Leveraging Public Health Assets in Medicaid Managed Care

Report Summary: Through effective partnership, state and territorial health agencies (S/THAs) and Medicaid agencies can maximize the value of federal and state investments to ensure the 38 million children and 40.6 million adults enrolled in Medicaid and the Children's Health Insurance Program (CHIP) have the best possible health outcomes. However, the two types of agencies have differences in terminology, tools, and procurement of services that can present barriers to alignment and collaboration. This three-part guide maps the public health capacities, assets, and resources onto the obligations and direction of Medicaid agencies and their managed care health plans.

- **Part I describes the current Medicaid and managed care context.** This background section provides a summary of Medicaid mandatory and optional benefits and populations. This segment of the report supports introductory learning and serves as a resource for references.
- **Part II describes the Medicaid managed care life cycle.** This summary section is intended to assist state and territorial health officials (S/THOs) in strategically and effectively timing outreach and partnership with Medicaid with respect to influencing managed care by describing the different phases.
- **Part III describes Medicaid managed care key obligations/goals and identifies public health assets that can assist Medicaid in meeting these obligations.** This final and critical section of the guide equips S/THOs to lead strategic coordination efforts between S/THAs and state Medicaid agencies by elevating the public health assets that can inform network adequacy, quality oversight and monitoring, quality and care delivery improvement, and consumer supports. This section provides the content and public health expertise that would be most attractive to Medicaid managed care and could serve as the basis for ongoing partnership.

Medicaid managed care is by no means the only context for a collaboration between state public health and Medicaid agencies, but because of the prevalence of managed care arrangements in Medicaid, it warrants a specific discussion. While this guide is intended for state and territorial health officials, it may also help other health department team members.

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Part I: Medicaid Managed Care Context

Medicaid is a federal-state partnership that provides jointly funded health insurance coverage to approximately 71.2 million people in the United States with low income. Each state can elect to have a Medicaid program, but no state is required to. If a state chooses to have a Medicaid program, it must provide certain services, known as mandatory services, to certain groups of people, known as mandatory populations. The Centers for Medicare and Medicaid Services (CMS) defines mandatory and optional services, as well as mandatory and optional populations who may be eligible for Medicaid coverage. In return for meeting these baseline requirements, the federal government pays a fixed percentage (never less than 50%) of the cost of the provided services; states must pay the remaining proportion of costs. States can tailor their programs with respect to how they deliver services, what range of services they offer, and who is eligible for services by electing to cover optional services and populations.

Medicaid programs across the nation are increasingly contracting with managed care organizations (MCOs) to provide health care services to Medicaid participants. In fact, more than 75% of the 72 million Medicaid enrollees receive some or all of their Medicaid services through managed care arrangements. Understanding the relationship between a Medicaid agency and managed care health plans can help S/THOs collaborate effectively with Medicaid leadership to strategically deploy public health interventions within a Medicaid program.

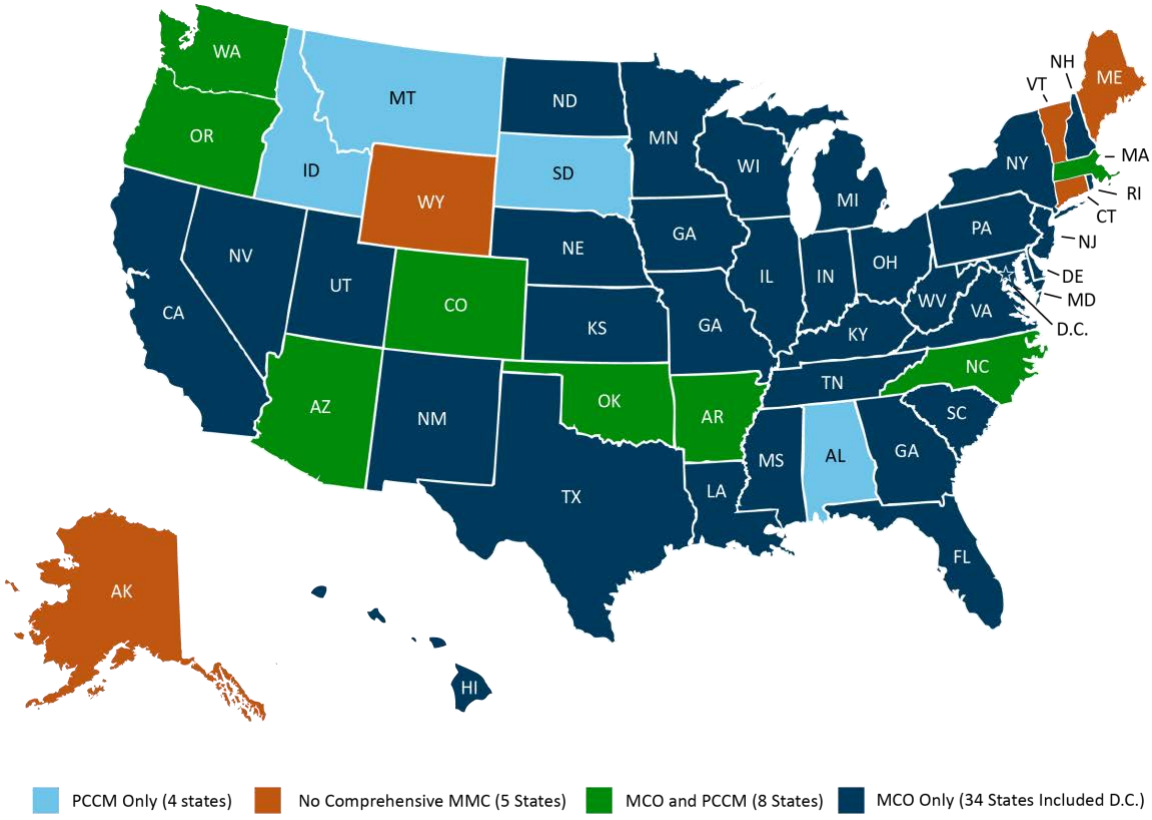
Medicaid managed care generally describes a health care payment and delivery system in which a state Medicaid program pays a fixed, per-person rate (referred to as a capitated or per member per month rate) to an MCO for the delivery of Medicaid services.

An MCO usually refers to a health plan that manages the risk of coverage, contracts with providers for provision of services, processes provider claims or bills, and is paid by the purchaser of coverage. The purchaser in this instance is a state Medicaid program.

Many different payment and delivery arrangements are commonly included under the umbrella term of Medicaid managed care.[1] [2] In addition to the MCO model noted earlier, there are two common prepaid, limited benefit plans that can be thought of as managed care for a specific subset of services (e.g., dental care or inpatient psychiatric care). These limited capitated arrangements are referred to as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs). Though similar, these arrangements take on different levels of risk.

Primary care case management is another reimbursement arrangement under Medicaid managed care. This model focuses on the primary care level and includes a per-person fee paid directly to providers for the provision of a set of support services such as case management, disease management, and/or patient navigation. States may use a combination of these arrangements for different populations and/or service sets.[3] This guide focuses on MCOs, PIHPs, and PAHPs.

Figure 1: Share of Medicaid Population Covered Under Different Delivery Systems: Types of Managed Care in Place (as of 2024)[4]



Medicaid managed care has grown in prevalence and reach for several decades. Figure 1 illustrates the breadth of Medicaid managed care across states; however, there are major differences in levels of managed care saturation and involvement among the states. Some states use managed care arrangements to provide most of their Medicaid services, including community-based long-term care and dental and behavioral health. In other states, managed care only provides medical and physical health, while other specialty services remain in the fee-for-service environment. Likewise, some states enroll all Medicaid-eligible populations in managed care, while other states keep specific populations in fee-for-service care.

Part II: Medicaid Managed Care Life Cycle

In general, Medicaid programs that use MCOs to administer benefits follow a similar procurement process across states. To initiate a Medicaid managed care program, a Medicaid agency develops and publishes a request for proposals (RFP) that lays out the general structure of the program, including performance expectations, quality measures, coverage rules, and reporting requirements for health plans. The state also develops a set of questions that plans must respond to in their proposal.

These questions help to signal state priorities and indicate where they are hoping for MCO investments. Health plans develop and submit proposals in response to the RFP and based on their competitive scores, are selected to enter contracts with the state for the provision of the corresponding services. In most instances, states must offer a minimum of two plans to meet federal obligations.

Once the state executes the contract, the health plan can develop its own approach to meeting the requirements of the contract in a manner that is consistent with federal and state requirements.[5] [6] As a result, there are as many ways of delivering Medicaid managed care as there are health plans.

For example, states use various approaches to require or encourage MCOs to provide community health worker (CHW) services. Some states require MCOs to provide CHW services as covered services in their MCO contracts. However, other states encourage MCOs to provide CHW services by providing financial incentives (e.g., through enhanced capitation payments), or they may ask about CHW engagement in the RFP process. If the state does not require MCOs to provide CHW services, MCOs have more flexibility to design CHW interventions, while the state may have less control over how the CHW program is developed.[7]

The Medicaid population often has complex health needs with disparities in health outcomes. S/THAs can provide valuable direction to Medicaid programs about how to address those complexities and mitigate disparities through evidence-based practices to improve population health, strategies to engage consumers and connect them to clinical and community services, and robust data to inform decision-making. Many state Medicaid agencies utilize MCOs to manage and deliver clinical care services; consequently, it is critical that S/THAs engage with Medicaid agencies in the development and implementation of MCO contracts as a primary component of their Medicaid partnership activities.

At a Glance

Checklist for Engaging with Medicaid About Managed Care in Your State

- ✓ Know who is in and out of managed care.
- ✓ Know what your state's managed care arrangements include.
- ✓ Identify your state's phase of managed care.
- ✓ Assemble the S/THA team and develop a targeted, focused plan of approach.

Know what your state's managed care arrangements include.

The second step is to assess which services your state's managed care delivery system provides. For example, some states contract with a single group of health plans for all services. However, frequently, there are also different health plans for different service lines (e.g., a state may contract with three health plans for traditional clinical services but contract with two others for long term care services, and still another health plan for behavioral health services). Some states also carve out prescription drug coverage, meaning those services may be delivered through different payment and delivery system entities.

Medicaid MCO coverage and contracting processes vary by state and may require thoroughly examining a state's Medicaid website and publicly available information. S/THA staff may also wish to engage Medicaid contacts in the state, if known, or build a relationship with appropriate Medicaid staff. CMS' website lists contact information for each state Medicaid agency.

Use the following steps to engage with Medicaid about managed care:

Know who is in and out of managed care.

The first recommended step in approaching a state Medicaid agency is to assess which Medicaid populations are enrolled in managed care in your state. This will help determine how to most effectively target specific public health tools and programs to Medicaid. For example, a state that excludes long-term care populations from its managed care plans may have less motivation to tackle that issue than a state where health plans bear risk for their performance on long-term care quality measures. S/THA staff can also find state-by-state information about which Medicaid populations are enrolled in managed care in the Demonstration waiver process, see the Medicaid About Section 1115 Demonstrations web page.

Identify Your State's Phase of Managed Care.

The third step in engaging your state Medicaid agency is to identify which phase of the managed care life cycle your state is in. Each state program is different, and even within a state, the current phase of managed care may differ for different service lines. Regardless, managed care contracting generally follows a standard process (see Figure 2). Depending on where a state stands with respect to its current phase of Medicaid managed care, certain activities will have more relevance and impact than others. States may also vary regarding how publicly accessible their MCO RFPs and contracts are. S/THA staff should examine state Medicaid websites and engage the Medicaid office for this information.

States may also seek Section 1115 Demonstration waivers for certain aspects of their delivery system, which would likely occur prior to the life cycle described in this document. For more information on the Section 1115

Develop a Targeted, Focused Plan of Approach.

The fourth step is to identify potential areas for collaboration with your state Medicaid agency based on current statewide health trends. Medicaid and S/THAs share many common pressures and demands and often serve different cross-sections of the same populations. As a result, identifying three to five overarching common goals — such as introducing Medicaid to the state health improvement plan (SHIP) and its top priorities or reducing the prevalence of emerging or priority conditions across the state — is helpful before focusing in on a more targeted set of objectives specific to the Medicaid population. S/THOs can target a few areas of mutual priority and help ensure that the business case for partnership is oriented toward meeting Medicaid's obligations as well as public health goals.

The four Medicaid managed care life cycle phases described below highlight the key elements present during the managed care procurement life cycle process and include identified areas of potential collaboration.

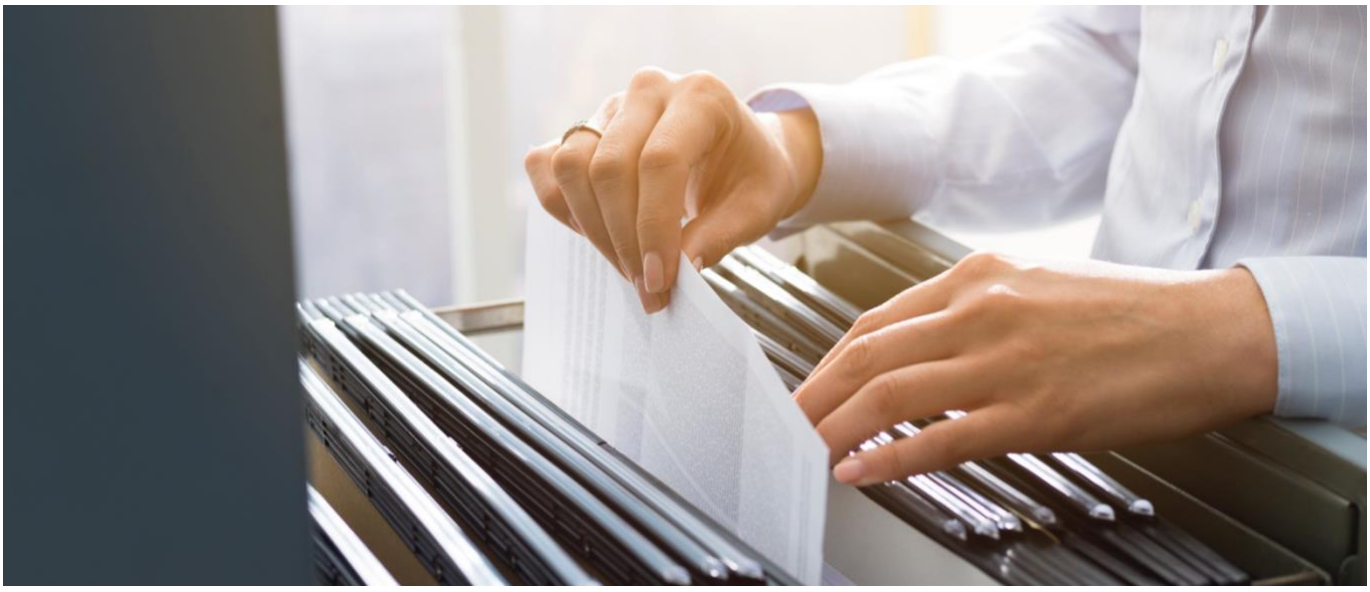
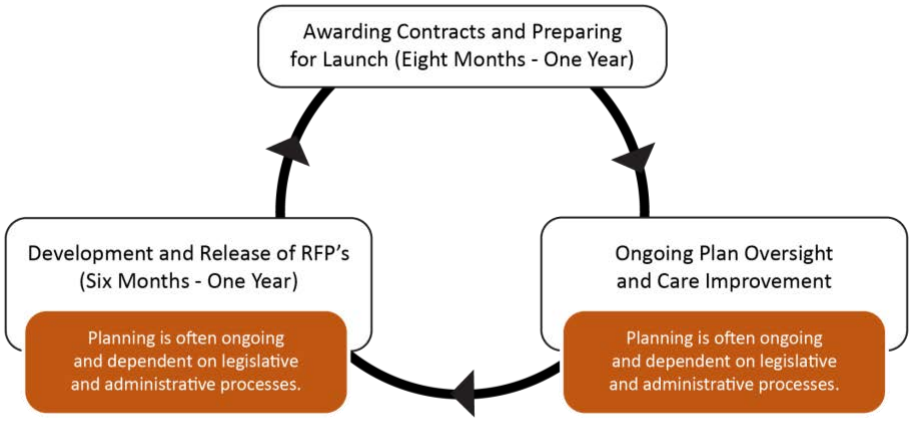


Figure 2: Life Cycle of Managed Care Programs and Contracting Process



Phase 1: Developing and Releasing the Request for Proposals

S/THAs can be especially instrumental during three components of the first phase of the managed care life cycle: educating Medicaid about valuable public health priorities and resources, incorporating public health priorities as managed care contract goals and metrics, and improving rate setting and risk adjustment with population-level data.

Educating Medicaid About Valuable Public Health Priorities and Resources

Depending on the state's legislative and administrative procedures, the strategic procurement planning process may begin prior to the RFP release. **The RFP is the basis of the future contract that will be executed between the state and the health plans. Subsequently, S/THAs can have the biggest influence on a Medicaid managed care program by engaging with state Medicaid agencies while they are still developing their RFPs, either when they are initiating the programs or amending or renewing existing contracts.** Engaging early in the process will provide S/THAs with the best opportunity to advocate for including population health interventions in the managed care delivery system, especially in managed care contracts.

During the managed care planning process, state Medicaid agencies often use data from a variety of sources outside of health insurance claims to inform their RFPs. S/THAs can identify and present relevant data (e.g., SHIPs, vital statistics, health opportunity indices, surveillance data, or analyses of administrative data such as claims or EHRs) and can also analyze specific populations' health needs and report their results to Medicaid leadership. Sharing such data can shape Medicaid contracting decisions that ultimately support specific public health initiatives or at-risk populations.

S/THAs can also identify effective interventions and services that are relevant to Medicaid programs and are already provided through public health programs and/or community-based public health service providers.

A S/THA should prepare the following information in anticipation of meeting with the state Medicaid agency about managed care procurement:

Table A discusses further how S/THAs can support strategic planning efforts in these early stages. By providing this information, S/THAs can encourage Medicaid agencies to include performance requirements in their RFPs and contract directing MCOs to target existing state health improvement priorities and to use existing public health assets and providers to meet contract goals and targets. For example, Michigan's 2023 Medicaid managed care RFP required MCOs to offer CHW services to enrollees with significant behavioral health issues and complex comorbidities. Michigan also required MCOs to maintain a CHW-to-enrollee ratio of at least one CHW for every 20,000 Medicaid enrollees.[8]

- The top three to five most prevalent health conditions in the state.
- Evidence-based public health services and interventions that are already deployed in the state to address the above priorities.
- The relative efficacy of the intervention(s) in preventing or mitigating the specific health condition and any cost reductions associated with that efficacy.
- Where and how those services or interventions are currently available for the at-risk population.
- Information about how residents (especially existing Medicaid members, if known) currently utilize those services.

Incorporating Public Health Priorities as Managed Care Goals and Metrics

The next opportunity for incorporating public health priorities into the Medicaid managed care space is for S/THAs to work with state Medicaid agencies to isolate a finite number of shared priorities (described earlier) and incorporate them as goals and with metrics into RFPs. After laying out the business case for public health interventions, S/THOs can work with Medicaid agencies to review different measure sets (described in greater detail later in this document) to choose appropriate metrics that both align with population health needs and would be feasible for health plans to collect. These metrics can be used to measure health plans' progress toward meeting their stated goals and requirements**.**

Improving Rate Setting and Risk Adjustment with Population-Level Data

At some stage of developing the RFP, states will offer proposed capitated rates to be paid to the health plan for each member (a per person per month flat payment). These rates may be based on categories as broad as services to be provided together with the Medicaid members' gender, age, or eligibility group. Population-level data about health outcomes and health related social needs (HRSN) may help Medicaid agencies set those rates and perform risk adjustment.[9] [10]

Such data include vital records (i.e., births, deaths, and infant mortality); registry data (e.g., from cancer registries); data regarding reportable diseases and conditions (e.g., STDs and HIV/AIDS); immunization data; data from WIC offices, family planning clinics, and reproductive health clinics; newborn screening data; environmental health data; electronic reportable laboratory results; and population-based surveys. Each year, states work with certified actuaries to set rates that reflect the expected cost of care for Medicaid members. These rates must follow federal rules to make sure they are fair and accurate. The federal government reviews and approves them before they are used.

Social indices like the Social Vulnerability Index, the Health Opportunity Index, or other informatics tools that compile data on income, education, housing, and other HRSN may be better aligned with Medicaid members' depth of need than traditional capitation rates based on broad demographic categories. For more information on using population-level data to adjust payment, the report "Addressing Health-Related Social Needs Through Medicaid Managed Care" includes best practices and state examples of HRSN data collection and risk adjustment in Medicaid programs. S/THAs can help to identify any assets that exist in this space and can collect the disparate data sets to help inform the risk adjustment process.

Table A: Engagement During the RFP Development Phase

State Medicaid Agency Engagement Ideas
Identify and provide data on: • The top 3-5 areas identified for improvement in SHIP. • Statewide disease surveillance data and registries. • Statewide natality, morbidity, and mortality. • Provider shortage designation areas. • HRSN and the health indices of communities Medicaid serves.
Identify evidence-based chronic and infectious disease programs that target needs identified in the SHIP.
Identify existing public health services and providers that Medicaid should require MCOs to contract with to serve Medicaid participants, such as:[11] • CHWs • Ryan White HIV/AIDS providers • Immunization clinics. • Housing assistance and home modification programs. • Lead poisoning prevention and abatement programs. • Tobacco cessation and prevention programs. • Diabetes participation prevention programs. • Hypertension prevention programs. • Unintended pregnancy prevention programs.
Identify areas for Medicaid cost savings and/or outcome improvements. Possible activities include: • Identifying opportunities to utilize CHWs and other community-based health and social service providers. • Using information from disease surveillance data to help identify and target health interventions for Medicaid-serving populations. • Working with local stakeholders to identify key community health needs and successful community health intervention strategies. • Providing data highlighting provider shortage areas (e.g., Health Professional Shortage Areas). • Identifying evidence-based care coordination programs, outreach language, and materials that promote positive healthy behaviors.
Propose goals and metrics to be in the contract that require the health plans to address: • Reducing and preventing the 3-5 top priority conditions in the state health improvement plan. • Emerging health issues, such as STD outbreaks and cancer clusters. • HRSN. • Requiring public health providers to be in all MCO networks.
Provide Medicaid with population-level data on HRSN to refine rate setting and risk adjustment.

Phase 2: Selecting Plans and Preparing for Launch

Once state Medicaid agencies select their health plans, they enter contracts and begin preparing to launch the programs. For health plans that are new to the state Medicaid program, this process may include readiness reviews of health plans' procedures and operations. Sometimes these reviews find gaps in the current plan capacity (e.g., no preparedness plan or insufficient consumer support capacities).

At this juncture, S/THAs can share best practices and respond to the identified gaps in care using the following suggestions:

Phase 3: Ongoing Plan Oversight and Care Improvement

- Review health plan RFPs for service gaps and/or quality improvement strategy gaps.
- Help health plans draft their own disaster preparedness plan or emergency communications tools to meet disaster preparedness and response requirements.
- Evaluate health plan proposals to address top state health improvement priorities, address HRSN, care for vulnerable/at-risk populations, establish cultural competency, and account for language needs. Verify sufficient data collection, monitoring, and quality improvement plans.
- Help health plans develop a needs assessment that includes HRSN.

Contracts with managed care plans typically last two to five years. Each year, the state may identify new quality improvement initiatives (e.g., performance improvement plans [PIPs]), quality metrics, or other modifications that health plans need to address. They must go through annual rate setting process, which may change during ongoing plan operations due to delivery system reforms, quality performance, and cost controls.

Many states are developing dashboards and other tools for hot-spotting problems and identifying areas needing focus or improvement. Often, Medicaid agencies will identify an area of concern and pull plans together to address and ameliorate the problems. For example, Medicaid agencies may assess claims data to identify opioid over-prescribing or high-cost populations' service utilization patterns indicating a lack of meaningful coordination or access to support services. In the state of Washington, epidemiologists at Public-Health Seattle and King County have successfully linked Medicaid claims data to enrollment data to estimate the prevalence of Medicaid members who use tobacco.

Collaboration opportunities during this period vary widely. Some S/THAs can work with health plans and Medicaid agency leadership to identify performance or quality improvement opportunities. Other public health programs work with Medicaid agencies to survey MCOs on how they reimburse for and deliver evidence-based interventions — such as long-acting reversible contraception or asthma medications or devices — to better understand barriers to uptake and opportunities for improvement. For example, for people living with HIV, the Ryan White HIV/AIDS Program can help Medicaid create viral load suppression performance measures and set benchmarks for performance improvement projects.

An example of this partnership is shared in the Medicaid and Public Health Partnerships in Iowa: Improving Access to Care for People Living with HIV report, which details how a data-sharing agreement between Iowa's Medicaid program and the HIV Surveillance program facilitates the analysis of viral suppression rates for Medicaid enrollees living with HIV. To engage with state Medicaid agencies during the contract management phase, monitor and support health plan progress in reaching contract goals and targets, focusing on:

- HRSN metrics.
- Network adequacy.
- Access to and outcomes of preventive services.
- Performance of chronic disease management programs.

Part III: Medicaid Obligations and Public Health Supports

Access: The 2024 Medicaid and CHIP Managed Care Final Rule, requires states to meet established standards to ensure timely access to care for Medicaid beneficiaries, including waiting times for appointments. The rule explicitly sets a wait time standard of 15 business days for routine primary care and obstetric/gynecological services, and 10 business days for outpatient mental health and substance use disorder services. In addition, states must establish an appointment wait time for a state-selected service. To validate the managed care plan's compliance with these wait time standards, states are required to use an independent entity to conduct annual secret shopper surveys and conduct an annual enrollee experience survey. By the first rating period on or after July 9, 2028, states will implement a remedy plan for any managed care plan that needs improvement in meeting access standards. States must submit quarterly progress updates to CMS of the remedy plan. Ensuring timely access to health care is crucial for preventing the worsening of health conditions, reducing health disparities, and promoting better health outcomes for vulnerable populations.

Quality:

a. **Quality Oversight and Monitoring**: States must establish a quality rating system for plans and have several transparency requirements for reporting quality data and performance assessment for managed care plans. Typically, states establish a set of quality metrics that all plans must report on that states use to evaluate plan performance and inform future contracting decisions. Health plans must report on quality and are expected to improve over time.

b. **Quality and Care Delivery Improvement**: Medicaid programs are expected to demonstrate that they are good stewards of the large public investment required to run Medicaid. Many states have a variety of health care delivery reforms and expect their plans to participate. These reforms may include initiatives such as accountable care organizations, Medicaid health homes, or payment reform. Medicaid also requires PIPs in its managed care contracts, which often target medical issues that have a significant impact on costs and outcomes (e.g., reducing cesarean birth rates and reducing hospital readmissions). Plans are typically expected to participate in one to three such initiatives each year and report data to demonstrate improvement.

In Lieu of Services (ILOS): MCOs can offer alternative services (e.g., housing or food support) or settings (e.g., community-based, non-clinical settings) as an immediate or longer-term substitute for a Medicaid covered service to address health-related social needs. With the opportunity to tackle root causes of health disparities, such as housing instability or food insecurity, MCOs can directly improve population health, reducing the need for more expensive medical interventions later. States must document their process to determine ILOS as medically appropriate and cost-effective, including identifying a clinically defined target population(s) for each ILOS. States must submit additional documentation and evaluate each ILOS after five years if the ILOS costs exceed 1.5% of the total capitation rate.

The following tables identify high-value opportunities for S/THAs to collaborate with state Medicaid agencies, categorized by the Medicaid obligation to which they best contribute. See Table B for more information regarding S/THA opportunities to support Medicaid managed care obligations by section.

Obligation: Access

Table B: Public Health Capacities, Funding, and Data Sources for Obligation: Access

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Data analysis, interpretation, and visualization. • Population health needs by geography. • Provider geographic availability. • Best practices in network maximization (rural health and alternative providers). • Public health service providers, school health clinics, and Title X Family Planning Clinics. • Credentialing and "top of license/training" practice, including CHWs in team-based care. • Provider shortage area programs (e.g., The Physician Shortage Area Program). • Supports for Medicaid medication assisted treatment.[12] Telehealth, telemedicine, and alternative visit types.	• Title X clinics and funding resources. • Community-based public health clinics and programs. • Immunization programs and tuberculosis clinics. • School health clinics. • Ryan White HIV/AIDS Program.[13] • Enabling services (e.g., environmental home assessments and other supports for health management).	• Licensure requirements and the distribution of licensed professionals. • Population health tools, including state data sets and statewide health planning tools. • Global information system tools and mapping for provider clusters, including Health Professional Shortage Areas. • CMS access rules compliance for guidelines and benchmarking for Medicaid managed care programs and plans. • Health informatics: managing and using patients' health care information.

The Medicaid managed care regulations require states to set standards for network adequacy based on time and distance metrics. It also allows states to use other measures of access and adequacy. Nationwide, states use multiple strategies to address network adequacy in the public health landscape. Three examples supporting network adequacy from a public health perspective include utilizing state primary care office efforts for workforce development, increasing health care worker availability and 'top of practice' utilization, and promoting Title X clinic connections to MCOs.[14]

The following are promising ideas to support network adequacy requirements:

Support Network Providers

In many states and territories, the S/THA includes a primary care office (PCO), a program that HRSA funds to support comprehensive health care service delivery in areas that lack adequate health professionals or access to care and provide technical and non-financial assistance to community-based providers. S/THAs and their PCOs can support providers through scholarship and loan repayment programs, coordinating National Health Service Corps program sites, training opportunities, and other partnerships. S/THAs can use information from the primary care needs assessment and shortage designations to inform network adequacy.

Best Practices in Network Maximization

CHWs may be able to effectively engage traditionally hard-to-reach patient populations to improve communication gaps, reduce cultural barriers to appropriate care, promote health equity, increase health literacy, and promote wellness. Integrating the CHW workforce into models of care delivery can maximize the limited resources of community health centers or chronic disease state programming to retain patient engagement and participation in care. Medicaid programs may include CHW services through defined reimbursement through Section 1115 Demonstration waivers, state legislation and state plan amendments for defined preventive services or broader Medicaid reimbursement, or reimbursement through managed care contracts.[15] [16] For example, Massachusetts received approval of a Section 1115 Demonstration waiver that includes funding for specific CHW services, while Michigan required MCOs to contract with CHWs through a state plan amendment approved in 2016.[17] In addition, certain state Medicaid programs require MCOs to contract CHWs. For example, New Mexico requires its MCOs to make CHWs available to offer certain services, including health care system navigation, informal counseling, and translation services.[18] The community health worker requirements outlined in the Michigan Comprehensive Care Plan contract for MCOs follows:

Figure 3: Michigan Comprehensive Health Care Plan Model Contract (2024)[19]

Contractor must, to the extent applicable, support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience.

Examples of CHW services include but are not limited to:

i. Conduct home visits to assess barriers to healthy living and accessing healthcare.
ii. Set up medical, dental and behavioral health office visits.
iii. Explain the importance of scheduled visits to clients.
iv. Remind clients of scheduled visits multiple times.
v. Accompany clients to office visits, as necessary.
vi. Participate in office visits, as necessary.
vii. Advocate for clients with Providers
viii. Arrange for social services (such as housing and heating assistance) and surrounding support services.
ix. Track clients down when they miss appointments, find out why the appointment was missed, and problem-solve to address barriers to care.
x. Help boost clients' morale and sense of self-worth.
xi. Provide clients with training in self-management skills.
xii. Provide clients with someone they can trust by being reliable, nonjudgmental, consistent, open, and accepting.
xiii. Serve as a key knowledge source for Services and information needed for clients to have healthier, more stable lives.

Many states and regions throughout the nation have CHW associations and training programs to prepare CHWs for delivering specialty care services.[20] CHWs' abilities to navigate community resources and build trust among underserved populations can help strengthen network adequacy to ensure that patients seeking services are connected to care. However, there can be challenges in developing and integrating a CHW workforce. Without a contractual requirement by the Medicaid agency for the MCOs to contract with CHWs, it will be up to individual health plans to decide whether and how much to use CHWs, and what services may be best suited for these providers.

During phase one of the Medicaid managed care life cycle, S/THAs can provide guidance and best practices to health plans and state agencies regarding how to maximize this community resource. During the procurement process, S/THAs can conduct learning sessions with plans and CHW forums or agencies. After the contract award, S/THAs can continue to facilitate interactions among the stakeholders about the benefits of using CHWs, including studying the quality and cost impacts.

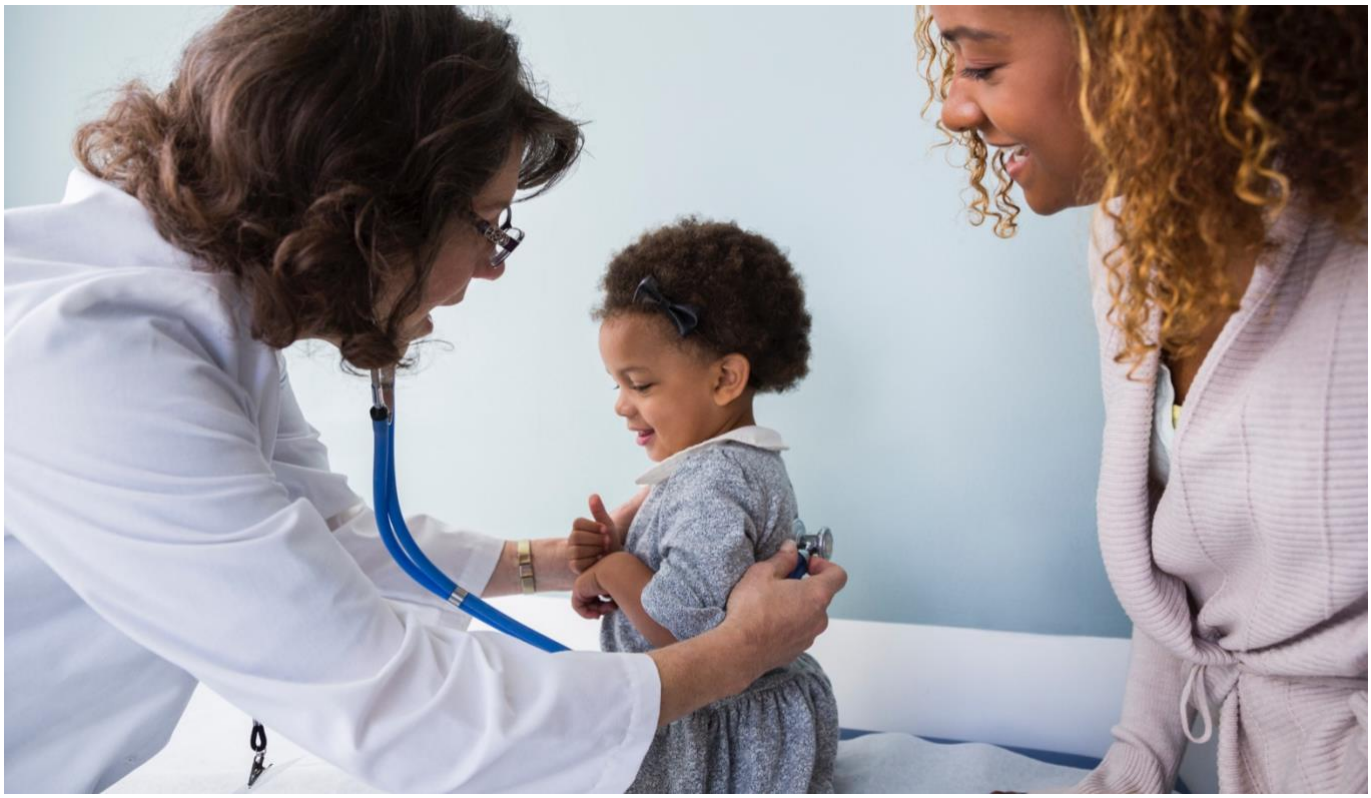
Promoting Rural Health Network Adequacy

State offices of rural health may also be able to share best practices in network maximization for rural areas. Beyond just sharing information on access barriers such as location, rural health offices can provide subject matter expertise on ensuring that states meet network adequacy standards in rural areas and can help Medicaid programs apply a rural health lens when developing policies. In 2018, CMS launched the first ever Rural Health Strategy, which encourages state Medicaid agencies to adopt a rural health lens in policies, programs, and initiatives related to network adequacy and beyond.

Promoting Title X Clinic Connections to Managed Care Organizations

Access to reproductive health services relies on strong primary care systems and includes providers like Title X-funded clinics. Many individuals seen in Title X clinics are enrolled in Medicaid, but despite receiving Medicaid reimbursement for services, these clinics often remain reliant on public health funding. In managed care states, Medicaid reimbursement requires contracts with the plans serving enrolled populations, as well as any direct fee-for-service payments for any carved-out populations.

Many Title X-funded sites struggle with operational and data systems, which can have a dramatic effect on their financial sustainability. S/THAs can assist these clinics with data matching tools, privacy protections, billing acumen, and support during MCO plan negotiations. These activities can take place during any phase of the MCO life cycle, but they may be more necessary when a state is undergoing changes to a family planning waiver. In addition, partnering with Title X programs for children and youth with special health care needs can be an effective way for state Medicaid agencies to improve quality of care measurements and care coordination.[21]



Obligation: Quality Oversight and Monitoring

Table C: Public Health Capacities, Funding, and Data Sources for Obligation: Quality Oversight and Monitoring

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Setting quality standards, including for long- term care, and supporting recipients living in the community. • Data tracking (comparison and baseline data). • Disease-specific knowledge to inform evidence-based interventions. • Supporting health plans' PIPs. • Hospital quality and surveillance and monitoring data (e.g., data related to readmissions for hospital-acquired infections). • Provider education and profiling (e.g., regarding issues like over-prescribing antibiotics). • Data analytics, including hot-spotting and trending from population-level statistics. • Survey and study design.	• Healthy People 2030 and quality report cards. • Chronic disease surveillance programs. • Prescription drug monitoring programs. • Public health laboratory services (e.g., for specialized testing like viral loads). • Disease reporting and monitoring through publicly available reports.	• Disease surveillance systems and public health lab reports. • Dashboard monitoring. • Immunization and other case reporting registries. • Epidemiological analyses. • Healthcare Effectiveness Data and Information Set measure comparison.[22] • Consumer Assessment of Healthcare Providers and Systems measures. • Health information exchanges (HIE) and electronic medical records (EMR) data warehouse. • HIE meaningful use compliance across the state.[23]

S/THA priorities, tools, and evidence-based initiatives could serve as a strong foundation for state Medicaid agency efforts to track and improve their program quality and performance transparency. The most important element of this partnership will be matching up S/THA interventions with Medicaid priorities. S/THA demographic modeling, performance improvement, and quality monitoring can be directed toward Medicaid's quality agenda. Two possible avenues in this arena are HHS' Healthy People 2030 (HP2030) initiative and prioritizing quality metrics. S/THAs can review regulations and the 2017 MACPAC report "Quality requirements under Medicaid managed care" to understand Medicaid's obligation, provide oversight for MCOs, and ensure quality service delivery.[24] [25]

The following offers promising ideas to support quality oversight and monitoring requirements:

Healthy People 2030

For the past 30 years, HHS has used the HP2030 initiative to track 1,200 health objectives across 42 topic areas. These objectives and targets, which can be tailored and focused at a state-specific level, provide goals ranging from preventive care to disease surveillance that inform quality monitoring and oversight for Medicaid agencies and MCOs.

Quality benchmarks, baseline data, and trending analyses are an important activity in all MCO life cycle phases and can be informed by HP2030. S/THAs can provide recommendations on goal setting during contract oversight and can provide comparative analytics across plans or state regions where health plans operate.

Setting Quality Standards

In 2024, CMS issues the "Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule," with updates to state regulations for quality standards. The rule establishes a CMS framework for Medicaid and CHIP Quality Rating System (MAC QRS) and introduces state requirements for mandatory measures for the quality ratings and how the measures must be updated in the future. The rule also establishes the state's MAC QRS website, which operates as a "one-stop-shop" for beneficiaries to access Medicaid and CHIP eligibility and managed care information, and compare managed care plans based on quality and other indicators.

For external quality review (EQR), states are required to report more meaningful data and information to be included in the annual EQR reports. The previous 2016 Medicaid managed care "mega-rule" requires states to develop and publish an annual quality report.[26] States can shape this report and implement new quality measurement strategies that will support sound Medicaid policy and managed care practices. Working with Medicaid, S/THAs can help identify a quality infrastructure that aligns with state health goals and incorporates best practices in population health assessment and measurement.

Many state agencies are looking to develop MCO dashboards that track quality indicators, plan performance, financial data, and health outcomes. States must also develop a quality rating system for their health plans under the 2024 rule, which builds upon previous rule-making in the 2016 and 2020 managed care final rules. To assist in these efforts, S/THAs could propose a list of indicators and provide support in measurement activities around selected quality indicators.

Support the Quality and Performance Improvement Strategy

State Medicaid agencies require health plans to conduct PIPs. These plans may include efforts to reduce the frequency of C-sections or pre-term delivery; control a specific chronic disease like asthma or hypertension; or address the needs of high-cost, complex populations like individuals experiencing homelessness, racial or ethnic groups with high rates of health disparities, or people living with HIV. Typically, the state will set metrics and review plan progress on these efforts. Plans may work on developing quality and performance improvement activities by using different planning models, such as a Plan-Do-Study-Act cycle.[27] However, plans are encouraged to innovate and implement best practices that will improve outcomes.

S/THAs can offer a wide range of supports, including identifying priority health needs for PIPs, helping Medicaid agencies define and track performance metrics, and working with health plans to maximize supportive tools and evidence-based interventions. Where plans have discretion on the topics and orientation for a performance improvement agenda, S/THAs can work directly with them to identify local resources, evidence-based initiatives, and provider-based opportunities to improve care.
Obligation: Quality and Care Delivery Improvement

Table D: Public Health Capacities, Funding, and Data Sources for Obligation: Quality and Care Delivery Improvement

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Epidemiologists and tracking disease state analyses; data can inform policy and programs. • Population health management. • Population-specific targeting. • Provider supports for health reform, like health homes and community resource referrals. • CDC's Community Guide, which summarizes evidence-based findings of the Community Preventive Services Task Force. • Antibiotic stewardship. • Supporting the state's managed care PIP with best practices and evidence-based strategies. • Risk stratification and modeling for clinical management and payment reform. • Drafting specific, measurable, achievable, relevant, and time limited objectives (a protocol for objective setting) for plans.	• Lead poisoning prevention and abatement. • Maternal and child health programs, including maternity care improvement programs, newborn screening, and supports for children with special health care needs. • Behavioral health programs and community supports. • HIV programs and resources, such as the Ryan White HIV/AIDS Program. • Wellness programs, including programs for obesity prevention, older adults, and disease management. Chronic disease interventions (e.g., CDC's National Asthma Control Grants).	• Geographic Information Systems data visualization tools. • Linkages to public health data systems for quality improvement projects. • Disaster preparedness plans and resources. • Data sharing platforms (e.g., HIEs and EMR data warehouses).

The following areas offer promising ideas to support quality and care delivery requirements:

Addressing Health Related Social Needs

S/THAs can help Medicaid agencies identify and understand HRSN and their impact on population health outcomes among Medicaid beneficiaries. S/THAs provide or link to support services relevant to these non-clinical needs and can connect Medicaid agencies with local health liaisons, community health offices, and health promotion offices to enhance care coordination efforts.

Using S/THA data resources and GIS capabilities, S/THAs can help state Medicaid agencies identify and classify critical HRSN and solutions to these disparities; work with Medicaid agencies to develop needs assessments that include social needs; help Medicaid agencies set RFP expectations for HRSN; coach health plans in assessing non-clinical needs and addressing HRSN; and work with providers to improve their capacity to engage with entities that can help patients on their HRSN.

Identifying Evidence-Based Practices for Priority Conditions

The Guide to Community Preventive Services (the Community Guide) is a collection of evidence-based findings of the Community Preventive Services Task Force.[28] This resource aims to help policymakers and researchers select interventions to improve health and prevent disease at a state, community, or population level. The Community Guide provides evidence-based recommendations on interventions across a wide range of health topics (e.g., injury prevention, HRSN, infectious and chronic diseases and health promotion). The interventions identified include quality and care improvement strategies that can be applied statewide or directly with a state Medicaid agency or MCO.

Where the Community Guide interventions reflect a state Medicaid agency's priorities, public health can recommend appropriate ways to include these in the state's managed care RFP during Phase 2 of the managed care life cycle. During plan oversight, S/THAs can publicize these best practices and work with plans on adopting these evidence-based programs to tackle important challenges.

Advising Medicaid Agencies on Innovation Approaches

CMS allocates federal funding to states to conduct innovation models for implementing and testing strategies for health system transformation that meet their residents needs around primary care (AHEAD), maternal health (TMAH), and behavioral health (BIH).[29] Many states have also applied for waivers, such as Section 1115 Demonstration waivers, to test innovative health care delivery approaches. New MCO configurations may be central to these approaches. For example, Oregon's Coordinated Care Organizations were created by a Section 1115 Demonstration waiver that focuses on collaboration between public health, health care, and community service providers to improve primary care and prevention.[30] S/THAs can provide information to MCOs on public health interventions for chronic disease or other promising practices from their grant-funded work to inform payment and delivery reform initiatives.

Obligation: Consumer Reports

Table E: Public Health Capacities, Funding, and Data Sources for Obligation: Consumer Supports

Public Health Capacity or Skill	Program or Funding Stream	Data Source
• Local health department and engagement with local entities in disease prevention. • Cultural competency and communications skills for minority populations and disadvantaged communities. • Identifying populations experiencing HRSN- related barriers to care and health disparities. • Emergency response planning regarding essential medicines and durable medical equipment for seniors and persons with disabilities. • Data support (e.g., connecting consumer populations to care). • Co-locating public housing and public health programs and initiatives. • Patient self-management and care management referrals.	• Aging disease management programs. • Food access programs (e.g., Feeding America). • Minority HIV/AIDS Fund from HRSA to improve access to care for disproportionately affected minority populations. • Community-based health promotion programs and enabling services for hard-to-reach populations. • Environmental health programs. • Public health campaigns, including harm reduction and mitigation strategies.	• Mobile communication and health-tracking technologies. • Databases of community resources. • Data on population demographics and language preference to inform culturally and linguistically appropriate service standards.

There is considerable overlap between Medicaid member populations and the populations targeted for state public health initiatives. The following strategies support outreach to both groups:

Patient Self-Management

Medical self-management is the provision of education and supportive interventions to increase patients' skills and confidence in managing their health. Management skills include regularly assessing progress and problems, goal-setting, and problem-solving support. An effective way to directly engage Medicaid members is to create informed programs using patient activation measures. Like self-management protocols, these programs have been well-received in targeted communities, especially when they include materials prepared at an appropriate level of health literacy. S/THAs have experience in behavior change, such as utilizing techniques for motivational interviewing, a curriculum for patient self-management programs, and identifying evidence-based programs.

One specific type of patient self-management, diabetes self-management and education (DSME), is a prime example of how S/THAs and Medicaid agencies can help members access programs and participate in health care.[31] The education provided through DSME establishes a foundation to help people with diabetes navigate the decisions and activities of daily living. DSME is cost-effective and is correlated with positive effects on clinical, psycho-social, and behavioral health outcomes of diabetes care.[32] [33] Applying best practices from the Diabetes Prevention Program (DPP) to the DSME education modules has also proven highly effective.[34] For a population of members with diabetes, DSME, informed by DPP best practices, can serve as a cost-effective tool to incorporate into members' support services. DSME and DPP are behavior change programs offered at many local health departments, with support from S/THAs.

Telehealth Efforts

Technology innovations have created many opportunities to optimize mobile communications in the Medicaid environment, as most low-income individuals own mobile devices.[35] S/THA's knowledge of healthy behaviors and culturally competent communications could be an advantage for Medicaid MCOs and Medicaid agencies and improve health outcomes. Natural next steps include home monitoring, community supports, and mechanisms that use mobile communications to keep people healthy outside of the clinic setting.

S/THAs can work with Medicaid regarding quality oversight to optimize telehealth and home monitoring. As state Medicaid agencies develop their RFPs, S/THA input can be important in helping understand shortage areas and working through licensure issues and provider oversight concerns that may arise as telehealth becomes more prevalent.

Conclusion

The concepts in this report are intended to kickstart or support coordinated initiatives to improve alignment between Medicaid and public health. There is no shortage of potential areas for strategic coordination between S/THAs and state Medicaid agencies. However, strong leadership, clarity of purpose, and diligence are required to realize their full potential. By identifying and leveraging public health assets within four state Medicaid obligation areas and across the life cycle of MCO contracting, this guide promotes collaboration opportunities and shared agenda-making moving forward.

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Appendix A: Additional Resources

Regulations and Guidance on Medicaid Managed Care

- Medicaid and CHIP Managed Care by CMS: Final rule guidance
- Medicaid and CHIP Managed Care Final Rule by CMS: Webinar presentation
- CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions by Kaiser Family Foundation
- State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval by CMS
- Issue Brief 1: Medicaid Managed Care Final Regulations and Health Equity by National Health Law Program
- Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems by National Health Law Program
- Model Medicaid Managed Care Contract Provisions – A Primer on Medicaid Managed by National Health Law Program

Access

- Issue Brief 3: Medicaid Managed Care Regulations: Network Adequacy & Access by National Health Law Program
- Promoting Access in Medicaid and CHIP Managed Care by CMS

Quality Oversight and Monitoring

- Issue Brief 4: Medicaid Managed Care Final Regulations: Quality and Transparency by National Health Law Program
- Medicaid/CHIP Managed Care Rules: Assuring Quality by Georgetown University Health Policy Institute
- Issue Brief 4: Medicaid Managed Care Final Regulations: Quality and Transparency by National Health Law Program
- Adult Health Care Quality Measures by CMS
- Children's Health Care Quality Measures by CMS
- HEDIS and Performance Management by National Committee for Quality Assurance
- About the CAHPS Program and Surveys by Agency for Healthcare Research and Quality

Quality and Care Delivery Improvement

- Delivery System Reform Incentive Payment Programs by Medicaid and CHIP Payment and Access Commission
- The Role of Medicaid Managed Care in Health Delivery System Innovation by the Commonwealth Fund
- How State Medicaid and Title V Partnerships Improve Care for Children with Special Health Care Needs in Medicaid Managed Care by National Academy for State Health Policy

Consumer Supports

- Issue Brief 6: Medicaid Managed Care Final Regulations: Older Adults by National Health Law Program
- Issue Brief 7: Medicaid Managed Care Final Regulations: BSS by National Health Law Program
- Medicaid Managed Care Rule: Improving the Enrollment Experience by Families USA
- Medicaid and CHIP Managed Care Final Rule (CMS 2390-F): Strengthening the Consumer Experience by CMS

Managed Care Demographics and National Context

- Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018 by Kaiser Family Foundation
- Medicaid Managed Care Tracker by Kaiser Family Foundation
- HMA Insights - Weekly Roundup by Health Management Associates

Federal and National Stakeholders

- CMS
- Medicaid and CHIP Payment and Access Commission
- Medicaid Health Plans of America

Other

- Medicaid Partnerships and Policy by ASTHO
- Community Health Workers by ASTHO
- Telehealth by ASTHO
- Implementing CDC's 6|18 Initiative: A Resource Center by Center for Health Care Strategies

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