Insight

Medicaid Managed Care and Medical Homes

TARA O'NEILL HAYES | NOVEMBER 10, 2016

Executive Summary

Medicaid is a program in great need of reducing costs and improving outcomes for its beneficiaries. Medicaid managed care programs can assist in accomplishing both of these goals. Medical homes, developed in conjunction with managed care programs, can provide even greater benefit, particularly for those patients with the greatest needs, such as children, the aged and the disabled. Medical homes provide for enhanced coordination of care, with particular consideration given to each patient's (and their families') desires and limitations. Medicaid managed care programs working in conjunction with medical homes could provide significant benefits to patients, as well as federal and state budgets. Quality metrics and evidence-based standards of care designed specifically for children and patients with chronic needs should be developed.

Background

In the 1980s, some states began transitioning their Medicaid programs from the standard fee-for-service (FFS) model to risk-based managed care models, through contracts with private health insurance organizations. In a managed care model, a capitated payment is typically provided by the state for each individual enrolled in the plan (similar to Medicare Advantage). This transition occurred largely as an effort to control costs. Traditional FFS Medicaid encourages greater use of services, and more expensive services, because it reimburses providers, as the name implies, for each service performed and without any quality controls or assessment regarding the value of those services. Managed Care Organizations (MCOS), as part of their contract with the state, are required to meet certain quality standards and are paid a fixed amount for each enrollee, thus eliminating the incentive to provide unnecessary services. (Primary Care Case Management (PCCM) organizations are also used to coordinate care of Medicaid beneficiaries, which can provide great benefit to the patient, but these types of MCOs do not share a financial risk like the other models.)

As of March 2016, more than 47 million individuals, or roughly 65 percent of Medicaid beneficiaries across 39 states and the District of Columbia, were receiving care through a MCO.[1] Across the categories of eligibility—children, low-income adults, expansion-population adults, and the aged and/or disabled—expansion population adults are the most likely to be enrolled in managed care (84 percent); the second group is children at 82 percent; followed by low-income adults (73 percent); and just over half of the aged and disabled beneficiaries are enrolled in managed care (53.6 percent).[2]

Since the aged and disabled Medicaid beneficiaries are the costliest beneficiaries, their lack of enrollment in managed care programs (and therefore continued enrollment in FFS) has resulted in much of the potential benefit offered by such programs to go unrealized. This lack of enrollment is the primary reason only 34 percent of all federal Medicaid expenditures are spent on MCOs. Aged and disabled beneficiaries account for 60 percent of all Medicaid expenditures despite being only a quarter of the Medicaid population.[3] Additionally, there are a significant number of children with complex medical conditions who have expenditures far above the average for children without such conditions. Many of these individuals with complex needs are not receiving the most

appropriate or beneficial care, and they—and the Medicaid budget—are worse off because of it.

The Value of Medicaid Managed Care Programs

While all individuals can benefit from managed care programs, individuals with above-average health care needs will benefit the most. Medicaid managed care programs are subject to stricter regulations regarding access to and quality of care and beneficiary protections. States with a managed care program must:

- develop and regularly measure quality metrics,
- require MCOs to regularly assess appropriateness of care and utilization of services, and
- conduct and evaluate the effectiveness of performance improvement activities.[4]

MCOs, like other insurers, manage the health care needs of their patients through a variety of means. MCOs establish a network of providers and connect patients with a primary care provider, disincentivize overutilization of services or use of high cost services, and incentivize and encourage wellness and preventive services. In the private sector, the most effective tool managed care models can use to incentivize patients to reduce costs is through differences in cost-sharing between cheaper and/or more effective goods or services and those that are more expensive. However, because individuals enrolled in Medicaid (except for some expansion population adults) may not be held responsible for any (or very little) share of the cost, these tools are not as readily available to Medicaid MCOs. Thus, Medicaid MCOs rely primarily upon limited provider networks, referral requirements and prior authorization for certain services to reduce utilization, which ultimately reduces costs. Measures to more directly contain costs include requiring generic drugs be used when available and holding care providers responsible for a share of the financial risk if costs exceed a given threshold.

These cost management strategies to discourage resource use, limit subspecialists and/or require approvals for referrals work very well for generally healthy populations with preventive and episodic health needs. Chronic complex populations, particularly children, have many specialized needs which must be closely integrated and delivered in a coordinated fashion, often on a daily basis, to be effective. A more integrated and coordinated approach is required for these populations.

One Step Further: Medical Homes

Individuals with complex health care needs will benefit even more from becoming part of a medical home. While MCOs, as providers of health care coverage, can incentivize certain services and remind patients of upcoming appointments or to take medications, MCOs are not (typically) directly providing the actual care received by the patient. Medical homes, conversely, are made up of the care providers themselves.

Medical homes provide patients with a central access point to their health care, coordinating all of the patient's care providers and managing all of the patient's health care needs, including hospital care and prescription drug use. The most robust medical homes are comprehensive and patient-centered, allowing for shared decision-making and accounting for the patient's desires and limitations. For example, these considerations should include a patient's tolerance for certain side effects and treatment frequency, as well as the ability and availability of the patient and his or her caregivers to make it to appointments. Providers are responsible for ensuring patients and their families are well-educated regarding the importance of treatment adherence and the patient's own responsibilities for his or her well-being. Medical homes should either be able to provide a patient with access to all goods and services the patient may need, or be able to refer the patient to outside specialists in a timely and coordinated manner, while maintaining contact and access to a patient's full medical records. To be

effective in highly subspecialty care such as pediatrics, medical homes must be able to operate seamlessly across state lines, given the geographic availability of specialized pediatrics is much lower than comparable adult services. For instance, if a patient visits the emergency room, sees a specialist, or does not pick up a prescription, the medical home should be aware and in contact with the patient and/or the care provider to figure out the problem. Medical homes are also held accountable for a patient's overall health outcomes while simultaneously held responsible for reining in costs; together, these provisions work to ensure the patient is receiving high-value care.

Working in Conjunction

An advantage to implementing medical homes in Medicaid is how easily such a model can work in tandem with existing Medicaid Managed Care programs. Across the country, 24 states are already making payments to medical homes for Medicaid beneficiaries, 15 of which also contract with MCOs. Just as MCOs are typically paid a flat fee to provide the services needed by the covered beneficiary, a portion of this fee can then be used to pay the medical home caring for a particular patient. Typically, care coordination fees are paid on a per member per month basis. However, depending on the depth and breadth of services a state's MCOs provide, a medical home in a given state may have more or less direct responsibility for a patient, which could be used as a justification for adjusting the portion of the payment paid to the medical home. This is particularly true for out-of-state patients, who must navigate across multiple Medicaid program requirements, requiring the medical home to provide additional coordination support. Additionally, payments to the medical home should be risk-adjusted based on the severity of the patient's condition in order to adequately provide the provision of all needed care.

States can easily apply and build upon the quality metrics and evaluation methods they have already established for their managed care programs. Quality metrics and evidence-based standards of care designed specifically for children and patients with chronic needs should be developed. Since medical homes are directly providing care to patients, they should be evaluated more vigorously than MCOs for patient outcomes and cost savings, the results of which may also impact a medical home's final payment for services.

North Carolina, one of the states utilizing both managed care programs and medical homes for its Medicaid beneficiaries, achieved savings of more than $336 million in fiscal year 2014, representing a return on investment of more than $3 to $1, while also improving outcomes for at least six quality metrics.

Conclusion

Medicaid managed care organizations have helped improve the quality of care that beneficiaries receive, while often saving money. Sometimes Medicaid MCOs save significant amounts of money in a program where spending is crippling Federal and state budgets. Medical homes can expand these benefits, particularly the quality of care received by patients with complex health care needs. While there is likely to be overlap in the services provided and benefits gained from the work of MCOs and medical homes, a truly robust medical home working in conjunction with a managed care model will provide the most comprehensive services and maximize the benefit to the patient.

[1] http://kff.org/data-collection/medicaid-managed-care-market-tracker/

[2] http://kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] http://kff.org/other/state-indicator/total-medicaid-mco-spending/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] https://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol4/pdf/CFR-2009-title42-vol4-sec438-240.pdf