

The Value of Medicaid Managed Care: Innovating in Medicaid



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Medicaid managed care plans deliver a wide array of telehealth programs increasing the ability of doctors and other health care providers to deliver care to patients when and where they need it.



Medicaid managed care plans are increasingly helping states to remove social barriers to health, a requirement of an increasing number of state Medicaid managed care procurements.



Medicaid managed care plans are improving the tools provided to their health plan members to make care easier to access. Using these new tools enrollees can locate doctors in their networks, view practice information, and rate their doctors.

Medicaid is the largest health care program in the country, covering about 1 in 5 Americans – including millions of children, older adults, people with disabilities, and 2 million veterans. Two-thirds of Americans enrolled in Medicaid are served in Medicaid managed care programs, a public-private partnership between federal and state governments and managed care plans. Medicaid managed care plans (also called managed care organizations or “MCOs”) are increasingly working with states to improve care delivery and benefits through innovative, cutting-edge programs. What kinds of innovations are Medicaid managed care plans using to deliver high-value, affordable care to enrollees? America’s Health Insurance Plans (AHIP) turned to experts at [The Menges Group](#) to conduct in-depth research to help us find out. A well-respected analysis and consulting firm, The Menges Group is committed to evaluating the highest quality and most cost-effective strategies to deliver care to high-risk, high-need populations. The result is a series of research studies AHIP will release in 2020.

Many state Medicaid agencies use formal procurement processes to select and contract with qualified Medicaid managed care plans. In most states, the Medicaid agency releases a Request for Proposal (RFP) that requires Medicaid managed care plans to implement innovative care delivery solutions.¹ The Menges analysis reviewed state Medicaid RFPs and accompanying model contracts and scopes of work from recent procurements in 8 states.² The Menges Group also reviewed 14 Medicaid plan proposals submitted in 6 states.²

The findings show that Medicaid managed care plans collaborate with their state partners to deliver successful public private partnerships uniquely tailored to meet the needs of each individual state and the populations that are served by that state’s Medicaid program, proving that when the public and private sector work together, Americans get the quality and value they deserve.

Telehealth

Telehealth is an area where Medicaid managed care plans are providing states with innovations beyond what is possible in fee-for-service Medicaid programs. **Five of the states reviewed require Medicaid managed care plans to cover telehealth services between patients and primary care physicians – and often between patients and specialists.** While most contracts did not specify how Medicaid managed care plans should focus their telehealth efforts, 1 state directed Medicaid managed care plans to focus telehealth strategies on rural areas, behavioral health services, and chronic pain management.

Medicaid managed care plans proposed innovative telehealth solutions to improve access for enrollees and providers alike. Most focused on areas such as **telepsychiatry, remote monitoring, virtual urgent care, and mobile applications in support of chronic condition management.** One Medicaid managed care plan proposed to implement Project ECHO, a tele-mentoring program that connects primary care providers and patients in rural areas to specialist physicians through a model that “moves information without moving people.”

1 Interested Medicaid managed care plans respond to the RFP with detailed information on their qualifications. In recent years, state Medicaid procurements have added significant requirements, calling for Medicaid managed care plans to address a range of innovations and improvements in care delivery and benefits. The procurement process also encourages Medicaid managed care plans to make commitments that exceed state contract requirements to earn contract awards. These efforts have allowed Medicaid programs with Medicaid managed care plans to offer high-value initiatives that improve care and outcomes for their residents while controlling costs for taxpayers.

2 Kansas, Nebraska, New Mexico, North Carolina, Virginia, and Washington.

Social Barriers to Health

All the Medicaid managed care plan contracts reviewed by The Menges Group included requirements related to social barriers to health. Social barriers range from a lack of stable housing to social isolation and food insecurity. The Menges review discovered some state contract provisions **requiring Medicaid managed care plans to ensure that health providers screen enrollees for social barriers** (Louisiana); **addressing social barriers in care management activities** (Kansas, Kentucky, Louisiana, and Nebraska); **partnering with community-based organizations and human services agencies to address social barriers** (North Carolina); and **using predictive modeling to identify enrollees' physical health, behavioral health, and social needs** (Louisiana).

Medicaid managed care plans proposed an array of innovative programs to mitigate specific social barriers to health. The programs largely fell into four major groups, described below with examples.

Identification and Referral <ul style="list-style-type: none"> Integrating clinical and claims information with external contextual data to identify unique conditions in neighborhoods and communities that may affect health care outcomes Maintaining Centers of Excellence focused on social barriers to health Operating a dedicated line to health plan enrollees and providers that links enrollees and their caregivers with an identified network of community resources 	Food Security <ul style="list-style-type: none"> Funding food vouchers so enrollees can shop in local supermarkets, supplementing nutrition benefits from other government programs Operating a mobile produce market to bring nutritious fresh vegetables to neighborhoods with limited supermarket access Providing cooking classes for enrollees with chronic health conditions where they learn to cook healthy meals Partnering with other Medicaid managed care plans and community organizations to develop community gardens
Home Environment <ul style="list-style-type: none"> Conducting Adverse Childhood Experiences (ACE) surveys with children, accompanied by a 14-question assessment for those with high levels of ACEs to identify specialized services they might need Early childhood home visiting programs for low-income families to promote access to medical services, assistance with managing chronic conditions, and regular well-child assessments and monitoring 	Training and Employment <ul style="list-style-type: none"> An apprenticeship and job training initiative that provides wrap-around support while individuals are in training programs, then hires them after graduation Launching a specialized program focused on training (including high school GED courses), career counseling, interview and resume coaching, and access to employment and volunteer opportunities

Washington state's RFP explored another aspect of social barriers to health, asking Medicaid managed care plans about their programs, successes, and challenges in transitioning individuals being released from prison into Medicaid managed care plans. The plans responded by proposing an array of innovative approaches, including scheduling corrections liaison workers to meet regularly with inmates before release to offer resources, make connections, and improve the transition to Medicaid managed care and partnering with community re-entry organizations to provide former inmates with resources on care coordination, medication adherence, and community resource referrals.

Most state RFPs encourage Medicaid managed care plans to implement value-based purchasing (VBP) arrangements, and several contracts require Medicaid managed care plans to have VBP arrangements in place with certain percentages of their network providers within specified timeframes.

Provider Networks and Access

Many Medicaid managed care plan innovations identified through the RFP responses focused on improving enrollee access to providers and supporting provider engagement with enrollees. Innovations were grouped into several major areas, with specific examples highlighted in each.

<p>Enrollee Information and Experience</p> <ul style="list-style-type: none"> Enhancing providers directories by delivering a “Find a Provider” tool that allows enrollees to both find and rate their doctors Setting up integrated care clinics to serve the whole health needs of pregnant women, including routine screening and referrals for behavioral health care and social barriers Collaborating with medical homes to coordinate visits for families with histories of inconsistent preventive care, reducing barriers to receiving routine preventive care such as lack of transportation and childcare Using non-emergency medical transportation drivers as auxiliary “eyes and ears” to assess enrollee barriers to care and relay issues to care coordinators Offering a dedicated call center designed to connect enrollees with community resources staffed with individuals who have used those resources themselves, including those who have been caregivers or who are current or former recipients of public benefits 	<p>Provider Services and Support</p> <ul style="list-style-type: none"> Employing specialized staff to support providers in advancing medical homes, population health initiatives, participating in risk arrangements, and improving quality performance Assigning provider representatives to assist network providers with operational issues like claims, reimbursements, authorizations, and referrals Enrolling high-quality nursing facilities and in-home personal care service providers into a “select partner” program Building a special claims portal to streamline claims submission for non-traditional providers (e.g. personal care attendants) Creating an online platform that permits monitoring of paid and non-paid caregiver supports; establishing a program to support caregivers, providing free training, peer support groups, virtual communities, and education on respite programs that offer temporary relief from caregiving.
<p>Connecting Enrollees with Care</p> <ul style="list-style-type: none"> Establishing designated “Clinic Days” with key pediatric providers to facilitate access to Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services Identifying and targeting underserved areas with periodic visits from a mobile health van or other mobile services staffed by doctors or nurse practitioners Stationing advocates in provider offices to assist enrollees with identified “care gaps” in scheduling appointments 	<p>Helping Providers Serve Enrollees</p> <ul style="list-style-type: none"> Making special grants to providers to improve accessibility for enrollees with physical disabilities Providing financial support for a youth center to expand the center’s primary care, behavioral health, and care coordination capacity Implementing a bed tracking tool with substance use rehabilitation facilities that allows health plan staff to quickly view available beds by facility statewide Arranging for chain pharmacies to access an integrated dashboard, identifying enrollees’ primary care doctor and encouraging follow-up and communication

Value-Based Purchasing. Seven of the state contracts reviewed require or encourage Medicaid managed care plans to implement value-based purchasing (VBP) arrangements³. While some VBP requirements were general, other states included specific objective requirements. For example, Nebraska’s contract requires Medicaid managed care plans to execute VBP arrangements with at least 30% of their provider networks by the third year of the contract, and at least 50% by the fifth year.⁴ In their proposals, **Medicaid managed care plans proposed a variety of approaches to transition collaborating with the Medicaid provider community to move toward VPB, including quality incentives, bundled payments, innovation payments, and shared risk arrangements.**

Behavioral Health and Behavioral/Physical Health Integration. State Medicaid contracts often include provisions designed to promote the integration of physical and behavioral health⁵ services among network providers.

³ Value-based purchasing arrangements tie provider payments to the value and quality of the care they provide.

⁴ Other examples include New Hampshire, where at least 50% of all Medicaid managed care plans medical expenditures must be in VBP arrangements within 12 to 18 months; and Louisiana, where Medicaid managed care plans must implement a VBP model for at least 40% of their provider payments, targeting \$12 million in provider payments by 2022.

⁵ Behavioral health includes emotional, psychological, and social wellbeing. Behavioral health conditions can include mental and substance use disorders.

Specific requirements in the reviewed contracts included **requiring that primary care physicians screen for common behavioral health issues**, and that **behavioral health providers send initial and quarterly summary reports to an enrollee's primary care physician**.

In addition, a number of the reviewed state contracts require Medicaid managed care plans to partner with providers to behavioral health care for Medicaid enrollees. For example, Louisiana has a range of requirements designed to **encourage enrollees to use behavioral health services they need**.⁶ In their RFP responses Medicaid managed care plans have also proposed a variety of innovative approaches such as: **employing crisis systems liaison staff** to facilitate referrals of enrollees to behavioral health evaluation, treatment, and inpatient psychiatric services; **arranging internships for college students with behavioral health providers whose backgrounds reflect local cultural and language characteristics, so students gain advance familiarity with the communities where they may be working; and using telehealth consultation for medication-assisted treatment (MAT) services for substance use disorders**.

Population Health. Five states require Medicaid managed care plans to implement population health programs. "Population health" generally refers to the health outcomes of a group of individuals, and the distribution of such outcomes within the group.⁸⁷ Population health requirements are a relatively new feature in Medicaid procurements, making their debut in 2018 and 2019 contracts. Some population health requirements included creating **prevention and wellness programs targeted to different population segments**, as well as **programs designed to address the leading health issues affecting enrollees**.

Some states also had additional requirements covering specific enrollees. For example, states required Medicaid managed care plans to:

- Create individualized, interdisciplinary care teams and care plans for children in foster care that integrate care managers, primary care physicians, and dental providers. (Kentucky's Supporting Kentucky Youth model)

- Conduct initial home visits with foster children within 48 hours of a new home placement and schedule an interdisciplinary care meeting within 7 days of the placement. (Kansas)
- Provide care management to at least 15% of the Medicaid MCO's total membership, targeting high-risk enrollees such as adults with HIV/AIDS, and to at least 50% of all high-risk enrollees (New Hampshire).

Medicaid managed care plans proposed providing enrollees with a range of supplemental or "value added" benefits (items and service that go beyond the Medicaid covered services covered by the state). Many of these benefits address particular population health and social needs. Examples include: **overnight respite care for caregivers of specialized populations, Kindle subscriptions for children in foster care, and coverage of pest control services**.

Reducing Preventable Hospital Readmissions. In the RFP responses reviewed, Medicaid managed care plans proposed and implemented a number of practices specifically designed to reduce avoidable hospital readmissions. They include:

- Employing "peer bridgers" to assist enrollees recently discharged from inpatient facilities by offering community resource referrals and other supports that reduce the chance of readmission.
- Enabling emergency departments to easily notify an enrollee's Medicaid managed care plan of a visit using an online portal instead of a telephone call.
- Posting community outreach workers in hospital emergency departments during high-volume hours, where they can educate enrollees on appropriate emergency department use and connect them with their primary care physician for follow-up appointments.
- Implementing a secure texting platform to enable direct enrollee communication, including transition support following an emergency room visit or inpatient admission.

6 Louisiana Medicaid managed care plans must ensure their contracted substance use disorder (SUD) residential care providers offer medication-assisted treatment (MAT) to Medicaid enrollees, either onsite or offsite. Medicaid managed care plans also must take steps to reduce the number of long-term emergency department (ED) stays of enrollees seeking behavioral health treatment in EDs due to a limited availability of behavioral health services. Louisiana also plans to implement requirements for care of enrollees with concurrent behavioral health and intellectual/developmental disability diagnoses, including annual counts of providers serving dual diagnoses enrollees, and targeted provider Medicaid managed care plans training.

7 What Is Population Health? Kindig D and Stoddart G, American Journal of Public Health, March, 2003; <https://ajph.aphapublications.org/doi/full/10.2105/AJPH.93.3.380>

Medicaid Managed Care Plans and Provider Participation in Medicaid

One of the biggest challenges all Medicaid programs face is provider participation. Participation barriers can be the result of low payment, enrollee challenges in identifying and locating providers, and clearly understanding which providers have capacity to take on additional patients. Medicaid fee for service rates are substantially lower than those paid by Medicare or commercial insurance. The Kaiser Family Foundation found that Medicaid payments to physicians nationwide are 72% of Medicare reimbursement rates overall, and 66% of Medicare for primary care services.⁸ Medicaid payment rates for primary care services are below 50% of Medicare's rates in 7 states and are above Medicare in only 2 states. Low reimbursement rates in fee-for-service can discourage providers from accepting Medicaid enrollees as patients, posing potentially significant barriers to health care that Medicaid coverage seeks to facilitate.

While the rates paid to Medicaid managed care plans are based on Medicaid fee-for-service rates, there are mechanisms Medicaid managed care plans use – both through state and federal regulatory requirements and oversight efforts, and through staff commitments, information technology capabilities, and innovative program features – to elevate provider engagement in serving Medicaid patients. Below are some of the mechanisms that states (from a regulatory perspective) and Medicaid managed care plans (from an operational perspective) have deployed to bolster providers' involvement in Medicaid managed care programs.

Enhanced Fees. A key mechanism for ensuring broad provider participation in Medicaid involves paying providers more than Medicaid fee-for-service rates. While specific details of payment rates agreed to between providers and Medicaid managed care plans are generally not disclosed, Medicaid managed care plans often do find it necessary to pay providers higher “mainstream” payment rates that make it more attractive and viable for providers to increase their Medicaid participation. This helps ensure that Medicaid enrollees have access to a range of providers for care and services.

Combining Medicaid with Other Coverage Groups. Medicaid managed care plans channel patient volume toward their contracted network providers. Many Medicaid managed care plans also serve enrollees with other kinds

of coverage – like Medicare and commercial plans – and require participating providers to accept all their enrollees. This “take one, take all” contracting approach motivates providers who might be reluctant to serve Medicaid enrollees to do so as part of providing care to a Medicaid managed care plan's entire covered population.

Access Incentives. Many states support access to doctors through bonus payments explicitly tied to a Medicaid managed care plan's quality performance measures. In addition, many Medicaid enrollees do not proactively select a health plan; instead, the state “auto-assigns” enrollees to specific Medicaid managed care plans. Several states have designed auto-assignment algorithms that enroll greater numbers of newly eligible enrollees into Medicaid managed care plans that demonstrate the strongest performance in access and quality.



“Our [state] requires us to maintain 90% of PCP practices as accepting new patients and we are monitored on this through routine reports. Despite this, we find that providers are not always forthright on this issue and we discover it through complaints. Once we are aware that a provider practice has closed their panel, we contact them to determine if the reason for closing the panel can be resolved. We are often successful.”

MEDICAID MANAGED CARE PLAN EXECUTIVE

Systematic Tracking of Actual Access. Many of the quality measures used in assessing Medicaid managed care plans demonstrate the degree to which enrollees are actually able to access preventive and acute care services. That means that details of Medicaid managed care plan performance are highly transparent and available, as states and other stakeholders track and publicize each Medicaid managed care plan's performance on a wide array of access measures. Provider Practices and New Medicaid Patients. State requirements and Medicaid managed care plan contracting standards often help

8 Source: Medicaid-to-Medicare Fee Index published on Kaiser Family Foundation website <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

ensure that network providers are open to accepting new Medicaid patients. Many states require Medicaid managed care plans to ensure that providers monitor access to their practices, and Medicaid managed care plans use techniques such as “secret shopper” calls to ensure providers will accept enrollees as new patients. Provider Directory Information. Medicaid managed care plan provider directories typically indicate whether providers are accepting new patients. States and Medicaid managed care plans are stepping up efforts to help enrollees access the most appropriate providers by including information such as icons denoting each provider’s cultural and linguistic capabilities, customer ratings, licensure and accreditation status, and whether public transportation is available near a provider’s location.

Encouraging Enrollees to Communicate Access

Concerns. Enrollee complaints and concerns are a key source of information through which Medicaid managed care plans become aware of provider access issues. Between the Medicaid managed care plan’s call center, online options (e.g., member portal), email, texting, social media, and regular mail, Medicaid managed care plans offer enrollees multiple channels to share provider access issues and other concerns. The Medicaid managed care plan’s enrollee handbooks and periodic newsletters frequently encourage enrollees to notify their plan of if they experience any access issues.

Ongoing Network Data Analysis and Data Maintenance.

Provider networks are in constant flux as offices re-locate, new practitioners join, existing practitioners retire or leave for other reasons, and provider organizations merge and/or are acquired. With these dynamics, maintaining accurate, up-to-date information on the details of network providers is a constant challenge. While Medicaid managed care plan contracts routinely require providers to notify the plan immediately of any changes, providers vary in their compliance (and timeliness) with this requirement. Medicaid managed care plans dedicate considerable resources to “network validation” efforts to ensure they have correct, updated information on providers participating in their networks.

Innovation Promotes High-Quality Health Care

Medicaid managed care plans are pursuing innovative programs that range from addressing social barriers to health to improving provider access, all in the service of providing enrollees with high-quality, affordable health care.

Whether operating hotlines to connect enrollees to additional services in their communities, facilitating access to high quality doctors by allowing enrollees to share their ratings for providers online, or facilitating “whole person” coordinated care by integrating behavioral and physical health, Medicaid managed care plans are committed to providing the health care their enrollees need and deserve.

The data are clear. Medicaid managed care plan innovations far exceed anything available in fee-for-service Medicaid programs.