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CURRENT AND EMERGING ISSUES IN MEDICAID RISK-BASED MANAGED CARE: INSIGHTS FROM AN EXPERT ROUNDTABLE

Executive Summary

Half of all Medicaid enrollees receive care through comprehensive risk-based managed care organizations (MCOs). Most Medicaid MCO enrollees today are low-income children and parents, but states are increasingly moving beneficiaries with more complex needs into MCOs. Enrollment of high-need groups in managed care may grow more rapidly as states work with the Centers for Medicare & Medicare Services (CMS) to implement initiatives to better integrate Medicare and Medicaid benefits and care for dual eligibles.

In light of the increasingly significant role of risk-based managed care in Medicaid, the Kaiser Commission on Medicaid and the Uninsured (KCMU) convened a roundtable meeting in Washington, DC on May 30, 2012 to learn more about how Medicaid MCOs are currently organized, to consider issues that the enrollment of higher-need populations in MCOs raises, and to discuss the implications for MCOs of the expansion of Medicaid under the Affordable Care Act (ACA). The meeting provided insights that complement the findings from a 50-state survey of Medicaid managed care that KCMU conducted in late 2010 in partnership with Health Management Associates. This brief summarizes key issues identified and discussed by the invited participants. Highlights include:

Provider networks, care delivery, and payment arrangements in Medicaid MCOs today

- Medicaid MCOs' current provider networks and care management features are designed to meet the needs of their current enrollees—mainly, low-income families and children. Community health centers and other safety-net providers are often integral to their networks.
- System-wide gaps in access to care are exacerbated in Medicaid, and current pressures are likely to grow as states expand managed care to higher-need beneficiaries, and coverage expands in 2014.
- MCOs are increasingly focusing on care management, and adoption of models that involve more linkages across providers is increasing.
- Physician payment approaches in MCOs are diverse, ranging from FFS to capitation, often with incentives for quality and efficiency. Some MCOs pay provider rates that exceed Medicaid FFS levels to garner more provider participation.

Expanding managed care to individuals with disabilities and dual eligibles

- Today's MCOs provide a foundation for serving people with disabilities and dual eligibles, but plan networks and care models will have to evolve to meet the specialized needs of these enrollees.
- Separate funding streams for community-based services and acute medical care, and for acute medical and mental health services, can complicate integration and coordination of care. This challenge is more important to address as more people with mental and behavioral health needs are moved into MCOs.
- Risk-adjustment developed primarily for children and parents will require change to take into account the needs of populations with more disease and disability. Risk-adjustment that relies

primarily on diagnostic factors may not work well for those whose functional status and long-term care needs drive their costs. Non-medical factors like homelessness may need to be incorporated.

- Developing enrollee trust is important to the effective implementation of new managed care programs for individuals with different kinds of disabilities and dual eligibles. Many people with severe mental illness or physical disabilities want to be engaged in directing their own care. They need to be "met where they are" and represented at the table when managed care initiatives are being developed.

- New care models offer the potential to improve care for beneficiaries with complex needs, but implementing such systems requires a long-term commitment and that potential can be undermined if managed care is undertaken primarily as a means to plug immediate budget holes.

- Managed care contracts are a critical policy tool for states. Contract requirements should be specific, "smart," and outcomes-oriented.

- Data are essential to manage and oversee care. The growing interest in bundled payment systems that provide incentives for more effective and efficient care is a positive development. But the loss of transaction-level data needed for measurement, monitoring, and plan and provider accountability, is a major concern. Also, data siloes pose barriers to care integration and oversight.

Looking forward to the 2014 expansion of coverage under the ACA

- The coverage expansion under health reform is an opportunity to streamline and integrate coverage through a single entry point. The challenge is to design systems that foster smooth transitions and continuity between Medicaid and exchange coverage and care. Effective HIT infrastructure and real-time access to federal data to determine eligibility are crucial to bridge Medicaid and the exchanges.

- Many MCOs are interested in participating in exchanges, but many plans built around safety-net providers would find it difficult to meet the reserve requirements. They also face capital and other resource constraints.

- Some states are developing models (e.g., bridge product and Basic Health Plan) to limit the disruptive impacts of coverage transitions on care and provider access. Potentially different benefit packages in Medicaid and the exchange, and even within Medicaid, could contribute to disruptions. The Medicaid-CHIP experience when CHIP was first implemented offers helpful lessons.

- Expanded coverage will increase demands on the health care system. Provider willingness to participate in MCOs could rise or fall in response to the expansion. While the new enrollee market may be attractive to providers, concerns about payment rates could deter participation.

- States have considerable experience implementing reforms in Medicaid, but implementing the ACA at a time when economic and political conditions have limited the financial and human resources available to them poses challenges. They need as much support as possible to develop and operate managed care programs that advance the goals of the ACA.