



SEVEN

OPPORTUNITY: WORKING WITH MEDICAID MANAGED CARE ORGANIZATIONS

Understanding the role of Medicaid managed care organizations (MCOs) and thinking about how to strengthen partnerships between schools and MCOs can be a winning strategy for states, school districts and the MCOs themselves.

Medicaid managed care organizations (MCOs) are private health insurance companies that work with Medicaid to provide health insurance, contract with providers, and handle billing and reimbursement. In many ways, MCOs are comparable to employer-based health plans: They have a defined benefit package and in-network providers, and they pay providers for the services delivered to their members.

Almost all children enrolled in Medicaid have [some type of managed care](#)¹⁶, and over two-thirds are enrolled in comprehensive managed care. All Medicaid MCOs must cover comprehensive care and are required to keep costs affordable by limiting out-of-pocket spending.

Each MCO has a state contract to provide a specific bundle of services and manage care for its members. The contract lists the different services that must be provided, along with the types of providers who may participate in the plan’s network. The MCO is paid a monthly fee by the state for each member who is enrolled—this is known as a capitated payment or capitation rate.

In most states, school-based Medicaid services are not the responsibility of the MCO; this is commonly known as being “carved out.” Instead, school districts, or local educational agencies (LEAs), directly bill the state Medicaid department for the services they provide, and the Medicaid department provides the reimbursement, as described in Chapter 2.

If school-based Medicaid services are included in the MCO contract (“carved in”), the MCO’s capitation rate reflects the included services, and the state will not pay LEAs for those services. In states where school-based Medicaid is carved into MCOs, LEAs must contract with the plans to seek reimbursement. In these cases, the LEA operates as a contracted provider to the MCO. In areas where there are several MCOs operating, LEAs might need to contract with several different plans to get reimbursement for all their students.

Information about which and how many MCOs serve students in a geographic region is available through state Medicaid departments. Kaiser Family Foundation maintains helpful charts showing the [number of children](#) enrolled in comprehensive Medicaid MCOs and the [MCOs operating in each state](#).

Partners To Achieve Quality

It is likely that your LEA already has a relationship with some MCOs in its area, even if school-based health services are not carved into the state’s MCO contract. Many MCOs

16. *Types of Managed Care Arrangements, Medicaid and CHIP Payment and Access Commission*: <https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/>

work with schools on back-to-school health insurance enrollment events, and on health fairs and vaccination efforts. These partnerships are not the same as a contractual relationship in school-based Medicaid, but having or developing a relationship with the MCOs is a good first step toward a strong partnership.

Taking the time to get to know the MCO helps both sides understand the role that Medicaid plays in supporting student health in general—and student health in schools. This is especially important when considering the challenges both MCOs and schools face when school-based Medicaid services are carved into the MCO model. Provider network arrangements, credentialing criteria and program requirements, including prior authorization of services, can vary between MCOs. Often the MCO policies governing these areas can take time to untangle.

An important element of a school/MCO partnership is understanding how school-based health services can help MCOs achieve the federal and state-specific quality metrics they are required to meet for their Medicaid populations, including many child-specific measures.

Common pediatric quality metrics that states require include child vaccination rates and well-child visits. In addition, there is a growing focus on improving outcomes on social determinants of health—and states are increasingly requiring plans to address such issues as food insecurity, unstable housing and exposure to violence. Some states are also considering requiring MCOs to improve quality metrics on measures such as reducing rates of chronic absenteeism.

Schools can help MCOs improve their pediatric quality outcomes in multiple ways. If MCOs need to reach children on specific measures, schools can provide access to students and their families, eliminating barriers for families in accessing the services. As partners, schools and MCOs can work together to address the needs of the community. But schools can't provide these additional services without resources, and MCOs will need to think carefully about how best to provide sustainable support to schools in order to achieve their annual metrics.

Over the next five years, the importance of quality metrics will become more transparent. Beginning in 2024, states will be required to publicly report Child Core Set measures, a standardized set of pediatric quality measures required for all states in the Medicaid program. The Child Core Set measures are already updated annually, but state reporting is voluntary.

As states look to 2024, they will increasingly rely on MCOs to deliver services necessary to improve quality. Now is the time to build meaningful relationships between schools and MCOs to achieve the quality metrics—and the goal of improved child health.

For more information about the Child Core Set, including the current measures, visit the CMS page on [Children’s Healthcare Quality Measures](#).

Seizing the Opportunity

Partnerships with MCOs present a tremendous opportunity to advance student health services. What’s more, it’s a win-win situation. LEAs can put in place structures to bill for school health services, and MCOs can help students get the services they need and meet their quality metrics. If you are interested in pursuing partnerships with MCOs, consider the following situations and questions:

- **I want to make the case that schools can play a big role in helping MCOs meet their quality metrics.** *What quality metrics are MCOs in my state responsible for meeting, and which of those can schools play a role in?*
- **I want to demonstrate to MCOs that schools are an important provider for improving child and adolescent health.** *What data can I use to show that the LEAs in my state are already providing a significant number of health and behavioral health services in schools?*
- **I had a conversation with MCO or health plan leadership, and it is clear they don’t understand the role that schools play in student health.** *How can I make the case for partnerships that reflect the LEA’s unique situation?*
- **I see the potential here, but I really don’t know where to start.** *What LEAs in my state have a relationship with MCOs? Where are MCOs already partnering with schools, and in what capacity?*
- **I want to encourage formal, contractual relationships between LEAs and MCOs.** *Are there any existing partnerships in my state? What type of formal contract or memorandum of understanding is there, and is it replicable?*
- **I understand that a good first step is to engage the right person at the MCO.** *Who at the MCO—or at the state health plan association—is the point person for student health or for local partnerships?*