

Lessons Learned from Health Management Associates Report on Medicaid Reimbursement for Evidence-Based Programs

Questions & Answers

These questions were in response to a webinar focused on the report, [Reimbursement for Evidence-Based Health Promotion Programs in the Community Strategies and Approaches to Medicaid and Medicare Advantage Coverage](#).

- **Several states have all-payer claims databases (APCDs) – have you seen successful collaboration between community-based organizations (CBOs) and APCDs in order to access needed data?**

We recommend reaching out to the Administration for Community Living (ACL) or Advancing States to see if they have information on this initiative.

- **Do all CBO networks need to include the local area agency on aging (AAA)? Or could it be comprised solely of other types of organizations?**

Not necessarily. There are no established standards for composition of organizations collaborating in a community integrated health network (CIHN). We encourage you to recruit partners with similar mission, capacity to meet the targeted service needs, resources and a commitment to succeed. Visit [NCOA's Road Map to Community-Integrated Health Care](#) for more information about network development. Additionally, the [n4a Readiness Assessment Tool](#) may provide insight on assessing your local marketplace and identification of optimal partners.

- **When you say “evidence-based program,” which particular programs are being reimbursed in the states mentioned?**

See the report, APPENDIX A: States – Selection Rationale, Financing Mechanisms, and Programs in the [report](#).

- **Are there examples of state health care authorities authorizing direct payment for public employees to take part in evidence-based programs?**

As referenced in the [report](#), at the time of research conducted for the paper, Washington state was negotiating with its state employee health insurance plans to cover evidence-based programs implemented by community-based organizations. This included programs offered in the community and digitally, such as Better Choices, Better Health© Online.

- **How would you recommend we, as a CBO, be proactive in the way you've described, but in the world of Medicare Advantage?**

Great question. Medicare and Medicaid operate under different authorities. Medicaid standards are heavily driven by federal standards, with lots of flexibility for states to append the program

design. Except for some Medicare/Medicaid integration demonstrations and other joint coordination initiatives, Medicare authority is primarily administered at the federal level. However, Medicare plans operating in each state must be licensed by the state insurance bureau. Check their website for information on Medicare Advantage plans in your state.

There is considerable advocacy at NCOA, ACL and other national organizations to include more evidence-based programs as benefits under Medicare Advantage. The **2018 Special Supplemental Benefits for the Chronically Ill** are a good example of the push to include evidence-based programs as services for high need Medicare beneficiaries. See this webinar ([Learn the Basics about Medicare Advantage and Position Your Organization for New Partnerships](#)) and fact sheet ([Medicare Advantage Supplemental Benefits: Consumer Facts](#)).

Dual Eligible Special Needs Plans are a type of Medicare Advantage plan noted in the [report](#) as a target market for evidence-based programs. We have seen more adoption of the recently expanded Medicare Advantage supplemental benefits in these plans because they serve Medicare-Medicaid dually eligible individuals, who typically have much higher needs than the Medicare-only eligible population.

You should connect directly with local Medicare Advantage plans for opportunities to offer evidence-based programs to their enrollees. **The timeline of your outreach is important.** Some considerations and next steps:

- Medicare Advantage plans typically begin the following year's application process soon after their current year's contracts are approved (usually in **July/August**).
 - It is important to connect with plans in **October-February** of the current year for consideration in the following year's benefit package.
 - Conduct research on the Medicare Advantage plan to identify their service area, information about the current benefit structure, STAR ratings, etc. to maximize your ability to promote products that meet their unique needs.
 - Concentrate on Special Needs Plans, which have more requirements regarding supplemental services to meet beneficiary needs.
 - Research if there are Medicare Accountable Care Organizations (ACOs) in your area. They may be interested in development of wrap around services for their enrollees.
- **Do you have suggestions for how to create a CBO network when potential member organizations view each other as competitors for contracts?**

While designing your integrated community health network composition strategies, there are myriad factors to consider, especially approaching competitors. Check out the following resources:

- [Webinar: Building Community-Integrated Networks through Purposeful Partnerships](#)
- [Webinar: Exploring the Value of Community-Integrated Networks for Community-Based Organizations, Older Adults, and Partnership Opportunities](#)
- [N4a Network Readiness Assessment](#)

- **How do you find out when the request for proposals (RFPs) come out from CMS?**

We recommend that your engagement to influence Medicaid waivers and/or State Plan Amendments occur 1-2 years before the RFP is released. Once the Medicaid Managed Care competitive bid RFP is published, it's almost too late to recommend significant changes.

Consider the following:

- Connect now with the bureau in your state responsible for Medicaid managed care and State Plan Amendment administration.
 - Share the [report](#) and local success stories.
 - Solicit information on proposals for reforms, specific state Medicaid needs assessment data, and get dates for existing waiver timelines and renewals, etc. If possible, register for waiver renewal and RFP listservs so that you can track progress and stay informed.
 - Once an active waiver reform or amendment is underway, state websites contain public information. Be sure to provide feedback and participate fully in the waiver process public comment opportunities.
 - Connect with state legislators who serve on the budget and health subcommittee to advocate for the inclusion of evidence-based programs in Medicaid reforms.
 - Connect with health plans with existing Medicaid contracts to encourage them to advocate for Medicaid coverage of evidence-based programs. They are more likely to consider offering the services if the state is including them as standard or optional benefits.
- **The [report](#) does not include the full literature review conducted by Health Management Associates – it only includes references for the six states highlighted. Is there a place where we can see the full list of findings from the literature review?**

The document includes foot notes for all references used to inform findings and conclusions.

- **Under what authority are they reimbursed? 1915(c)?**

See the [report](#), *Background – Financing and Program Authorities* (page 7), for authorities used by states to support reimbursement of evidence-based programs with Medicaid dollars. They include, but are not limited to Section 1915(c) Home and Community-Based Waivers and Medicaid Section 1115 Demonstration Waivers.