Introduction to Medicaid Care Management Best Practices

By Allison Hamblin and Stephen A. Somers, PhD, Center for Health Care Strategies, Inc.   DECEMBER 2011

Many of those served by Medicaid are relatively healthy, with only routine health care needs and nominal annual health-related costs. Yet, a small subset of the program's beneficiaries includes many of the country's highest-need, highest-cost patients. This includes adults and children with physical and behavioral health disabilities, those with long-term care needs, as well as low-income frail elders. Roughly five percent of Medicaid beneficiaries account for close to 60 percent of total program expenditures,[1] with annual outlays estimated at roughly $190 billion.[2] Reducing even a fraction of spending for this high-cost population by improving care management can provide meaningful savings for states.

Implementing care management strategies is a key way for states to improve care delivery and address the high health costs of Medicaid's most complex need beneficiaries. Focusing on high-need, high-cost populations takes on even more importance with the Affordable Care Act expanding Medicaid coverage to roughly 25 percent of all Americans in 2014. This comes at a time when Medicaid agencies are facing strapped, over-extended budgets, and legislatures are looking to stem rising health costs. States will need to more effectively use existing resources to provide services for an expanded population, including the potential of many new beneficiaries with complex needs. Indeed, based on a recent review of existing state programs for low-income childless adults, the expansion population is likely to include a significant number of individuals with multiple chronic conditions, high levels of service use, and higher annual costs than generally healthy beneficiaries.[3] It is likely that many of these new beneficiaries will be candidates for intense care management.

This brief[4] provides a glimpse of some of the innovative programs being implemented in states across the country that use care management approaches to address the

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[1] *This brief is an excerpt of a chapter from C. Schraeder and P. Shelton (Eds.). Comprehensive Care Coordination for Chronically Ill Adults. (Wiley-Blackwell, 2011), www.wiley.com. This material is reproduced with permission of John Wiley & Sons, Inc.*

IN BRIEF

Enhancing care management is one promising way of improving care and reducing costs for Medicaid's highest-need beneficiaries. While recognized as a valuable endeavor, the concept is often not clearly defined, making it challenging for states and health plans to adopt care management practices. This brief describes the complex populations who often benefit from care management and outlines several key aspects of an effective approach to care management. State examples cited in the brief represent participants in the *Rethinking Care Program*, a national initiative developed by the Center for Health Care Strategies to help states better integrate care for Medicaid beneficiaries with

complex physical, behavioral, and psychosocial needs of Medicaid's highest-risk populations. It sheds light on the program's high-risk beneficiary subsets and outlines core elements essential for effective care management approaches.

Who Are Medicaid's Highest-Need, Highest-Cost Beneficiaries?

Understanding the unique care needs and requirements of Medicaid's highest-cost subsets is the first step toward developing appropriate care management interventions. The program's highest-need subset has multiple chronic physical health problems and typically faces a variety of socioeconomic barriers (e.g., unstable housing, lack of transportation, etc.) that impede access to care. Mental illness and substance abuse are also endemic among the program's highest-need, highest-cost beneficiaries. More than 50 percent of Medicaid beneficiaries with disabilities are diagnosed with mental illness.[4] This pervasiveness is particularly high among the program's most expensive five percent of patients, with mental illness present in three of the top five most prevalent pairs of diseases for this high-cost subset (Figure 1).[5]

Mental illness is closely linked to poor health outcomes and the presence of mental illness can exacerbate problems related to chronic physical conditions. For example, a recent analysis demonstrated that health care spending is substantially higher for Medicaid beneficiaries with chronic physical conditions who also have a mental illness. Among those with common chronic physical conditions (e.g., asthma, diabetes, hypertension, coronary heart disease), the presence of a co-occurring mental illness is linked with health care costs that are 60 to 75 percent higher than for beneficiaries without a mental illness.[6]

Yet despite the high prevalence, as well as the human and financial costs of mental illness, the majority of Medicaid beneficiaries with mental illness are in fragmented systems of care. Behavioral health services are typically provided separately from physical health care with little to no coordination between the two delivery systems. As a result, patients typically receive care from a confusing array of disparate providers that are frequently unaware of the individual patients' overall needs as well as the treatments and prescriptions they are receiving from other providers.

The programs outlined in this brief showcase innovative care management approaches that integrate the full array of physical health, behavioral health, and psychosocial services. These best practices can serve as a starting point to guide program design and evaluation for other states and health plans.

Core Elements of Care Management

Most of Medicaid's highest-cost, highest-need beneficiaries receive care through fragmented and uncoordinated fee-for-service delivery systems. In this context, care management programs can serve as a vital mechanism for helping individuals achieve better access to needed care, navigate their way through complex systems, and increase the self-management and self-advocacy skills necessary to function as informed and "activated" health care consumers. Within fee-for-service systems, states contract with care management organizations of various kinds to deliver these services (or in some cases build this capacity internally). In the case of managed care, states are increasingly requiring their health plan partners to offer targeted care management strategies to beneficiaries with complex needs.

Across the country, innovative states are implementing programs that provide "high touch" care management for targeted groups of beneficiaries. Best practices from around the country suggest a core set of elements that should be considered in the design of

While Medicaid's highest-need users have high rates of physical and behavioral health comorbidities, they continue to receive care largely in fragmented health systems, lacking coordination of care.

FIGURE 1: Mental Illness Among Medicaid's Highest-Cost Population	
Prevalent Disease Pairs	**Frequency Among Highest-Cost 5% of Medicaid Beneficiaries**
Psychiatric illness and cardiovascular disease	40.4%
Psychiatric illness and central nervous system disorders	39.8%
Psychiatric illness and pulmonary disorders	28.6%

SOURCE: R.G. Kronick, M. Bella, T.P. Gilmer. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Center for Health Care Strategies, Inc., October 2009.

complex care management programs (see Figure 2).

The following section provides a brief outline of each of these elements with accompanying state examples to illustrate how these strategies can be incorporated into care management approaches. The states highlighted are participants in the *Rethinking Care Program*, a national initiative developed by the Center for Health Care Strategies (CHCS) to design and test better approaches to care for Medicaid's highest-need, highest-cost beneficiaries. Through support from Kaiser Permanente, four state pilot demonstrations — in Colorado, Pennsylvania, New York, and Washington — are testing and refining how to implement the following core program elements to best serve Medicaid's "high-opportunity" beneficiaries.

Stratify and Triage Beneficiaries by Level of Risk and Need

Determining how to invest limited program resources to effectively meet the needs of Medicaid's highest-risk, highest-cost beneficiaries, is a conundrum faced by every state. Identifying the patients who are most likely to benefit from care management and designing programs tailored to meet their needs is an extremely valuable, but not necessarily clearly defined, endeavor. Stratification efforts typically use claims data to identify one or more of the following characteristics: high medical expenditures (historic or expected), high hospitalization or emergency department visit rates (historic or expected), and specific types or numbers of existing diagnoses.

Ideally, identification and stratification efforts should use additional data to supplement information available via health care claims, particularly in the case of new enrollees for whom limited claims history is available. Along these lines, upon enrollment, Medicaid programs should ideally have a mechanism in place to rapidly identify new beneficiaries who may have immediate physical health, behavioral health, or psychosocial needs. Promptly linking new patients with needed care management services can help reduce exacerbations of chronic conditions and avoid potential costs related to unnecessary emergency department visits or hospital stays. A variety of strategies can be used to identify the health needs of newly enrolled beneficiaries, including: referrals from a provider or specialist, a beneficiary's own self-identification, or initial health screens.

An initial health screen can be used to quickly assess and identify high-risk beneficiaries with pressing health and care coordination needs. Such screens typically include questions that address both clinical and non-clinical issues to capture the full range of beneficiary needs. For the higher-risk subset, a state may choose to implement a more in-depth clinical assessment to more completely understand beneficiary needs, prioritize risk levels, and connect them to services that will best meet those needs. Both initial health screens and clinical assessments can be used on a periodic basis to re-evaluate beneficiary level of need.

Another mechanism for states to assess the needs of beneficiaries on an ongoing basis is through predictive modeling. While

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FIGURE 2: Core Elements of Medicaid Care Management Programs

1. Stratification and triage by risk/need;
2. Integration of services;
3. Designated "care home" and personalized care plan;
4. Consumer engagement strategies;
5. Provider engagement strategies;
6. Information exchange among all stakeholders;
7. Performance measurement and accountability; and
8. Financial incentives aligned with quality care.

predictive models are often used to forecast costs for rate-setting purposes, states can also use these tools to identify "high-opportunity" candidates for care management. Predictive models use data from various sources to estimate an individual's future potential health care costs and/or opportunity for care management. Adapting predictive models to address the Medicaid population's complex array of needs, including physical and behavioral health comorbidities as well as socioeconomic issues, is a critical consideration for states.

Washington State offers an example of an innovative use of predictive modeling. The state used internal resources to develop a customized predictive modeling tool to identify high-risk Medicaid populations for enrollment in care management programs. Based on the Chronic Disability Payment System,[7] Washington's tool uses a variety of information to target care management needs, including: prescription drug use; preventive care opportunities; emergency room use; provider contact information; and mental health, substance abuse, and long-term care service use. The secure web-based tool is available for approved Washington State's Department of Social and Health Services staff, and is also available for use by contracted care managers as a source of timely information on enrollee care needs and service use.

Promote Integration of Services Across the Delivery System

As mentioned above, high-risk beneficiaries often have care needs spanning across and beyond traditional silos of the health care delivery system. These needs may include primary and specialty medical care, mental health care, substance abuse treatment, long-term care services, and community supports (e.g., housing, transportation, energy, job training, etc.). Effective care management programs ensure the coordination of services across these domains, connecting providers and enabling the exchange of relevant information so

that treatment for any one of the patient's needs recognizes the full range of those needs. Such coordination is essential to prevent a broad array of clinical mishaps, including adverse medication interactions, duplicative tests and/or treatments, and unrealistically complicated self-management regimens.

An example of integrated care management can be found in Pennsylvania, where the state has partnered with physical and behavioral health plans and providers in two pilots to better integrate physical and behavioral health care for adults with serious mental illness. In each pilot, a designated care manager is accountable for managing the range of physical and behavioral health needs for his/her clients, and is supported in doing so through access to timely, integrated information on health needs, provider relationships and service use across systems.

Establish a Designated "Care Home" and Personalized Care Plan

Establishing a consistent care home that is acknowledged by the consumer, provider, and care management organization provides a central hub to coordinate all physical, behavioral, and psychosocial needs. The care home is often a primary care provider practice or community health setting, but for beneficiaries with severe mental illness, the care home is just as likely to be a mental health provider in the community. Regardless of the setting, the care home should be supported by a team-based approach to care management that provides access to clinical, psychiatric, chemical dependency, social work, and pharmacy expertise. Within this care team, each beneficiary should have a dedicated "go-to person" serving as her/his primary care manager. Providing one go-to person is valuable for both the beneficiary in terms of familiarity and consistency as well as the primary care provider. Depending on the

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needs of the beneficiary, the go-to person may vary (e.g., nurse, care manager, social worker, etc).

A personalized care plan that is accessible and approved by all the members of the multidisciplinary care team serves as the ongoing framework to guide care management decisions. The care plan is an individualized plan of care that maps out the beneficiary's physical, behavioral, and psychosocial needs, primary care and specialty providers, home environment, transportation needs, etc. It documents an agreed-upon set of goals for the beneficiary and his/her care team. Care plans should be developed in concert with beneficiaries to help them to set and prioritize attainable and compelling goals. In Pennsylvania's pilot program for adults with severe mental illness, an integrated web-based care plan automatically incorporates data from participating physical and behavioral health plans. Care managers can access and update information through an online interface.

Engage Consumers at Their Level to Meet Their Needs Effectively

Without meaningful consumer engagement even the best designed care management intervention is bound to fail. Effectively reaching consumers, understanding their needs and goals, and ensuring that care management efforts are aligned with those goals are essential to program success. Yet, engaging beneficiaries is perhaps one of the most difficult tasks of any Medicaid care management program designed to address complex physical and behavioral health issues.

Poor contact information, unstable housing, overwhelming socioeconomic challenges and, in some cases, lack of trust, all intersect to make finding, enrolling, and meaningfully engaging patients with chronic illnesses and mental health and substance use issues exceedingly difficult. That said, investments in creative and persistent approaches to locate and engage

high-risk beneficiaries can yield positive results for care management programs.

In Washington State's Department of Social and Health Services, the Research & Data Analysis Division uses an innovative approach to finding beneficiaries that has substantially increased the state's engagement rate of a complex need, and in some cases, homeless population. Factors contributing to the success include a client-finding team that is dedicated to persistent outreach and sleuthwork; use of consumer incentives; and a highly personalized approach that focuses on messages that are compelling to consumers.[8]

Once consumers are enrolled in a care management program, consumer engagement continues to be an important element to program success. Taking the time to understand the consumer point of view can help care managers design programs that directly speak to beneficiary needs. Some states are employing motivational interviewing training and techniques to more effectively support beneficiaries in setting and reaching goals for changing behavior. Motivational interviewing is a "collaborative, person-centered form of guiding to elicit and strengthen motivation for change."[9]

Engage Providers as Part of Care Team

Care management is most effective when it is closely integrated with care delivered by the patient's physicians and other treating providers. To this end, successful care management programs invest substantial effort in establishing and maintaining relationships with the provider community. Demonstrating the value of care management to providers can be key to engagement, and can be facilitated by: seeking provider input in program development, accepting provider referrals into the program, and providing access to clinically valuable patient information (with patient consent, including for

example pharmacy fills, diagnoses, recent health care service utilization, etc.).

In some models, care managers are co-located at physician practice sites. For example, in Colorado and a number of other states, Medicaid health plans have placed care managers in high-volume community clinics to ensure close coordination between the care managers and the primary care physicians.

Establish Information Exchange among All Stakeholders Including Consumers

The push for greater use of information technology in health care is rooted in the understanding that access to timely, relevant clinical information is key to identifying care needs, anticipating future health risks, and avoiding negative outcomes. As mentioned above, effective care coordination requires that relevant information is made available to all members of a care team as needed, including consumers. This information may include basic data on diagnoses, lab results, service use including hospital admissions and emergency room visits, prescription medications and provider contact information. Ideally, it also includes alerts regarding potential gaps in care (e.g., annual screening exams for diabetics), potential adverse medication interactions, and real-time notifications upon critical events such as hospitalizations to ensure coordinated discharge planning.

To note, while access to information technology, such as electronic health records, greatly facilitates the process of information exchange, much can be done in its absence. For example, in one of the Pennsylvania pilots mentioned above, integrated health profiles are developed and shared with all members of the care team in hard copy form pending the availability of an electronic solution.

Incorporate Ongoing Performance Measurement and Accountability

Promoting some measure of accountability, through shared risk, shared savings, or a combination thereof, is a critical element to influence a successful care management approach. By linking performance measures with financial incentives, states can align providers, including primary care, behavioral health and other specialists, as well as care management organizations, to common goals. States should consider performance measures that go beyond standard HEDIS measures to recognize the complexities of the population. Prevention quality indicators, for example, are a set of measures that are used with hospital inpatient discharge data to identify beneficiaries with ambulatory care sensitive conditions.[10] These conditions are recognized as issues for which outpatient care can potentially prevent the need for hospitalization. Process measures can also be used to support the implementation of effective care delivery (e.g., outreach and enrollment targets, completion of a patient-centered care plan, achievement of care plan goals, etc.). Once measures are established, processes must be put in place to ensure consistent and effective performance monitoring.

Establish Financial Incentives that Align with High-Quality, Coordinated Care

As with all aspects of health care delivery, payment mechanisms provide critical levers for driving desired processes and outcomes of care. "You get what you pay for" holds true in health care as in any other industry, and in the case of care management, states must consider how to most effectively align financial incentives with overall program goals. Incentives may need to be specifically designed to address any of the following goals, among others – maximizing enrollment, encouraging rapid assessment of health needs, reducing avoidable admissions and emergency room visits, coordinating care across systems, and transitioning

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patients out of care management as needs are stabilized. Alternative mechanisms for aligning incentives with these goals include: establishing different payment rates for different stages of patient engagement/ enrollment; linking incentive payments (or withholds) to targeted thresholds of performance on a set of key measures; and developing gain-sharing arrangements that allow partners to share in the savings associated with reduced medical costs.

To align incentives for its physical-behavioral health integration pilots, Pennsylvania created a shared incentive pool that rewards the pilot partners for high performance on measures associated with effective integration. The performance measures can be influenced by both physical health and behavioral health care management partners, and both are jointly accountable for the measures. In the first year, the measures focused on measures of cross-system collaboration and integrated care processes (e.g., member assessment, stratification, and jointly developed plan of care). In the second year, the measures evolved to capture intermediate outcomes, such as reduced use of emergency departments and reduced inpatient admissions.

Summary

Ensuring that patients receive the right care in the right setting at the right time is the underlying goal of care management. Innovative leaders in health care are employing many of the elements outlined in this brief to help Medicaid beneficiaries with complex needs achieve this critical goal. These elements can also be used as a framework to guide the evaluation and ongoing quality improvement, of existing care management approaches. As states across the country prepare to absorb the new demands of the expansion population, employing such tools to advance effective care management models takes on even greater importance.

Endnotes

[1] Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimate based on 2004 MSIS data.
[2] CHCS estimate using Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimate based on Centers for Medicare and Medicaid Services-64 reports, March 2009; and National Health Expenditure Projections, 2009-2019.
[3] S.A. Somers, A. Hamblin, J.M. Verdier and V.L.H. Byrd. *Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States*. Center for Health Care Strategies, August 2010.
[4] R. G. Kronick, M. Bella, T.P. Gilmer. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Center for Health Care Strategies, Inc., October 2009.
[5] Ibid.
[6] C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin, and L. Martin. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies, December 2010.
[7] R. Kronick, T. Gilmer, T. Dreyfus, and L. Lee. "Improving Health Based Payment for Medicaid Beneficiaries: CDPS." *Health Care Financing Review*, Spring 2000, 21(3):29-64.
[8] For more information, see resources from CHCS Webinar: *Strategies for Finding and Engaging Medicaid Beneficiaries for Complex Care Management,* October 5, 2010, at http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261169.
[9] W.R. Miller and S. Rollnick. Behavioral and Cognitive Psychotherapy 2009;37:129-140.
[10] For more information, see Prevention Quality Indicators, Agency for Healthcare Research and Quality, March 2012, http://www.qualityindicators.ahrq.gov/Modules/pqi_overview.aspx

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 and high-cost health care needs. For more information, visit www.chcs.org.

About CHCS' Rethinking Care Program

The care management program examples cited in *Introduction to Medicaid Care Management Best Practices* represent states participating in the *Rethinking Care Program*. This national initiative, made possible by Kaiser Permanente, was developed by CHCS to design and test better approaches to care for Medicaid's highest-need, highest-cost beneficiaries. The initiative is linking state pilot demonstrations — in Colorado, Pennsylvania, New York, and Washington — with a national learning network committed to advancing Medicaid's capacity to serve these "high-opportunity" beneficiaries. For more information about the *Rethinking Care Program*, as well as tools for improving care management for Medicaid beneficiaries with complex needs, visit www.chcs.org.