# Engaging Providers in Building Managed Care Delivery Systems: Tips for States

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**In Brief**

As states move to managed care delivery systems for individuals with complex needs, it is important to engage medical, behavioral health, and home- and community-based providers as well as hospitals and nursing facilities in establishing new programs. Providers can play an essential role by sharing successes and challenges with states and educating patients about the managed care program. This technical assistance brief offers tips to help states effectively engage providers in managed care program design and implementation.

State Medicaid programs are moving from fee-for-service (FFS) to managed care delivery systems for individuals with complex care needs, particularly those who are dually eligible for Medicare and Medicaid or who use long-term services and supports. To provide better integrated and more cost effective care, states are developing managed long-term service and supports (MLTSS) programs or capitated financial alignment demonstrations for dually eligible individuals. Under these new arrangements, providers of medical and behavioral health services and long-term services and supports often must contract with managed care organizations (MCOs) rather than have a provider agreement directly with the state. However, states sometimes have other arrangements with providers such as service carve-outs or county-based systems for certain services such as behavioral health.

As states develop managed care programs for populations with complex needs, it is important for them to engage with medical, behavioral health, and home- and community-based service providers, as well as hospitals and nursing facilities. These providers will remain an important channel for communication with state policymakers and administrators about how the managed care program is faring. Providers are able to highlight best practices and help identify and address issues before problems occur. For programs with voluntary enrollment, providers can also serve as champions and important sources of information for individuals deciding whether to participate.

This technical assistance brief, developed through support from The Commonwealth Fund and The SCAN Foundation, provides tips to help states engage providers in designing, implementing, and overseeing a managed care delivery system for individuals with complex care needs.

## Tip #1: Build Capacity to Engage Providers

Smoothly transitioning from a FFS to a managed care delivery system involves communicating detailed, technical information to a wide range of providers and soliciting their ongoing feedback. This includes developing strong communications skills among staff administering programs. These staff can look to internal and external channels to engage providers. They may consider partnering with other agencies (e.g., aging, behavioral health, disability, etc.) and contracted MCOs to maximize available expertise and staff resources. They can also use trusted local entities to help convey program features and goals (e.g., Area Agencies on Aging, State Health Insurance Programs; Aging and Disability Resource Centers; Health Insurance Counseling and Advocacy Programs). Potential strategies to build capacity include:

- Developing MCO delivery system expertise through staff training.
- Acquiring new and strengthening existing leadership skills around communications and contract management.

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- Identifying and addressing communication issues for providers who may be unfamiliar with managed care, such as those that are smaller and/or rurally located.
- Partnering with MCOs to augment state staffing and assist with provider communications.
- Partnering with external organizations to help educate state and provider staff around issues with which they may be unfamiliar, such as behavioral health and home- and community-based services.

### Building Capacity Without Hiring Staff

Both New Mexico and Ohio have found innovative ways to enhance their provider engagement efforts without hiring staff. **New Mexico's** Coordination of Long-Term Services (CoLTS) program staff partnered with contracted MCOs to educate providers about the transition from FFS to managed care. They jointly held regional forums to explain: (1) program design and goals; (2) what the change to managed care would mean to providers; (3) contracting processes; and (4) what relationship providers would have with the state going forward. This state-MCO partnership also created a positive communication environment for providers in which they could address technical issues and the state could follow-up with targeted training.

**Ohio's** Medicaid agency identified the need to educate staff about behavioral health issues for its financial alignment demonstration. It partnered with the Department of Mental Health and Addiction Services to build the behavioral health knowledge of the Medicaid agency's staff. Ohio also created linkages with external, expert behavioral health organizations to address provider concerns around how behavioral health benefits would be coordinated and provided under the demonstration.

## Tip #2: Tailor Provider Outreach Efforts

Provider outreach efforts should reflect the state's managed care environment and relationships with providers. Provider groups have varying degrees of experience with and exposure to managed care. States can build on existing relationships and use established forums as a starting point. It is important to include providers who are allies, as well as challengers, to ensure all issues and concerns are clearly communicated and addressed early in the process. Potential strategies to help target communication efforts include:

- Identifying providers who can communicate program benefits and those most in need of additional information.
- Considering a diverse group of providers for outreach efforts, including: medical and behavioral health providers; home- and community-based providers (e.g., personal care attendants, care coordinators and visiting nurses); nursing facilities; and hospitals.
- Engaging providers based upon existing relationships and communication resources, as well as links to local communities.
- Developing compelling messages to communicate program benefits to specific types of providers (i.e., home- and community-based providers, medical and behavioral health providers, nursing facilities, and hospitals).
- Identifying providers that serve special populations and providing them with information specific to the people they serve (e.g., Medicare-Medicaid enrollees, complex populations with comorbidities, over 65, under 65, individuals with serious mental illness, and substance abuse).

### Messaging Around Common Goals

**South Carolina** targeted communication for its financial alignment demonstration by developing messages specific to hospitals and nursing facilities. Messages highlighted how participation in the demonstration could help providers realize shared goals (i.e., reducing avoidable hospital readmissions to avoid penalties or transitioning nursing facility residents back to the community to participate in shared savings programs). Providers were more receptive to the idea of managed care when they realized how participation could help them to achieve their goals.[1]

## Tip #3: Build a Flexible Communications Approach

The number and diversity of providers that a state needs to engage to successfully launch a managed care program requires a multi-pronged communications strategy. No single method can reach all providers and not all providers will respond to the same types of messages. In addition to traditional mailers, websites, and workgroups, online resources such as webinars, virtual training, and social media are also effective. Potential strategies include:

- Using tailored communications approaches to reach providers in different geographic areas – implementation council representation, presentations at state or locally led regional forums, after-hours webinars, and/or meetings of professional organizations.
- Being available when providers are available – if possible, holding events after working hours.

### Adapting to Providers' Schedules and Locations

A flexible communications strategy should adapt to providers' schedules and locations. **California's** outreach campaign for its financial alignment demonstration implementation is similar to a "boots on the ground" political campaign. The Medicaid agency is partnering with local community groups to educate providers and beneficiaries. The campaign touches providers of all types including medical, home- and community-based services, nursing facilities, and hospitals.

The state's periodic "Wednesday night call-ins" with physician offices offer an opportunity to discuss payment regulations and the benefits of its financial alignment demonstration program at a time that is convenient for providers. The state used multiple provider associations to get the word out about the meetings including the Ethnic Physician Medical Association, California Medical Association, and other physician organizations.

## Tip #4: Identify Communication Goals and Track Progress

It is important to identify goals and priority issues for both the state and providers. Once these are established, it is helpful to track progress, share best practices, and keep states, providers, and MCOs accountable for completing their "assignments" and next steps. Recording completed efforts and resolutions reinforces a sense of accomplishment from working together. Specific tasks could include:

- Building consensus with providers and other stakeholders such as provider organizations and contracted MCOs to create a list of high priority issues to address.
- Systematically addressing priority issues with providers and creating provider-specific workgroups as needed.
- Establishing a separate forum to address pre-existing and individual provider issues.
- Using a matrix to: (1) track issues and concerns identified by providers; (2) clearly identify issues specific to the program versus pre-existing issues; (3) record who is responsible for next steps (e.g., state, MCO, or provider); and (4) record progress toward resolving issues.
- Developing a clearly identifiable website that is regularly updated with program materials, a calendar of events, minutes from meetings, and links to other sites where participants can find additional information.

### Coming to Consensus on Priority Issues

Identifying state and provider goals and developing provider-specific workgroups can help work through issues and build consensus for managed care program development. **South Carolina's** Medicaid agency identified its policy goals, created a communications work plan, and then invited key providers, like the state's largest nursing home association, to a provider communications forum. After a series of education sessions, the state and providers committed to create provider-specific workgroups to address program elements identified as ineffective or in need of change. These provider groups will also be used to identify best practices and administrative efficiencies.

## Tip #5: Promote Ongoing Provider Engagement

As managed care programs evolve from design to implementation, state Medicaid agencies should maintain relationships with providers to identify program best practices as well as provider challenges that need to be addressed. Potential strategies include:

- Continuing provider engagement through local-level provider organizations (e.g., community, provider, and medical associations).
- Transitioning design- and implementation-phase councils or advisory groups (like implementation councils and subgroups) into on-going program oversight bodies (like Medicaid advisory councils).

### Transitioning from Design to Implementation

Provider engagement should continue from the design of the managed care program through implementation and ongoing program oversight. **Ohio's** managed care enrollment workgroup includes a diverse group of community advocates, providers, and beneficiaries. This workgroup was instrumental to Ohio obtaining provider review of enrollment materials and facilitating additional outreach to other providers and beneficiaries. Ohio plans to transform this workgroup to a standing implementation workgroup that will include providers and have a charter outlining the scope of activity and how it will conduct business.

## Conclusion

Communication between state Medicaid agencies and providers is important to the success of managed care programs during both the design and implementation phases. Prior to beginning the design phase of a new managed care program, states should plan their

communications with providers. States can continue to benefit from critical provider input by identifying which providers are the most critical to engage; targeting messages to them; and making those messages easily accessible.

## About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex needs.

## Endnotes

[1]For more information about the Medicare Hospital Readmissions Reductions Program (HRRP) see: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.