ACAP 2021 Leadership Academy Kick-Off Meeting

February 22 and 25, 2021

Association for Community Affiliated Plans

Strengthening the Safety Net Since 2000

About ACAP

- **Our mission** is to strengthen not-for-profit Safety Net Health Plans in their work to improve the health and well-being of lower-income people and/or people with significant health needs.

- **Our vision** is a country with accessible, affordable, high-quality care, regardless of income, provided through coordinated care entities.

Milestones: 2000 - 2020

Founding

Seventeen health plans associated with community health centers join to form the Association for Health Center Affiliated Health Plans (AHCAHP).

2000

Expansion

The association expands to serve all nonprofit Safety Net Health Plans; adopts the Association for Community Affiliated Plans (ACAP) name to reflect the broader scope.

2004

Drug Rebate Equalization

ACAP CEO Meg Murray testifies before the HHS Medicaid Commission, which **endorses ACAP's Medicaid drug-rebate proposal.**

2005

Medicare

ACAP expands to support Medicare D-SNP plans offered by its members.

2006

Affordable Care Act

The Affordable Care Act is enacted. It contains several of ACAP's top priorities, including drug rebate equalization. ACAP begins work on its implementation issues.

2010

Marketplaces

Health Insurance Marketplaces open for the first time. Sixteen ACAP-member Safety Net Health Plans offer coverage through Qualified Health Plans.

2014

Medicaid is US

In the face of proposed catastrophic cuts to Medicaid, ACAP launches a seven-figure multimedia campaign to preserve public coverage programs.

2017

ACAP COVID-19 Accomplishments

Privacy (42 CFR Part 2)

CARES Act permanently aligned 42 CFR part 2 with HIPAA (with initial consent).

Continuous Eligibility

The Families First Act required states to keep Medicaid enrollees continuously enrolled through the public health emergency to receive the 6.2% FMAP increase.

Telehealth

CMS allows Medicare telehealth encounters to be eligible for risk-adjusted payments & issued guidance on to what extent telehealth can be eligible for individual market risk adjustment.

Interoperability Rules Delayed

Helped secure 6-month delay of interoperability regulation enforcement (to July 1).

90-Day Grace Period

Secured guidance from CMS allowing issuers to delay consumers' grace periods to prevent coverage terminations.

CMS is suspending current RADV audits

CMS is not initiating new audits, not requiring plans to submit HEDIS or CAHPS, and is delaying MA data validation.

LTSS Regulatory Relief for COVID

CMS will allow states to provide regulatory relief on in-person encounters on the LTSS side due to the COVID emergency.

Medicaid Fiscal Accountability Rule

Successfully advocated for rescission of the MFAR rule to protect Medicaid financing and payment programs during the pandemic.

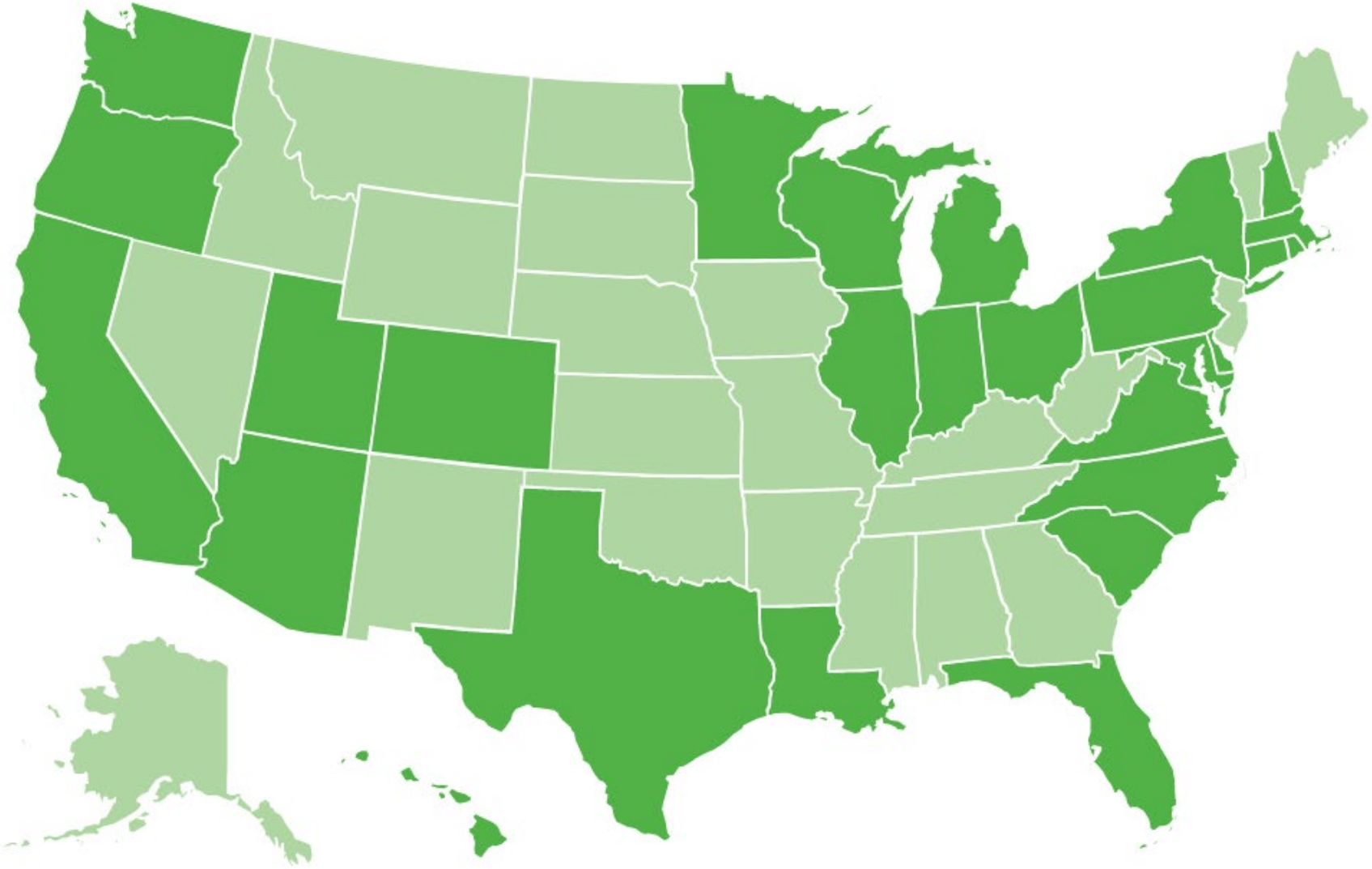
Goals: 2020-2022

- **Trusted Authority.** Be the expert on publicly-sponsored coverage programs.

- **Advocate for People with Low Incomes or Significant Health Needs.** Lead public policy to support continuation and improvement of publicly-sponsored health coverage programs and Safety Net Health Plans.

- **Center for Best Practices.** Strengthen ACAP members strategically and operationally.

ACAP's 78 Member Safety Net Health Plans Cover More than 20 Million People



Our plans cover more than **20 million people** in Medicaid, Medicare, Marketplaces and other publicly-supported programs.

ACAP's 78 Member Safety Net Health Plans

AZ Banner University Health Plans

CA Alameda Alliance for Health
CA CalOptima
CA CenCal Health
CA Central California Alliance for Health
CA Community Health Group
CA Gold Coast Health Plan
CA Health Plan of San Joaquin
CA Health Plan of San Mateo
CA Inland Empire Health Plan
CA Kern Family Health Care
CA L.A. Care Health Plan
CA Partnership HealthPlan of California
CA Santa Clara Family Health Plan
CA San Francisco Health Plan
CO Denver Health

CT Community Health Network of CT.

DC AmeriHealth Caritas D.C.
DC Health Svcs. for Children w/Special Needs

DE AmeriHealth Caritas Delaware

FL Community Care Plan
FL Prestige Health Choice

HI AlohaCare

ID Mountain Health CO-OP*

IL CountyCare

IN MDwise

LA AmeriHealth Caritas Louisiana

MA Boston Medical Center HealthNet Plan
MA Commonwealth Care Alliance

MD Maryland Community Health System*
MD Priority Partners
MD Maryland Physicians Care

ME Community Health Options*

MI Blue Cross Complete of Michigan
MI Southwest Michigan Behavioral Health

MN Hennepin Health
MN South Country Health Alliance

MT Montana Health CO-OP*

NH AmeriHealth Caritas New Hampshire

NH Well Sense Health Plan

NY Affinity Health Plan
NY Amida Care
NY Elderplan & HomeFirst
NY Hamaspik Choice
NY iCircle Care
NY Nascentia Health
NY VillageCareMAX
NY VNSNY CHOICE

NC Alliance Health
NC AmeriHealth North Carolina
NC Cardinal Innovations Healthcare
NC Partners Behavioral Health Management
NC Trillium Health Resources

OH CareSource

OR CareOregon

PA AmeriHealth Caritas Pennsylvania
PA Gateway Health Plan
PA Geisinger Health Plan
PA Health Partners Plans
PA Keystone First
PA UPMC *for You*
RI Neighborhood Health Plan of Rhode Island

SC Select Health of South Carolina
TX Community First Health Plans
TX Community Health Choice
TX Cook Children's Health Plan
TX Driscoll Health Plan
TX El Paso Health
TX Parkland Community Health Plan
TX Sendero Health Plans*
TX Texas Children's Health Plan

UT University of Utah Health Plans

VA Virginia Premier Health Plan

WA Community Health Plan of Washington

WI Children's Community Health Plan
WI Common Ground Healthcare Cooperative*
WI My Choice Family Care

WY Mountain Health CO-OP*
** Partner or Associate Plan*

37 Safety Net Health Plans Operate Medicare D-SNP, MLTSS or MMP Plans

AZ	Banner University Health Plans	DSNP	MLTSS	
CA	CalOptima	DSNP	MLTSS	MMP
CA	Community Health Group		MLTSS	MMP
CA	Health Plan of San Mateo		MLTSS	MMP
CA	Inland Empire Health Plan		MLTSS	MMP
CA	L.A. Care Health Plan		MLTSS	MMP
CA	Santa Clara Family Health Plan		MLTSS	MMP
CO	Denver Health	DSNP		
HI	Aloha Care	DSNP	MLTSS	
IL	County Care		MLTSS	
MA	BMC HealthNet Plan	DSNP		
MA	Commonwealth Care Alliance	DSNP		MMP
MN	Hennepin Health		MLTSS	
MN	South Country Health Alliance	DSNP		
NY	Elderplan and HomeFirst	DSNP	MLTSS	
NY	Hamaspik Choice	DSNP	MLTSS	
NY	iCircle Care		MLTSS	
NY	Nascentia Health	DSNP	MLTSS	
NY	VillageCareMAX	DSNP	MLTSS	
NY	VNSNY CHOICE Health Plans	DSNP	MLTSS	
OH	CareSource	DSNP		MMP
OR	CareOregon	DSNP		
PA	AmeriHealth Caritas Pennsylvania	DSNP	MLTSS	
PA	Gateway Health Plan	DSNP		
PA	Geisinger Health Plan	DSNP		
PA	Health Partners Plans	DSNP		
PA	UPMC *for You*	DSNP	MLTSS	
RI	Neighborhood Health Plan of R.I.		MLTSS	MMP
SC	Select Health of South Carolina			MMP
TX	Children's Medical Center Health Plan		MLTSS	
TX	Community Health Choice	DSNP		
TX	Cook Children's Health Plan		MLTSS	
TX	Driscoll Health Plan		MLTSS	
TX	El Paso Health	DSNP		
TX	Texas Children's Health Plan		MLTSS	
VA	Virginia Premier Health Plan	DSNP	MLTSS	
WA	Community Health Plan of Wash.	DSNP		
WI	My Choice Family Care	DSNP	MLTSS	

17 Safety Net Health Plans Operate Plans in Marketplaces

CA L.A. Care Health Plan

CO Denver Health Medical Plan

ID Mountain Health CO-OP*

MA BMC HealthNet Plan

NY Affinity Health Plan *(Basic Health Plan)*

RI Neighborhood Health Plan of R.I.

OH CareSource

ME Community Health Options*

MT Montana Health CO-OP*

PA Geisinger Health Plan

PA UPMC *for You*

TX Community Health Choice
TX Sendero Health Plans*

UT University of Utah Health Plans

VA Virginia Premier

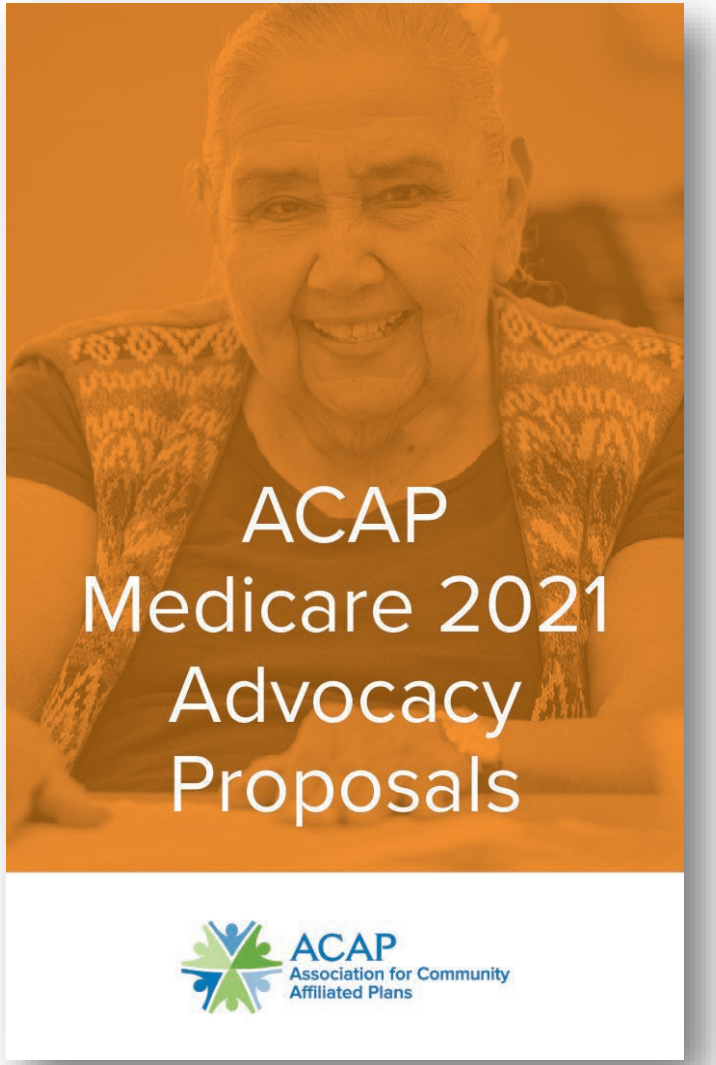
WI Children's Community Health Plan
WI Common Ground Health Cooperative*

*** Partner or Associate Plan**

Criteria for Full ACAP Membership

- Local, community-affiliated health plan.
- Not-for-profit, or owned by a not-for-profit organization. Not publicly traded.
- Must have a Medicaid contract.
- At least 51 percent of members must come from publicly-sponsored coverage programs.
- Affiliated with or owned by community health center, government, hospital or other provider group.
- If managed by an outside for-profit firm, the CEO and senior staff must be employees of the plan, not the management firm. Only plan staff may attend ACAP meetings and conference calls.
- Agree with ACAP's mission and principles.
- New membership is at current members' discretion.

Health Policy Proposals for Transition to the Biden Administration



Read them all:
communityplans.net/transition

ACAP Leadership Academy Project Team

Enrique Martinez-Vidal
Vice President for Quality and Operations
Emartinez-vidal@communityplans.net

Asfiya Mariam
Program Associate
amariam@communityplans.net

Schedule of Events

Mon. 22 Feb.

1-5:30 pm ET

Leadership Academy 2021 Cohort Kick-off Meeting

Tue. 23 Feb.

1-5 pm ET

ACAP Fly-in Programming (Policy Sessions) – *Separate Registration*

Wed. 24 Feb.

(Virtual) Hill visits*(if any)

Thu. 25 Feb.

1-4pm ET

Leadership Academy Combined Session (2020 and 2021 Cohorts)

Quality and Operational Support

Quality and Operations Activities

Plan Collaboratives

- **Behavioral Health Learning Collaborative (PCORI-Supported):** 13-plan learning collaborative to use evidence-based practices to improve behavioral health services in Medicaid.
- **Telehealth Learning Collaborative (PCORI-Supported):** 28-plan learning collaborative focused on research findings, successful evidence-based reforms, and implementation strategies related to telehealth
- **Interoperability Final Rules Implementation:** Activities include all-plan call with CMS; interoperability vendor showcase; group discount on FHIR training; FAQ. Participating plans receive eight educational Webinars, discussion forum, RFP template (optional). **Part 2 (Spring 2021): March to December 2021**

ACAP Plans Working Together: Joint Purchasing, Learning Opportunities

- Unconscious Bias/Cultural Competency Training
- Medicaid Training
- Training on Strategies for Case Management Education
- Marketplace Risk Adjustment Training
- Salary/Compensation Survey
- Medicaid 101 web-based training; discounted tuition for ACAP-member plans.

Weighing in Often on Proposed Regulations, Guidance, Standards

- Past 5 years, nearly 200 **comment letters** to regulators and others: CMS, FTC, HHS, ONC, IRS, NAIC, NCQA, Homeland Security, more.
- ACAP-member plans play a key role in shaping response
- Often lead to desired changes in regulations, quality measures, implementation timelines, more
  - E.g., Interoperability regs enforcement delayed six months; MFAR withdrawn

Gathering Data to Inform Your Operations, Strategy

- **Monthly Federal Activity Digests:** Summary of posted regulations, guidance; upcoming deadlines, organized by LOB (Medicaid, Medicare, Marketplace)
- **Plan Surveys:** General statistics, executive compensation, CIO/Information Technology, plan operations (e.g., MLR, telehealth, pharmacy, network adequacy, etc.)
- **Benchmarking:** HEDIS/CAHPS, Staffing, PQA Opioid Measures, Social Determinants of Health (SDOH) Assessment

ACAP Award Winners: 2019-2020

2020 Leadership in Advocacy Award:

C. Virginia Fields
nominated by Amida Care

Supporting the Safety Net Award:
Shalom Farms - *nominated by Virginia Premier*

John G. Lovelace Policy and Research Fellow:
Yara Elbeshbishi, UPMC *for You*

ACAP Scholarship:
Joanna Valenzuela, Health Plan of San Joaquin

2020 Making a Difference Award:
Ann Oshel, Alliance Health

Resources for You

ACAP RESEARCH

- Continuous Eligibility
- Actuarial Soundness
- Social Determinants of Health
- Rx Utilization
- Plans that "Overlap" with Medicaid, QHP Coverage

More:
communityplans.net/research

PLAN RESOURCES

- Dashboards
- Emergency preparedness plans
- Health risk assessments
- Job descriptions
- Marketing materials
- RFP responses

More:
communityplans.net/plan-resources

BIBLIOGRAPHY

- Influential research from third parties
- Medicaid managed care
- Medicare
- Marketplace

More:
communityplans.net/bibliography

Networking Opportunities

CEO SUMMIT

- Signature 2-day event
- For plan and health care thought leaders
- Past keynote speaker (2020) Former HHS Sec. Kathleen Sebelius
- Other topics: ACAP plan CEOs on leadership, disparities, social determinants, Election 2020

~~IN-PERSON~~ ZOOM MEETINGS

- Membership Council
- Capitol Hill Fly-Ins
- CMO/Quality Managers
- Chiefs (CFOs/CIOs/COOs)
- Medicare/MLTSS
- Marketplace
- Special topics (e.g., Rx, Public Relations, HR, Interoperability)
- ACAP Collaboratives

ROUNDTABLE CALLS

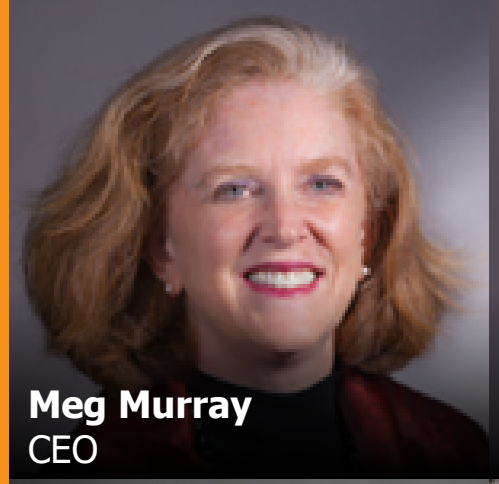
- On the phone or Zoom
- **100+ calls/year** on a wide range of topics
- Ranging from manager/director level to C-suite
- Dedicated CEO calls during COVID on provider/plan stability, finance, reopening, etc.

Visit **communityplans.net** for a Catalog of Policy, Operations, Research Resources

- **Slides and video** (where available) of past Roundtable calls, Webinars
- Members-only **plan resources**; plan-to-plan **discussion board**
  - Includes opportunity to communicate directly with Preferred Vendors
- **Jobs board:** post your open positions at no cost
- **Policy documents** and analysis
- **Research papers**
- **Training opportunities**

ACAP Preferred Vendor Program

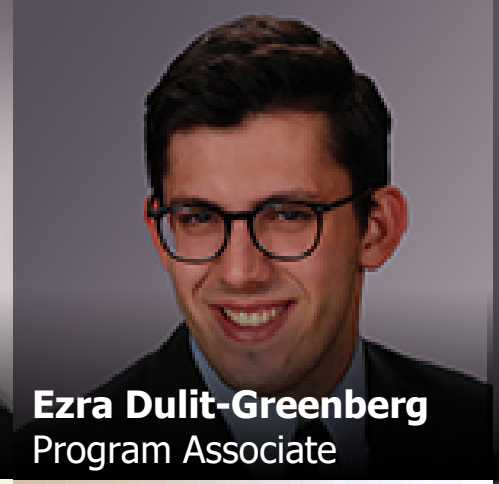
- **Preferred Vendors:** vetted by Board; can lose status for subpar performance, service conflict, contract dispute
- **Strategic Alliances** with PopHealthCare, Softheon, Altruista
- **Preferred Vendor Education Series** – online library available
- New **Preferred Vendor Connection** bulletin board - links you with Preferred Vendors. Post RFIs, RFPs, questions to all vendors at one time. Receive responses directly or post anonymously.



Meg Murray
CEO

Jennifer Babcock
Sr. V.P. Medicaid Policy;
Director, Strategic Ops

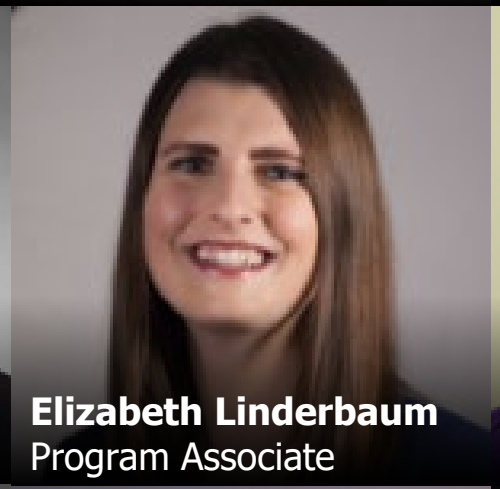
Tanara Blanchard
Executive Assistant



Ezra Dulit-Greenberg
Program Associate

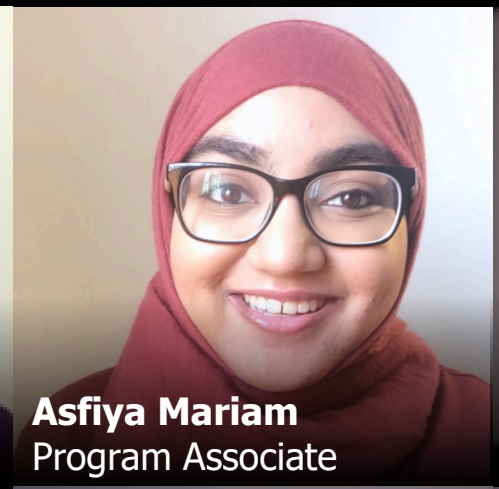
Heather Foster
V.P., Marketplace Policy

Sharon Gibson
Chief Administrative
Officer

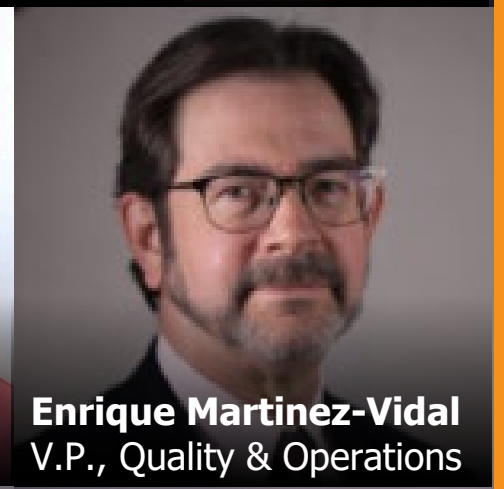


Elizabeth Linderbaum
Program Associate

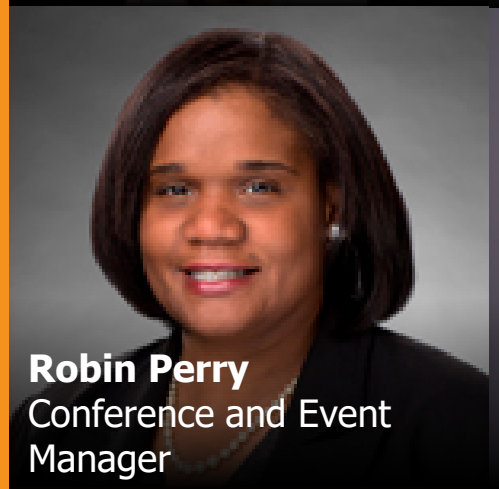
Christine Lynch
V.P., Medicare Policy



Asfiya Mariam
Program Associate



Enrique Martinez-Vidal
V.P., Quality & Operations

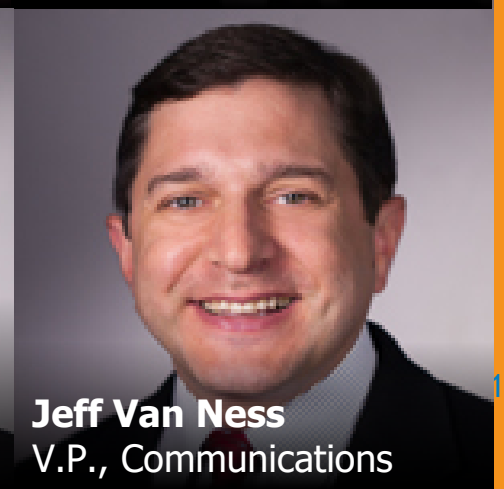


Robin Perry
Conference and Event
Manager

Selma Quarles
Administrative Assistant

Caroline Rourke
Communications Associate

Pramila Shrestha
Accounting Manager



Jeff Van Ness
V.P., Communications

INTRODUCTIONS

Jennifer McGuigan Babcock, Senior Vice President for Medicaid Policy

Heather Foster, Vice President for Marketplace Policy

Christine Aguiar Lynch, Vice President for Medicare and MLTSS Policy

Jeff Van Ness, Vice President for Communications

Introduction to the Leadership Academy

ACAP Leadership Academy

February 22, 2021

Overview of this Part of the Meeting

Introduction to Academy Advisors

Overview of Leadership Academy

Overview of Virtual Fly-InThis Week

Gretchen Brown

- Chief Operating Officer, Director of Customer Service, Director of Program Development and part of original start-up team for CalOptima, Medicaid managed care plan serving Orange County, California
- Executive Director, Medicare plans for LA Care Health Plan overseeing Dual Eligible Special Needs Plan (D-SNP) and Medicare-Medicaid Plan (MMP)
- Vice President, Business Development, SCAN Health Plan, a Medicare managed care plan, conducted analyses for expansion of SNP plans serving dual eligible beneficiaries in multiple states and PACE program development
- Legislative Assistant for Health, US Senate
- Policy Analyst, The Henry J. Kaiser Family Foundation
- Presidential Management Fellow, Centers for Medicare and Medicaid Services (CMS)

Kathy Kuhmerker

- Medicaid Director for New York State
  - Response to 9/11
  - Refocusing LTSS programs
  - Implementing NYS' precursor to the ACA – the Family Health Plus program
- ACAP's Vice President for Medicaid Policy
- Senior staff in New York State Division of the Budget, with a focus on Medicaid and health care
- Vice President, The Lewin Group, States and Payors Group
- President, Kuhmerker Consulting Group, LLC
- Treasurer, Kent Attainable Housing, Inc.

Christine Nye (Tina)

- Director of Medicaid for HCFA (CMS) and the state of Wisconsin
- COO and SVP for Schaller Anderson (Aetna/CVS), a Medicaid managed care company
- Regional Vice President - United Healthcare for Medicare managed care operations
- Director for Special Health Care Initiatives for the Elderly and Disabled at the Johns Hopkins Health System - implemented a PACE site
- Deputy Director of Aging Programs - Wisconsin
- Senior Fellow – NORC at the University of Chicago
- President, CHN-HC, LLC

Role of Academy Advisors

- Advise ACAP on Webinar Topics and Content
- Identify Resources and Provide Background Educational Material to Leadership Academy Participants
- Present Subject Information During Webinars
- Lead and Participate in Discussion Groups During Webinars
- Be Available to Leadership Academy Participants to Discuss and Address Questions
- Serve as Mentors to Leadership Academy Participants

Overview of the Leadership Academy

Webinars

- 7 Leadership Academy webinars planned for 2021-2022
- Topics tentatively include: Leadership, Quality, Health Equity, Social Determinants of Health, Plan Operations, Delivery System and Payment Reform
- These may change (remember COVID?)

Chiefs' Meeting

- Participants will have the opportunity to participate in the ACAP's Fall Meetings (Date and Location TBD)
- Ancillary meetings with plan COOs, CIOs, and CFOs

Academy Advisor Sessions

- Bi-monthly sessions with Advisors and a sub-group of Participants
- Participants will be divided into three groups and each group will meet with each Advisor twice

Resources & Information

- Targeted and related documents will be provided with an understanding that time is precious and too much information can lead to overload

Discussion Forum Using Zulip App

ZULIP

2021acapleadershipacademy.zulipchat.com

Access to the forum is by invite only

ACAP Leadership Academy

ACAP Leadership Academy Zulip Onboarding Guide

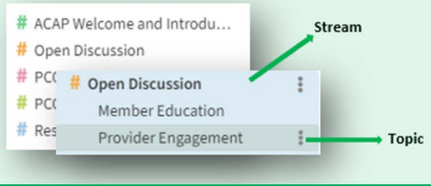
STEP 1: Access the Discussion Forum on Zulip

You can access the discussion forum by typing 2021acapleadershipacademy.zulipchat.com into your browser. Access to the forum is by invite only. You will be prompted to create an account prior to accessing the forum. You can also download a web-based application using the links below

- *Windows OS*
- *Mac OS*

STEP 2: Familiarize Yourself with the Zulip Format

On your left-hand side, you can view a list of Streams. Streams allow you to easily categorize discussions. Each Stream has Topics that you can use as you converse with your peers. An example of this is located below:



STEP 3: Start a Conversation!

Select a Stream and navigate to the bottom of your screen. Click on 'New Topic'. This will pop up a box where you can compose your message and type in a new topic. Previously used topics will also populate for use. Once you are finished, click on the green 'Send' button to post your message with the group. An example of this is located below.

You can also attach documents to your message, add emojis, and preview your message prior to sending it!

Your Turn: Introduce yourself on Zulip!

You will have received an email invitation to join the Learning Collaborative on Zulip. Download the application from Step 1. Once done, navigate to the stream titled '#ACAP Welcome Page', and then click on 'Welcome and Introductions'. Type in your name, job title, and health plan. Hit 'Send' once you are done – ACAP staff will react to your post using a thumbs up to confirm!*

If you have not received your invite, please email amariam@communityplans.net.

Overview of Virtual Fly-In This Week

February 22 – 2021 Cohort

- Introductions -> provide an opportunity for you to meet us and each other
- Level-setting for future discussions -> Fundamental background information on Medicaid and Medicaid managed care
- Leadership discussion -> an opportunity to learn more and share thoughts on leadership

February 25 – Joint Session of 2020 and 2021 Cohorts

- Joint meeting with 2020 Leadership Academy participants
- Presentations and discussion with key leaders on Medicaid and Medicaid managed care and leadership:
  - Emerging Federal/State Health Policy Trends: Cindy Mann, Partner, Manatt Health and former Director of the Center for Medicaid and CHIP Services (CMCS) at CMS
  - Emerging Medicaid Managed Care Trends: Jennifer Moore, Founding Executive Director, Institute for Medicaid Innovation
  - Lessons from Executive Leadership:
    - Frank Dominguez (El Paso Health, TX)
    - Liz Gibboney (Partnership HealthPlan of California, CA)
    - Kathy Pettway (Priority Partners, MD)

Academy Advisors

Gretchen Brown
gretchen.brown3@verizon.net
310-351-9464

Kathryn Kuhmerker
kathy.kuhmerker@gmail.com
518-496-8764

Christine Nye
christinehelennye@gmail.com
850-597-0916

Questions?

Rapid Round Robin Participant Introductions – Part 1

Getting to Know Each Other - Introductions

- Rapid Round Robin – Today's agenda includes three 30 minutes segments for introductions
- We ask that each participant tell us the following --->
  - Name, Plan, Title, Role and Responsibilities
  - Briefly – Describe your career path in getting to managed care
  - Briefly – What were the worst and best things about the COVID-19 pandemic (personally and/or professionally)?
- **Please keep this to 4 minutes or less**, which can be difficult!
  - Good luck!

Rapid Round Robin Participant Introductions - Part 1

Steven Belec

Tammy Brass

Chantay Cooper

Lynda Crooms

Kris Lum

John Miller

Angela Mitchell

Ashley Simms

The Fundamentals of Medicaid

ACAP Leadership Academy

February 22, 2021

Kathy Kuhmerker

Overview of Presentation

- Introduction
- Administration and Funding
- Eligibility and Enrollment
- Services
- Spending

Introduction and Basic Administration of the Program

- Medicaid is a comprehensive health insurance program for low-income individuals
- Established in 1965, with enactment of PL 89-97
  - Established along with Medicare
- It is an entitlement program – eligible individuals with eligible services at approved payment levels
- It is jointly funded and administered by the Federal government and the states
  - Federal CMS establishes national standards and program policies
  - "Single State Agencies" develop program policy, enroll providers, establish rates of payment, combat fraud

Medicare vs Medicaid

Medicare

- For those over 65, with certain diseases (e.g., ESRD) and on SSI
- A national program, consistent across all states
- A social insurance program
  - Eligibility is consistent nationwide
  - Once established, eligibility is not reviewed
  - No income or resource limitations
- The same services are available nationwide
  - Parts A, B, C and D
- Services are delivered consistently across the nation (e.g., Medicare Advantage)
  - Except for demo programs

Medicaid

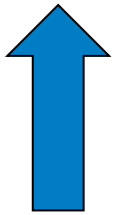
- For those meeting certain income and resource levels
- A grant-in-aid program to states, operating under federal guidance
- A means-tested entitlement program
  - Eligibility varies depending on the state
  - Eligibility is reviewed periodically
- States can provide different services
  - Optional vs mandatory services
- States can have varying delivery systems
  - Types of MMC programs; differing requirements for participation

Funding is Shared By States and the Federal Government

Also called "FFP"

- "FMAP" or Federal Medical Assistance Percentage
- FMAP varies by state, based on a "per capita personal income" (PCPI) formula
  - No state can get less than 50% (CA, CO, NY, NJ, MA,)
  - No state can get more that 83% (MS, WV, NM)
- Under Medicaid financing rules, there is no cap on the amount of the federal share (except for territories)
- CHIP funding is higher (E=enhanced)
  - E-FMAP, which is at least 23% higher, up to 100%
- Local governments can contribute to the state's share

Demand for Medicaid is Countercyclical

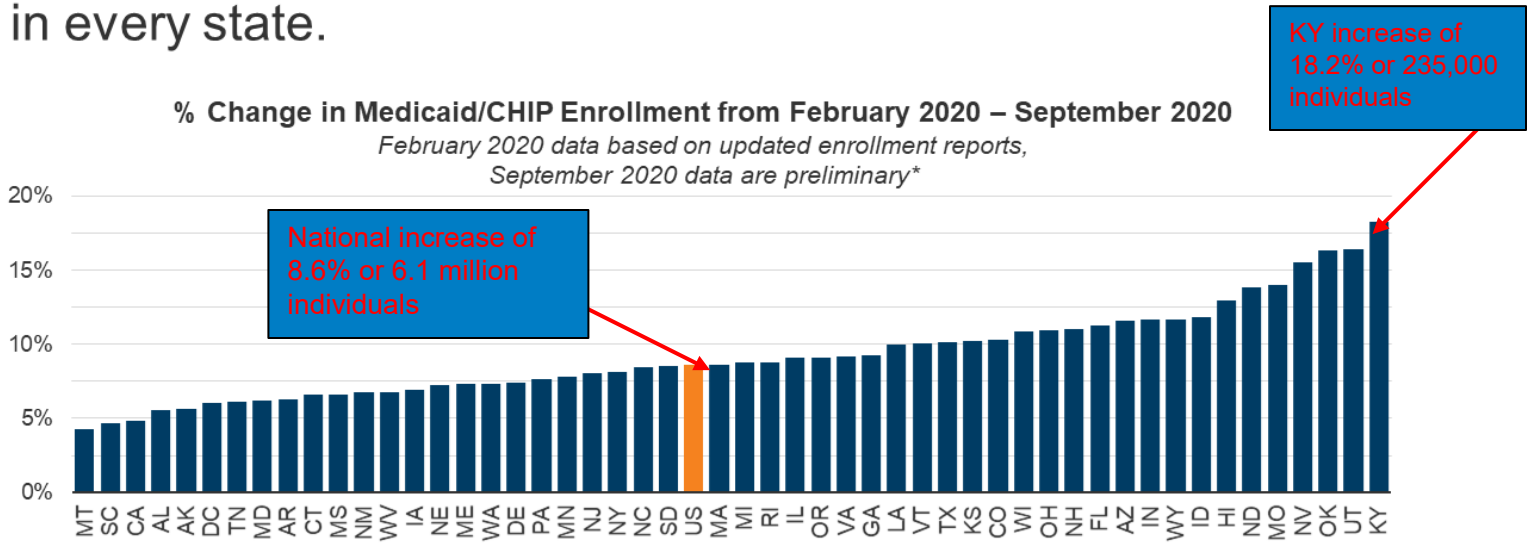


- Enrollment and spending increase when there is a downturn in the economic cycle
  - Decrease in # of employers offering health benefits
  - Increase in number of unemployed people
- States have less revenue to pay for coverage during a recession, but cannot run deficits
- Annual FMAP updates do not take into account recent changes in PCPI

Medicaid Enrollment has Increased Since the Pandemic

Figure 2

Enrollment from February 2020 to September 2020 increased in every state.



NOTES: * September 2020 data are preliminary and subject to change. Medicaid & CHIP enrollment reports are submitted monthly by state Medicaid agencies, reflecting enrollment on the last day of the month. With each update, states often revise data for the previous month(s) to better align with reporting criteria, such as including retroactive enrollment or other criteria.

SOURCE: CMS, Medicaid & CHIP: Monthly Application and Eligibility Reports, last updated January 15, 2021.

KFF

Source: https://www.kff.org/report-section/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/

Congress Has Enacted Temporary FMAP Increases in Times of Economic Downturns

- Additional FMAP
  - Addresses increased demand for Medicaid
  - Gets funding into states "quickly"
- States have not needed to reduce program coverage or eligibility levels to extent that would have been necessary without increased funding
  - Could have worsened impact of recession and made Medicaid inaccessible when most needed
- Continued discussion about establishing an automatic "trigger" in such circumstances

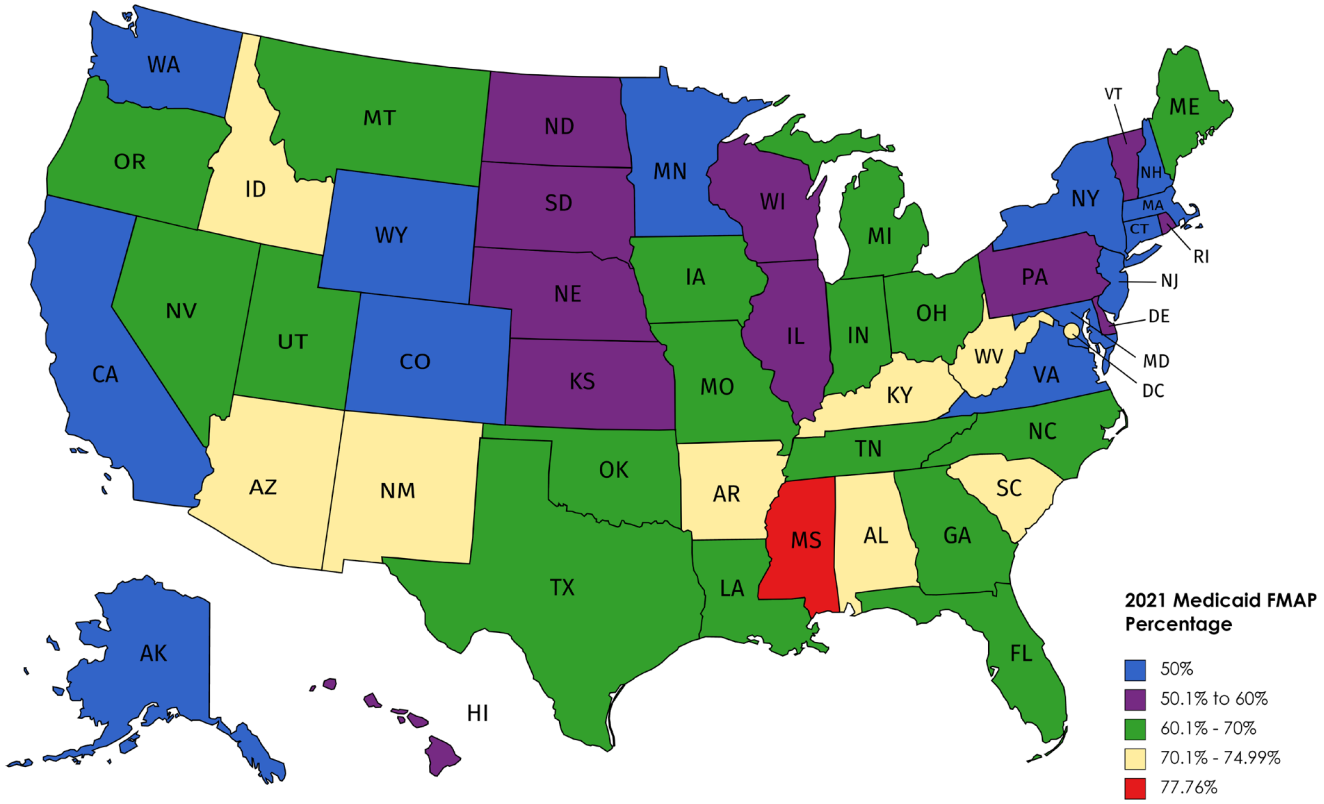
6.2% Covid-19 increase in effect from 1/1/20 until the quarter after public health emergency ends

Poll: What is Your State's FMAP?

- Pick the percentage range that applies to your State
  - Your State's 2021 Medicaid (not CHIP) FMAP
  - Do not count the 6.2 percentage point COVID-19 increase
- Here are the ranges:
  - 50%
  - 50.1% - 60%
  - 60.1% - 70%
  - 70.1% - 74.99%
  - 77.76%

Please answer the poll question on your screen. Select one option from the list. Poll results will be shared after attendees have finished voting.

What is Your State's 2021 FMAP?



2021 Medicaid FMAP Percentages; not including COVID-19 6.2%

Created with mapchart.net

Source: MACSTATS; Exhibit 6; Federal Medicaid Assistance Percentages (FMAP)…

State FMAP – LA Participant States

- If everyone answered, and answered correctly:
  - 50%: 9 (California, Massachusetts)
  - 50.1% – 60%: 2 (Hawaii, Wisconsin)
  - 60.1% – 70%: 11 (Louisiana, North Carolina, Oregon, Texas)
  - 70.1% – 74.99%: 1 (Arizona)
  - 77.76%: 0

If a State Participates in Medicaid…

- It **must** comply with federal "mandatory" requirements
  - States must cover "mandatory" groups (e.g., low-income children) and "mandatory" benefits (e.g., doctors and nursing home care)
- It **may also** provide "optional" coverage and services
  - States may cover "optional" groups, such as children at income levels above federal minimums and "optional" benefits, such as pharmacy and home and community-based services
- It **can** design its delivery system and payment rates, subject to federal parameters and review
  - Rates paid to managed care organizations can be structured as a state wishes, but must be "actuarially sound"
- Waivers can provide additional flexibility and funding approaches

State Plan and State Plan Amendments (SPAs)

- A State Plan is the "agreement between a state and the federal government describing how that state administers its Medicaid and CHIP programs."
- States submit SPAs to establish, update or make changes to their program.
- As long as the change or update is statutorily allowed, CMS does NOT have the discretion to disapprove a SPA.
  - There are time frames for approval of SPAs (but you can "stop the clock") and for public notice of any changes
  - SPAs are generally NOT time-limited

The Other Way to Structure Some or All of a Medicaid Program: Waivers

- By definition, waivers are a way to structure and run a Medicaid program that is different than the regular, standard SPA-oriented way to run the program
- Waivers are discretionary on the part of CMS
  - Waivers are generally time-limited and they require ongoing reporting
  - Public notice is required and approval can require significant negotiation among the parties
- There are two types of waivers
  - Section 1915 waivers – limited in scope
  - Section 1115 waivers – broad in scope; experimental pilot programs; states often use to restructure their program

Managed Care Programs Can Operate under All Three Types of "Authorities"

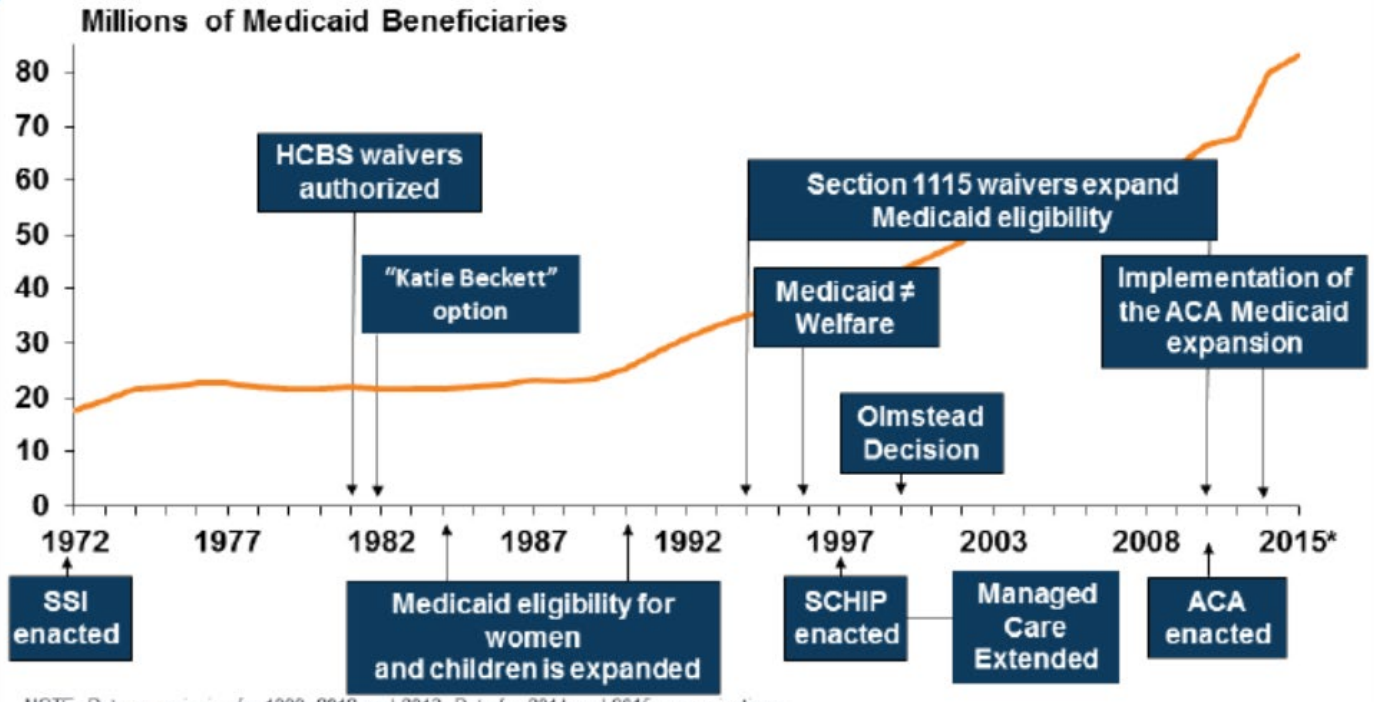
- ***State Plan*** authority under Section 1932(a)
  - Dual eligibles, American Indians and children with special needs cannot participate in an MMC program operating under this provision
  - This authority does not need to be renewed
- ***Waiver authority*** under Sections 1915 (a) or (b)
  - No limitations on eligible participants
  - State must demonstrate that the program is cost-effective, efficient and consistent with the principles of the program
  - Waiver authority is limited to two years; renewals permitted
- ***Waiver authority*** under Section 1115
  - Groups not otherwise eligible for Medicaid can participate
  - Services not typically covered can be included and innovative delivery systems can be used
  - Waiver authority can be 3-5 years

Three Tenets of the Medicaid Program Do Not Need to be Adhered to in MMC

- ***Statewideness*** – the requirement that all services be available to all eligible participants statewide
  - MMC can operate in only some parts of a state (e.g., urban only; certain counties)
- ***Comparability of services*** – the requirements that all benefits must be available to all people, regardless of eligibility group
  - Services provided to MMC participants can be different than those provided in FFS
- ***Freedom of choice*** – the requirement that Medicaid participants can choose to receive services from any enrolled provider
  - Medicaid enrollees can be required to participate in an MMC plan and not be able to go outside of the plan to receive care

Figure 3

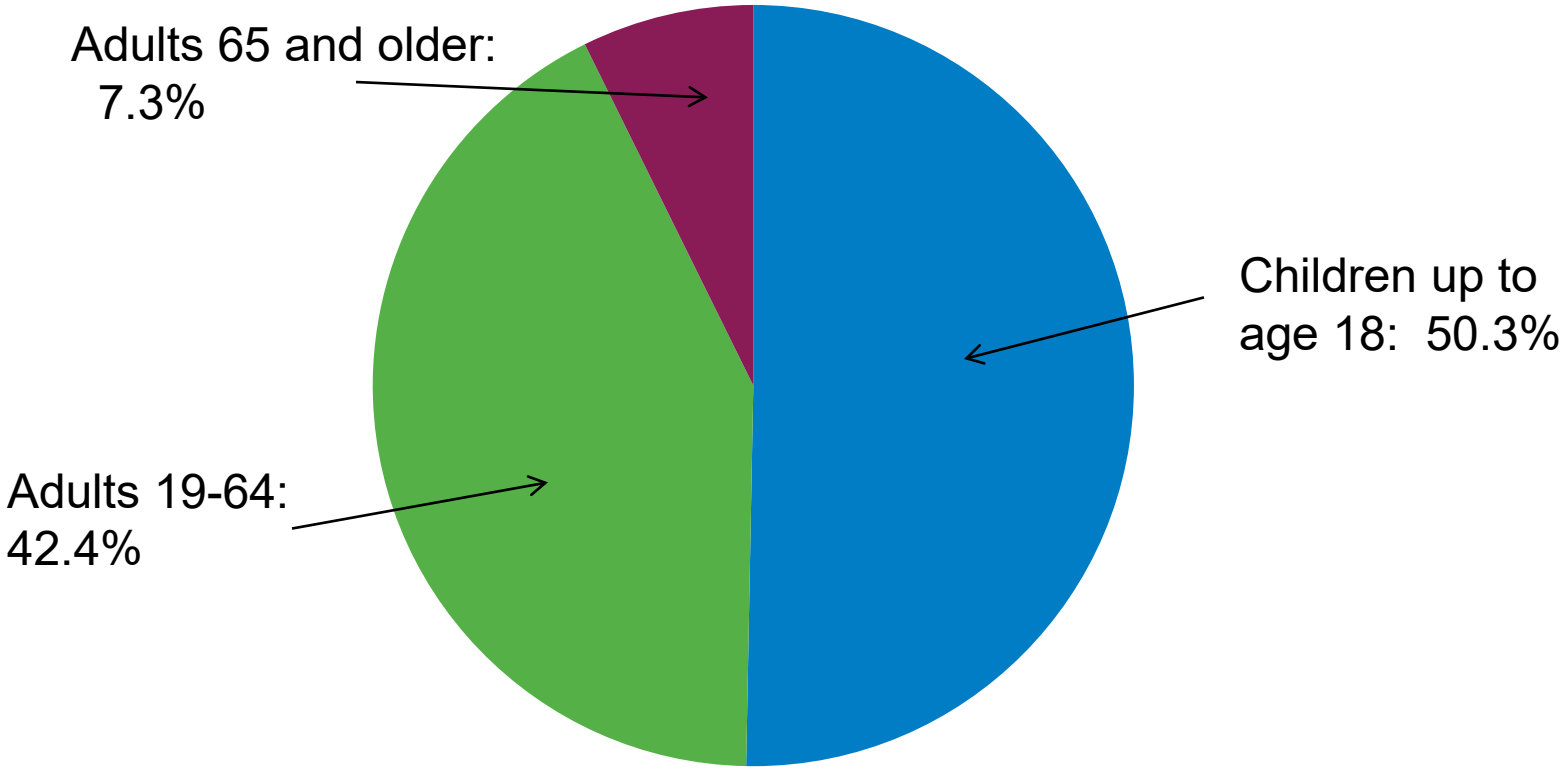
Medicaid has evolved over time to meet changing needs.



NOTE: Data are missing for 1999, 2012 and 2013. Data for 2014 and 2015 are projections.
SOURCES: 1972-1998: Unduplicated, ever-enrolled counts as reported in the 2000 House Ways and Means Committee Green Book http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=&packageId=GPO-CPRT-106WPRT61710.
2000-2011: KCMU and Urban Institute estimates based on unduplicated, ever-enrolled data from FFY 2000-2011 MSIS.
2014-2015: Unduplicated, ever-enrolled counts as reported in the March 2015 CBO baseline.

KFF

More Than Half of all Medicaid Enrollees Are Children



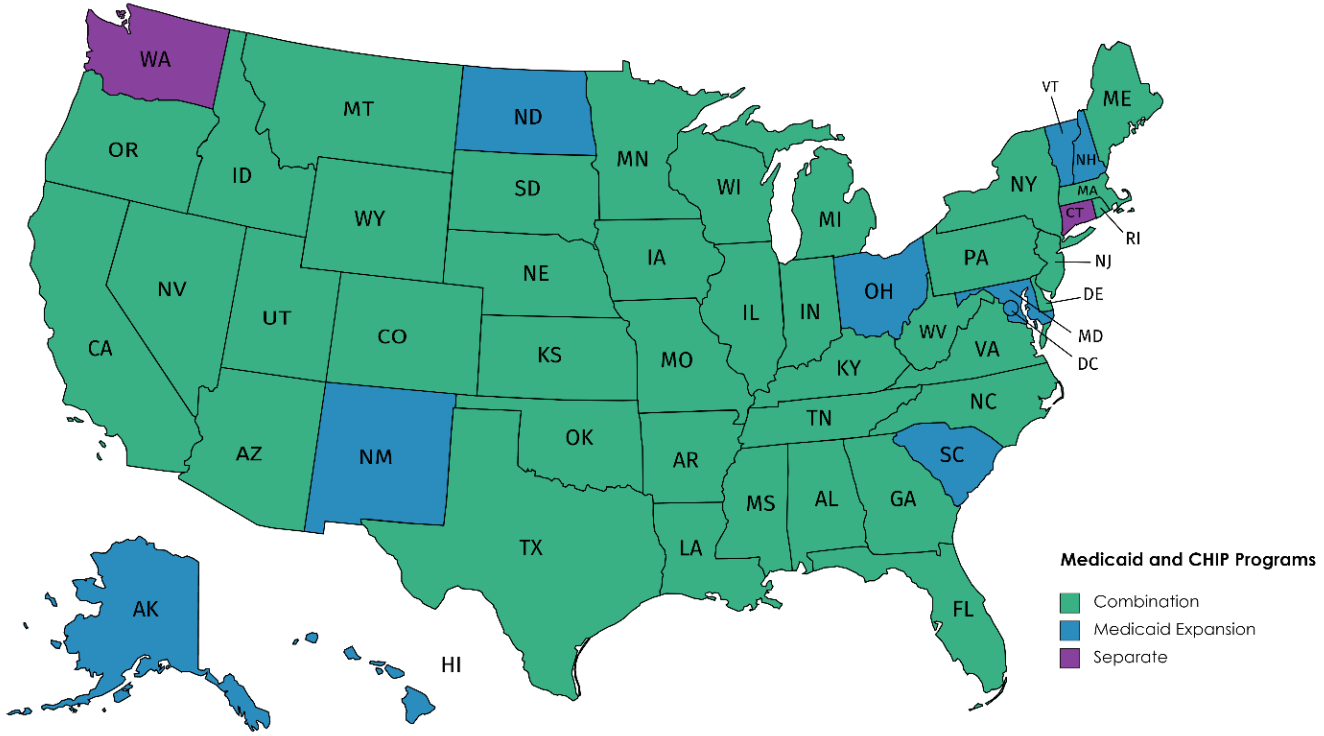
Source: MACSTAT Exhibit 2; 2018 data; includes CHIP enrollees

Poll: How Does Your State Operate its CHIP Program?

- Three options:
  - ***Combination:*** CHIP funding supports children in the Medicaid program and in a separate CHIP program. Services likely differ between the programs.
  - ***Medicaid Expansion:*** All CHIP children are in the Medicaid program. CHIP children receive the same services as those funded by Medicaid.
  - ***Separate:*** The state's Medicaid and CHIP programs are separate. Services differ between the program.
- What does your State do?

Please answer the poll question on your screen. Select one option from the list. Poll results will be shared after attendees have finished voting.

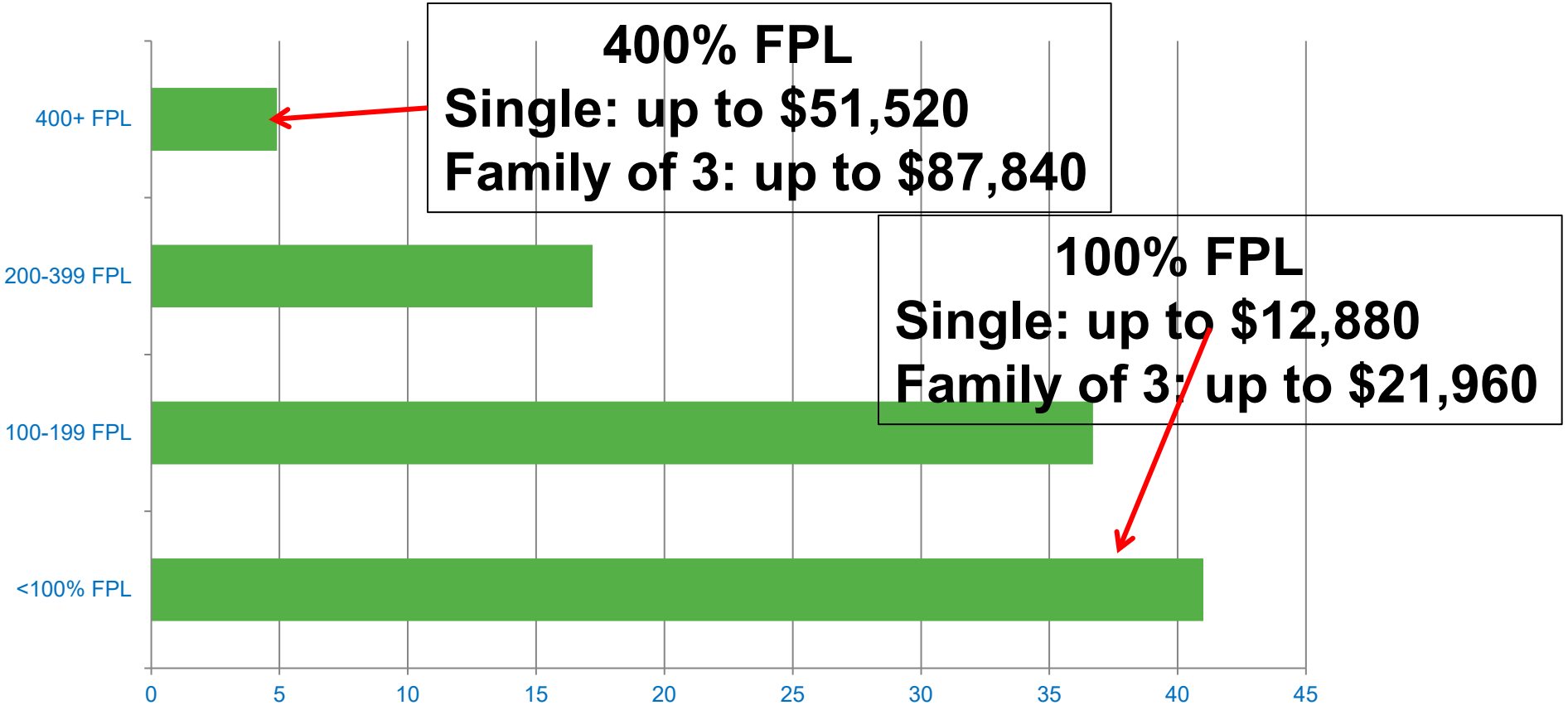
How Does Your State Operate Its CHIP Program?



Created with mapchart.net

Source: MACSTATS; Exhibit 35; Medicaid and CHIP Income Eligibility Levels…; August 2020 data

59.7% of All Enrollees Have Incomes Under 138% FPL



Source: MACSTAT Exhibit 2; 2018 data; includes CHIP enrollees; FPL effective as of 1/13/2021

Other Demographic Facts About 2018 Medicaid Enrollees

- Almost 94% of them are citizens – similar to those with other types of insurance
- 47% of them report their health as being excellent or very good
  - Only 22% report fair or poor health
  - Health status is better than for those on Medicare, but not for those with private coverage
- Over 60% of those over age 19 report that they are working full or part time – much less than for those with private coverage or who are uninsured

So, What are Those Mandatory Services?

- Inpatient hospital services
- Nursing facility services
- Home health care
- Child/Teen health care
- FQHCs and RHCs
- Outpatient hospital services
- Physician services
- Family planning
- Laboratory and X-ray
- Transportation to medical care (often admin funded)

ACA/Medicaid Expansion Beneficiaries Can Have Different Required Services

- Family planning
- FQHCs and RHCs
- Physical and mental health parity
- 10 Essential Health Benefits:

- **Ambulatory patient services**
- **Emergency services**
- **Hospitalization**
- **Maternity and newborn care**
- **Mental health services and addition treatment**
- **Prescription Drugs**
- **Rehabilitative/ habilitative services**
- **Laboratory services**
- **Preventive/wellness services and chronic disease treatment**
- **Pediatric services**

And Those "Optional" Services?

(major ones listed only)

- Clinics (not rural clinics or FQHCs)
- Prescription drugs *(hard to believe…)*
- Dental
- Personal care/Private duty nursing
- Transportation
- Case Management
- ICFs/developmentally disabled
- Eye care/ Audiology/Chiropractic/Podiatric
- Hospice
- Prosthetics and orthotics
- Physical, speech and occupational therapy
- HCBS services
- Religious non-medical services

Many services are "optional" only for adults. Because of the EPSDT program, these services (such as dental) are often considered mandatory for children. See later discussion.

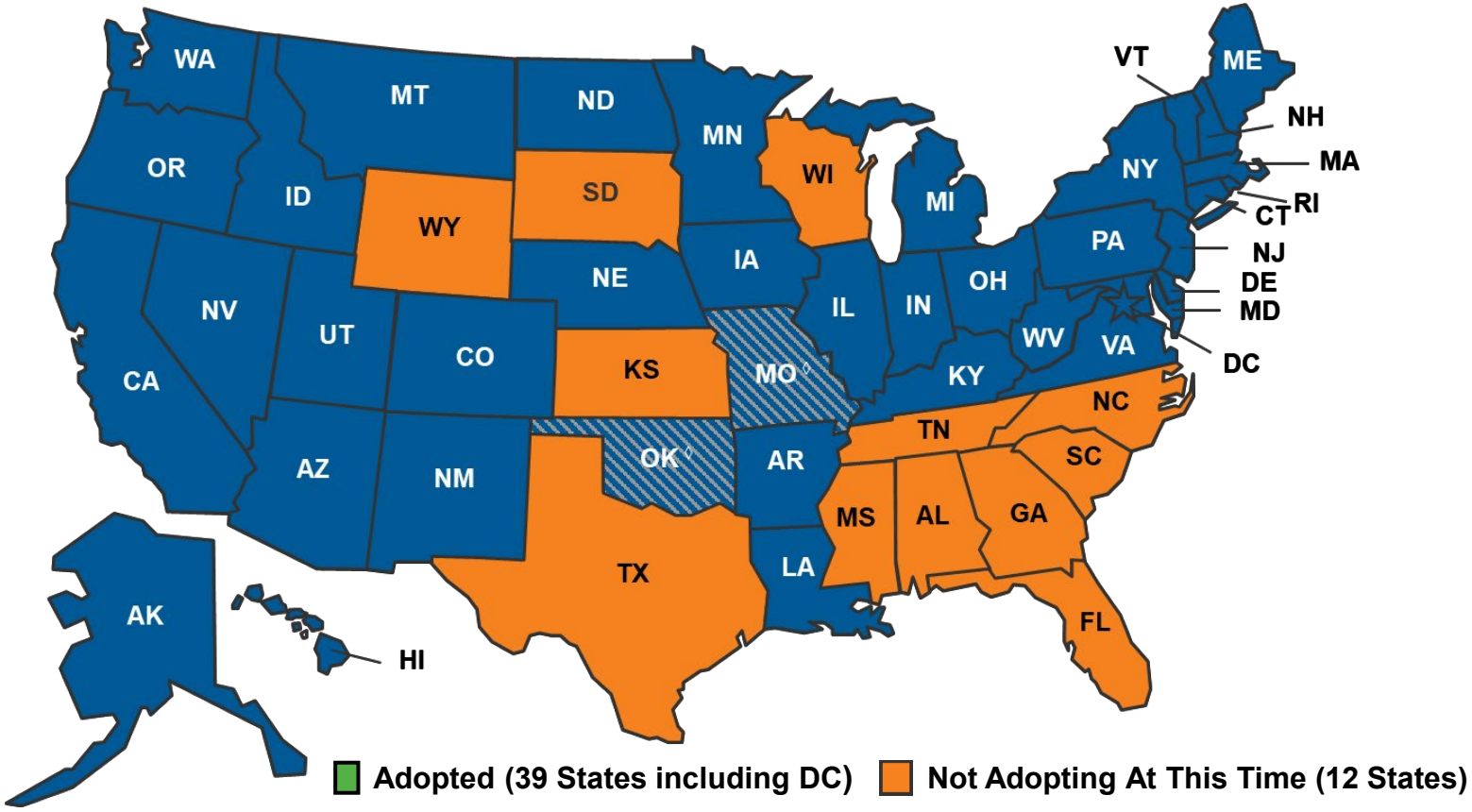
Poll: Has Your State Expanded its Medicaid Program?

- The ACA allowed states to expand its Medicaid program to include non-disabled childless adults under age 65 with incomes up to 138% FPL ("New Adults")
- 39 states have expanded (2 not yet implemented)
- What has your State done?
  - Expanded
  - Not Expanded

Please answer the poll question on your screen. Select one option from the list. Poll results will be shared after attendees have finished voting.

39 States Have Adopted the Medicaid Expansion

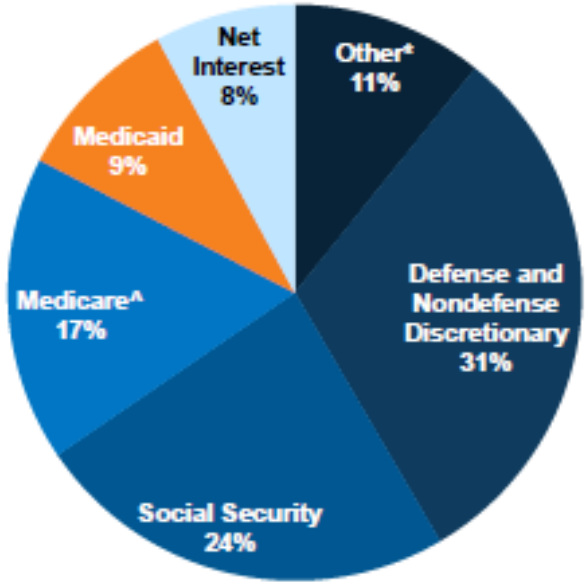
(as of 2/1/2021)



SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated February 1, 2021. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act

Figure 9

Medicaid is the third largest mandatory spending program in the federal budget.

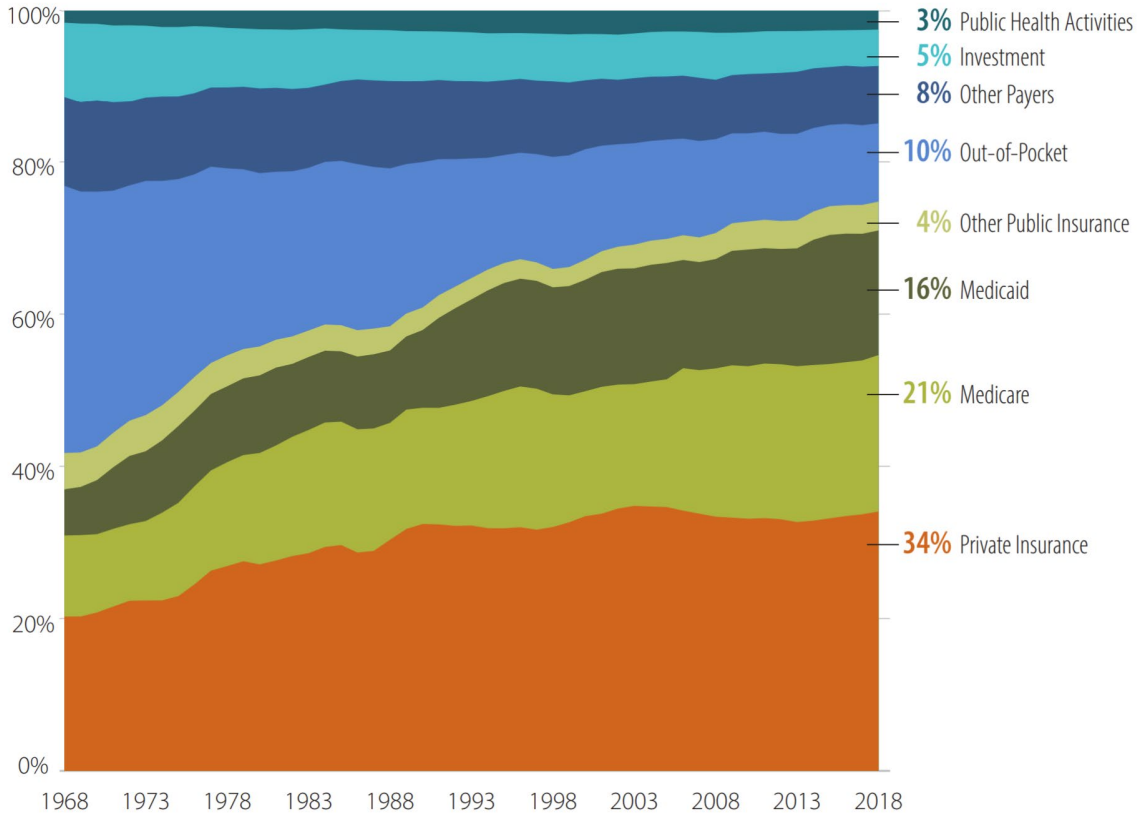


Actual FY 2018 Total Federal Outlays: $4.1 Trillion

NOTE: ^ Amount for Medicare is mandatory spending excluding offsetting receipts. * Other category includes other mandatory outlays (such as CHIP and Health Insurance Marketplace premium subsidies).
SOURCE: Kaiser Family Foundation based on Congressional Budget Office, Budget and Economic Outlook Fiscal Years2019-2029, January 2019.

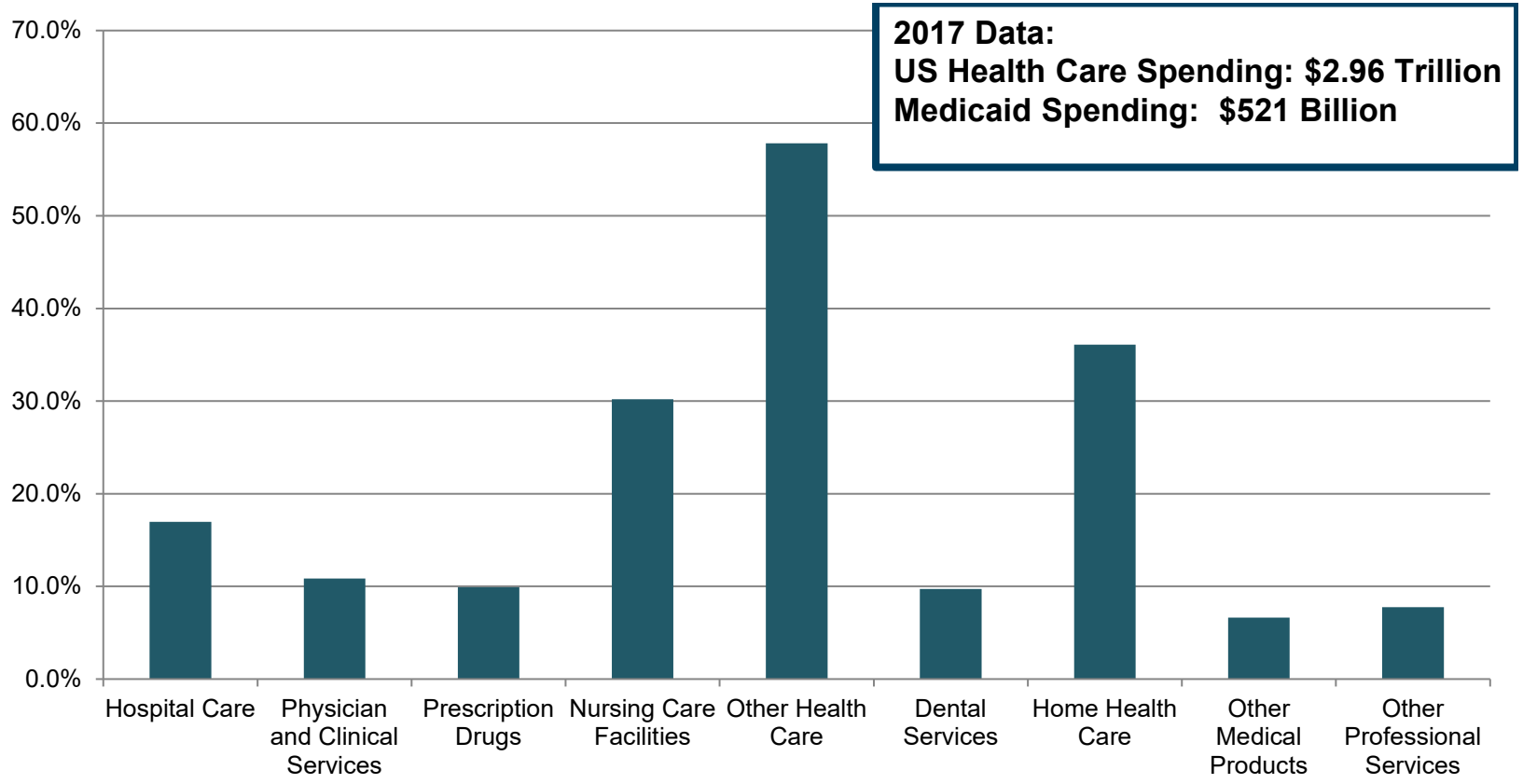
KFF

Medicaid is the Payer for 16% of all US Health Care Spending…



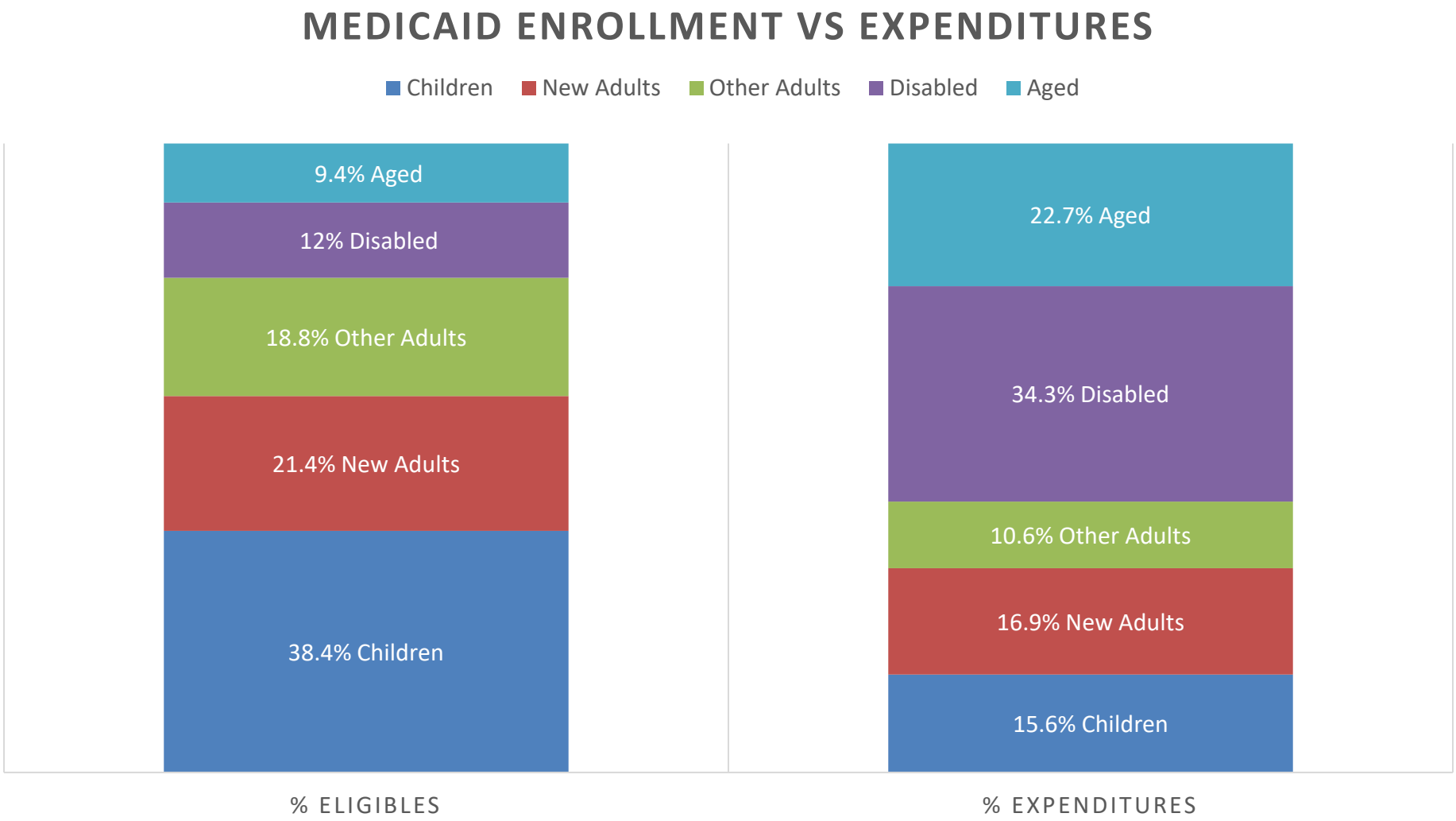
Source: 1968-2018 NHE data compiled by CHCF in 2020

… And Its Funding Supports Large Portions of the Health Care Industry



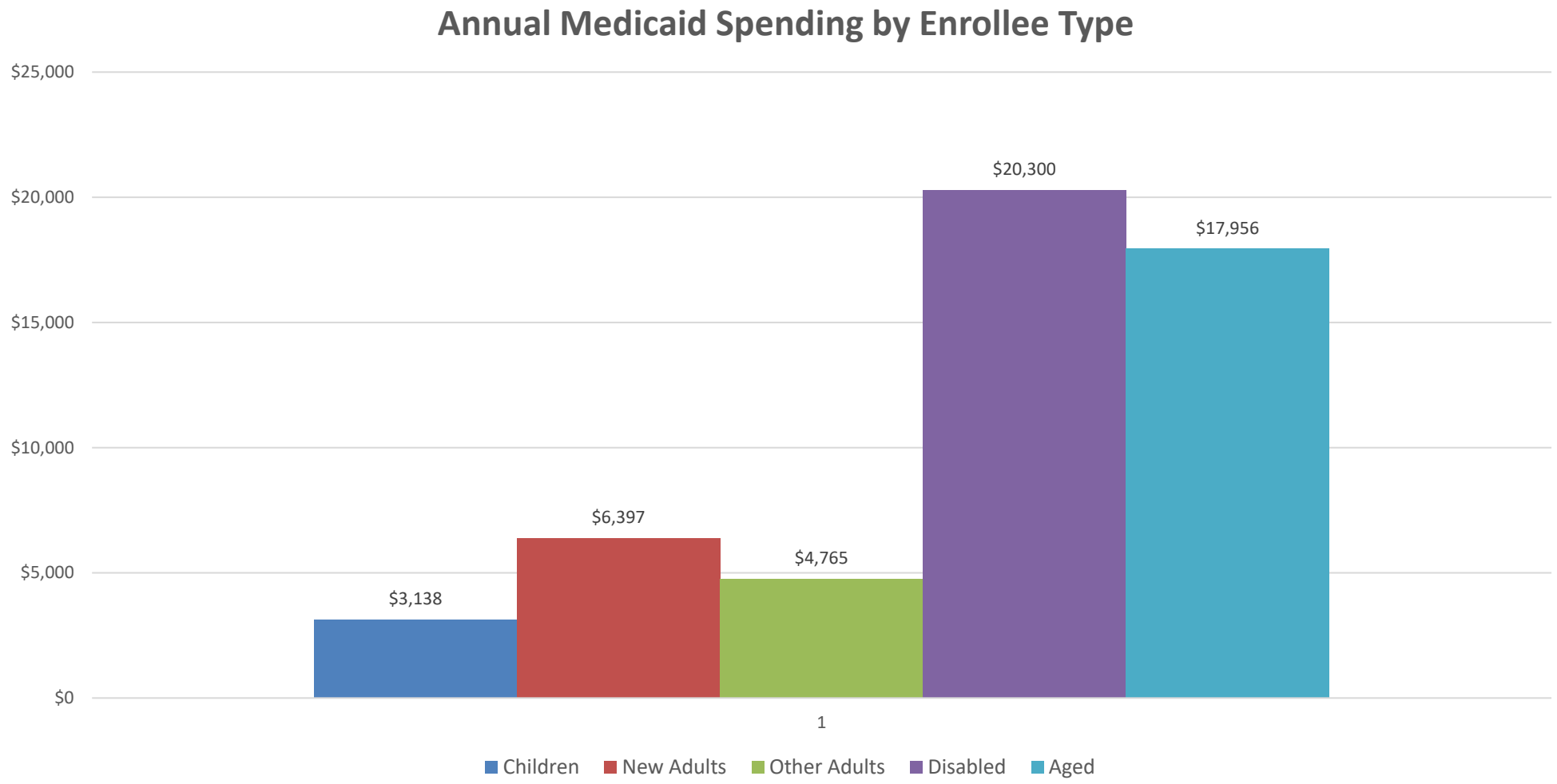
Source: 2017 NHE data compiled by CHCF in 2019

Almost 60% of Medicaid Spending is Driven by the 21% of Beneficiaries Who Have Disabilities or are Elderly



Source: MACSTATS Exhibits 14 and 21a; FY 2018 data

Annual Spending Per Enrollee Data Show Large Differences in Spending Patterns



Source: MACSTATS Exhibit 19: Medicaid Spending per Full Year Equivalent; FY 2018

Questions?

Rapid Round Robin Participant Introductions – Part 2

Getting to Know Each Other - Introductions

- Rapid Round Robin – Today's agenda includes three 30 minutes segments for introductions
- We ask that each participant tell us the following --->
  - Name, Plan, Title, Role and Responsibilities
  - Briefly – Describe your career path in getting to managed care
  - Briefly – What were the worst and best things about the COVID-19 pandemic (personally and/or professionally)?
- **Please keep this to 4 minutes or less**, which can be difficult!
  - Good luck!

Rapid Round Robin Participant Introductions - Part 2

Angela Ahsan

Eric Buben

Jamie Heberer

David Lima

Michelle Martin

LaShern McEwen

Alexandra Rawson

Allison Stewart

BREAK!

See you at 3:30 pm ET

Opportunities and Challenges for Today's Medicaid Managed Care Plans

ACAP Leadership Academy

February 22, 2021

Gretchen Brown

Tina Nye

Overview of Presentation

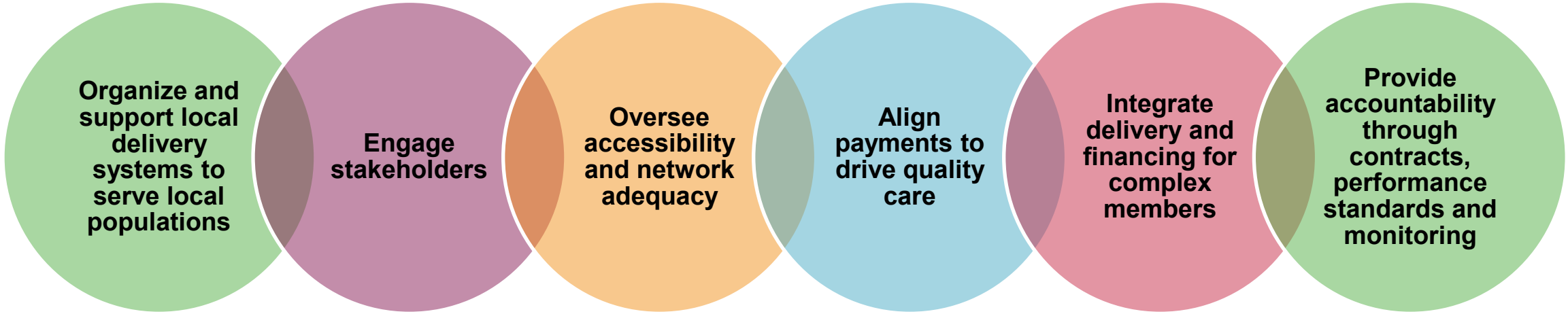
- Introduction
- Medicaid Managed Care Today
- Expansion of Roles for Medicaid Managed Care Plans
- Medicaid Managed Care in 2021 and Beyond

Medicaid Managed Care Today

Why States Continue to Move to Managed Care

- Budgetary predictability and containing spending
- Promote accountability and support decision-making
- Monitor quality and health outcomes and reduce unnecessary utilization of services
- Enhance member experience and satisfaction
- Use of alternative payment methods to incentivize improvements in care and to address multi-payer alignment
- Promote integration of care and blending of financing streams
- Expand coverage to additional populations

Plans Support State Objectives



Focus of State Procurements

Continued Focus:

- Extend integrated medical, behavioral and long-term care services to additional populations
- Enhance alignment by serving dual eligibles
- Reform and re-align payments to providers

Addressing New Priorities:

- Use community-driven initiatives to improve population health with support of Social Determinants of Health (SDOH)
- Address structural racism and health inequities in health care system

Many States Use Capitation to Pay for Medicaid Services

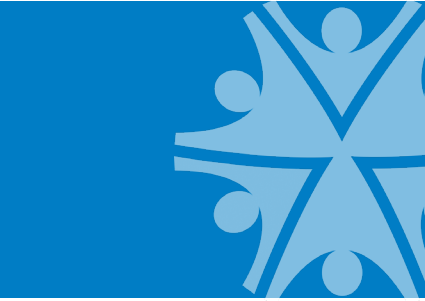
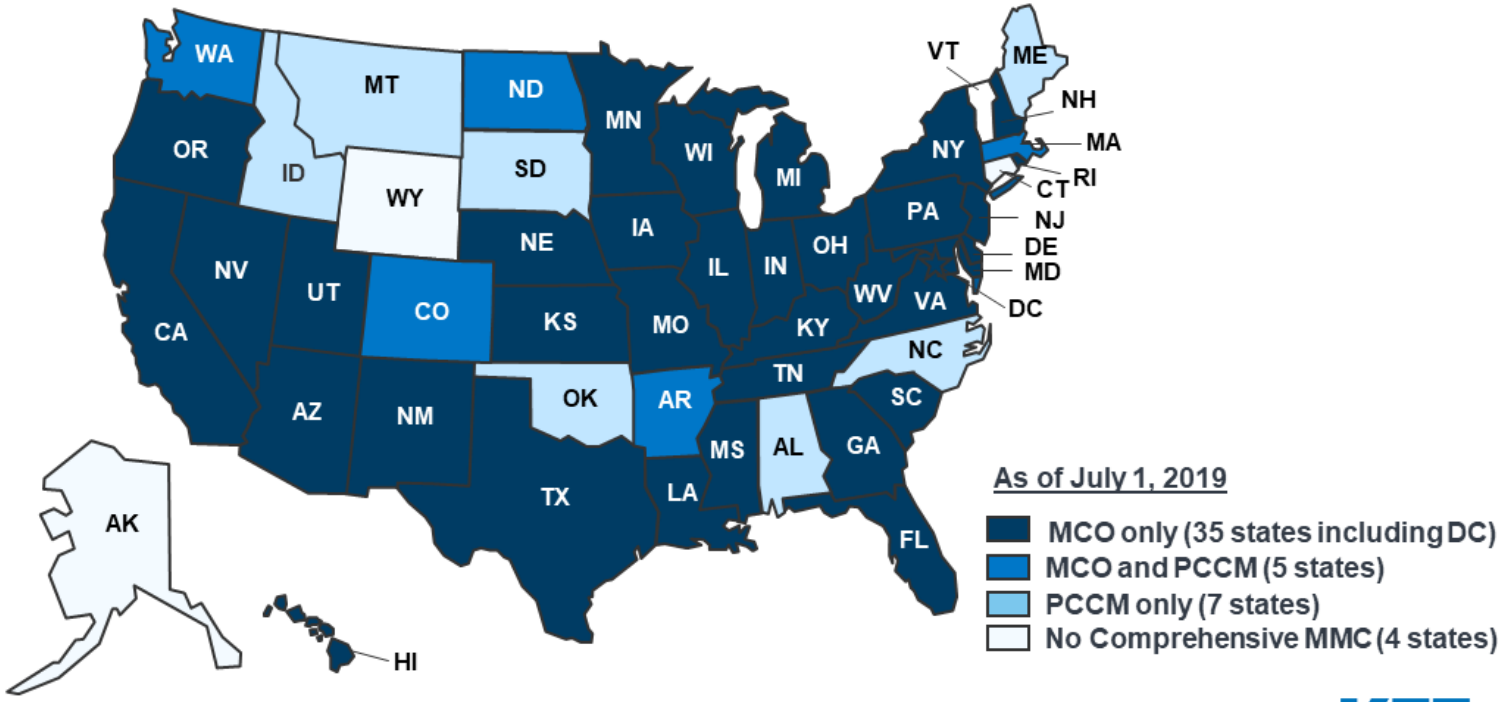


Figure 1

As of July 2019, 40 states used capitated managed care models to deliver services in Medicaid.

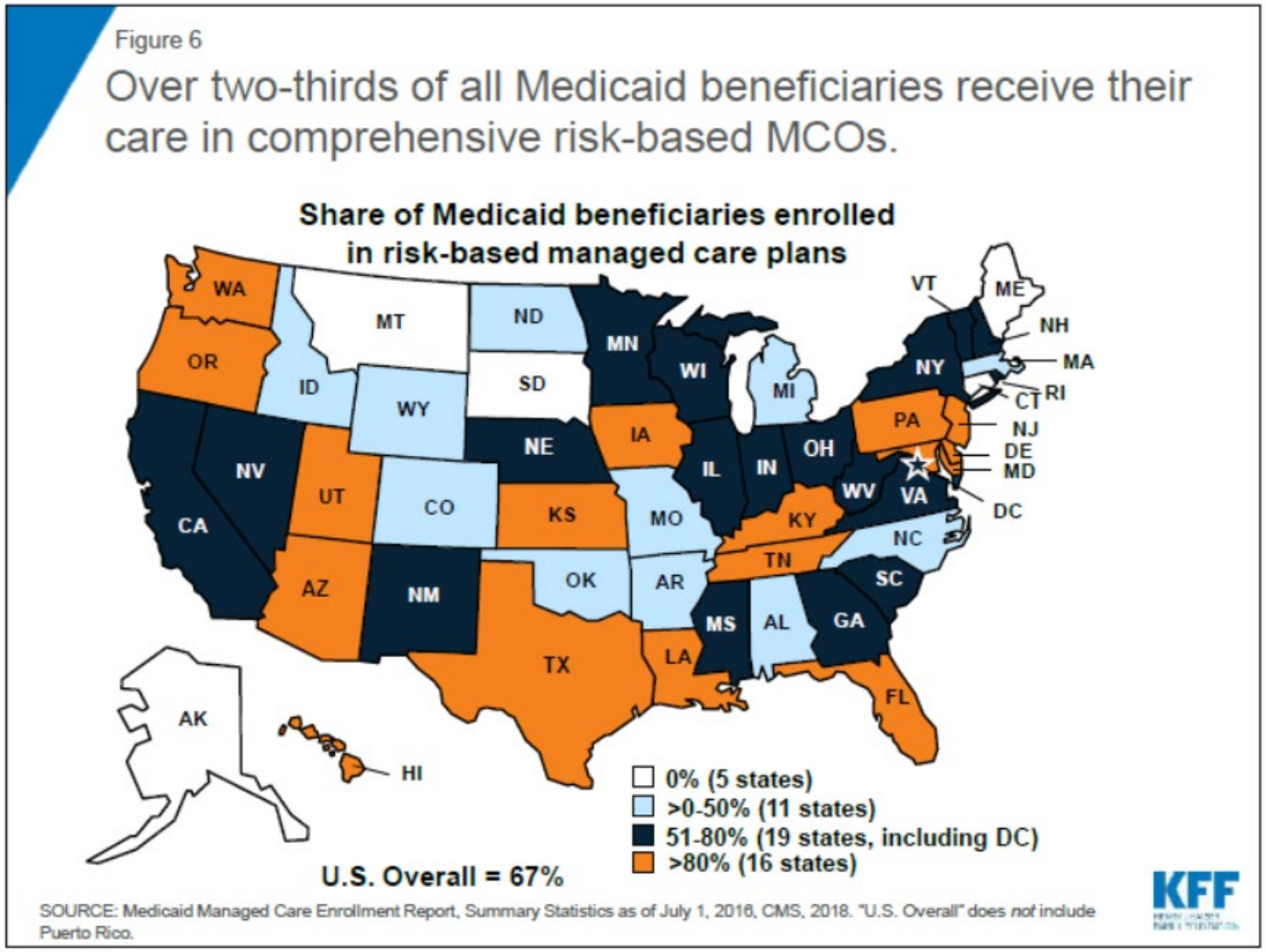


NOTES: CA has a small PCCM program operating in LA County for individuals with HIV. SC uses PCCM authority to operate a small, children's care management program and is not counted here as a PCCM.

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

KFF
HENRY J KAISER FAMILY FOUNDATION

Majority of States Contract with Plans for Medicaid Services

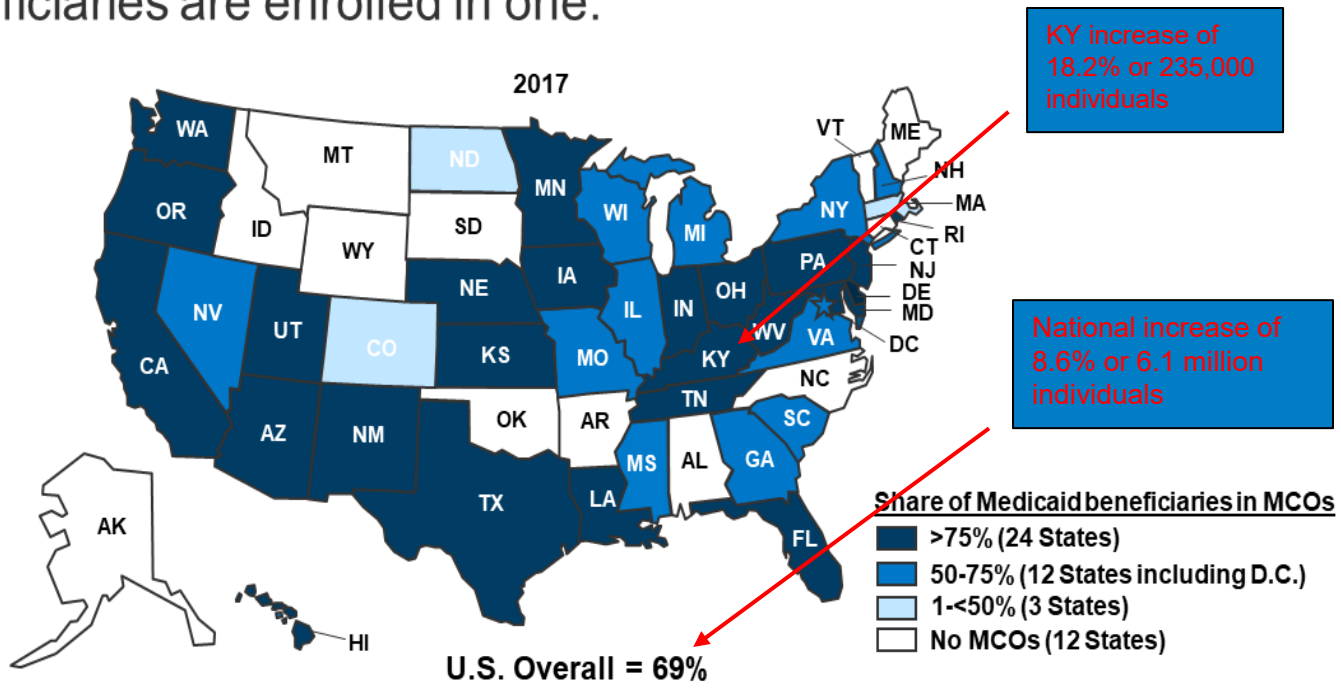


SOURCE: Medicaid Managed Care Enrollment Report, Summary Statistics as of July 1, 2016, CMS, 2018. "U.S. Overall" does *not* include Puerto Rico.

Majority of Beneficiaries Enrolled in Plans

Figure 2

In most states with comprehensive MCOs, at least 75% of beneficiaries are enrolled in one.



KY increase of 18.2% or 235,000 individuals

National increase of 8.6% or 6.1 million individuals

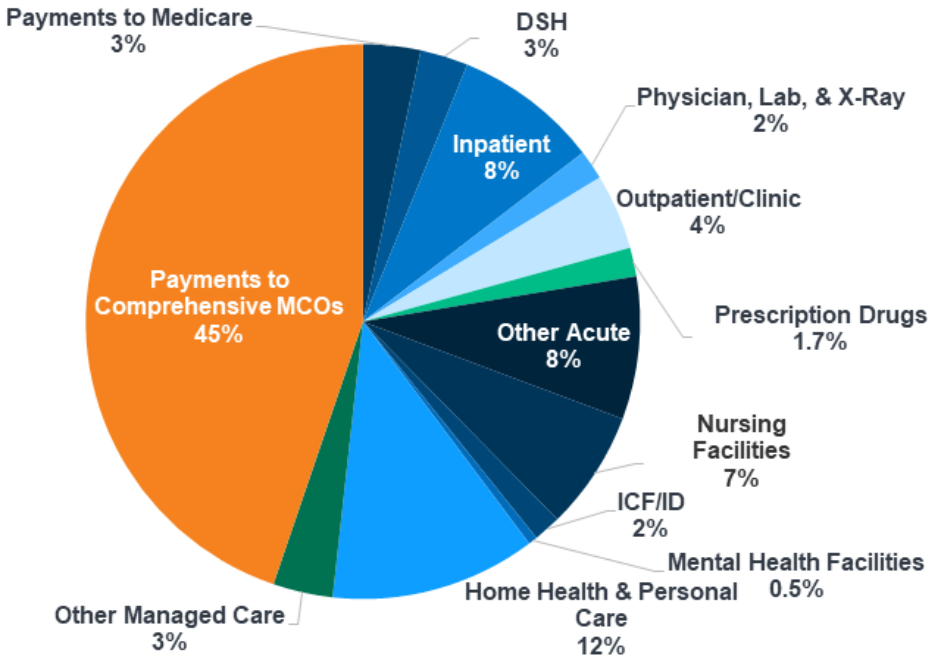
SOURCE: Medicaid Managed Care Enrollment Reports, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, 2019.

KFF
HENRY J KAISER FAMILY FOUNDATION

Plans Account for Nearly Half of Total Medicaid Spending

Figure 5

Payments to comprehensive MCOs account for almost half of total national Medicaid spending.



FY 2018 Total Medicaid Spending: $592.7 Billion

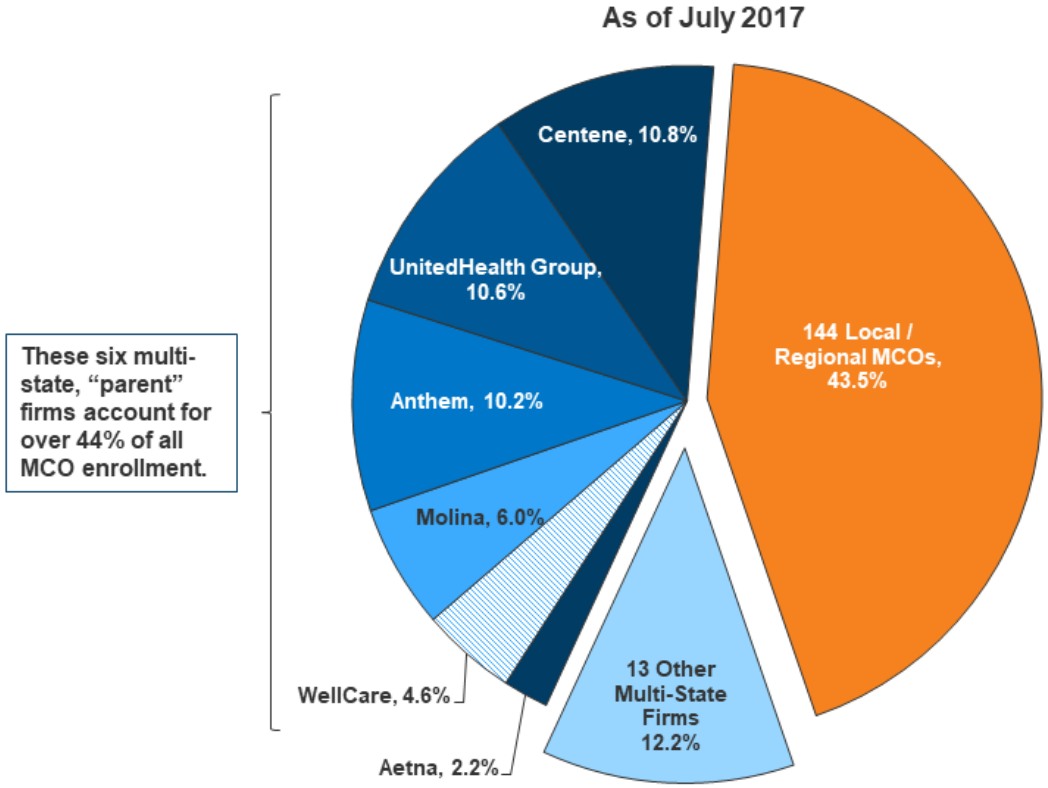
NOTE: "Other Managed Care" includes prepaid health plans (PHPs), primary care case management (PCCMs), programs of all-inclusive care for the elderly (PACEs) as well as premiums and coinsurance paid toward employer group insurance plans and premiums paid for other insurance or remedial care. Prescription Drug spending is for fee-for-service only, managed care prescription drug spending is included in "Payments to Comprehensive MCOs". Excludes administrative spending, adjustments, and payments to the territories.
SOURCE: Urban Institute estimates based on FY 2018 data from the CMS-64, prepared for the Kaiser Program on Medicaid and the Uninsured.

KFF
HENRY J KAISER FAMILY FOUNDATION

Market Share: Medicaid Managed Care Plans

Figure 8

In the 39 MCO states, six Fortune 500 firms have almost half of the Medicaid MCO market.



SOURCE: Medicaid Managed Care Enrollment Reports, Centers for Medicare and Medicaid Services, 2019.

KFF HENRY J KAISER FAMILY FOUNDATION

Expansion of Roles of Medicaid Managed Care Plans

Poll: Have Your Plan's Responsibilities Expanded Recently?

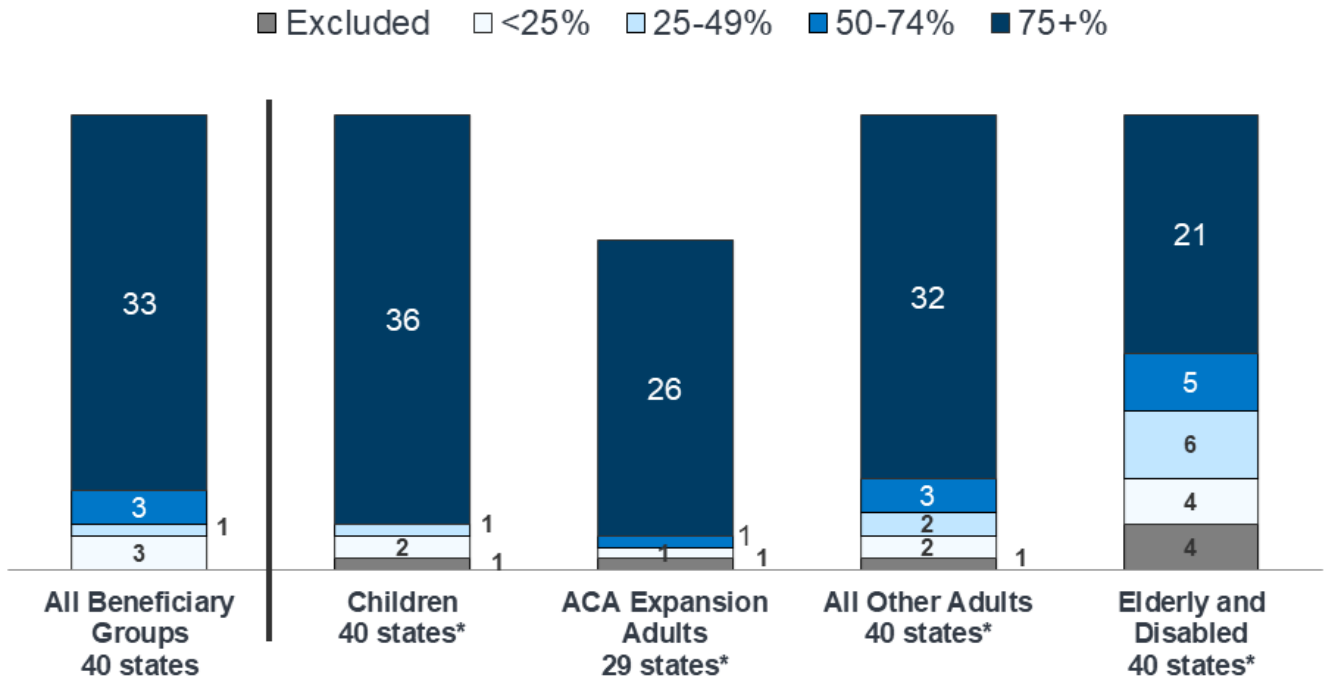
- The ACA allowed states to expand eligibility for Medicaid to new populations, such as non-disabled childless adults under age 65 who meet income criteria.
- States use Section 1115 and other waiver authorities to reform their Medicaid programs. A number of states have used these authorities to provide integrated services to vulnerable beneficiaries.
- States also use waiver authorities or plan procurement policies to encourage plans to assume new responsibilities or implement new products.
- What has your plan done?
  - Expanded coverage to serve new populations
  - Expanded coverage services to include new benefits
  - Offered new product lines to address alignment for specific populations

Please answer the poll question on your screen. Select one option from the list. Poll results will be shared after attendees have finished voting.

Beneficiaries with Complex Needs Increasingly Enrolled in Plans

Figure 4

MCO managed care penetration rates have grown across Medicaid eligibility groups.

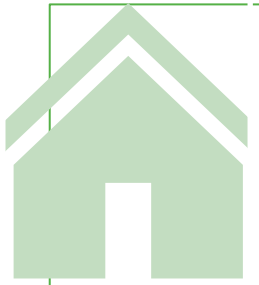


NOTES: Limited to 40 states with MCOs in place on July 1, 2019. Of the 34 states that had implemented the ACA Medicaid expansion as of July 1, 2019, 29 had MCOs in operation. *Maryland reported the MCO penetration rate for "All Beneficiary Groups" but did not report penetration rates for the individual eligibility categories and Georgia reported the MCO penetration rate for all categories except "All Other Adults"; therefore, the rates reported in the 2018 survey were used for the missing penetration rates.

SOURCE: KFF Survey of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2019.

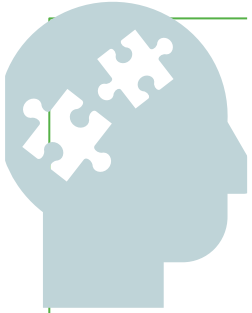
KFF

New Benefits Being Carved into Plans



Long term services and supports (LTSS)

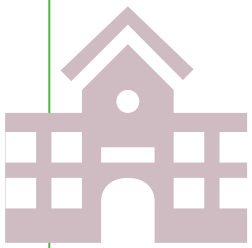
- Skilled nursing stays
- Personal care services
- Home health services



Behavioral health services

- Mental health services
- Substance use disorder services

Pharmacy benefits

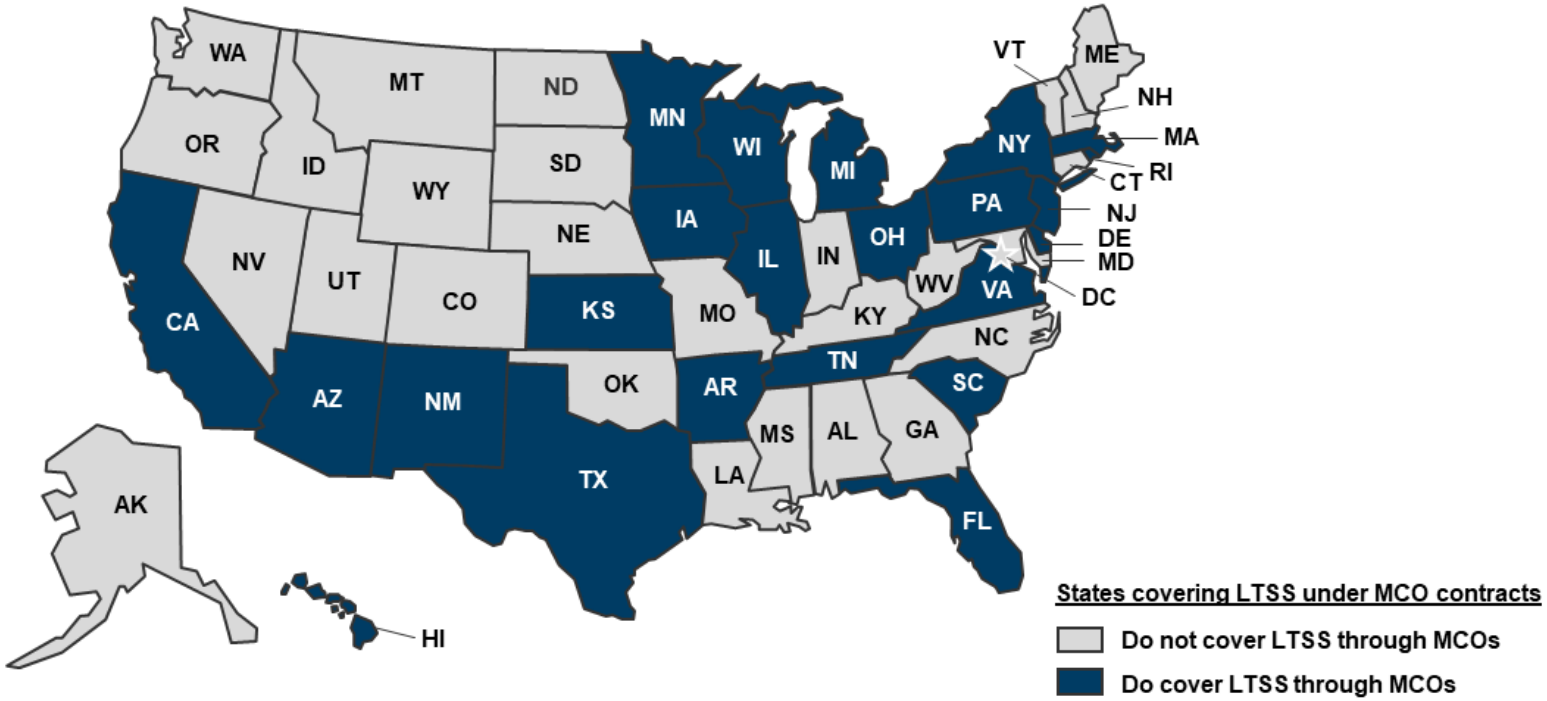


School-based health center services

LTSS Increasingly Covered under Plan Contracts

Figure 5

As of July 1, 2019, 23 states covered LTSS under Medicaid MCO contracts.



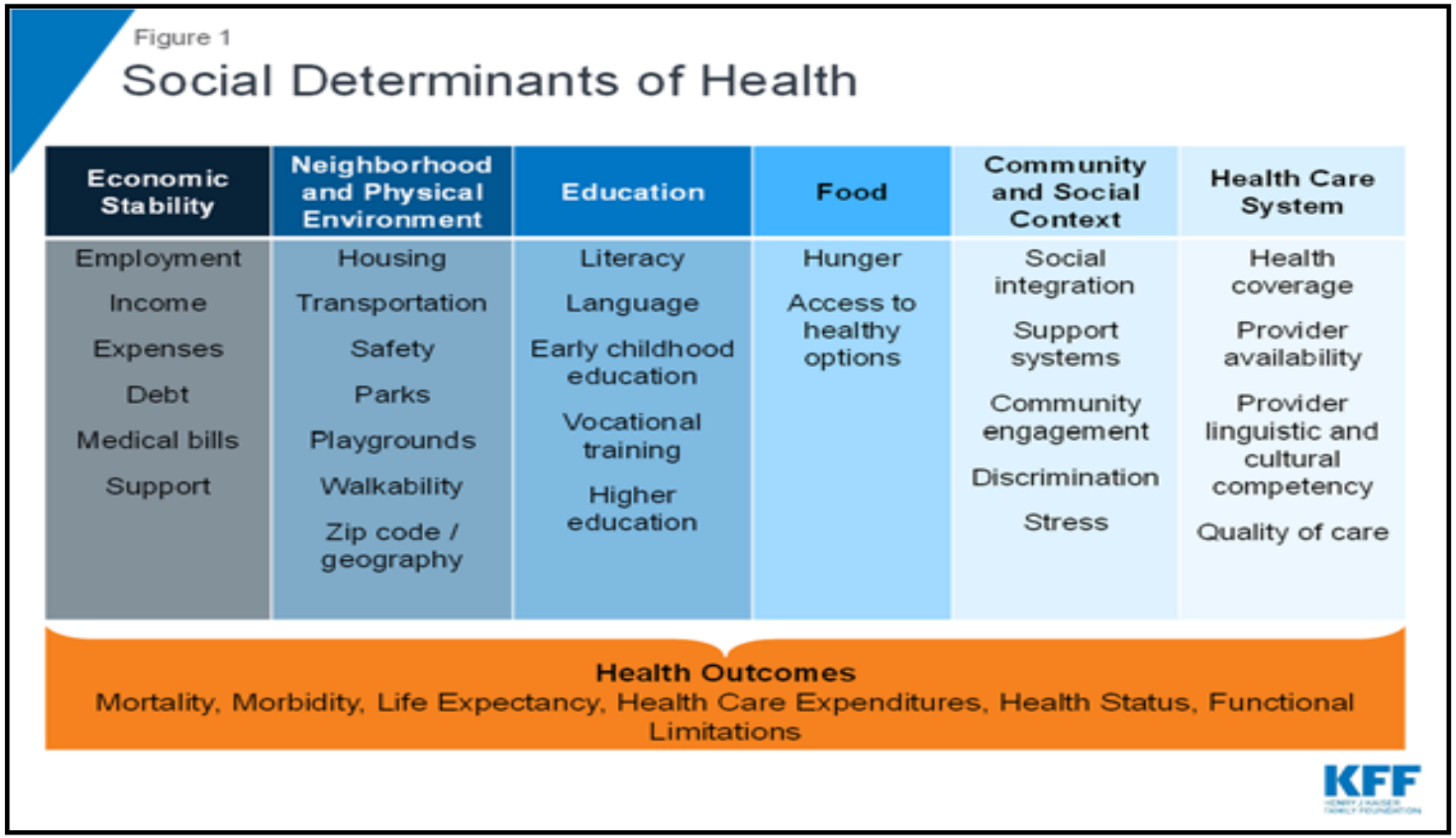
KFF

SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.

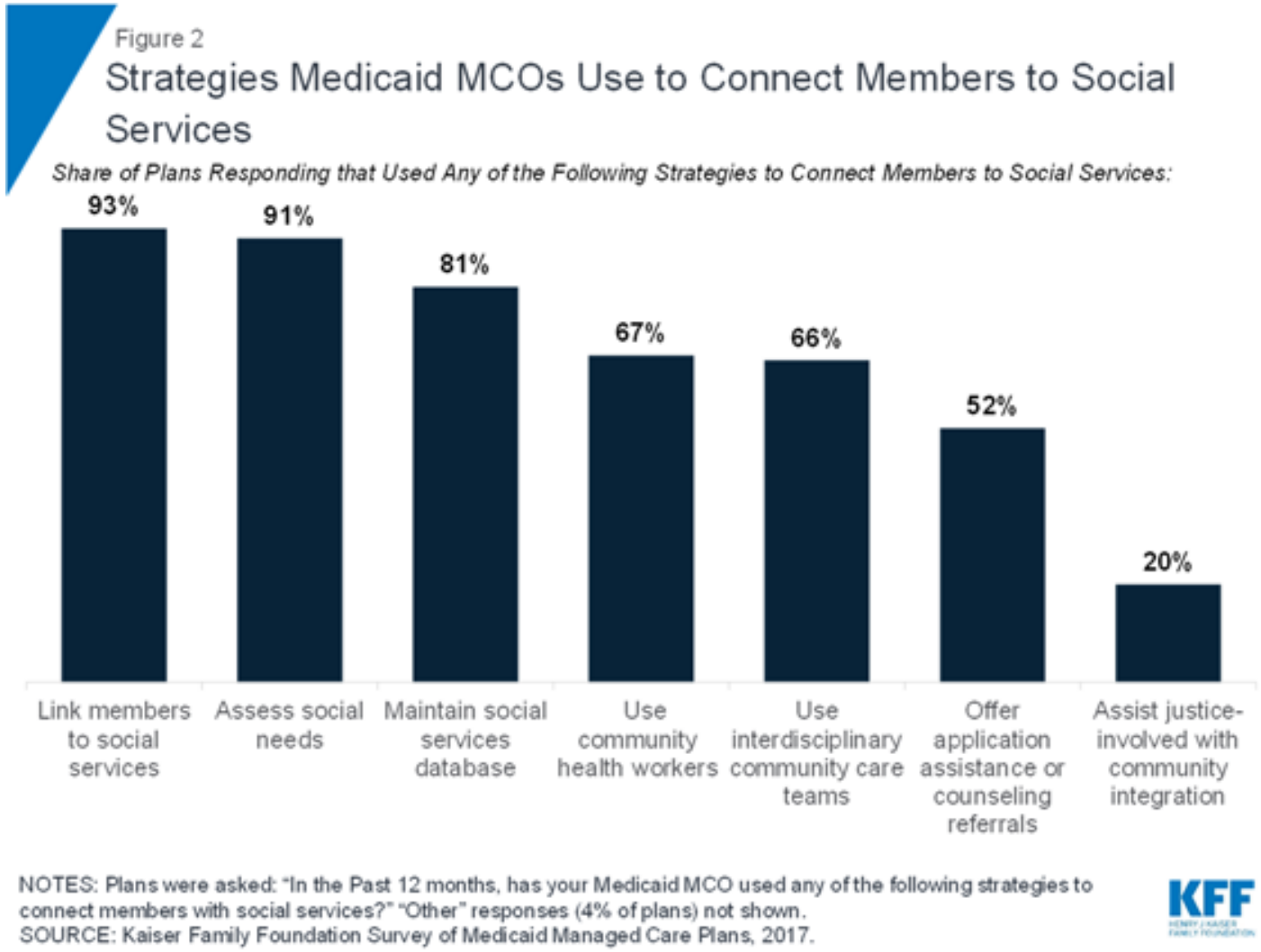
Plans Tackling Physical and Behavioral Health Integration

- Various attributes of state integration efforts:
  - Organizations - MCO, Health Homes, Primary Care Case Management, ACOs, etc.
  - State-wide or regional
  - Target population - all Medicaid beneficiaries, children only, adults only, elderly only, or various combinations, SMI only or all MH
  - Integration with Medicare or private insurance
  - Pilot or permanent program

Growing Focus on Addressing Social Determinants of Health (SDOH)



Plan Strategies to Address SDOH



Poll: Has Your Plan Implemented Strategies to Advance Health Equity?

- COVID-19 highlighted longstanding health inequities that result in poorer health status and outcomes for people of color.
- To advance health equity, plans have:
  - Launched task forces on the issue
  - Promoted diversity throughout the plan staff
  - Conducted training for staff, providers, vendors, etc.
  - Mined existing data sources to assess impact and identified improvements in data capture to better support identification of impacted members and their needs
  - Engaged communities and community-based organizations
  - Develop metrics to measure inequities
  - Develop payment strategies to reward providers who reduce disparities
- What has your plan done?

Please answer the poll question on your screen. This is a multiple-choice poll. Poll results will be shared after attendees have finished voting.

Alternative Payment Models to Promote Delivery System Change

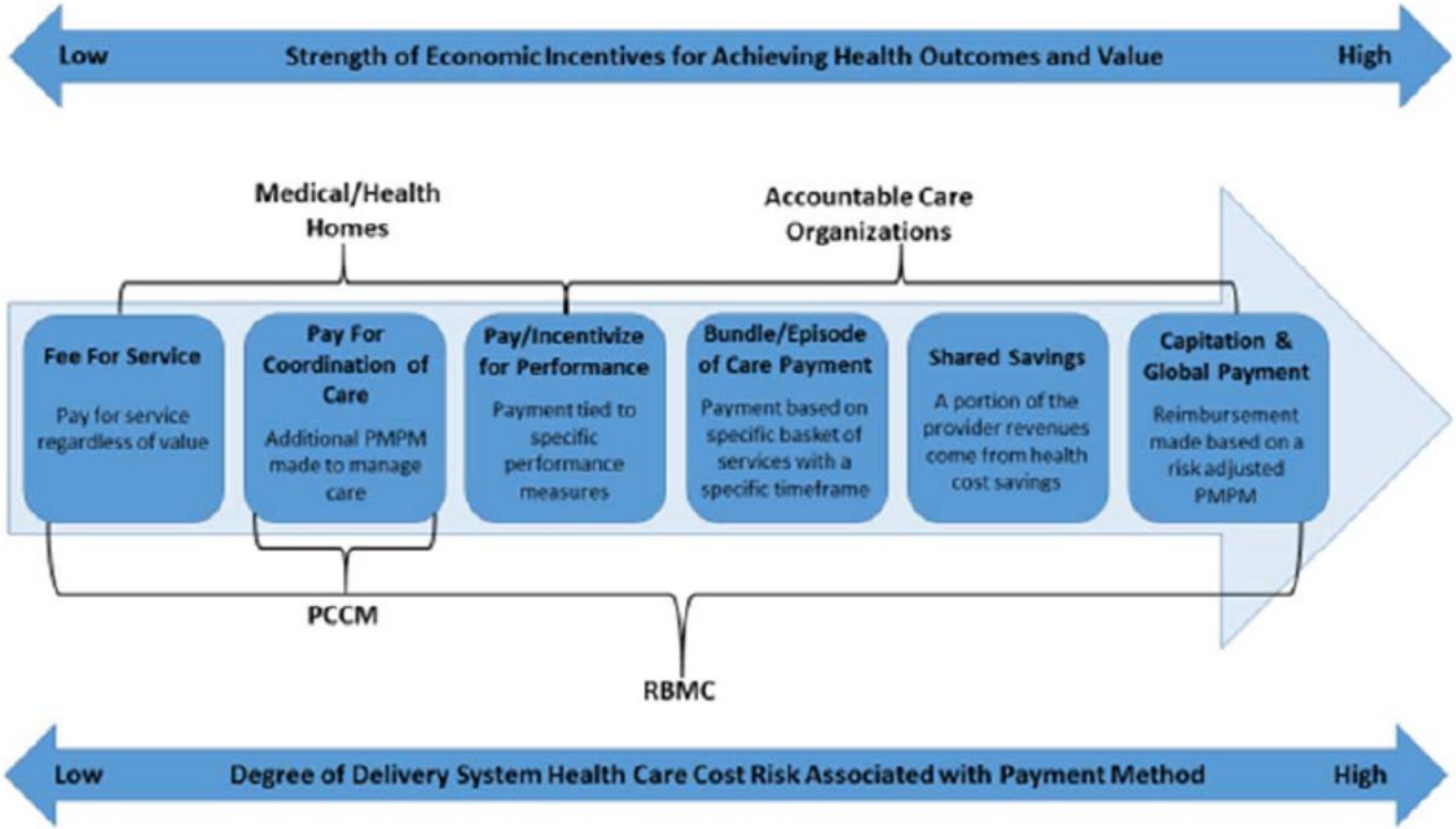


Figure A.1. Medicaid Delivery System Models and Aligned Payment Methods

Source: HMA

Medicaid Managed Care 2021 and Beyond

What We Might See Going Forward….

- Plan Enrollment
  - Continuous coverage required by FFCRA will end when PHE ends
    - Impact of membership losses due to redeterminations
  - May see legislation:
    - Extending post-partum coverage from 60 days to 12 months
    - Covering incarcerated individuals 30 days prior to release
  - SCOTUS ruling on ACA expected by June 2021
  - Lingering effects of COVID economy/health impacts

What We Might See…(cont.)

- Plan Finances
  - Increased FMAP (6.2 percentage point) ends when Public Health Emergency (PHE) ends
  - Decline in state revenues as result of economic downturn and PHE
  - Reduction in rates to plans
  - Pharmacy carve-outs may continue (effort pre-dates PHE)

What We Might See…(cont.)

- Demonstration Waivers
  - Reversals of waivers approved by last Administration
    - Waivers limiting coverage (e.g., work requirements - now pending before Supreme Court)
    - Caps on overall spending (e.g., block grant-type waivers)
  - More on LTSS
    - Policies/legislative action focused on disparities uncovered during PHE
  - More on SDOH
    - Policies/legislative action focused on SDOH needs exacerbated by PHE

Questions?

Rapid Round Robin Participant Introductions – Part 3

Getting to Know Each Other - Introductions

- Rapid Round Robin – Today's agenda includes three 30 minutes segments for introductions
- We ask that each participant tell us the following --->
  - Name, Plan, Title, Role and Responsibilities
  - Briefly – Describe your career path in getting to managed care
  - Briefly – What were the worst and best things about the COVID-19 pandemic (personally and/or professionally)?
- **Please keep this to 4 minutes or less**, which can be difficult!
  - Good luck!

Rapid Round Robin Participant Introductions - Part 3

Gabrielle Ault-Riche

King Jones

Jeanine Plante

Jennifer Samale

Isabel Silva

Tammy Thomas

Nicole Tuite

Leadership-Focused Activity: Break-Outs and Group Reporting

Leadership Perspectives

Leadership can occur at all levels of an organization, but it is definitely important at the “top”

There are many types of leaders – some work better in some situations than others; some are more positive; some are more negative

There are many skills that leaders need – it is said you can be born with them; but you can definitely develop them

Simple definition of a leader: “***A Leader helps groups solve problems that the group, without the leader, could not accomplish***.”

Breakout Group Topics and Participants

Leadership in Community-Affiliated Plans and Addressing Health Equity

- **Facilitator: Tina Nye**
  - Angela Ahsan
  - Steven Belec
  - Tammy Brass
  - Chantay Cooper
  - Ashley Simms
  - Nicole Tuite

Leadership in Community-Affiliated Plans and Managing Organizational Change

- **Facilitator: Gretchen Brown**
  - Eric Buben
  - Lynda Crooms
  - Angela Mitchell
  - Jennifer Samale
  - Isabel Silva
  - Allison Stewart

Leadership in Community-Affiliated Plans and Managing Organizational Crises

- **Facilitator: Kathy Kuhmerker**
  - Jamie Heberer
  - King Jones
  - Kris Lum
  - LaShern McEwen
  - Alexandra Rawson
  - Tammy Thomas

Leadership in Community-Affiliated Plans and Working with Community Based Organizations and Providers

- **Facilitator: Enrique Martinez-Vidal**
  - Gabrielle Ault-Riche
  - David Lima
  - Michelle Martin
  - John Miller
  - Jeanine Plante

Directions for Breakout Groups

Discussion groups will meet for 25 minutes & then there will be a 20 minutes report out to the entire group

Please choose a volunteer to take notes of the key points from your discussion and to report out to the entire group

Break-out groups will be rejoined to the full group after 25 minutes

Breakout Group Discussion Questions

Group 1 – Leadership and Health Equity

- What leadership qualities are needed to address health equity internal and external to the organization? Are they the same; if not, how do they differ?
- What is the leadership role of community plans in addressing health equity in communities? What role might community plans play? Who are the key partners?
- What is your role in addressing health equity in your plan?

Group 2 – Leadership and Managing Change

- What leadership qualities are needed to manage change in your health plans?
- What are the key challenges that leaders must address when managing change and what are ways to manage these challenges?
- How do leaders know if they are effectively managing change? What short and long-term objectives do they look for?

Group 3 – Leadership and Managing Crisis

- Are there unique attributes that leaders need when managing during a crisis?
- What has your COVID-19 experience taught you about needed leadership attributes and what are they?
- How do leaders know that they are effectively managing a crisis? What are they key elements that need to be considered?

Group 4 – Leadership and Working with Community Partners and Providers

- What leadership qualities are needed by leaders of community plans in working with CBOs and community-based providers?
- Do community plans have a unique leadership role in working within the community and what is it? What leadership roles can community-based plans play?
- What is your role in providing leadership in your community?

Happy Hour!