Mastering Medicaid: Strategies For Successfully Managing Medicaid MCOs

April 2016

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During the last decade, state Medicaid agencies have embraced managed care as the predominant delivery system. In addition to the goals of reducing cost and improving clinical outcomes, states are looking to more efficiently and effectively deliver care to the roughly 21.3 million additional Americans who could be insured through the Affordable Care Act's (ACA) Medicaid expansion.[1] While states share a number of common objectives, each state also employs a unique approach to managed care and an individualized mix of innovation and quality improvement tactics. These innovative Medicaid managed care models are driving healthcare transformation and, in conjunction with federal incentives, are leading to effective care delivery modalities that may very well extend beyond Medicaid.

This article summarizes the increasingly prevalent Medicaid managed care model to help inform providers' strategies for serving Medicaid patients. It also presents real solutions for addressing some of the key challenges organizations face in managing their Medicaid members.

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1 "Expanded Coverage Under the Affordable Care Act: Information for Health Care Professionals," http://www.medicaid.gov, accessed on October 18, 2015.

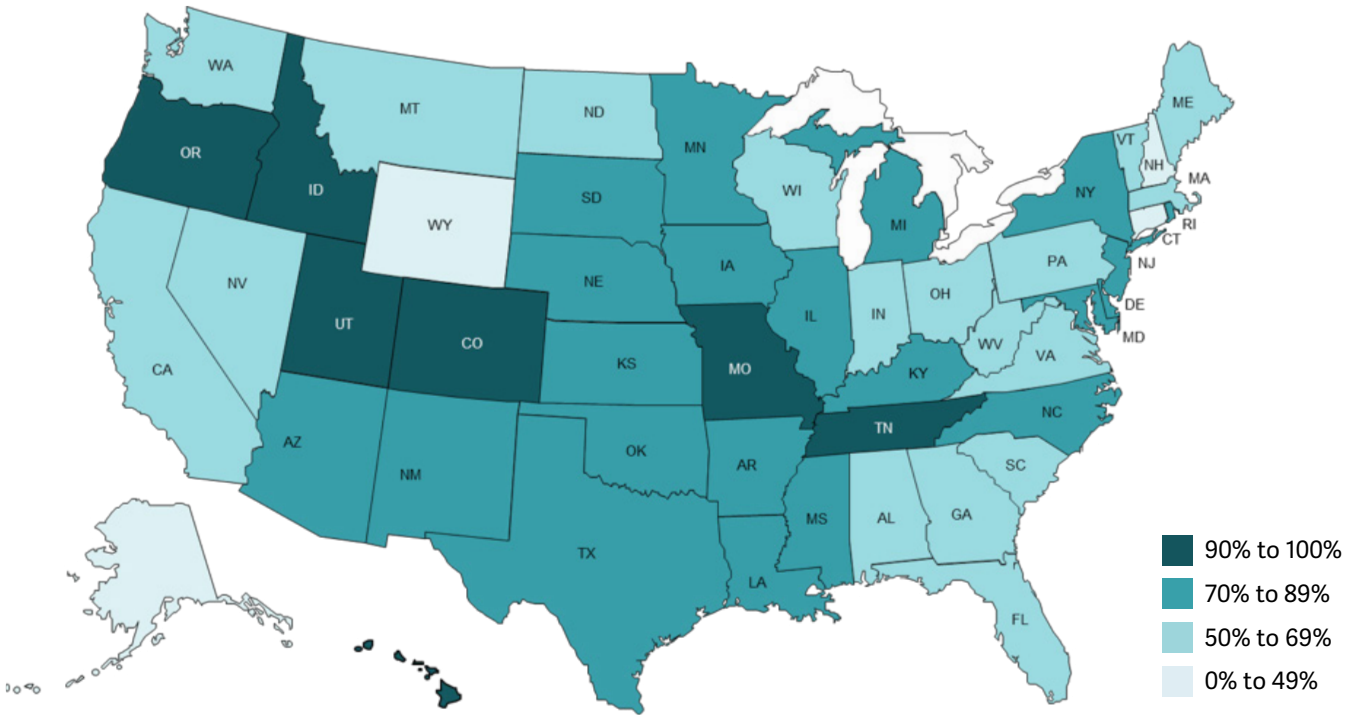
HISTORY OF MEDICAID MANAGED CARE

Medicaid managed care delivery systems grew rapidly during the 1990s. In 1991, 2.7 million beneficiaries were enrolled in some form of managed care. Currently, managed care is the most common Medicaid delivery system, with all states except Alaska and Wyoming having all or a portion of their Medicaid population enrolled in managed care programs, covering more than 50 million recipients nationally.[2]

Of the 39 states (including Washington, D.C.) with managed care organizations (MCOs), more than 75% of the Medicaid population is enrolled in an MCO, and more than half of these states have expanded Medicaid managed care in the last 2 years by adding new eligibility groups, mandating managed care enrollment, and/or expanding MCO coverage to new geographies.[3] As seen in Figure 1, by 2013, seven states had over 90% of their Medicaid population enrolled in MCOs. Since then, six more states have moved to enroll over 90% of their population in managed care.

States have been motivated to move to managed care primarily to control costs, but the expanded availability of federal funding has provided an added incentive. The State Innovation Models (SIM) Initiative and the Medicaid Innovation Accelerator Program (IAP) are two federally funded initiatives created to help states overcome the financial burden of implementing innovative infrastructure to support healthcare transformation. Under the SIM program, awarded states have received nearly $1 billion from CMMI to test innovative delivery models and build infrastructure to support the movement of Medicaid populations to managed care more quickly. The IAP program complements these efforts and provides additional federal support and tools for improved data integration, quality measurement, peer-to-peer learning, and spreading lessons learned.

Figure 1 — Percentage of Medicaid Enrollment in Managed Care by State, 2013 [4]

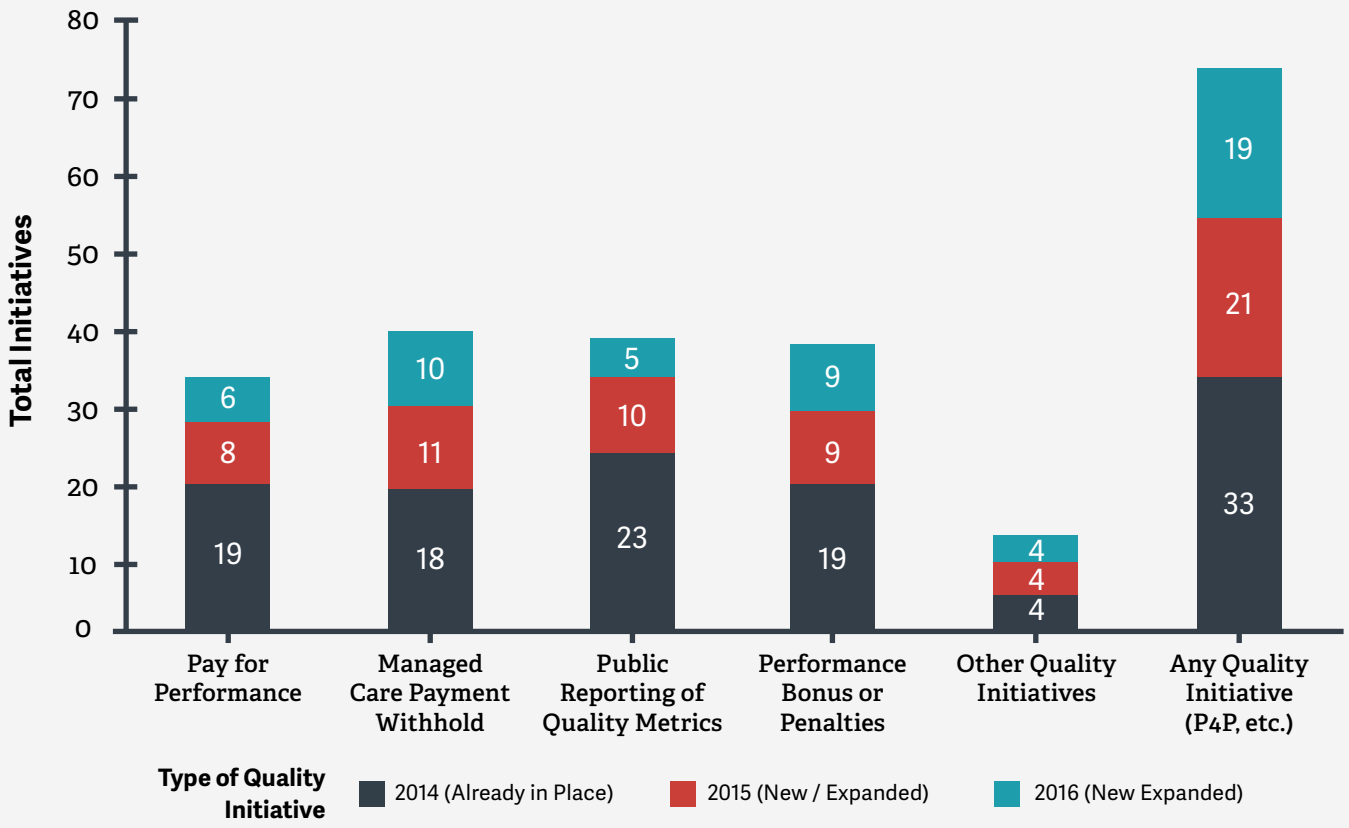


2 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/2011-Medicaid-MC-Enrollment-Report.pdf

3 http://www.medicaid.gov.

4 http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/.

Figure 2 — National Trends for States With Innovation and Quality Initiatives [5]



INNOVATION STIMULUS

Medicaid MCOs typically perform care management and coordination functions as part of their state contracts, with the goal of funding these activities using the expected savings from reductions in unnecessary hospitalizations, ER use, and other costly services, and through effective management of patients with chronic conditions via primary care provider accountabilities. Medicaid care coordination strategies include health homes, patient-centered medical homes (PCMHs), accountable care organizations (ACOs), and the integration of behavioral health into primary care. All of these initiatives rely on technologies to create greater clinical integration between providers, facilitate patient engagement, and standardize care delivery. These initiatives are becoming increasingly prevalent as part of each state's approach to managed care, as seen in Figure 2, with varying degrees of success toward achieving savings.

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5 Vernon K. Smith et al., "Medicaid Reforms to Expand Coverage, Control Costs, and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016," The Henry J. Kaiser Family Foundation, October 15, 2015.

CHALLENGES AND SOLUTIONS FOR MEDICAID MANAGED CARE

Although the federal and state governing bodies continue to emphasize improving and expanding Medicaid coverage, research continues to highlight the various challenges and gaps in Medicaid managed care efforts. Given that Medicaid currently covers about one in every five Americans, these challenges must be understood and addressed by providers and payors who wish to continue to serve these populations. Some of these challenges, along with potential strategies to address them, are outlined in the table below.

Eligibility

Challenge

A consistent care model can be difficult to implement for a majority of the Medicaid population because of the short duration of enrollment. Low-income individuals have volatile annual incomes, which often results in "transition"—a mandated change in eligibility that often requires enrollment in a new program (e.g., Medicaid ↔ exchange). Others experience "churn"— repetitive termination and re-enrollment, often accompanied by a gap in coverage—that results from data matches or eligibility redeterminations. These frequent changes in eligibility, the short duration of enrollment, and gaps in coverage make it difficult to offer comprehensive, coordinated care that ensures continuity across all providers and sites of care.

Strategies to Address

Communication Technologies — Invest in communication technologies that enable continuous and comprehensive patient engagement and outreach regardless of payor.

Provider Networks — For Medicaid managed care and exchange products, structure common provider networks to avoid care disruption upon transition across programs.

Primary Care Attribution — Utilize statewide all-payor databases or attribution algorithms to attribute patients to an appropriate PCP under any plan.

Incentives — Align clinical and financial incentives for providers to manage population health across all payor contracts.

Data — Seek opportunities to collaborate and share data to ensure handoffs or transitions of care if members are no longer part of an organization's network, and utilize other providers in the area.

Access

Challenge

Building complete networks with access to all specialties for members can be a challenge because specialty groups in many states will not contract at current Medicaid rates.

Strategies to Address

Rate Levels — Consider the value, where necessary, of offering contracts at rates that are higher than Medicaid.

Telemedicine — Consider access to specialists in hospitals offering telemedicine as a way to fill network specialty gaps.

Historic Treatment Patterns

Challenge

For many beneficiaries, a lack of previous coverage has forced patients to seek care in expensive care settings, such as the ER. Providers and care coordinators are challenged to break these patterns of care without a large enough profit margin to induce those behavior changes through financial incentives.

Strategies to Address

Site of Service Payment Incentives — Structure "site of service" payment incentives with a measurable return on investment to deliver care in the clinically appropriate setting.

Patient Education — Implement education programs to help patients understand the importance of a medical home foundation and ongoing primary care for chronic conditions, with appropriate financial incentives to participate.

Care Coordination — Deploy care coordinators into expensive care settings, such as ERs, that are part of the triage process and can redirect patients to more appropriate sites of care.

Member Engagement

Challenge

The Medicaid population is one of the most challenging to manage, mostly due to the fact that these patients are hard to reach.

Strategies to Address

Patient Outreach — Develop a patient outreach strategy, including welcome calls and letters as well as ongoing outreach to schedule appointments or services.

Communication — Consider various forms of communication to connect with members—phone, email, and text.

Patient Incentives — Consider incentivizing patients to complete routine tests, screenings, and exams (if allowed by the state contract).

Community Organizations — Pursue opportunities to connect with community organizations, such as public health departments, churches, and homeless shelters, to locate members and initiate engagement.

Member Information — Utilize phone number and address lookup vendors if information is not available for members for initial contact.

Quality Measurement

Challenge

Many states require National Committee for Quality Assurance accreditation for plans pursuing Medicaid managed care contracts. However, very little quality data is collected by the states, and very little is done to use quality data to drive improvements or set performance standards.

Strategies to Address

Partnerships — Pursue partnerships between providers, payors, and states to build quality data infrastructure to facilitate quality reporting and offer providers a system to monitor performance throughout the plan year.

Technology Costs

Challenge

The cost of building the technology to support innovative delivery systems is often too high given the reimbursement levels and potential profit margins for Medicaid managed care models. Innovative and clinically integrated networks of care require providers to be connected and share health information in real time, have the ability to engage with patients and conduct outreach automatically, measure quality and value with innovative techniques that require data integration, and support the work flow of care coordinators in new ways.

Strategies to Address

Scalable Technology — Invest in scalable technology that can be used across multiple value-based contracts at the organizational level to drive population health and provider performance improvement.

IT Optimization — Determine the technology cost per member as care models are built. Select technologies that will optimize the work of care coordinators while minimizing the total FTE count.

Public Resources — Identify state and federal technologies available through the SIM Initiative and IAP or other funding opportunities, such as CHIP grants, to support system purchase or development.

CONCLUSION: MAKING THE MOST OF MEDICAID MANAGED CARE

Medicaid managed care has the potential to significantly improve access to healthcare and health outcomes for one of the most challenging and complex patient populations—Medicaid members. It may also have the potential to reduce program costs and improve the overall quality of care delivered. However, these goals cannot be achieved unless MCOs are able to create partnerships between providers and payors that can strengthen the delivery of effective, high-quality managed care to the Medicaid population.

The financial and operational challenges for Medicaid MCOs are difficult to overcome, but with proper market insights, patient engagement methodologies, and payor strategies, some key tactics can be used to address the specific issues in each state. Depending on the circumstances, some of these strategies may be more feasible to implement than others, particularly in regard to cost-sensitive strategies such as IT investments. Regardless, employing these tactics can help organizations maximize margins from their Medicaid business under the new MCO model and ultimately deliver better care to a population that has traditionally been underserved.

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