Partner Experienced MCOs With Emerging Provider-Led Health Plans To Modernize and Stabilize Medicaid

OVERVIEW

Medicaid populations present unique challenges for health care providers and state budget environments. Medicaid beneficiaries have higher rates of complex health conditions and disability than other populations. They tend to delay obtaining care and are more likely to use more costly care settings such as the emergency department and inpatient hospital. They have few financial resources and unstable social circumstances. It is common for beneficiaries to churn on and off the program resulting in coverage gaps and disruption of provider relationships.[1] It is a complex population that requires integrated support beyond simply providing a health service.

For more than three decades, states have relied on the expertise of managed care organizations (MCOs) to provide integrated care and support for Medicaid populations. MCOs have demonstrated an ability to improve care coordination, achieve outcomes, manage risk, and produce cost savings in Medicaid programs. Currently 39 states contract with MCOs to provide coverage for more than half of all Medicaid beneficiaries nationwide, and the numbers continue to grow.[2] Benefits commonly associated with the use of MCOs in Medicaid include their ability to:

- Focus on primary care strategies and incentivize care in the most cost effective settings.
- Use targeted care coordination strategies to manage expensive chronic conditions and disabilities characteristic of Medicaid populations.
- Assume financial risk and associated insurance functions successfully in the delivery of medical services.
- Track, report on, and accomplish established national and state quality and performance indicators.
- Educate and provide social supports as appropriate to enhance personal responsibility and accountability for health outcomes.

---

1 Cantor, J.C., Chakravarty, S., Tong, J., Yedidia, M.J., Lontok, O., and DeLia, D. (2014). The New Jersey Medicaid ACO Demonstration Project: Seeking Opportunities for Better Care and Lower Costs among Complex Low-Income Patients, *Journal of Health Politics, Policy and Law*, 39 (6), p. 1185-1221.

2 Kaiser Family Foundation. (2014). Medicaid Managed Care Market Tracker. Retrieved from http://kff.org/data-collection/medicaid-managed-care-market-tracker/.

Experimenting with Provider-Led Health Plans

A handful of states are currently testing the use of provider-led health plans in their Medicaid programs. Given the unique context which exists in NC, this type of provider led model is considered essential to any type of reform efforts. While, the provider-led model incorporates some of the features of the MCO model; however,unlike MCOs, the ability of the provider-led model to coordinate care, improve quality and outcomes, manage risk and administrative functions, and control costs is unknown. It will be some time before the effectiveness of the provider-led models can be assessed.

To modernize and stabilize Medicaid, without compromising access to quality care for Medicaid beneficiaries, a hybrid approach that emphasizes the use of experienced MCOs while pilot testing the use of provider-led health plans is warranted. Contracting with experienced MCOs will assure consistent statewide coverage for Medicaid beneficiaries from the outset as well as provide access to important care coordination systems, administrative infrastructure, financial solvency, and risk bearing experience. This Medicaid MCO umbrella can coexist and coordinate with provider-led health plans as they are established and take time to mature. It can also serve as a backstop should a provider-led health plan be unable to meet its intended objectives. This hybrid strategy would allow for planned and supported growth and would minimize potential disruptions in care for Medicaid beneficiaries and avoid financial instability for the Medicaid program.

Challenges Facing Provider-Led Health Plans

Medicare began experimenting with provider-led health plans under the Pioneer ACO program in 2011. The evaluation of the first two years of Pioneer revealed hefty start-up costs that only a few of the provider-led plans were able to offset with savings. It is still unclear whether the participating plans will be able to achieve sufficient savings to meet operating costs, finance clinical transformation, and reward providers in the long run.[3] Early feedback on the use of Medicaid provider-led health plans is consistent with the experience in the Pioneer ACO program. Significant up-front time and investment has been required. Common implementation challenges identified with provider-led health plans include:

- Providing technical assistance to providers to promote culture change in coordinating care and measuring quality across medical, behavioral health, and social services sectors.
- Accessing adequate capital to make necessary investments in health information technology and other care coordination techniques to improve delivery systems and manage high cost patients.
- Establishing administrative infrastructure to accept risk and perform insurance functions.

[3] Patel, K. and Lieberman, S. (2013). Taking Stock of Initial Year One Results for Pioneer ACOs. Health Affairs Blog. Retrieved from http://healthaffairs.org/blog/2013/07/25/taking-stock-of-initial-year-one-results-for-pioneer-acos/.

- Creating large geographic provider networks that can provide care for an array of complex conditions and minimize disparities in programs and services between communities.
- Defining core quality measures and attaining agreement on performance standards.
- Developing appropriate risk adjustment methodologies and methods for allocating shared savings across the federal and state governments as well as providers.
- Addressing violations of antitrust rules and collusion concerns due to provider-led collaboration.
- Educating patients about managing their health and appropriately accessing services.[4]

Select State Experiences with Provider-Led Health Plans

Florida has one of the longest track records with Medicaid provider-led health plans dating back to 1997. The State's goal was to achieve widespread use of provider-led health plans in its Medicaid program. In the first year of the program, the State was able to contract with only a single health plan (although 20 submitted letters of intent) due to many of the challenges noted above.[5] Over the past two decades the number of provider-led health plans participating in its Medicaid program has risen to just 9 – and the plans were not equipped to accept capitation until 2008. As a result, the State continues to rely heavily on MCOs to successfully provide and manage care for its Medicaid population.

Ohio aggressively pursued Medicaid managed care in the 1990's and quickly awarded capitation-based contracts to organizations, including several provider-affiliated, that did not have sufficient infrastructure or experience with managing risk. In Cuyahoga County alone (which includes Cleveland), of the 11 plans that entered the market in 1996 only four remained by 2000 leaving thousands of Medicaid beneficiaries without a medical home. Experts concluded that a key mistake was awarding contracts to "start-up entities" without a track record of coordinating care across providers, accepting capitation and managing risk, and insufficient capital and reserves to make necessary infrastructure investments or offset unanticipated losses.[6] The State was forced to revamp its approach and now contracts with only five traditional MCOs statewide under stringent guidelines and oversight.

More recently, Illinois initiated a two-year plan to transition to Medicaid provider-led "Accountable Care Entities" (ACEs). The State's initial plan was to provide these entities with as much as $60 million in care coordination fees for the first 18 months of their operation, while still paying claims on a fee for

---

4 Kocot, L., Dang-Vu, C., White, R., and McClellan, M. Early Experiences with Accountable Care in Medicaid: Special Challenges, Big Opportunities, *Population Health Management*, 16(1), p. S4–S11.; Robert Wood Johnson Foundation. (2013). Progress Report: Accountable Care Organizations Testing Their Impact (summarized research from JSI Research & Training Institute and Bailit Health Purchasing, Ohio State University College of Medicine, and Integrated Healthcare Association).

5 Duncan, R.P., Lemak, C.H., Vogel, W.B., Johnson, C.E., Hall, A.G. and Porter, C. (2008). Evaluating Florida's Medicaid Provider Services Network Demonstration, *HSR: Health Services Research* (43)1, Part II, p. 384-399.

6 The Center for Health Affairs. (2007). *The Evolution of Medicaid Managed Care in Ohio*. Cleveland, OH.

service basis. The State has since reversed course due to the significant up-front administrative and financial investment by the State and the extensive administrative oversight required. Also, more than half of the entities proved to be unsuccessful at managing utilization. The cost-benefit was not supported as the ACE's showed minimal care coordination improvement and no reduced emergency department utilization compared with traditional MCOs. So not even a year into the effort, the State announced it would no longer pay care coordination fees and that ACEs must be able to accept full risk by mid-2015. If the ACE is unable to accept full risk it must either identify an MCO partner with which to share risk or to merge with and transition ACE members. Only one (1) ACE so far has indicated an ability to accept full risk, so it is expected that most ACEs will merge with existing MCOs by summer of 2015.[7]

Other states have learned from the experiences of early adopters and are pursuing a cautious approach when considering whether to rely solely on provider-led health plans for their Medicaid delivery systems. For example, New Jersey permits Medicaid provider-led health plans to partner with experienced Medicaid MCOs for support with care management activities and to share in savings. Alabama has a fallback clause that requires the State to contract with an experienced MCO if the provider-led health plan being tested is terminated or fails to deliver adequate care. Such strategies protect Medicaid beneficiaries' access to care and provide time for a state to assess whether a provider-led health plan can deliver on its quality and outcome targets as well as cost control.

Anchoring Medicaid Transformation with Experienced MCOs

MCOs have a proven track record in managing care, achieving quality outcomes, and delivering cost savings in Medicaid. Key benefits of using MCOs as the backbone for redesigning health care delivery – especially when transitioning to a risk-based payment methodology -- include immediate access to:

- **Emphasis on Primary Care and Chronic Care Coordination:** Care coordination that emphasizes primary care and use of cost-effective care settings is a fundamental underlying principle of managed care. MCOs use care managers to work with providers and beneficiaries to emphasize the importance of preventive care such as screenings, vaccinations, and preventable hospitalizations. Chronic care management receives special attention, as care coordination for such conditions can reduce unnecessary hospital utilization, enhance quality of life for members, improve outcomes, and yield cost savings.

[7] Illinois Department of Healthcare and Family Services. (2015, February 20). Medicaid Advisory Committee Meeting Minutes. Chicago, IL. Retrieved from: http://www2.illinois.gov/hfs/SiteCollectionDocuments/032015_macminutes.pdf; Schorsch, K. (2015, February 28). Illinois hospitals, health care groups oppose Rauner's cuts to managed care. *Crain's Chicago Business*. Retrieved from http://www.chicagobusiness.com/article/20150228/ISSUE01/302289986/illinois-hospitals-health-care-groups-oppose-rauners-cuts-to-managed.

- **Alignment of Care Delivery, Outcomes, and Payment:** MCOs recognize the interconnectedness between care delivery, outcomes, and payment. A key focus is the use of quality and performance measurement systems (such as HEDIS and others) to promote system change and to respond to payment incentives designed to focus on achieving targeted outcomes. MCOs emphasize high value services which translates to improvements in health outcomes in a cost effective manner.

- **Access to a Continuum of Care**: MCOs create and manage extensive provider networks that include medical, behavioral health, and social services over large geographical areas. These vast provider networks support the full continuum of care integration and offer the highest potential for achieving targeted outcomes and accumulating Medicaid cost savings. MCOs also pursue linkages to community-based resources so that Medicaid beneficiaries have the necessary social supports to address factors that can interfere with accomplishing personal health objectives.

- **Member Education and Accountability Strategies**: MCOs invest significant resources, such as multilingual member education materials and nurse advice lines, to support members taking responsibility for their own health and promoting appropriate use of health care services.

- **Established Administrative Functions.** MCOs are ready-to-go with respect to administrative functions -- billing, enrollment, credentialing, and other related capacities are already in existence and do not require a long design or implementation phase.

- **Sophisticated Information Technology**: MCOs regularly collect clinical, claims, and performance data and have the capacity to analyze information at the individual or population health level. They also rely on electronic health records to enable more efficient management of provider practices and provide whole person integrated care.

- **Budget Predictability and Managing Risk**: States pay MCOs a set amount per month and the MCO is at full risk, therefore, the state is guaranteed budget predictability for these services. MCOs place emphasis on preventive care services, and ensure coordination of care through an effectively managed provider network, allowing MCOs to provide cost-saving measures without compromising quality or access. In addition, MCOs often reinvest in extra services for Medicaid beneficiaries that a state can neither afford nor provide under current Medicaid rules.

- **Commitment to Financial Solvency**: MCOs are held to strict reserve and financial solvency requirements by states. These types of requirements are important because they provide assurance that the organization has the capacity to manage risk and absorb unexpected losses with compromising care delivery, payment to providers, or organizational viability.

SUMMARY: MCOS AND PROVIDER-LED HEALTH PLANS SHOULD COEXIST

The following table summarizes the level of preparedness of MCOs versus the provider led health plan recently released by the North Carolina Hospital Association. It helps illustrate the necessityof engaging experienced MCOs alongsideprovider-led health plans in Medicaid redesign to enhance the probability of long term success.

	MCOs	**Provider-Led Health Plans**[8]
Patient-Centered Care	Yes	Yes
Integrated Provider Network	Yes	Yes
Access to Physical Health Services	Yes	Yes
Access to Behavioral and Mental Health Services	Yes, as negotiated with State	Not until full capitation for physical health achieved (at least 2 years)
Pharmacy Management Services	Yes, as negotiated with State	Yes, but only after 5 years
Ability to Successfully Manage Risk	Yes	Could take up to 3 years
Budget Predictability	Yes	Could take up to 3 years
Administrative Functions (Claims, Billing, Enrollment, Etc.)	Yes	Requesting “careful design”
Data Sharing and Access	Yes	Must be designed and implemented
Quality Standards	Yes	Once a Quality Assurance Committee is established statewide and by each provider-led health plan.
Population Health Management	Yes	Once all services are integrated, which could take up to 5 years
Proven History of Success	Yes	Undetermined

[8] Based on the NC Provider Community Medicaid Reform Proposal