

Research



Moving Beyond Fee-For-Service: The Case for Managed Care in Medicaid

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Fee-for-service (FFS) reimbursement is at the heart of what is wrong with the Medicaid program. By underpaying providers for uncoordinated care, FFS has impaired patient access, led to lower quality outcomes, and hampered efforts to instill greater program accountability. This paper makes the case for moving to managed care in Medicaid to deliver more consistent and higher quality care.

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RESTORING MEDICAID'S PROMISE

Medicaid is a means-tested, in-kind entitlement, originally established under the Social Security Act of 1965 to ensure low-income and disabled Americans had access to basic healthcare coverage. The program was promised to be a safety net for Americans when they needed it the most.

Unfortunately after four decades, the program is starting to default on its promise. Today, Medicaid enrollees face limited access to lower quality care at the same time that the program's budget is bankrupting states and the federal government. Without reform, Medicaid will fail to meet its promise to the more than 60 million Americans who depend on it.

The program's decline has been driven by an inefficient fee-for-service (FFS) payment system that pays providers for more, not better, care. By paying for fragmented care, FFS provides little incentive for different care providers to work together and remove waste from the delivery system.

Managed Medicaid is the solution. By paying a bundled payment for each patient, Managed Medicaid allows states to improve access to care through private insurance networks, facilitate care coordination across providers, instill provider accountability, and deliver better outcomes.

IMPROVING ACCESS TO CARE

Improving access to care is an imperative for the Medicaid program. Currently Medicaid coverage does not guarantee access to care. Increasingly individuals and families enrolled in the Medicaid program face barriers to receiving care from primary care physicians, specialists, behavioral health professionals, and other critical medical providers. The problem stems from fee-for-service (FFS) reimbursements, which averaged only 72

percent of the rates paid by Medicare (Medicare rates are also well below the rates paid by private insurers).[1]

The unsustainably low reimbursement rate has led many primary physicians and specialists to stop accepting Medicaid enrollees. The problem is especially pronounced in rural areas where provider shortages present major public health concerns:

- A June 2010 nationwide survey of physicians found that 54.5 percent of primary care physicians, 45.6 percent of medical specialists, and 49.3 percent of surgical specialists are no longer accepting new Medicaid patients.[2]
- In a separate 2010 survey of 1,800 emergency room physicians, 71 percent of respondents expect emergency visits to increase, and 47 percent anticipate conditions will worsen for patients.[3]
- Increased overutilization of America's emergency departments by Medicaid enrollees could cost states, hospitals and physicians as much as \$35.8 billion over the next decade in unaccounted for expenditures.[4]

Managed Medicaid improves access to care because it partners beneficiaries with healthcare providers at the time of enrollment. Managed Medicaid companies are able to do this through in-network resources and negotiating differential rates based on geographic area. This creates an ongoing partnership between Medicaid patients and non-ER providers, which leads to greater preventative care and better disease management of chronic conditions like diabetes and asthma.

Managed Medicaid is also better equipped to address difficult socio-economic challenges confronting Medicaid populations like illiteracy, English as a second language, and limited access to transportation. In the FFS model, these challenges make it nearly impossible for Medicaid enrollees to navigate the healthcare system. Under Managed Medicaid, states have made great strides at addressing these social-economic challenges. For instance:

- New Mexico's Salud program, which includes three managed care options, has been lauded for its success in addressing cultural and linguistic barriers to care. The state's directory of providers indicates the languages spoken in their offices and each of the state's three Medicaid managed care plans offers services specifically designed to assist beneficiaries for whom English is not a primary language.[5] Programs will arrange for an interpreter to accompany patients to clinician office visits.
- In Tennessee, Managed Medicaid plans arrange transportation and childcare options for high-risk pregnant mothers to enable them to keep regularly scheduled prenatal appointments. In combination with nutritional outreach, this has helped the program achieve a 12.7% reduction in neonatal intensive care (NICU) days.[6]

Managed Medicaid plans have also demonstrated the ability to rapidly adopt emerging communication technologies. General medical and Managed Medicaid plan information is typically available online. This is in addition to text-messaging outreach services and videoconferencing with which Managed Medicaid companies are experimenting with to bring providers and patients together in new ways.

FACILITATING CARE COORDINATION

The coordination of health services is critical to improving chronic disease management in the Medicaid program. Currently more than 60% of Medicaid enrollees suffer from a chronic condition and account for more than 75% of total healthcare expenditures annually.[7]

Improving care coordination requires better communication among physician specialists. In the fee-for-service model, physician specialists often operate independent of one another leading to duplicative testing and potentially lethal drug interactions. The fragmented approach incentivized by FFS routinely leads to conflicting patient advice and insufficient follow-up care.

Conversely, bundled State payments to Managed Medicaid companies encourage plans to address communication issues through case management and new health information technology (HIT) platforms that are able to draw historical and current patient information from Medicaid cla

ims, pharmacy records, lab reports, and other information databases.

Care coordination is most needed in addressing Medicaid long-term care services. Medicaid has become the country's largest payer of long-term care, funding approximately 50 percent of all long-term care spending and nearly two-thirds of all nursing home residents. The widespread use of the FFS reimbursement is expected to fuel an average growth in long-term care costs of 7.5% annually over the next decade. [8] To stop this cost growth and deliver long-term care in a home-based setting, States should again look to Managed Medicaid plans.

In Tennessee, Managed Medicaid for LTC has facilitated coordinated care in home-based settings, which are preferred by most patients. This has also alleviated critical nursing home access issues while reducing the cost burden on the state. *USA Today* reports that in 2009, about 90 percent of Tennessee's Medicaid long-term care funding went to nursing homes resulting in long waiting lists for enrollees who need nursing home-based services. Tennessee addressed this crisis by awarding managed long-term care contracts to three Managed Medicaid health plans, and soon thereafter the waiting lists shrank sharply.[9]

INSTILLING PROVIDER ACCOUNTABILITY

Achieving meaningful Medicaid reform requires instilling accountability throughout the care delivery system. By emphasizing provider accountability and quality improvement, States can capture operational efficiencies and optimize Medicaid patient satisfaction.

States should focus immediately on provider accountability for fraud, waste, and abuse by contracting with Managed Medicaid plans. Nationwide the current improper payment rate for Medicaid is over 10% and costs U.S. taxpayers up to \$60 billion annually. [10] If designed effectively, Managed Medicaid plan contracts can create compelling financial incentives necessary for Medicaid managed care plans to root out potential enrollment errors and flag dubious provider claim submissions using predictive modeling and electronic processing systems.

To promote accountability among providers for care quality, States can design Managed Medicaid contracts that require rigorous utilization reviews to improve patient outcomes and deter fraud. Studies indicate that waste and duplication may account for up to 50% of the nation's healthcare spending.[11] PricewaterhouseCoopers' Health Research Institute estimated that unnecessary medical tests alone contributed \$210 billion to the U.S. healthcare costs in 2008.[12] By working together to eliminate waste, States and Managed Medicaid plans can

alleviate the growing budgetary threat posed by Medicaid.

Finally, States can promote provider accountability by measuring patient satisfaction scores. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey employed by most states offers a valuable insight into patient satisfaction with health plans and providers alike. Survey results help to identify program weaknesses and opportunities for improvement.

DELIVERING BETTER OUTCOMES

Managed Medicaid plans consistently deliver higher rates of screening and immunization than their fee-for-service counterparts. For example:

- In South Carolina, in the three-year period from 2006 to 2008, children enrolled in the state's Healthy Connections voluntary managed-care program were consistently more likely to have had a well child visit than those enrolled in fee-for-service.[13]
- In New York, Medicaid managed care enrollees were nearly twice as likely to have had screenings for cervical cancer as fee-for-service plan enrollees.[14]
- Under the Mommy and Me plan in Kentucky, the percent of pregnant women who received a prenatal visit within the first trimester or within the first 42 days of enrollment increased from 78% to 92%.

Managed Medicaid plans consistently deliver more manageable care to patients suffering from a chronic disease like asthma and diabetes:

- In California, targeted interventions resulted in a 21% decrease in ED visits and a 35% decrease in hospital admissions for enrollees with asthma.[15]
- In another program, the number of diabetics obtaining recommended eye exams increased from 37.9% to 49.43% over a five-year period.[16]

Finally, Managed Medicaid plans deliver more cost savings for States and the federal government.

- According to a Lewin study, Arizona's adoption of a statewide Medicaid managed care model resulted in a 7% savings over fee-for-service delivery over a 10 year period.[17]
- In 2002, a managed care model enabled Wisconsin to achieve 10.7% savings in program expenses.

THE CLOSING ARGUMENT

The problems with Medicaid are well-documented: diminishing access to care for recipients, low reimbursement rates for doctors, fraud, and a growing financial burden on states. The next logical question is how to fix it in order to fulfill our commitment to future generations.

Moving to a managed care model in Medicaid is a fiscally responsible plan forward. This approach is based on smaller, successful programs across the country and has shown to improve access to care, coordination of care, provider accountability and quality outcomes for patients. Washington has ignored the problem long enough. It is time for a solution that keeps the promise of Medicaid to Americans and saves states from the crushing debt burden caused by the program's current structure.

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