

POINT OF VIEW

HOW TO SUCCEED IN MANAGED MEDICAID

AUTHORS

Jim Fields, Partner
Parie Garg, Principal

Don't believe what you've heard about Medicaid. It's not a profit-free zone. It's not mysterious. And it's not something you can afford to ignore. Here's how to participate successfully in a market that may soon account for a quarter of all health plan revenue.

Historically, Medicaid has been viewed as the stepchild of healthcare – an incredibly complicated market in which the rules change state by state and profits are difficult (though not at all impossible) to achieve. But as the Medicaid market continues to grow – driven by demographics, the Affordable Care Act, the economy, and a host of other factors – health plans and providers alike are seeking ways to participate in it successfully. And with the growth of Medicaid, the increased reliance of states on Managed Medicaid, and the success of several Medicaid players, there are reasons to be hopeful. Medicaid grew from 10 percent of total health plan revenue in 2006 to more than 18 percent in 2012, and that number is expected to continue to increase over the next few years as states increasingly turn to Managed Medicaid as a way to control costs.

Individuals with Medicaid coverage are starkly different from the commercially covered populations that dominate most health plan books of business. Becoming an effective Medicaid organization requires a laser focus on what makes them different, but also an emotional connection with – and a desire to do well by – what is arguably the highest-need segment in healthcare. By focusing on the following success factors, we believe that organizations can prepare themselves for a lucrative career in Medicaid.

UNDERSTAND THE POPULATION, THE MARKET – AND THE FINE PRINT

The Medicaid-eligible population is extraordinarily complex. At one end of the range are relatively low risk populations such as children and families needing temporary assistance. At the other are high-cost, high need individuals: the aged, blind, and disabled (ABD) and those with intellectual disabilities/developmental disabilities (ID/DD), spinal cord injuries (SCI), and traumatic brain injuries (TBI). The needs of these populations are remarkably different, and even individuals within a given population can have needs that vary considerably. To succeed in Medicaid, you need to understand which populations you are serving, what their overarching needs are, how to serve them, and how much customization you will have to provide.

Complicating this already complex picture is the fact that, unlike Medicare, Medicaid is controlled at a state level. Each state has the authority to run its program as it chooses, and most states choose to implement more than one. Each state forms a unique Medicaid market, with different covered populations, varying benefit structures, and differential reimbursement mechanisms. It is not enough to understand the market as a whole. You need to thoroughly understand the unique characteristics of each individual program you participate in: who is eligible, what is covered, what the exclusions and waivers are, how you are evaluated, where you can be creative, where you can't. There are also rules covering enrollment processes, network adequacy, contracting operations, and broader patient considerations, such as home health, HCBS providers, CMCs, and FQHCs.

The point is not just to be compliant, though that is important. Rather, the goal is to have a deep, nuanced understanding of your members, your market, and your customer. In particular, it is crucial to treat each state where you operate as a significant, valued customer. If you ask a health plan executive to name his top employer customers and their key decision makers, chances are that he can rattle off a good number of them. In Medicaid – a \$450 billion business, \$125 billion of which goes through Managed Medicaid – it is rare to find a health plan that makes the effort to build a strong relationship with state administrators. In order to be successful, health plans need to treat states like valued customers. Know the organization inside and out, prepare the team for administrative leadership change during election cycles, and above all else, build deep, lasting relationships. Medicaid is a small world, and people cross paths often. Giving the state its due respect can go a long way in establishing a successful Medicaid offering.

PURPOSE-BUILD YOUR CARE MANAGEMENT OFFERING

An effective care management (CM) program is the cornerstone of a successful Managed Medicaid offering. But this is an area where plans should ignore conventional wisdom. The individuals covered by Medicaid are so different from the commercially covered population that it makes little sense to attempt to address their needs by simply redesigning an existing CM program. Plans should go back to the drawing board and create a Medicaid-specific CM program, following these principles:

Design for Medicaid, not around it: Design the program considering the needs of the Medicaid population. Go beyond immediate healthcare needs and incorporate other aspects of life that can have a substantial impact on an individual's use of healthcare resources: employment assistance, living conditions, social support, and others. It isn't a question of how to "add" these services on top of existing ones, but rather how you incorporate them into the daily activities of your care programs.

Assess, assess, assess: The care plan assessment is an extraordinarily important part of the CM process. It serves to provide a true picture of an individual's needs (within and outside the healthcare arena) and informs how much and what types of services the person needs and the plan will pay for. It can also be a way to identify if the individual qualifies for additional services or reimbursements from the State. MCOs that build a thoughtful assessment tool are able to manage their costs and reimbursements better while ensuring members are receiving the services that they need.

Go beyond the nurse: Medicaid CM programs need a host of services that supplement and complement medical care. In our experience, the most successful programs employ multidisciplinary teams that include social workers, respite support, home health aides, nutritionists, and providers supporting activities of daily living (ADLs), among others.

Put a face with a name: Establish a field force capable of forming personal connections with individuals. Many of the highest-cost Medicaid beneficiaries have living situations that contribute to poor health outcomes: lack of permanent housing, poor ventilation, inadequate heating and cooling. With personal connections and first-hand interactions

your team can provide relevant coaching and connect people to appropriate services to put them on a path to success. These interactions are the difference between checking the box that a call was completed and making a difference in someone's health and life.

Use the community: Strong connections with the community you serve will bolster the CM program, providing additional reach in unexpected places. Successful Medicaid plans achieve their success through care managers who use churches, community centers, and homeless shelters to locate hard-to-find members or to make a difference in their care. The community is where your members live their lives. To manage their health, your team needs to be there too.

MANAGE DRIVERS OF REVENUE AND COSTS

Medicaid was designed to be financially lean. Building programs that help keep your members well is a crucial step toward profitability, but it won't be enough unless you also diligently manage revenue and cost drivers. In particular, we believe plans should focus on three areas:

Assess risk accurately: While the details vary by geography, most states use some form of risk adjustment program to help ensure that (1) capitation/reimbursement rates for each health plan are appropriate, (2) highest-need individuals receive appropriate services, and (3) population shifts are being appropriately monitored and addressed. In order to be paid accurately, health plans need to report the risk profiles of their patients accurately, and respond to the specific demands of each state where they operate. This will be particularly true in states that adopt CMS's new proposed rules.

Respect quality measures: In the past, Medicaid quality measurement took place at the state level, and there was considerable variation in the transparency of the process. (New York, for example, publishes a quality rating of its Medicaid plans. Texas, among other states, does not.) For managed care organizations that serve the dual-eligible population, Medicare Star scores have provided a reasonable proxy measure. CMS, however, is currently encouraging states to make more use of quality programs and to standardize them, with the Medicare Star Ratings program as a model. CMS's proposed rules still allow states to choose the specific measures and programs they will use, but it doesn't take too much creativity to envision that Medicaid quality scores will increasingly be tied to reimbursement and incentive programs the way they are in Medicare.

Mercilessly monitor fraud & abuse: Unfortunately, the Medicaid market is rife with fraudulent practices: providers billing for services that were never delivered, family members receiving reimbursement for in-home care that wasn't provided, and physicians creating care assessments inflating the services a patient requires, to name just a few. Fraudulent practices can significantly drive up a health plan's costs. The proposed CMS rules call for increased screening of fraud and abuse, but health plans should be merciless in monitoring provider billing and delivery practices, medical necessity, and taking action on providers/stakeholders that engage in inappropriate practices.

DO THE RIGHT THING

Finally, while any organization can put the right building blocks in place, a key differentiator is the mindset of the organization. It is important to keep in mind who the end customers are and make service to these individuals a key part of your mission and culture. The Medicaid population is arguably society's highest-need segment, composed of seriously underserved people who would benefit more than almost any other group from better healthcare, better care coordination, and better understanding of their needs and drivers. Organizations where the workforce (1) recognizes the importance of what they are doing (2) feels empowered to treat the person and not just the patient and (3) promotes a culture of doing the right thing for the member – are the ones that tend to thrive in Medicaid.

Medicaid – a \$125 billion market that promises to be one of the fastest-growing segments of healthcare for the foreseeable future – is an important business opportunity. But it is also an immense opportunity to meaningfully impact lives by connecting beneficiaries to community resources to help get them back on their feet, providing them confidence to overcome substance abuse issues, or checking in on an expectant mother to make sure she is equipped to care for herself and her baby. It is an inspiring opportunity for health plans to improve lives and communities.

“Always do right,” Mark Twain once wrote. “This will gratify some people, and astonish the rest.” We believe Medicaid is one of the greatest opportunities in healthcare to do good, do well, do better, and astonish the world.

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