

Medicaid Payment and Delivery Reform: Insights from Managed Care Plan Leaders in Medicaid Expansion States

Sara Rosenbaum, Rachel Gunsalus, Maria Velasquez, Shyloe Jones, Sara Rothenberg, J. Zoë Beckerman

ABSTRACT

ISSUE: Managed care organizations (MCOs) are integral to Medicaid payment and delivery reform efforts. In states that expanded Medicaid eligibility under the Affordable Care Act, MCOs have experienced a surge in enrollment of adults with complex needs.

GOAL: To understand MCO experiences in Medicaid expansion states and learn about innovations related to access to care, care delivery, payment, and integration of health and social services to address nonmedical needs.

METHODS: Interviews with leaders of 17 MCOs in 10 states that have seen large Medicaid enrollment growth and have undertaken payment and delivery reforms.

FINDINGS AND CONCLUSIONS: MCO leaders regard their ability to enroll and serve the Medicaid expansion populations as a signal achievement. They have focused on identifying and helping high-risk populations and addressing the social determinants of health. MCOs are testing value-based payment strategies that link payment with performance and are increasingly focused on engaging patients in their care. Leaders report common challenges: setting appropriate payment rates; managing members whose needs differ from traditional Medicaid beneficiaries; ensuring access to specialty care; and effectively implementing payment reform and practice transformation. All point to the need for a stable policy environment and a strong working relationship with state Medicaid agencies.

KEY TAKEAWAYS

- ▶ Two-thirds of Medicaid's nearly 75 million beneficiaries are enrolled in managed care organizations.
- ▶ With Medicaid expansion under the ACA requiring plans to rapidly increase capacity to meet the demand for care, managed care plan leaders have focused on identifying high-risk populations and addressing the social determinants of health.
- ▶ Plan leaders are finding needed reforms difficult to achieve when community providers lack experience with alternative payment methods and the infrastructure necessary to manage financial risk.

INTRODUCTION

With nearly 75 million beneficiaries, Medicaid is the nation's largest public health insurer.¹ What is referred to today as managed care has been an element of the program for decades.² Since 1997, states have been permitted to require most beneficiaries to enroll in managed care and enrollment since then has grown substantially.³

Most Medicaid beneficiaries are members of managed care organizations (MCOs) that cover and furnish care across the spectrum of health needs. Some MCOs specialize in providing certain services, such as behavioral health care. Others may specialize in serving certain special-needs Medicaid populations such as children or adults with severe disabilities. MCOs may be sponsored by national publicly traded companies or owned and operated by local organizations or health care provider systems.⁴

MCO sponsors may also sell qualified health plans in the marketplaces. When Medicaid and private marketplace plans share the same provider network, members who shift between Medicaid and the marketplace because of small changes in income are still able to maintain continuity in their care.⁵

Today managed care is integral to Medicaid; indeed, the Affordable Care Act's (ACA) Medicaid expansion was predicated on enrolling the newly eligible population in managed care.⁶ Thirty-nine states have incorporated MCOs into their Medicaid programs.⁷ Two-thirds of all beneficiaries are members of comprehensive MCOs and in 28 states, managed care accounts for 75 percent or more of beneficiaries and over 40 percent of total Medicaid spending.⁸

About the Study

Following our earlier study of health care delivery and payment reform in California, Colorado, Connecticut, Maryland, Massachusetts, Michigan, Minnesota, New York, Ohio, and Washington,⁹ we explore in this issue brief how MCOs in these 10 Medicaid expansion states are responding to rapid enrollment growth. The states all have long track records as managed care purchasers, and all have experienced tremendous growth in enrollment under the expansion.

We focus on MCOs serving adult beneficiaries and families whose members are eligible because of low income; we did not include plans specially designed for beneficiaries with serious disabilities. We interviewed CEOs and financial and operational managers from 17 MCOs to determine whether common issues are emerging. Because participants were offered anonymity in order to speak candidly, we do not report the results by state or plan. Together the participating MCOs cover over 4.5 million Medicaid members and range in size from 670 to more than 1.3 million members.¹⁰ Their locations and service areas are diverse and include both urban and rural communities.

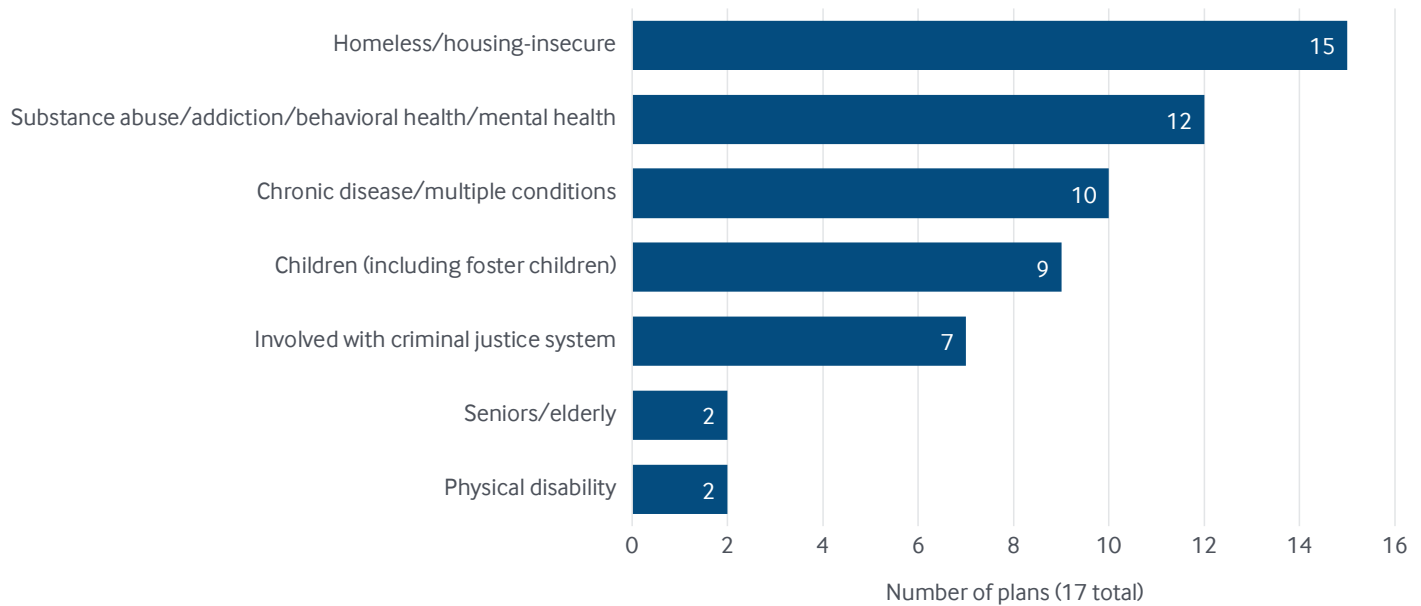
FINDINGS

Meeting a surging need for health care. Medicaid expansion required plans to rapidly increase capacity to meet demand for care among a newly insured population that had considerable pent-up health care needs.¹¹ And as with traditional beneficiaries, new beneficiaries were likely to live in low-income, medically underserved communities, complicating the task of expanding provider networks and ensuring access to care. Nearly all MCO leaders regarded their ability to rapidly enroll new members and connect them with care as a signal achievement. Leaders described various strategies to meet demand: expanding use of advanced practice nurses and physician assistants; increasing the involvement of community health workers to connect people to care; encouraging existing providers to accept more Medicaid beneficiaries through bonus payments; and expanding their networks to include more community providers. Respondents noted that they focused particularly on growing primary care capacity.

A heightened focus on the social determinants of health. As they enrolled more people, MCO leaders placed greater focus on identifying high-need or high-risk members, consistent with trends among safety-net provider activities (Exhibit 1).¹² Most commonly, plans focused on members who are homeless or housing-insecure, followed by members with mental illnesses or substance use disorders, and then people with chronic diseases or multiple medical conditions. Several plans focused on children placed in foster care and members with involvement in the criminal justice system.

Exhibit 1. High-Need, High-Cost Populations Served by Medicaid MCOs

Populations



To address beneficiaries' needs, many plans offered assistance in securing supportive housing, enhanced mental health services, nutrition and food access services, and expanded addiction treatment (Exhibits 2 and 3). Some plans also offered community reentry programs for former prisoners, transportation supports, health education, employment training, and child care coverage.

All plans reported having greater involvement in integrating clinical care with social supports. Rather than just making referrals, they offered “warm handoffs” to social service providers and collaborated with these providers through formal agreements. As Medicaid expansion has meant enrolling low-income parents along with their children, MCO leaders also reported efforts to develop family-focused interventions such as helping parents find treatment for substance abuse. Other respondents reported piloting whole-person care models in which providers assess members' medical and nonmedical needs and develop comprehensive plans to meet them.

Payment and treatment innovation. Most MCO leaders reported that they are either employing value-based

purchasing strategies or are in the process of doing so. As illustrated in Exhibit 4, their approaches include:

- full or partial capitation bonuses linked with performance outcomes
- incentives tied to accountable care that is coordinated and high-quality
- bundled payment for episodes of care
- alternative payment models for federally qualified health centers.

The 2016 Medicaid managed care rule permits states to use their managed care contracts to substitute certain services for those normally covered under their state plan, such as home visits for new mothers rather than in-office mother and infant care. This flexibility to provide other types of care in lieu of normally covered services has been a focus of interest. Although no MCOs had yet developed such “in lieu of” agreements with their states, leaders expressed interest in doing so.¹⁵ As we learned in our previous study, these types of changes presented challenges to MCOs in terms of defining the scope of permissible service substitution and accurately pricing such services.

Exhibit 2. How Medicaid MCOs Address Social Determinants of Health

Social determinants of health

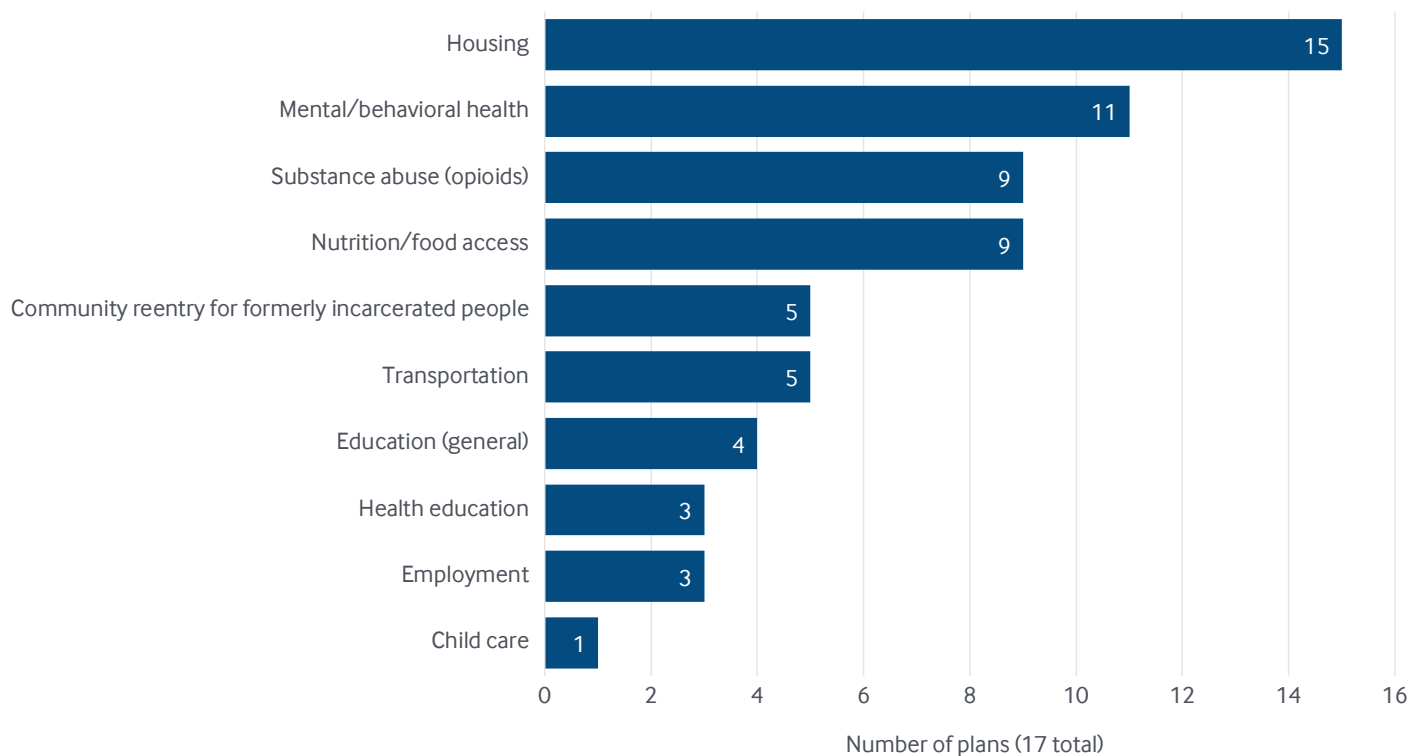


Exhibit 3. Health and Social Service Innovation: What Some Plans Are Doing

HOUSING AND SOCIAL SERVICES

- Consolidating health and social services in a single setting
- Conducting housing needs assessments and supportive services in emergency department settings and developing shelter services for homeless patients following hospital discharge
- Adding housing management as a plan offering and support for transitional housing
- Emergency housing for refugees

COMMUNITY REENTRY FOR FORMERLY INCARCERATED MEMBERS

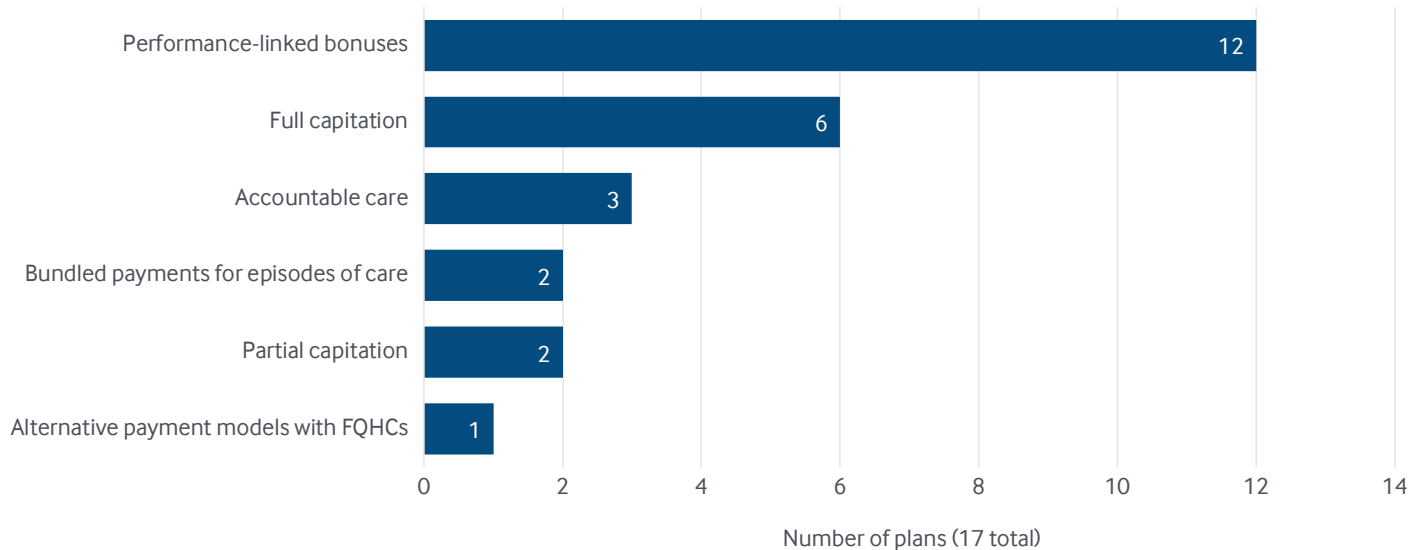
- Pilot reentry programs to complete Medicaid and plan enrollment before inmate discharge
- Special needs assessment and support programs for formerly incarcerated members, including rapid enrollment into substance abuse treatment

FOOD AND NUTRITION

- Provision of food in community locations
- Support for community food bank operational and food-stocking costs
- Coordination of home-based health services with food delivery programs
- Coordinating senior nutrition programs with hot lunch delivery for members

Exhibit 4. Medicaid MCOs' Efforts in Value-Based Purchasing

Payment innovations



Leaders said that implementing payment reforms is easier in local health care markets where providers have become accustomed to alternative payment models such as payment bundles and partial capitation, in which providers share the risk of losses as well as the opportunity for gains. Leaders stated that tolerance for risk comes with experience and sophisticated budgetary management capabilities. As a result, they noted that progress in payment innovation will be sensitive to provider experiences as well as the type of service involved. Several noted that they distinguish among their network providers, using alternative payment strategies such as capitation for primary care providers while maintaining fee schedules or episodes of care for specialists. Several also noted that their payment reform strategies were part of their State Innovation Model grants.¹⁴

Common challenges. MCO leaders reported common challenges, most prominently, setting the appropriate level of per member per month capitation payment rates for various plan member classes, particularly newly eligible adults who gained coverage under the ACA (Exhibit 5). In their view, these new members'

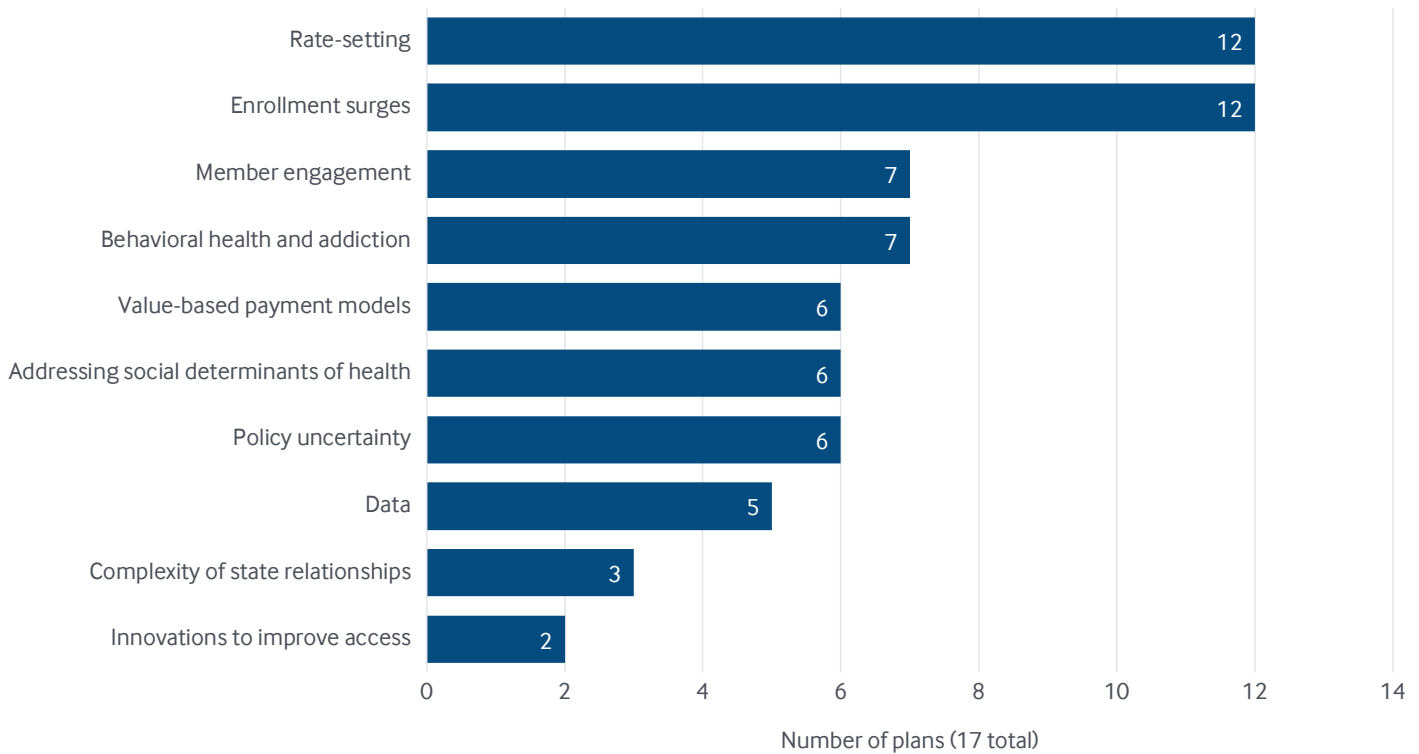
demographic and health characteristics differed substantially from those of traditional beneficiaries, creating greater unpredictability. In addition, many new members initially had more extensive health needs because of their prior lack of coverage.

Leaders further noted that the higher level of need among new enrollees — who may have been uninsured for a considerable amount of time — was magnified by the initial enrollment surge. New enrollees also have the same risks that confront Medicaid beneficiaries generally, including limited understanding of how the health system works or how to engage with it, and greater exposure to social conditions that threaten health.

In terms of plan management, MCO leaders underscored the challenge of implementing large-scale payment reform, which they viewed as demanding long-term commitment. Leaders noted the complexity of the payment models and the significant management and technical resources needed to implement them and measure their effects. They also noted that some providers were not prepared to practice in new financial, information, and practice management environments.

Exhibit 5. Common Challenges Faced by Medicaid MCOs

Challenges



A few leaders saw the complexity of state program requirements as a challenge, but most said they had strong relationships with their state Medicaid agencies. Many worried about the policy uncertainty surrounding the Medicaid program (at the time of our interviews, Congress was actively considering a far-reaching restructuring of Medicaid as part of an ACA repeal-and-replace strategy) and emphasized the need for stable coverage as a foundation for long-term health care delivery and payment reform.

Finally, MCO leaders noted the challenge of building a network of providers to ensure access to care, particularly specialty care, and of building the information technology infrastructure needed for their payment and delivery reforms.

CONCLUSION

Because of increased funding and significant changes in the number of people covered, Medicaid expansion created an enormous opportunity for MCOs to promote

the large-scale changes necessary to improve the quality and efficiency of care for beneficiaries. By making income the sole requirement for eligibility, the expansion made it possible for plans and provider networks to reach a large proportion of residents of low-income communities and eliminated the historic exclusion of most working-age adults. This enabled MCOs to introduce new approaches to health care organization, delivery, and payment and gave them the opportunity to more closely align clinical and social services.

At the same time, MCO leaders identified challenges. Leaders, including those overseeing provider-sponsored plans, noted that ambitious payment reforms are difficult to achieve when community providers lack experience with alternative payment methods and the information and management infrastructure necessary to manage financial risk. They also pointed to the challenge of building provider networks that can offer the full range of covered services in a timely fashion.

Leaders cited the need to experiment with alternative care models that move away from a high number of office-based, face-to-face encounters for all members and toward a strategy that makes better use of alternative communication strategies. These strategies may include telephone and text consultation coupled with “high touch” time (such as home visiting) for members with serious health needs requiring greater integration of health and social services. An additional challenge for MCOs is that many newly insured members have never received regular health care as adults. According to the interviewees, while these challenges can be separated, their cumulative effect makes it harder to set appropriate rates.

A final challenge is the uncertainty that continues to surround Medicaid. This study was carried out at a time of legislative uncertainty surrounding the program’s future. While the immediate legislative threat to the program may have abated, the Trump administration is actively encouraging Section 1115 state demonstrations that could have a significant downward effect on working-age adults’ eligibility and enrollment stability. Because of the link between stable coverage over time and the success of long-term investments in promoting higher-quality, more efficient care delivery, demonstrations that reduce or undermine enrollment could similarly be problematic for delivery and payment reform. Those we interviewed were uniform in their view that delivery and payment reform are the follow-on results of insurance expansion and that a strengthened health care system cannot emerge without coverage.

NOTES

- ¹ Centers for Medicare and Medicaid Services, *Monthly Medicaid and CHIP Application, Eligibility Determination, and Enrollment Reports and Updated Data* (CMS, n.d.).
- ² Medicaid and CHIP Payment and Access Commission, *June 2011 Report to Congress: The Evolution of Managed Care in Medicaid* (MACPAC, June 2011).
- ³ Centers for Medicare and Medicaid Services, *Medicaid Managed Care Enrollment and Program Characteristics, 2014* (CMS, Spring 2016).
- ⁴ Kaiser Family Foundation, *Medicaid MCO Parent Firm Activity by State and Insurance Market* (Henry J. Kaiser Family Foundation, n.d.).
- ⁵ Ibid.
- ⁶ J. Paradise, *Data Note: Medicaid Managed Care Growth and Implications of the Medicaid Expansion* (Henry J. Kaiser Family Foundation, April 2017).
- ⁷ Ibid.
- ⁸ Medicaid and CHIP Payment and Access Commission, “Exhibit 29. Percentage of Medicaid Enrollees in Managed Care by State, July 1, 2015,” in *MACStats: Medicaid and CHIP Data Book* (MACPAC, Dec. 2017).
- ⁹ S. Rosenbaum, S. Schmucker, S. Rothenberg et al., *Medicaid Payment and Delivery System Reform: Early Insights from 10 Medicaid Expansion States* (The Commonwealth Fund, Oct. 2017).
- ¹⁰ Kaiser Family Foundation, *State Health Facts: Medicaid MCO Enrollment* (Henry J. Kaiser Family Foundation, n.d.).
- ¹¹ J. Holahan, G. Kenney, and J. Pelletier, *The Health Status of New Medicaid Enrollees Under Health Reform* (Urban Institute, Aug. 2010).
- ¹² See, for example, The Menges Group, *Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way* (Association for Community Health Plans, June 2014). Also see H. J. Heiman and S. Artiga, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity* (Henry J. Kaiser Family Foundation, Nov. 2015); and L. M. Gottlieb, A. Quiñones-Rivera, R. Manchanda et al., “States’ Influences on Medicaid Investments to Address Patients’ Social Needs,” *American Journal of Preventive Medicine*, Jan. 2017 52(1):31–37.
- ¹³ 42 CFR §438.3(e)(2).
- ¹⁴ For more, see Centers for Medicare and Medicaid Services, *State Innovation Models Initiative: General Information* (CMS, n.d.).

ABOUT THE AUTHORS

Sara Rosenbaum, J.D., is the Harold and Jane Hirsh professor of health law and policy in the Department of Health Policy and Management at the George Washington University's Milken Institute School of Public Health. Her work focuses on health reform and health law, as well as health care access for medically underserved and vulnerable populations.

Rachel Gunsalus, M.P.H. candidate, is a senior research assistant in the Department of Health Policy and Management at the Milken Institute School of Public Health at the George Washington University.

Maria Velasquez, M.P.H. candidate, is a research assistant in the Department of Health Policy and Management at the Milken Institute School of Public Health at the George Washington University.

Shyloe Jones, M.P.H. candidate, is a research assistant in the Department of Health Policy and Management at the Milken Institute School of Public Health at the George Washington University.

Sara Rothenberg, M.P.H., is assistant director for the Consortium for Infant and Child Health at Eastern Virginia Medical School, and a consultant to the Department of Health Policy and Management at the George Washington University's Milken Institute School of Public Health.

J. Zoë Beckerman, J.D., M.P.H., is adjunct professor in the Department of Health Policy and Management at the George Washington University's Milken Institute School of Public Health. Her work focuses on on health reform and medically underserved and vulnerable populations.

Editorial support was provided by Martha Hostetter.

For more information about this brief, please contact:

Sara Rosenbaum, J.D.
Harold and Jane Hirsh Professor of Health Law and Policy
Milken Institute School of Public Health
George Washington University
sarar@gwu.edu

About the Commonwealth Fund

The mission of the Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by the Commonwealth Fund. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

