

Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools

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ABSTRACT

ISSUE: It is widely recognized that social factors, such as unstable housing and lack of healthy food, have a substantial impact on health outcomes and spending, particularly with respect to lower-income populations. For Medicaid, now dominated by managed care, this raises the question of how states can establish managed care rates to sustain investments in social supports.

GOAL: To explore practical strategies that states can deploy to support Medicaid managed care plans and their network providers in addressing social issues.

METHODS: Literature review, interviews with stakeholders, and analysis of federal regulations.

FINDINGS AND CONCLUSIONS: We identify the following options: 1) classify certain social services as covered benefits under the state's Medicaid plan; 2) explore the additional flexibility afforded states through Section 1115 waivers; 3) use value-based payments to support provider investment in social interventions; 4) use incentives and withholds to encourage plan investment in social interventions; 5) integrate efforts to address social issues into quality improvement activities; and 6) reward plans through higher rates for effective investments in social interventions. More needs to be done, however, to assist interested states in using these options and identifying pathways to braid Medicaid dollars with other social services funding.

KEY TAKEAWAYS

- ▶ **Social factors like unstable housing and lack of healthy food are widely known to affect health care outcomes and spending. While Medicaid traditionally has not covered or reimbursed for social interventions, it offers more practical options for doing so than is commonly recognized.**
- ▶ **With the predominance of Medicaid managed care, states require new contract and rate-setting strategies to enable plan and provider investment in social interventions.**
- ▶ **Options available to address social drivers of health include: classifying certain social services as covered Medicaid benefits, using value-based payments to support provider investment in social interventions, and rewarding managed care plans with higher payment rates.**

INTRODUCTION

It is now widely recognized that social factors, such as unstable housing, lack of healthy food, unsafe neighborhoods, and unemployment, have a substantial impact on health care outcomes and spending, particularly with respect to lower-income populations.¹ Moreover, there is an emerging body of research on which interventions are most likely to result in better outcomes and reductions in spending.² As the nation's largest payer for health care services for low-income populations, many of whom have substantial social service needs, Medicaid is front and center when it comes to these issues. State Medicaid agencies are increasingly focusing on how the program can cover and reimburse for nonclinical interventions, particularly in managed care, now the dominant service delivery model in Medicaid.

This report identifies practical strategies that states can deploy to support Medicaid managed care plans and their network providers in addressing social issues. Based on a literature review and on interviews with state officials, health plan leaders, actuarial experts, and other stakeholders, we identify options for states to consider if they are interested in incorporating the cost of social interventions into Medicaid managed care rates (Exhibit 1). While the

strategies do not represent a comprehensive solution to the issue of Medicaid's role in addressing social issues, they are an essential building block.

BACKGROUND

States face several questions about what role they want Medicaid to play in addressing social issues that directly affect the health of Medicaid beneficiaries and the cost of serving them. Do they want to move their Medicaid programs beyond paying for medical services to tackling affordable housing, economic insecurity, unsafe neighborhoods, and access to adequate and healthy food? In some states, the priority is finding more effective ways to deliver traditional medical care. Other states, particularly those that have implemented an expansion of coverage to low-income adults or are adopting a population health approach to their Medicaid programs, look to their managed care plans and providers to address such issues (Exhibit 2). In all cases, states must evaluate the extent to which federal Medicaid rules permit coverage and payment for discrete nonclinical services.

Rate-Setting Tools in Context

A Medicaid managed care financing and payment strategy is an essential element, but far from the only required element, of any approach to use Medicaid as a vehicle for addressing social determinants of health. During our interviews, we consistently heard that while there is strong interest in innovative rate-setting options, states have many other challenges they need to tackle for Medicaid to play a role in addressing social issues. These other challenges include the need for more staff with different skills, such as social service experience or actuarial proficiency; a data infrastructure to identify and address social factors; and sufficient time and resources for plans and providers to prepare to address social issues (see [Appendix D](#)). While these are important issues, they are not the focus of this report, which addresses options available to states for creating a payment and managed care contracting strategy that supports investments in social interventions.

Exhibit 1

STATE OPTIONS AND CONSIDERATIONS

1. Classify certain social services as covered benefits under the state's Medicaid plan
2. Explore the additional flexibility afforded states through Section 1115 waivers
3. Use value-based payment to support investment in social interventions
4. Use incentives and withholds to encourage plan investment in social interventions
5. Integrate efforts to address social issues into quality improvement activities
6. Reward plans with effective investments in social interventions with higher rates

Exhibit 2**MEDICAID EXPANSION: IMPLICATIONS FOR THE IMPORTANCE OF ADDRESSING SOCIAL DETERMINANTS OF HEALTH**

In the states that expanded their Medicaid programs to all adults with incomes below 138 percent of the federal poverty level (31, plus the District of Columbia), newly eligible adults often have extensive social needs. According to research from the Medicaid and Children's Health Insurance Program Payment and Access Commission, 70 percent are below the federal poverty level, but, even so, only about half receive benefits from the Supplemental Nutrition Assistance Program.^a In our interviews with Medicaid directors in expansion states, they reported that gaining these new enrollees has

reinforced the importance of Medicaid addressing social issues: first, because of the relatively high prevalence of mental illness and substance abuse among the population,^b and second, because of Medicaid's increasingly important role in the coverage and care of low-income families. Finally, interviewees noted that, as Medicaid coverage became more stable and states and managed care plans began to implement value-based payment policies, plans and providers were better positioned to address the social needs of their enrollees and patients.

^a M. Heberlein, "New Findings from the Health Reform Monitoring Survey," Presentation at the Medicaid and CHIP Payment and Access Commission (MACPAC, March 24, 2015).

^b Medicaid and CHIP Payment and Access Commission, "Chapter 4: Behavioral Health in the Medicaid Program—People, Use, and Expenditures," in *Report to the Congress on Medicaid and CHIP* (MACPAC, June 2015).

Medicaid Managed Care Rate-Setting: Rules, Policies, and Procedures

The question at the center of this analysis is how states can support plan investment in social services that improve health outcomes and are cost-effective. In states with Medicaid managed care, this translates into a question of how to set Medicaid managed care capitation rates in such a way that plans are incentivized or required — and, even more importantly, have the resources — to address social issues that directly affect the health outcomes of their members.

The starting point for answering this question is the federal Medicaid managed care rules that require states to ensure that capitation rates are actuarially sound. This means that rates must be sufficient to cover the costs that plans incur to provide covered benefits to their enrollees, as well as related administrative and operational expenses. Notably, capitation rates must be based only on services covered under the state plan and services necessary to achieve mental health parity requirements.³

In other words, states cannot directly build the cost of social support services *not* covered under the state plan into their capitation rates (Exhibit 3).⁴

The regulations also specify that rates should reflect reasonable nonbenefit expenses associated with providing the covered benefits and meeting mental health parity requirements. These nonbenefit expenses include administrative costs; taxes, licensing, and regulatory fees; contribution to reserves; profit or risk margin; the cost of capital; and other operational costs. As further discussed below, quality initiatives can be considered part of operational costs, potentially creating a vehicle for covering social interventions that are part of a plan's quality initiatives.

A distinct but related issue is that states also must set their capitation rates at a level that results in plans, on average, being projected to incur a medical loss ratio (MLR) of at least 85 percent.⁵ The MLR calculation is designed to ensure plans are spending a sufficient amount of their

Exhibit 3**VALUE-ADDED AND “IN-LIEU-OF” SERVICES**

Under the federal Medicaid managed care rules, plans may cover **value-added services**, which are services that are not covered under the state plan, but that a managed care plan chooses to spend capitation dollars on to improve quality of care and/or reduce costs.^a For example, a managed care plan might elect to provide supportive housing for a beneficiary with a mental illness who otherwise would cycle between hospital stays and homelessness. The cost of value-added services cannot be included in the capitation rates; it can, however, be included in the numerator of the medical loss ratio (MLR) if it is part of a quality initiative.

States and plans also may elect to cover **“in-lieu-of” services**, which substitute for services or settings

covered in a state plan because they are a cost-effective alternative. For example, a state could allow plans to provide medically tailored meals as a substitute for a home visit by an aide in selected circumstances. The actual costs of providing the in-lieu-of service are included when setting capitation rates, and they also count in the numerator of the MLR.^b In-lieu-of services, however, can only be covered if the state determines the service or alternative setting is a medically appropriate and cost-effective substitute or setting for the state plan service; if beneficiaries are not required to use the in-lieu-of service; and if the in-lieu-of service is authorized and identified in the contract with Medicaid managed care plans.

^a 42 CFR § 438.3(e)(1)(i). In some states, value-added services are required in the contract between a state and managed care plans even though value-added services are optional. In these instances, plans may offer to cover some value-added services when they bid to participate in a state’s managed care program, and then these services are enshrined in the contract. Even though the services are part of the contract, plans are not necessarily paid to provide them. By definition, value-added services are not covered benefits under a state plan, so the cost of providing them cannot be built into the capitation rate for managed care plans, leaving plans to pay for them out of profits.

^b See 42 CFR § 438.3(e)(2).

capitation funds on services for beneficiaries, rather than administrative costs, profits, or other similar expenses (Exhibit 4). This means it is key to assess where the cost of social interventions fits into the MLR calculation; if investing in social services helps plans to meet an 85 percent MLR threshold, they will be more likely to make such investments. If doing so harms their ability to reach an 85 percent threshold, such investments are likely to remain small and/or short-lived. Although they are not required to do so by federal regulations, some states also recoup money from plans that fail to meet a minimum MLR. If states elect to do so, federal regulations require that the MLR they establish must be 85 percent or higher.

Finally, from a plan perspective, these rules and requirements also raise the prospect that future capitation

rates could be lower if social interventions are effective in driving down use of medical care. In our interviews, some actuarial experts and plans questioned whether this issue, often referred to as “premium slide,” should be a significant concern. They point out that plans ought to be able to accept lower rates provided they have a source of funding for social interventions and receive a reasonable profit margin. Indeed, these experts note that a key purpose of managed care is to better manage costs, making it a sign of success if premiums decline or grow at a slower rate than they otherwise would. Even so, others suggested that concerns about premium slide could nevertheless dampen plan interest in aggressively tackling social factors, especially if plans are not provided with funding for the cost of the interventions.

Exhibit 4**FORMULA TO CALCULATE THE MEDICAL LOSS RATIO**

The medical loss ratio (MLR)^a is calculated by summing the cost of claims for services covered by Medicaid, quality improvement expenses, and fraud prevention expenses.^b The sum of these elements, often referred to simply as “the numerator,” is divided by a plan’s capitation revenue minus taxes and fees, which is referred to as the “denominator” of the MLR. The more

spending that is included in a plan’s numerator, the higher its MLR. If a plan cannot consider investments in social services as part of the numerator, such investments drive down the plan’s MLR. In effect, if investments in social interventions are treated in the same way as profits and administrative costs, it creates a disincentive for plans to make such investments.

$$\text{Medical loss ratio} = \frac{\text{Claims} + \text{Quality improvement expenses} + \text{Fraud prevention expenses}}{\text{Premiums} - \text{Taxes and fees}}$$

^a See 42 CFR § 438.8(d).

^b See 42 CFR § 438.8(e-f).

Value-Based Payment: A Jumping-Off Point

Over the past decade and certainly since passage of the Affordable Care Act in 2010, state Medicaid agencies have sought to move away from fee-for-service payment structures to more value-based payment strategies — from volume to value (Exhibit 5). Initially the focus was on the relationship between states and providers, with states increasing reimbursement for providers that met patient-centered medical home standards and sharing savings with providers that could meet minimum quality standards and bring down costs. However, states that deployed managed care delivery models did not have direct payment relationships with providers. Thus, the question became how to inject these new provider payment strategies into Medicaid managed care.

The release of the Medicaid managed care rule in the spring of 2016 has accelerated states’ use of value-based payment.⁶ The rule provides authority for states to require plans to engage in value-based payments and other delivery system reforms, as well as allowing states to use payments or withholds to incentivize plans to meet such goals or mandates (Exhibit 6). For example, the rule highlights that states can require plans to participate in a patient-centered medical home initiative, which, depending on the state, could include a strong emphasis on connecting beneficiaries to social supports. Moreover, the rule grants states some authority to directly shape payment arrangements *between* plans and their network providers. Certain guardrails apply, including that the state cannot direct the value or the frequency of the payments to individual providers, cannot condition payments on intergovernmental transfers, and must link the requirements to the state’s Medicaid quality strategy.⁷

Notably, value-based payments — including state performance bonus payments and shared-savings payments to providers — are built into capitation rates and considered “claims” for purposes of calculating the

MLR and so are part of the numerator.⁸ With the managed care rule’s changes and clarifications, it is now easier for states to pay for value through managed care, including when value can be obtained through cost-effective investments in social services.

Exhibit 5

WHAT IS VALUE-BASED PAYMENT?

Value-based payment^{a,b} — that is, payment based on the value (i.e., quality and cost) of care, rather than exclusively on the quantity of services provided — incentivizes better care, better outcomes, and lower costs, and it is increasingly being used among payers in

the Medicaid, Medicare, and commercial markets. For example, a Medicaid managed care plan might pay a bonus to providers for strong performance on outcome measures and allow providers to share in the savings if costs are kept below a target level.

^a See 42 CFR § 412.160.

^b Note that states can develop their own definitions for value-based purchasing, which may be broad or narrow.

Exhibit 6

STATE OPTIONS TO INCENTIVIZE PLANS TO MEET VALUE-BASED PAYMENT REQUIREMENTS

The Medicaid managed care rule gives states the authority to require plans to use value-based payments and offer fiscal incentives to meet the requirements.^a

- **Incentive payments** are a payment mechanism under which plans receive additional funds — *over and above* their capitation payment — for meeting targets in the contract. Such arrangements can be up to 5 percent of a plan’s capitation revenue, an amount that could total tens of millions of dollars. States can elect to use incentive payments to reward plans that perform well on quality metrics
- **Withhold arrangements** are any payment mechanism under which a portion of a plan’s capitation payment is withheld unless a plan meets performance targets. States can use withhold arrangements to incentivize plans to meet metrics linked to social supports. Withhold payments returned to plans are considered part of revenue and so are included in the denominator of the MLR.^b

^a When states design incentive payments or withhold arrangements, federal regulations require that they are designed to support the goals of their managed care quality strategy.

^b See 42 CFR § 438.6 for additional detail. Several additional requirements and caveats apply, including that withhold and incentive arrangements must be linked to a state’s quality strategy. Moreover, arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are considered a penalty, not a withhold arrangement. In addition, contracts that provide for a withhold arrangement must ensure that the capitation payment, minus any portion of the withhold that is not reasonably achievable, is actuarially sound. The total amount of the withhold, achievable or not, must be reasonable and take into consideration the financial operating needs of participating plans.

STATE OPTIONS FOR INCENTIVIZING OR REQUIRING PLAN INVESTMENT IN SOCIAL INTERVENTIONS

For states interested in using their Medicaid payment and managed care contracting strategies to support investments in social interventions, we identify six options that could provide plans with the resources and flexibility to so invest. In general, the options are not mutually exclusive and likely would need to be combined in order to develop a comprehensive strategy that both provides plans with the resources to finance social interventions and moderates the impact on future rates if they are effective in driving down medical costs. Indeed, it is not unusual for states to rely on a multipronged strategy to address social issues (Exhibit 7).

Option 1: Classify Certain Social Services as Covered Benefits Under the State's Medicaid Plan

States have some discretion to classify a range of social supports as Medicaid plan benefits.⁹ By doing so, states can include these services in plans' benefit packages and build their cost into the states' Medicaid managed care rates in the same way as hospital services, physician services, or other "traditional" medical services. Moreover, plan payments to providers for these services are classified as part of "claims" (i.e., included in the numerator) for purposes of the MLR calculation and so do not count against plans when it comes to future rate-setting. The allowable services include connecting people to housing, food assistance, and peer support services (Exhibit 8).

Exhibit 7

ARIZONA'S MULTIPRONGED APPROACH TO ADDRESSING SOCIAL ISSUES

States interested in tackling the social issues of Medicaid beneficiaries are likely to require a range of strategies, sometimes relying on Medicaid and sometimes going outside of Medicaid. Arizona has adopted a multipronged approach, serving those with serious mental illnesses through Regional Behavioral Health Authorities (RBHAs).

- Maximize use of Medicaid coverage for nonclinical services.** Arizona includes several nonclinical services in its Medicaid benefit package, including respite services and care management.
- State and local funding for nonmedical services.** Arizona provides approximately \$35 million in state-only grants for housing to RBHAs. The money is used to create partnerships with housing authorities and secure housing subsidies for members. By design, there is only one RBHA for each geographic region in the state.
- Reinvestment requirements.** Arizona requires RBHAs to reinvest 6 percent of their profits back into the community. Some plans directly fund housing or food banks, while others set up mini-competitive grant programs to finance community-based organizations.
- Leverage equity requirements.** Arizona allows plans to use a share of their equity as a line of credit to invest in low-income housing. One plan partnered with a nonprofit organization to purchase large housing complexes, with a requirement that a portion of the units are set aside for Medicaid beneficiaries.
- Value-based payments.** Arizona's value-based payment strategy allows for plans and providers to provide a continuum of health and social services.

Exhibit 8**SOCIAL INTERVENTION SERVICES COVERED BY MEDICAID AS MEDICAL ASSISTANCE BENEFITS^a**

- **Linkages to social service programs** that offer help with food assistance, rent, childcare costs, heating bills, and other major household expenses.
- **Stable housing support** provided through services that help people find and remain in homes, including assistance locating a home, assistance making home repairs, and training in navigating relationships with landlords or other tenants.
- **Assistance in finding and retaining employment**, particularly for people with disabilities, including ways to prepare to enter the job market or to find and keep jobs.
- **Peer support** offered by individuals who come from a beneficiary's community or who have had similar experiences and can offer counseling, advice, and other support.

^a D. Bachrach, J. Guyer, and A. Levin, *Medicaid Coverage of Social Interventions: A Road Map for States* (Milbank Memorial Fund, July 2016).

Considerations

While Option 1 represents a straightforward way to build the cost of social interventions into a managed care strategy, there are some issues to consider. First, if a state elects to cover a social service as a Medicaid benefit, it is subject to the same requirements as other Medicaid benefits, including “statewideness,” which requires that the benefit generally must be provided on a statewide basis, and “comparability,” which requires that a benefit be provided on a comparable basis to nearly all Medicaid beneficiaries regardless of their pathway to Medicaid eligibility.¹⁰ In our interviews with plan officials, some suggested that this poses a bigger problem for a social intervention than a medical need, because social service needs and resources are highly community-specific. For example, one community might have a strong peer support program because of the efforts of a local community leader, but other parts of a state might be devoid of such resources. States may prefer to target their social support services toward specific high-need areas or subpopulations, but the Medicaid rules generally would require statewide coverage for all members.¹¹

In addition, some of the Medicaid benefits that offer a vehicle for addressing social needs carry unique requirements and obligations. For example, states could opt to classify the cost of connecting families to the Supplemental Nutrition Assistance Program (SNAP) or other help finding adequate food as part of “case management” or “targeted case management,” which are both optional Medicaid benefits. But if they do, they must ensure that their managed care plans meet federal requirements, such as offering yearly assessments for each beneficiary receiving the service and developing individualized plans.¹²

Finally, whatever the benefits of this approach, it is not a full solution. Some key social supports simply cannot be classified as Medicaid benefits. These include the direct costs of essentials such as food and housing. Federal laws and regulations are clear that such services cannot be considered part of the Medicaid benefit package or directly paid for with Medicaid funds.

Option 2: Explore the Additional Flexibility Afforded States Through Section 1115 Waivers

States also have the flexibility to pursue 1115 waivers, which offer broad authority to waive provisions of the Medicaid statute and to provide financing for services not otherwise included in Medicaid. They must further the purposes of the Medicaid statute and be budget-neutral to the federal government. Unlike the other options discussed, 1115 waivers can require considerable negotiation with the Centers for Medicare and Medicaid Services (CMS), but they have the advantage of offering sweeping authority for states to experiment with greater support for social interventions.

In recent years, 1115 waivers frequently have been used for Medicaid delivery system reform and, in this context, some states have sought to encourage investments in social interventions. Oregon, the best-known example, has established Coordinated Care Organizations (CCOs) that are given a global budget to provide physical health, behavioral health, and “health-related” services, which is to say services not otherwise covered by Medicaid

that affect health.¹⁵ The health-related services offered by CCOs include short-term housing for individuals discharged from the hospital who otherwise would be at risk for readmission, as well as home improvements that can make it more viable for people to remain in the community (installing handrails, for example) or that can reduce unnecessary hospitalizations (such as use of air conditioners to reduce asthma attacks). In its 1115 waiver, Oregon secured clarification of how it can encourage CCOs to provide such services and build their cost into capitation rates (Exhibit 9).

Considerations

The process of negotiating a Medicaid 1115 waiver can be time-consuming and complex, requiring extensive discussions with CMS. Moreover, such demonstrations are intended to test out new ideas, not to serve as the permanent vehicle by which a state operates its Medicaid program. For example, delivery system reform waivers, such as the one secured by Oregon, are expected to phase out over time. Indeed, a number of the waivers already

Exhibit 9

OREGON’S SECTION 1115 WAIVER: USING MEDICAID TO PROVIDE “HEALTH-RELATED” SERVICES

Using a Section 1115 waiver, Oregon operates its Medicaid program through coordinated care organizations (CCOs), which are community-based partnerships of managed care plans and providers that manage physical, behavioral, and oral health services for a defined Medicaid population. Like managed care plans, CCOs take on risk and are paid rates developed in accordance with the Centers for Medicare and Medicaid Services’ rate-setting requirements for Medicaid managed care.

A major goal of Oregon’s initiative is to “address the social determinants of health and improve health equity across all low-income, vulnerable Oregonians.” To this end, Oregon encourages its CCOs to offer “health-related services,” which include “flexible services” (cost-effective services offered voluntarily to individuals as an

adjunct to covered benefits) and “community benefit initiatives” (community-level interventions focused on improving population health and health care quality). They can include, for example, short-term housing assistance post-hospitalization or a public education campaign to increase vaccination rates.

Oregon secured clarification in its 1115 waiver that it can put the cost of such services in the numerator of the MLR if the services are related to a quality initiative (see [Option 5](#) below). Moreover, Oregon incentivizes plans to offer health-related services by rewarding high-quality and relatively efficient plans with a higher profit margin. To date, CCOs have dedicated a relatively small share of their capitation funds to such services, but the state continues to encourage them to do so.

in place explicitly require that some of the innovation taking place will gradually be built into a state's Medicaid managed care contracting strategy, creating a long-term, sustainable approach to financing that can outlive the waiver.

The Trump administration has suggested that under certain circumstances it will permit waivers to continue indefinitely. Still, it has restricted some of the tools used in the past to help finance waivers.¹⁴ And, as with prior administrations, it does not appear willing to authorize Medicaid coverage of significant social interventions.

Option 3: Use Value-Based Payments to Support Investment in Social Interventions

Value-based payments create an opportunity to address social issues when doing so would deliver value to Medicaid and improve health outcomes. Historically, Medicaid has been a program that pays for Medicaid-covered benefits — for the most part clinical services — delivered to Medicaid-eligible beneficiaries. It has not been in a position to cover social interventions, even when it would be cost-effective to do so, unless they could be squeezed into the Medicaid box. Because value-based payments — whether paid by the plan or the Medicaid agency — are not linked to providing specific medical services, they can be used by providers for social

investments even beyond those included in the Medicaid benefit package. Of course, this assumes the provider is persuaded that investment in social interventions will have a positive impact on health outcomes and its performance under the value-based payment arrangement.

Arizona offers an example of how value-based payments can be integrated into a Medicaid managed care contracting strategy that supports plans in addressing social issues. The state requires managed care plans to ensure that a specified share of payments to providers are made under value-based payment arrangements. It reinforces the requirement by withholding 1 percent of premiums and allowing plans that meet the value-based payment threshold to compete against each other to earn a share of the withheld funds based on their performance on quality metrics. In response, plans have established shared-savings arrangements with Medicaid providers that deliver an array of medical and nonmedical services (Exhibit 10).

Considerations

First, value-based payments offer a helpful tool for financing the cost of social interventions, but they do not automatically solve the issue of premium slide. Plans may remain concerned that future rates will be based on

Exhibit 10

USING VALUE-BASED PAYMENTS TO PROVIDE A CONTINUUM OF HEALTH AND SOCIAL SERVICES: AN EXAMPLE IN CIRCLE THE CITY

Medicaid managed care plans establish shared-savings arrangements with organizations such as Circle the City, a nonprofit community health organization in Maricopa County, Arizona, that works with people who have been or are currently homeless.^a It provides a continuum of health care and related social services that helps people to remain outside of a hospital or nursing home and reside in the community. These services include medical respite care for people recently discharged from the

hospital or living on the street with acute conditions, primary care at an outpatient clinic, and mobile medical services. The shared-savings payments made by plans to Circle the City and other such organizations, which can be used to finance the full array of services that they provide, are considered part of a plan's medical claims and are built into capitation rates and the numerator of the MLR.

^a For more details, see the [Circle the City](#) website.

lower medical costs without including the costs of social investments that helped achieve those lower medical costs. One state has said that it attempted to address this issue by telling plans that it will continue to include value-based payments in the rate calculations even if medical utilization declines over time. As nonclinical interventions become more effective, states and plans will need to identify more formal long-term strategies for providing plans with sustainable funding streams for their nonclinical interventions.

Second, value-based payment requires states and plans to have an effective way to measure and reward performance outcomes. To date, most quality metrics used in value-based payment strategies are focused on process or specific clinical outcomes, such as inpatient utilization, readmission rates, diabetes and asthma management, and delivery of preventive services (e.g., immunization rates, well-child visits). Some of these metrics do likely incentivize investments in social interventions. For example, there is solid evidence that diabetics are more likely to be hospitalized at the end of a month when SNAP benefits are running short, making food security an important issue if plans are paid to lower hospital utilization rates or reduce emergency department visits.¹⁵

But states interested in encouraging plans and providers to address social issues will want to explore whether there are additional or alternative metrics aimed more squarely at these objectives. For example, they could establish a measure that looks at the extent to which high-risk individuals complete a health risk assessment, are provided with a housing plan, and, ultimately, are connected with and able to remain in housing.

Third, interviewees noted that states and plans need an accounting system to track, monitor, and build shared-savings and other value-based payments to providers into their Medicaid managed care rates. The claims-based system used for clinical encounters is not appropriate because value-based payments, by design, often are not linked to specific services provided but rather to a plan or provider's success in keeping costs below target levels while maintaining or improving quality. Several states

already incorporate value-based payments into the claims data used for rate-setting, typically by identifying these payments separately in the reporting template they use to collect financial data from managed care plans.

Finally, shared-savings models run the risk of incentivizing providers to cut costs without delivering value, making it important to have a robust set of quality metrics to measure performance. Indeed, there is a risk that shared-savings models could be vulnerable to many of the same concerns that plagued the initial rollout of managed care into Medicaid in the 1970s and 1980s, when news stories surfaced of plans pocketing capitation funds without providing services. To prevent such concerns from arising in the context of shared-savings models, states can establish strong oversight mechanisms prior to implementation.

Option 4: Use Incentives and Withholds to Encourage Plan Investment in Social Interventions

As a fourth option, states can make incentive payments or use withholds to reward plans for improving outcomes for beneficiaries, including outcomes linked to improved social circumstances. Incentive payments are excluded from the MLR calculation entirely, while withhold payments are treated as part of plan revenue and are included in the denominator of the MLR.¹⁶

While states cannot direct plans to invest in non-Medicaid social supports, they can indirectly encourage such investments by linking incentive and withhold payments to outcomes that can be improved by offering social supports. For example, a state might make such payments to plans that succeed in reducing unnecessary use of medical care by connecting beneficiaries to social supports; addressing food security, social isolation, or housing issues; or reducing disparities in outcomes. In addition, incentives and withholds can be combined with Option 3 to reinforce plan incentives to participate in value-based purchasing arrangements.

Considerations

From a state perspective, a major issue with incentive payments is that they are an “add-on” to capitation payments and require additional funding. For states

dealing with a budget squeeze or simply committed to minimizing Medicaid expenditures, the additional cost could be prohibitive. From a plan perspective, this reality may mean that incentive payments are considered an unreliable or short-term source of revenue, dampening plan interest in making longer-term investments in social supports. Similarly, withhold arrangements are not necessarily considered by plans a reliable funding mechanism for sustained social investments, because such arrangements depend on plans meeting targets and in some cases are only available to those plans that outperform other plans.

As with the value-based payment option, discussed above, much of the success of an initiative rooted in using incentive or withhold payments will depend on a state selecting appropriate quality metrics. To incentivize investments in social supports, the metrics need to encourage plans to take a whole-person approach to care, providing not only medical services but also social supports when appropriate.

Option 5: Integrate Efforts to Address Social Issues into Quality Improvement Activities

States have the authority to include the cost of quality improvement activities in the nonbenefit portion of their Medicaid managed care rates. In addition, the cost of quality improvement activities is considered part of the numerator of the MLR (Exhibit 11). This means that states can incorporate into their managed care rates the cost of social investments that are considered quality improvement activities. The issue, of course, is whether a particular social intervention can be considered a quality improvement activity.

Considerations

While it is clear that the cost of quality improvement activities can be taken into account in rate-setting and considered part of the numerator of the MLR, the extent to which CMS will allow states and plans to classify initiatives aimed at social issues as part of quality improvement activities remains uncertain.¹⁷ States

Exhibit 11

ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY: WHAT COUNTS?^a

States can include the costs of activities that improve health care quality in the numerator of the MLR. In general, federal regulations require that such activities be designed to improve health quality; increase the likelihood of better outcomes in ways that can be “objectively measured” and produce verifiable results; be directed toward individual enrollees (or, if directed more broadly, result in no additional costs); and be grounded in evidence-based medicine, widely accepted best clinical practices, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations.

States also must ensure that the activity is primarily designed to improve health outcomes; improve hospital

readmissions through a comprehensive discharge program; improve patient safety, reduce medical errors, and lower infection and mortality rates; implement, promote, and increase wellness and health activities; enhance the use of health care data to improve quality, transparency, and outcomes; or support meaningful use of health information technology. There are also activities that cannot be considered quality activities, such as setting up a network of providers, combating fraud, and conducting utilization reviews.

States interested in classifying some of their activities as health care quality improvement activities will want to review these various requirements closely. For more details, see 45 CFR § 158.150.

^a See 42 CFR § 438.8(e).

certainly do not have carte blanche to characterize anything that their plans and providers are doing as part of quality improvement activities. However, they may be able, for example, to classify efforts to connect individuals with serious mental illnesses to housing as part of a quality initiative aimed at reducing unnecessary readmissions. On the other hand, they presumably will not be able to classify activities such as paying for rent as part of a quality initiative.

While there is some literature describing such possibilities, we have not yet found states that are taking advantage of this option to support social interventions. In addition, classifying too many activities as part of “quality” could undermine more broadly the effectiveness of the MLR, which is designed to ensure that issuers do not use an undue amount of their capitation funds for administrative costs or profits.

Option 6: Reward Plans with Effective Investments in Social Interventions with Higher Rates

The options above would offer plans some resources to finance the cost of social interventions, but they do not squarely address concerns about premium slide. States, however, have some options for providing plans that invest in social interventions with a cushion against the impact on their rates if the interventions drive down costs. Specifically, as noted above, Medicaid managed care rates include a nonbenefit component, which, in turn, includes a profit margin or, for nonprofit plans, a risk margin. States can elect to provide a higher profit and risk margin to plans that demonstrate they have lowered medical costs through investments in social interventions.

A related strategy is for the state to establish an MLR above the 85 percent required in regulation for rate-setting purposes, then offer relief from this higher standard to those plans that invest in social interventions and succeed in driving down medical utilization as a result. For example, a state might generally require plans to meet a MLR of 88 percent, but then allow plans that invest in social interventions and thus lower medical costs to receive an MLR of 85 percent.

Considerations

While this option helps to address premium slide, it could pose both operational and political issues. States will need to design criteria to establish which plans should receive a higher profit margin — or, in the variation, relief from the MLR standard — and determine how best to monitor and evaluate plan compliance with the criteria. For example, they could require plans to make a certain level of investment in social interventions as part of quality initiatives and to provide evidence of the impact of those interventions on medical utilization. From a political perspective, it could prove challenging to publicly justify a higher profit margin for selected Medicaid managed care plans even if the basis is lower medical utilization because of social interventions. Similarly, plans are likely to push back on MLRs greater than 85 percent.

CONCLUSION

State Medicaid programs are increasingly looking for ways to improve health outcomes using both clinical and nonclinical interventions. Managed care plans typically are willing partners in such efforts, but they often face a rate-setting process that discourages sustainable investments in social interventions. In this analysis, we have outlined several options available to states to modify their approach to Medicaid managed care rate-setting to send clear signals that they value such investments and want them to continue over time. None represents a perfect or comprehensive response to the challenge of incentivizing social investments. Together, however, they offer each state the opportunity to design an initiative consistent with its goals and priorities.

Indeed, as we found when speaking with some of the states that are furthest along, it almost surely will take a broad array of strategies to significantly increase the role of Medicaid managed care plans in addressing the social factors that affect health. In the months and years ahead, it will be important to support states not only in pursuing such options, but also in identifying the limits of these strategies and finding ways to combine them with non-Medicaid initiatives to address the social and economic issues that can drive poor health outcomes and inefficient care.

Notes

- ¹ B. C. Booske, J. K. Athens, D. A. Kindig et al., *Different Perspectives for Assigning Weights to Determinants of Health* (University of Wisconsin Population Health Institute, Feb. 2010).
- ² L. M. Gottlieb, A. Quiñones-Rivera, R. Manchanda et al., “States’ Influences on Medicaid Investments to Address Patients’ Social Needs,” *American Journal of Preventive Medicine*, Jan. 2017 52(1):31–37.
- ³ See 42 CFR § 438.3(c)(ii).
- ⁴ In a typical process, a state would work with an actuarial firm to review its recent claim experience (including fee-for-service and other non-claim-based payments to providers); apply appropriate trend adjustments to reflect anticipated price and utilization changes; reflect the impact of any program design changes; add in administrative expenses, profit margin, and other “nonbenefit” expenses; make other reasonable adjustments; consider historical and projected medical loss ratio (MLR); and, finally, apply any risk-adjustment factors.
- ⁵ See 42 CFR § 434.4(b)(9).
- ⁶ Based on the Medicaid managed care rate as of June 2017; note the delayed provision date. Some provisions of the new regulations went into effect immediately, while others are effective for plan years beginning in July 2017 or later. See Center for Medicaid and CHIP Services, “[Medicaid and CHIP Managed Care Final Rule \(CMS-2390-F\) Implementation Dates](#),” Presentation (Centers for Medicare and Medicaid Services, n.d.).
- ⁷ Ibid. These provisions went into effect for contracts starting on or after July 1, 2017.
- ⁸ See 42 CFR § 438.8(e).
- ⁹ D. Bachrach, J. Guyer, and A. Levin, *Medicaid Coverage of Social Interventions: A Road Map for States* (Milbank Memorial Fund, July 2016).
- ¹⁰ Selected eligibility groups are not subject to the comparability requirement, such as those who qualify for Medicaid because of medical bills that allow them to “spend down” to eligibility (i.e., the medically needy). States also can elect to disregard the “statewideness” and comparability requirements in certain circumstances, such as if they are using the authority provided in the Medicaid statute to offer an alternative benefit plan.
- ¹¹ D. Bachrach, J. Guyer, and A. Levin, *Medicaid Coverage of Social Interventions: A Road Map for States* (Milbank Memorial Fund, July 2016).
- ¹² One exception is that states can provide targeted case management to a subset of Medicaid beneficiaries, including beneficiaries living in a particular geographic area. In addition, states can provide alternative benefit plans without regard to “statewideness” and comparability requirements, as discussed further in D. Bachrach, J. Guyer, and A. Levin, *Medicaid Coverage of Social Interventions: A Road Map for States* (Milbank Memorial Fund, July 2016).
- ¹³ The state also distributes incentive payments based on each CCO’s performance on 17 different performance metrics.
- ¹⁴ On Dec. 15, 2017, the administration issued a Dear State Medicaid Director letter that phases out expenditure authority for Designated State Health Programs in Section 1115 demonstrations, a strategy used by several states to finance the nonfederal share of the cost of waivers. See <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17005.pdf>.
- ¹⁵ D. Bachrach, J. Guyer, and A. Levin, *Medicaid Coverage of Social Interventions: A Road Map for States* (Milbank Memorial Fund, July 2016).
- ¹⁶ Withhold payments that are not made because a plan has failed to meet a standard are excluded entirely from the MLR calculation.
- ¹⁷ See 42 CFR § 438.8(e).

APPENDIX A. BIBLIOGRAPHY

State Innovations in Rate-Setting

J. J. Bartholomew, L. Coyner, T. M. Doyle et al., “Payment Reform and Medicaid Rate Development, Session 33 L,” Panel at 2016 Society of Actuaries Annual Meeting and Exhibit (SOA, Oct. 2016).

Center for Health Care Strategies, *Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations*, Technical Assistance Brief (CHCS, Jan. 2016).

Center for Health Care Strategies, “Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights,” Webinar (CHCS, Aug. 16, 2016).

Medicaid and CHIP Payment and Access Commission, “Section D: Payment Policy in Medicaid Managed Care,” in *Report to the Congress: The Evolution of Managed Care in Medicaid* (MACPAC, June 2011).

Oregon Health Authority, *Application for Amendment and Renewal, Oregon Health Plan 1115 Demonstration Project, Medicaid and Children’s Health Insurance Program* (OHA, Aug. 2016).

Oregon Health Authority, *CCO Rate Development Actuarial Certification, January 1, 2017 – December 31, 2017 Capitation Rates* (OHA, Oct. 2016).

Oregon Health Authority, *Concept Paper on Increasing Use of Health-Related Services and Value-Based Payments* (OHA, n.d.).

Oregon Health Authority, Office of Health Policy and Analytics, *Where We Are and Where We’re Going: Rate Setting for Coordinated Care Organizations* (OHA, April 2015).

State Innovations in Value-Based Payment and Social Intervention Investments

M. Crawford and R. Houston, *State Payment and Financing Models to Promote Health and Social Service Integration* (Center for Health Care Strategies, Feb. 2015).

L. M. Gottlieb, A. Quiñones-Rivera, R. Manchanda et al., “States’ Influences on Medicaid Investments to Address Patients’ Social Needs,” *American Journal of Preventive Medicine*, Jan. 2017 52(1):31–37.

R. Mahadevan and R. Houston, *Supporting Social Service Delivery Through Medicaid Accountable Care Organizations: Early State Efforts* (Center for Health Care Strategies, Feb. 2015).

R. Manchanda, S. Ackerman, and L. Gottlieb, *Building Medicaid Managed Care Systems That Address Social Determinants of Health. A Case Study Synthesis* (University of California, San Francisco, and Health Begins, Feb. 2016).

New York State Department of Health, *Medicaid Redesign Team, A Path Toward Value Based Payment: Annual Update, New York State Roadmap for Medicaid Payment Reform* (NYS DOH, June 2016).

E. Rogan and E. Bradley, *Investing in Social Services for States’ Health: Identifying and Overcoming the Barriers* (Milbank Memorial Fund, May 2016).

A. Spencer, J. Lloyd, and T. McGinnis, *Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons* (Center for Health Care Strategies, Dec. 2015).

Medicaid Managed Care Regulation and Rate-Setting Guidance

Actuarial Standards Board, *Actuarial Standard of Practice No. 49: Medicaid Managed Care Capitation Rate Development and Certification*, Doc. No. 179 (ASB, March 2015).

Centers for Medicare and Medicaid Services, *2017 Medicaid Managed Care Rate Development Guide: For Rating Periods Starting Between January 1, 2017 and June 30, 2017* (CMS, n.d.).

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APPENDIX D. ADDITIONAL CHALLENGES STATES FACE IN USING MEDICAID TO ADDRESS SOCIAL ISSUES

- **State staffing and expertise.** New (or redirected) staff resources are needed to develop Medicaid managed care policies and contracting requirements, identify appropriate performance standards, and engage in other tasks discussed in this report. Several interviewees highlighted agency staffing and expertise as a potential impediment to advancing new managed care payment strategies.
- **Data infrastructure.** States will need a data infrastructure that allows them (or plans or providers acting on their behalf) to identify the social and economic issues confronting Medicaid beneficiaries, as well as to monitor and track the effectiveness of their efforts. Although some providers and plans already gather such information, we consistently heard that there is a need for a systematic approach to gathering and sharing the data, for example, which beneficiaries are struggling with housing, facing employment challenges, recently leaving a jail or prison, or confronting domestic violence. A common mechanism for sharing data can allow Medicaid managed care plans to avoid the need to collect all the same data again when a beneficiary changes plans; it also can make it easier to track and build on social investments. Similarly, states, plans, and providers need systematic data and tools to evaluate the effectiveness of social interventions. Do they see declines in hospitalizations among diabetics if individuals have a steady source of food and some extra help at the end of a month when SNAP runs out? How cost-effective is it to provide housing to individuals with serious mental illnesses? In the absence of such resources, it will be difficult to sustain investments in social interventions over time.
- **Lead time for managed care plans and providers.** Managed care plans and providers will require time to identify and enter into agreements with social service organizations or to build additional in-house capacity or infrastructure to track and offer social service options. Many plans and providers are not accustomed to working directly with social service organizations, and they need to develop those relationships as well as conduct the “nuts and bolts” work of setting up contractual arrangements with social service providers.

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