savings goals to the eligibility and coverage policies of the broader SMMC program (including LTC plans) that would affect Medicaid health services expenditures, provider uncompensated care costs, and administrative costs.[174]

New Jersey

In New Jersey, nearly all Medicaid populations are subject to mandatory enrollment in managed care. According to NJ FamilyCare, the managed care delivery system has proved essential in implementing innovative services such as autism and doula benefits, for example. Additionally, providing such services through MCOs has proven to be cost effective and allows the state to allocate additional resources for innovative benefits.[175] While state enrollment in managed care has grown significantly in recent years, having the managed care delivery system under the authority of the 1115 New Jersey FamilyCare Comprehensive Demonstration (NJCD) waiver has

resulted in significantly lower expenditures when compared to projected spending without the waiver.[176] For example, in a cost analysis of the MLTSS HCBS benefit provided exclusively through managed care, interim findings suggest an overall per-beneficiary saving and a decrease in total incremental all-cause health care costs before and after implementation (after subtracting program implementation costs). The MLTSS program, when analyzed alone, has resulted in cost savings among beneficiaries and surpassed implementation costs on a per beneficiary basis.[177]

North Carolina

North Carolina's 1115 waiver entitled "North Carolina Medicaid Reform Demonstration" was approved by CMS in October 2018. The waiver set the state on the path to establishing a Medicaid managed care program, which launched on July 1, 2021. The State set out three goals for the demonstration: measurably improve health outcomes via the new delivery system, maximize high-value care to ensure sustainability of the Medicaid program, and reduce substance use disorder. In maximizing high-value care under new the managed care delivery system, DHHS has established specific objectives focused on decreasing non-urgent emergency department visits and hospital admissions for ambulatory sensitive conditions; increasing the number of individuals receiving care management services; reducing Medicaid program expenditures; and increasing provider satisfaction and participation in the Medicaid program. DHHS will evaluate the reduction in Medicaid program expenditures by extracting claims and encounter data of health plan enrollees to analyze out-of-pocket costs to Medicaid enrollees, costs of Medicaid-funded services and components, and total expenditures (including administrative costs) to the Medicaid program and components. DHHS ensures the completion of these demonstration goals and objectives through its procurement and partnership with PHPs as they will be leading the State's initiatives on increasing the use of alternative payment models, providing care with a whole person orientation, enhancing access to care, and applying use of evidence-based practices and medicines.[178]

Texas

Texas Medicaid's incremental expansion of managed care has proven an effective strategy in mitigating Medicaid spending over time. Today's Texas Medicaid managed care program, which operates under 1115 waiver authority, has reduced total state spending when compared to the state's projected spend were the demonstration not in place.[179] This finding proves the state's long-term hypothesis that appropriately timed, region- and population-based expansions of Medicaid managed care, are investments that do not over-extend the state's resources and ultimately drive down health care costs. To grow from this success, Texas is looking to the future of Medicaid managed care, using Medicaid contracting as an accountability tool to motivate MCO adoption of increased financial risk. The state has Medicaid payment programs to incentivize MCOs to mitigate potentially preventable events and the onset of chronic disease in its members, which could ultimately save the state millions in unnecessary health care costs per year.[180]

Improvements in Quality and Access to Care

Managed care plans play a critical role in shaping and providing a framework for tracking, ensuring compliance, and improving performance related to access and quality for their beneficiaries. Section 1932 of the Social Security Act and regulations at 42 CFR §438 outline the quality assessment and performance improvement requirements for states that contract with MCOs. States operating Medicaid managed care programs are required to have a managed care quality strategy, accreditation reporting, a quality assessment and performance improvement program (QAPI), and external quality review.[181] Quality strategies must be written and contain specific requirements, receive public comment before submission to CMS for approval and must conduct evaluations of effectiveness at least once every three years.[182] States are increasingly incorporating quality measures into payment and purchasing strategies and setting quality standards in managed care contracts. Additionally, many states are implementing risk-based models that further incentivize quality improvement on key metrics.

Managed care plans are required to report to the state if they have received accreditation from an accrediting entity. Currently, almost all states either require or recognize health plan accreditation from the National Committee for Quality Assurance (NCQA), which enables consistent data collection and reporting across states and plans.[183] The NCQA requires annual submission of data including the HEDIS measures and CAHPS surveys.[184]

Arizona

In Arizona, AHCCCS in partnership with their managed care plans continues to promote integration at the provider level to support the delivery of integrated care through primary care, integrated clinics, health homes, and more as part of their continuous quality improvement efforts. The agency continues to test new models to improve the quality of care for beneficiaries and is

focused on moving toward value-based care in order to link and incentivize provider payments to quality of care while further lowering costs.[185] AHCCCS recognizes several of their initiatives and best practices that are aimed at quality outcomes and innovation including accessing behavioral health in schools, housing programs, telehealth services, health information technology, transforming EMS delivery, and more.[186] As a result, the state's most recent interim evaluation report for its 1115 waiver concludes that many quality of care indicators for its various managed care programs have either improved or remained the same over the life of the waiver, demonstrating the success the state has had partnering with plans to improve patient outcomes. **Some key improvements found in the 2021 interim evaluation include an increase in children's access to immediate care, decreased emergency department visits, increased use of alcohol and other drug abuse or dependence treatment, increased use of mental health services, and increased flu shot administration.[187]**

California

California's comprehensive quality strategy includes managed care which outlines quality goals in response to federal managed care requirements.[188] In 2016, DHCS launched the Medi-Cal Managed Care Performance Dashboard that displays comprehensive data on a variety of measures, including enrollment, health care utilization, appeals and grievances, network adequacy and quality of care. Since 2019, grievances DHCS has received relating to quality of care have decreased by approximately 30.9%. **In reviewing the dashboard and the external quality review reports, other highlights include better scores in weight assessment, postpartum care, immunizations, and emergency department visits.[189,190]** These reports reflect that Medi-Cal and DHCS have demonstrated that both quality and access to care have been at the forefront of the Medi-Cal managed care approach, and the transformation to CalAIM has allowed DHCS and the states' contracted managed care plans to continuously review and identify successful practices for expansion as well as those that have been less effective. In the 2021 Medi-Cal Facts and Figures Almanac, DHCS recognized that there was still work to be done when it came to disparities in access, quality of care, and health outcomes for enrollees of color, as the program would be facing significant changes in the coming years. In the most recent Comprehensive Quality Strategy, released in 2022, DHCS mapped out goals and guiding principles that allow the agency to build on the Population Health Management framework that is the foundation of CalAIM. In partnership with the state's managed care plans, the DHCS Comprehensive Quality Strategy aims to engage members as owners of their own care, keep families and communities healthy via prevention, provide early interventions for rising risk including patient-centered chronic disease management, deliver whole person care for high-risk populations, and address social drivers of health.[191] When it comes to driving improvements in quality and access for Medi-Cal members, the most effective tools accessible to DHCS are the incentives and disincentives built in to how the agency pays the state's managed care plans. The quality strategy includes a piece that begins in 2023, the fact that quality payments to plans will be adjusted depending on performance with quality measures. Enhancements of data collection for transparency and accountability, the design of a health equity road map, and expansion of Medi-Cal coverage to new provider types are additional key factors of both the CalAIM program and quality strategy.[192]

Florida

Prior to SMMC, there were disconnected quality improvement activities for the various delivery systems and much of the focus was on administrative processes. Florida's shift from multiple delivery systems to the SMMC program offered a greater emphasis on performance improvement and quality measurement. The SMMC program allowed the Medicaid agency to have an integrated, person-centered, and comprehensive quality strategy that delivered data-driven, focused, and systematic feedback to health plan contract managers, policy, and clinical staff. In the first five years of the SMMC program (2013-2018), Florida Medicaid saw the introduction of expanded benefits, enhanced provider networks, improved health outcomes, and high patient satisfaction. Data from CAHPS survey indicate Medicaid recipients continue to be more satisfied with their health plans than individuals enrolled in commercial plans in Florida. Managed care was also proven to be effective in transforming the LTC delivery system by continuing to promote receipt of services in the community versus an institution. Since July 2013 (pre-SMMC), the number of Medicaid recipients in nursing facilities has declined by 13.6% from 50,122 to 43,303, and the number of recipients receiving services within their community has increased by 60.9% from 34,124 to 54,886. The state further strengthened the SMMC program in the re-procurement process for the 2018-2023 managed care cycle considering feedback from stakeholders (members, providers, and health plans) and capitalizing on new developments in technology and managed care service delivery. The second SMMC program (2018-2023)

provided beneficiaries with enhanced after-hours appointment availability, access to remote patient monitoring, and enhanced network adequacy standards. For providers, SMMC plans allow for increases in value-based purchasing opportunities and reduced administrative burdens for high performing providers.

In 2019, the SMMC program continued to show some of the highest quality scores in Florida Medicaid's history. The results showed improvement in an overwhelming majority of quality measures. As the SMMC program continues, health and dental plans have committed to continued improvement in the quality, access, and timeliness of care.[193]

New Jersey

Since the implementation of the NJCD 1115 waiver in 2012, New Jersey has achieved significant accomplishments.

The National Core Indicators-Aging and Disabilities 2018-2019 survey found that New Jersey outperformed the national average on key quality measures including: individuals that had physical and wellness exams, flu shots, dental visits, and vision exams.[194]

The Scan Foundation recognized New Jersey with its 2020 Pacesetter Prize for Choice of Setting and Provider and called the state, "a national leader in utilizing managed care to give people needing LTSS more choices of care providers and settings for receiving care."[195] Finally, external quality review activities conducted from January 1, 2021, through December 31, 2021, demonstrated that DMAHS and the MCOs share a commitment to continued improvement in providing high-quality, timely, and accessible care for all members. The 2021 NJ external quality review report found that most HEDIS measures remained constant from 2019-2020. There were significant improvements (over or equal to 5% change) for the following measures: one or more rates of statin therapy for patients with cardiovascular disease, weight assessment and counseling for nutrition and physical activity for children/adolescents, follow-up after hospitalization for mental illness, follow-up after emergency department visit for alcohol and other drug abuse or dependence, and asthma medication ratio.[196]

North Carolina

NC DHHS is transitioning to Medicaid managed care to advance high-value care, improve population health; engage and support beneficiaries and providers; and establish a sustainable program with predictable costs. In its managed care transition and implementation, DHHS created the Medicaid Managed Care Quality Strategy which outlines DHHS' goals for accessible, high-quality care and smarter spending, and describes plans for achieving those goals. The Strategy's framework is structured around three central aims: Better Care Delivery; Healthier People and Healthier Communities; and Smarter Spending. Each aim has its respective goals and objectives that are tied to a series of focused interventions used to drive improvements within and across the goals and objectives set forth in the Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, these interventions are tied to a set of metrics to assess progress. As baseline data for health plan performance becomes available (in FY 2023), DHHS intends to further refine the objectives to target specific improvement goals, including additional metrics that address health disparities.[197]

Texas

Managed care plans are required to report to the state if they have received accreditation from an accrediting entity. Currently, almost all states either require or recognize health plan accreditation from the National Committee for Quality Assurance (NCQA), which enables consistent data collection and reporting across states and plans.[198] The NCQA requires annual submission of data including the HEDIS measures and CAHPS surveys.[199]

Through its sophisticated managed care contract oversight process, Texas has established a quality program that holds its MCOs accountable. The state established a quality system through its contracts that rewards MCO achievement of quality measures and penalizes MCOs that fall short, all through the lens of close collaboration between the state Medicaid agency and MCOs. Preliminary data indicates that Texas' gradual transition to managed care and increased contract oversight yielded improvements in access to care, care coordination, health outcomes, and quality of care in key managed care populations.[200] In state fiscal year 2021, Texas enhanced its data collection and reporting on the social drivers of health of Medicaid members, invested in care coordination for special populations, and made efforts to increase public awareness of telemedicine services to improve its quality of care. Looking to the future, Texas Medicaid has launched improved evaluation efforts and targeted initiatives to improve quality of care among its members.[201] Texas Medicaid saw year-over-year improvement in measure years 2018, 2019, and 2020 on CMS core quality measures assessing antidepressant medication management and behavioral health related to SUD treatment and prevention.

Conclusion

The Medicaid landscape is markedly different in 2022 than it was 25 years ago at the passage of the Balanced Budget Act (BBA). In transforming the federal regulatory framework for Medicaid managed care, the BBA accelerated state efforts to design new and innovative managed care programs, and at the same time unlocked new potential and possibilities in the form of effective partnerships between state regulators and MCOs. As federal requirements have continued to evolve to mandate greater accountability and transparency from Medicaid managed care programs, states and their contracted MCOs have worked together to deliver greater value by improving quality and access and controlling the growth of program costs over time. This report has attempted to shine a light on the tremendous work being done to improve the lives and health of Medicaid beneficiaries – work that is only possible because of the unique public-private partnership, and collaboration between federal government, state government, and private industry, that is our Medicaid system.

There will be additional items on the horizon looking ahead to 2023 as policymakers prepare for the end of the public health emergency and states continue to submit and receive approval for 1115 demonstration waivers to test new innovations to advance health equity, increase coverage and access, and develop new payment approaches. Future reports in this series will focus on the continued efforts of states and their managed care partners to meet the goals and objectives of the Medicaid program. Other states and health plans will be highlighted as we continue to chronicle the evolution of these public private partnerships and the successes that can come from effective partnership and fruitful collaboration.

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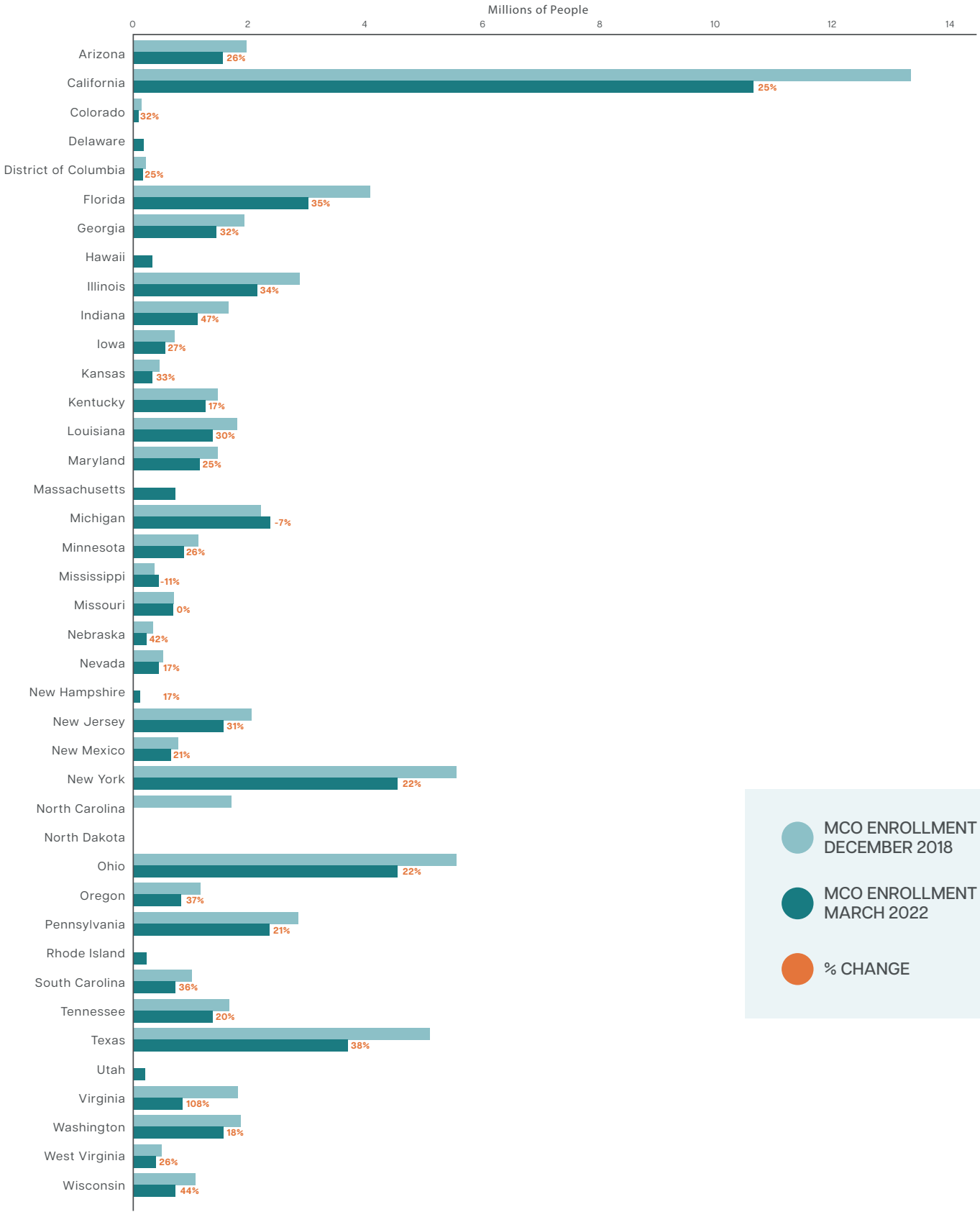
SECTION 6

Addendum

MCO Enrollment



BACK

Total Medicaid/Managed Care Spending