CHCS Center for Health Care Strategies, Inc.

Policy Brief

Eight Key Lessons for Managing Care in Medicaid in 2011 and Beyond

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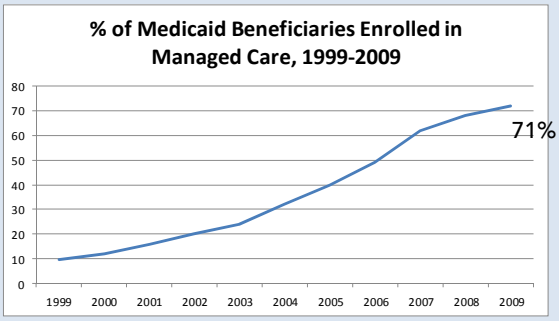
Many states are looking to managed care partners to help them meet their expanded coverage responsibilities in 2014. As they address Medicaid spending and simultaneously prepare for expansion, being able to rely on effective purchasing from managed care entities has great appeal. This includes states turning to managed care for the first time, as well as states beginning to enroll high-need, high-cost populations in managed care, including children with complex needs, seniors and adults with disabilities, those in need of long-term care, and those dually eligible for Medicaid and Medicare.

The shift of Medicaid populations into managed care has grown steadily over the last two decades, with currently over 71 percent of beneficiaries in some type of managed care arrangement.[1] In FY2010, more than a dozen states expanded managed care for Medicaid beneficiaries, with as many as 20 states planning managed care expansions in FY2011.[2] There are a number of significant reasons why states have moved in this direction; well-designed managed care programs can:

- Provide budgetary predictability for states;
- Increase access to a comprehensive provider network;
- Generate rich patient data to drive care management decisions and increase accountability;
- Capitalize on strong incentives to prevent exacerbations of illness and reduce unnecessary use of emergency rooms, hospitals, or institutions; and
- Offer a vehicle for blending financing streams in order to integrate care and use resources flexibly to meet the needs of patients with multiple conditions.

IN BRIEF

Over the last two decades, states have increasingly turned to managed care as a way to improve quality and hold down Medicaid costs. As many states look to expand managed care for new populations, including people with chronic illnesses and disabilities, this brief draws from prior state successes and outlines critical lessons to guide additional states in better managing care and costs for Medicaid beneficiaries.



Source: 2008 and 2001 Medicaid Managed Care Enrollment Reports, CMS. Note: Includes managed care beneficiaries receiving comprehensive and limited benefits.

But the most critical ingredient for success is for the state to be an active purchaser – from the request for proposal phase through setting contract expectations and monitoring performance. Following are eight lessons for effective managed care drawn from the Center for Health Care Strategies' (CHCS) experiences over the past 15 years. These lessons are particularly important for managing the care of the program's highest-cost subset of beneficiaries with chronic conditions and disabilities.

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1. Tailor managed care approach to state and local conditions.

Traditional fully capitated health plans work well for many states, but they are not the only successful model. Depending on the existing state infrastructure as well as current and future needs, a variety of options can be effective, such as partial capitation and enhanced primary care case management. Emerging models supported by the Affordable Care Act (ACA), including health homes and accountable care organizations, offer potential new avenues for improving care coordination for patients with chronic needs. While some states (e.g., Arizona's managed care for all and North Carolina's enhanced primary care case management) have found success in using one statewide approach, others (e.g., Pennsylvania) use a mix of delivery models to tailor care for various regions of the state.

2. Ask stakeholders what they need.

If you build it, they may not come readily -- unless their needs are met. Listening upfront to the concerns of consumers, providers, plans, and partner agencies will increase buy-in from the full range of stakeholders. Gaining the trust of consumers with complex needs who require a broad range of services and specialty providers is critical. California and Wisconsin have used an extensive consumer engagement process to ease the launch of care management programs for seniors and people with disabilities. Adding new populations to managed care will also expand the types of providers with which the plans must contract. However, providers that serve Medicaid fee-for-service beneficiaries may be reluctant to contract with health plans, fearing changes in rates and administrative protocols. Thus, garnering adequate provider support at the outset of a managed care expansion is imperative. This includes not only traditional primary care providers, but also care managers, community-based service providers, and long-term care providers: all of whom may have different historical relationships with beneficiaries and the state.

3. Make sure providers are accessible for all needs in all regions.

Medicaid programs are required by federal law to guarantee adequate access to a comprehensive provider network for all beneficiaries. They, in turn, require their managed care organizations (MCOs) to assure network adequacy, something that MCOs can often do more effectively than a state because of their ability to pay higher rates depending on market conditions. As the frontline of the Medicaid delivery system, primary care providers (PCPs) play a critical role in helping patients avoid costly emergency room visits and hospital stays. Yet, those PCPs that accept Medicaid are often overburdened and in low supply. States, including Michigan and Pennsylvania, are working with their contracted health plans to identify high-volume, under-resourced primary care providers and invest resources to build their capacity for staying in the game and delivering better care. Innovative programs, like Project ECHO, a telemedicine program based at the University of New Mexico that links specialty providers with primary care physicians, could be used to expand the latter's capacity to treat complex chronic conditions in medically underserved communities.[3] Health plans also have the same network adequacy obligations vis-à-vis specialty care – a big problem for many state fee-for-service programs.

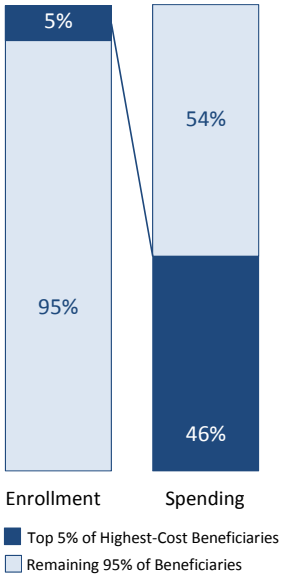
4. Align payment to drive high-quality care.

"You get what you pay for" is a critical lesson for Medicaid purchasers, who can and should demand more for the taxpayer dollar. This includes maximizing opportunities to purchase higher quality and better services, not *more* services. To link dollars more directly with desired care processes and outcomes of care, states are exploring the use of innovative payment mechanisms for better management of care, including: bundled payment; episode of care models; medical/health homes; provider incentives, such as pay-for-performance (and disincentives); shared savings; and global payments. New York, for example, has a comprehensive pay for performance program that rewards health plans for reaching quality goals and, at the same time, denies reimbursement for "never events" – i.e., a set of avoidable hospital complications and medical errors that are identifiable, preventable, and should never happen. States can work with their existing managed care partners to structure these payment arrangements in ways that maximize the impact at the point of care.

5. Follow the money – integrate financing for everyone and everything.

Although more than 70 percent of Medicaid beneficiaries are currently enrolled in managed care, most of these individuals are relatively healthy pregnant women and children. As a result, managed care spending accounts for only about 20 percent of total Medicaid costs.[4] The bulk of Medicaid's high-need, high-cost population in many states is still in fragmented, fee-for-service systems of care. Across the country, there are tremendous opportunities to better manage the care of *all* these beneficiaries, particularly children with complex behavioral health conditions and youth in foster care, seniors and people with chronic illnesses and disabilities, and those with long-term care needs. With California poised to enroll roughly 400,000 beneficiaries with disabilities into capitated managed care for their medical services on July 1, 2011, the pendulum is beginning to shift. Some states, e.g., Tennessee, are going further by integrating financing and services for all physical, behavioral, and long-term services under one managed care organization. Having single entities responsible for the full array of such services may be the wave of the future, including for those dually eligible for Medicaid and Medicare. Other states that have significant experience through managed care with full integration include Arizona, Massachusetts, Minnesota, Texas, and Wisconsin.

5% of Medicaid Beneficiaries Account for Nearly Half of Spending



Source: Kaiser Commission on Medicaid and the Uninsured estimates based on MSIS 2007/2008

6. Demand system-wide accountability.

In order for states to know that they are getting value for their money, states have to write their managed care contracts to demand that all Medicaid beneficiaries are getting the right care, at the right time, at the right place, *and* at the right cost. Rigorous contractual expectations, performance standards, and monitoring processes are all critical for identifying what is working and what needs to be fixed. States can also push accountability down to the provider level by collecting clinical data, ideally via electronic health records. Pennsylvania, for example, is collecting provider, plan, and state-generated data to monitor (and reward) quality at multiple levels and for multiple populations, including those with chronic conditions and disabilities. Indeed, national leaders in measurement, including the National Quality Forum and the National Committee for Quality Assurance, are paying heightened attention to developing measures that address the requirements of a complex needs population.

7. Anticipate the needs of those newly eligible in 2014.

Most observers expect nearly all of the 16-20 million newly eligible Medicaid beneficiaries, many of whom will have pent-up demand and complex conditions, to be enrolled in some kind of managed care. Akin to Massachusetts' experiences with enrollee churning through its Connector program,[5] policymakers know that today's Medicaid beneficiary could be tomorrow's exchange enrollee and vice versa. States are rethinking current Medicaid managed care purchasing and delivery systems to align them with those to be offered through the state insurance exchanges. This will help to mitigate the effects of inevitable churning between traditional Medicaid, new Medicaid, and the exchange population. By developing a more seamless delivery model, states can use managed care to ensure continuity of services and facilitate migration across systems as eligibility changes.

8. Think beyond Medicaid.

Today Medicaid covers more Americans than any other health insurer and with health reform expansion it is projected to surpass Medicare in total spending by 2016. States can use this tremendous purchasing leverage to partner with other public and private payers to help drive improvements across the health care delivery system. Statewide efforts that use managed care to standardize measurement and reporting processes improve population health outcomes can be led by Medicaid. Oregon's current work to transform its statewide health system, for example, is focusing first on Medicaid as the platform for restructuring the state's overall delivery system to achieve better health care, better health and lower costs for its Medicaid, exchange, and state employee populations, and ultimately, for all state residents.[6]

Medicaid already leads the health care system in maximizing limited resources to provide comprehensive services for a diverse population, including many with complex needs. Indeed, a recent analysis found that Medicaid has lower costs per beneficiary than private insurance as well as lower overall spending growth during the last decade.[7] This efficient use of resources is attributable, in part, to the benefits that state Medicaid agencies have gotten from better managing care. The current fiscal crisis is pushing states to do even more. Building on these lessons from successful programs is one place to start.

Resources from 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 quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. Visit **www.chcs.org** for a variety of resources to support the development and implementation of managed care strategies for Medicaid populations.

Endnotes

[1] *Medicaid and Managed Care: Key Data, Trends, and Issues*. Kaiser Commission on Medicaid and the Uninsured. February 2010. Note: Includes beneficiaries receiving comprehensive and limited benefits, e.g., in fully capitated managed care plans, primary care case management programs, Program for All Inclusive Care, etc.
[2] V. Smith, et al. *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage, and Policy Trends: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011*. Kaiser Commission on Medicaid and the Uninsured. September 2010
[3] Project ECHO (Extension for Community Healthcare Outcomes) is an innovative program developed to treat chronic and complex diseases in rural and underserved areas of New Mexico. For more information, visit http://echo.unm.edu/.
[4] *Medicaid and Managed Care: Key Data, Trends, and Issues*, op cit.
[5] A. Raymond. *Lessons from the Implementation of Massachusetts Health Reform*. Blue Cross Blue Shield of Massachusetts Foundation. March 2011.
[6] For more information, visit http://www.oregon.gov/OHA/health-system-transformation.shtml.
[7] J. Holahan, L. Clemans-Cope, E. Lawton, and D. Rousseau. "Medicaid Spending Growth over the Last Decade and the Great Recession, 2000-2009." Kaiser Commission on Medicaid and the Uninsured. February 2011.