Care management for Medicaid

Optimizing new models of care for better population health and lower costs

Penny Edlund, RN, MBA, CPHQ

Traditional care management programs of Medicaid managed care health plans, or managed care organizations (MCOs), are evolving. With the goal of improving care and reducing costs, a combination of factors is shaping new frameworks for models of care. The working language of care management today increasingly includes terms like population health, whole person, medical/behavioral integration, social determinants of health (SDOH), health equity, and community-based care. However, the actual work required to transition from the old to the new is greater than a changing lexicon. Efforts to innovate Medicaid care management programs are both challenging and necessary, but the rewards can be substantial for plans, providers, state agencies, and beneficiaries alike.

This paper will explore some of the key drivers for evolution in the Medicaid care management space, address the challenges in transitioning to new models of care, and propose approaches that Medicaid MCOs can take to implement and optimize new care models. It is also important to note that, while not in scope for this paper, healthcare payment reform and the linkage between value-based payment/alternative payment models and value-based care are also central to emerging models of care.

Medicaid growth

Healthcare spending represents 18% of U.S. gross domestic product (GDP), far more than countries of similar economic standing. Despite its proportionally concentrated spending on healthcare, the United States ranks near the bottom on many core quality healthcare measures.[1,2,3] Medicaid is the third-largest payer in the U.S. health insurance landscape, following private insurers and Medicare, and accounts for 16% of the total national healthcare spend.[4] Consider the following trends within Medicaid from the past 10 to 20 years:

- **Medicaid enrollment more than tripled since 2000**. In 2000, Medicaid/Children's Health Insurance Program (CHIP) enrollment was at 34.5 million lives.[5] By 2010, the number of enrollees reached 54.5 million. Following the Patient Protection and Affordable Care Act (ACA), the percentage of uninsured individuals dropped from more than 16% to 9% in 2018. In 2019, there were more than 75 million lives covered by the Medicaid program.[6] By April 2021, enrollment reached 82.3 million covered lives, with a 15.5% increase since February 2020 reflecting the economic impact of COVID-19.[7,8]
- **Medicaid covers almost one in five Americans**. Children account for over 40% of Medicaid enrollment and only 20% of the expenditure, whereas disabled persons account for 15% of enrollment and 40% of total spend.[9] Medicaid provides health insurance for some of the most vulnerable populations, and states increasingly turn to MCOs to serve more medically complex beneficiaries.
- **Total Medicaid expenditure more than tripled since 2000.** In 2000, the total Medicaid expenditure was $206.2 billion. By 2010, it increased to $401.5 billion, and in 2019 the total Medicaid spend reached $639.4 billion. Furthermore, state Medicaid capitation expenditures increased from $90 billion in 2010 to $281 billion in 2018.[10]
- **Medicaid enrollment in managed care continues to grow.** In 2010, 51% of Medicaid beneficiaries were enrolled in managed care plans. By 2017, 69% of state Medicaid recipients received their care from risk-based MCOs. By 2019, almost 80% of Medicaid beneficiaries were enrolled in MCOs.[11,12]
- **Accreditation among Medicaid managed care plans continues to grow.** In 2015, 71% of Medicaid managed care enrollees were enrolled in plans accredited by the National Committee for Quality Assurance (NCQA). By 2018, the proportion of accredited managed care plans reached 77%.[13]

- **Accredited MCOs have demonstrated an impact on quality of care.** From 2014 to 2018, NCQA-accredited Medicaid managed care plans improved their performance on 26 of 30 key Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) quality measures. State programs increasingly reward quality outcomes with performance bonuses.[14]
- **NCQA introduced population health management standards.** For many years, NCQA standards for complex case management and disease management were included in the Quality Management and Improvement standards. In 2018, that changed with the introduction of a new set of standards: Population Health Management (PHM), which every health plan must meet to achieve NCQA accreditation.

Care management for Medicaid

As both Medicaid membership and costs continue to rise and Medicaid membership moves increasingly to managed care, the impetus for MCOs to deliver better outcomes and lower costs through transformative change is growing. MCOs play an essential role in achieving the Triple Aim goals of the Institute for Healthcare Improvement (IHI): improved population health, lower costs, and better care experience[15] as well as the six priorities of the Centers for Medicare and Medicaid Services (CMS) Quality Strategy.[16] The following section focuses on emerging models of care for Medicaid MCOs, including new requirements, key components for redesign, considerations and challenges for implementation, and how MCOs might optimize new care models to meet the needs of the Medicaid population.

TRANSITIONING TO NEW REQUIREMENTS

Evolving Medicaid contract requirements and accreditation standards are driving change among MCOs' models of care. Since the introduction of managed care, case management and disease management programs have become mainstays of many plans attempting to improve health, reduce costs, and meet accreditation standards. Case management generally focuses on high-cost/high-risk members with complex needs, while disease management focuses on specific conditions, such as the "big five" (diabetes, heart failure, coronary artery disease, asthma, and chronic obstructive pulmonary disease), end-stage renal disease (ESRD), cancer, transplants, and neonates requiring intensive care.[17] These programs, and their impact, can vary widely across plans. Newer requirements demonstrate a shift from a medical model (*manage the disease*) to whole-person health (*person-centered care*), with increased emphasis on social determinants of health (SDOH), support services, and mental/behavioral healthcare needs. This convergence of state contract requirements and accreditation standards is shaping the models that MCOs need to deliver to improve health outcomes and reduce costs. The bottom line for MCOs: meeting new requirements may be essential to stay in business.

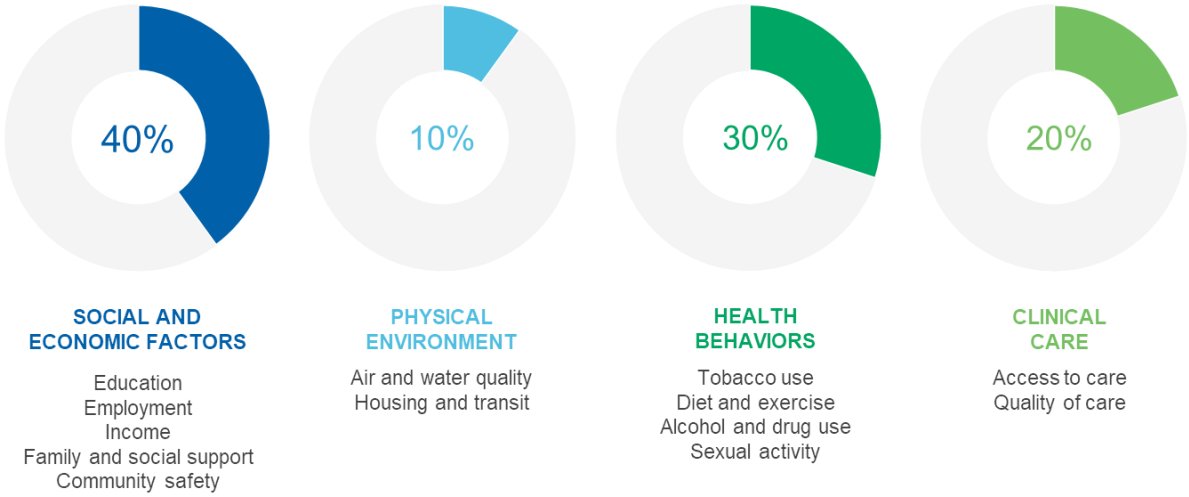
EMERGING CARE MODELS

Emerging models reflect changes from a growing number of innovative practices in alignment with NCQA's 2018 PHM standards for health plan accreditation.[18] Based on a definition from the Population Health Alliance, NCQA defines PHM as "a model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population" with the goal "to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions."[19] Population health models include person-centered care for high-risk/high-need populations, with SDOH, medical and behavioral care needs, and use of local community services and resources at its core. Emerging care models may include many, if not all, of the following key components.

- **New populations of focus**. Candidates for care management typically include members with chronic conditions, high-cost claimants, and children and adults with special healthcare needs. New populations of focus may now include, for example, those identified as rising risk, living with serious mental illness (SMI), justice-involved, experiencing housing instability, and pregnant with substance use disorder (SUD). Identifying populations requires systematic collection, integration, and assessment of member data. While plans may have some flexibility in determining their populations of focus and how they are defined, state contracts may explicitly define not just the specific populations but also target percentages for enrollment in care management. In any event, an MCO's data use and analytic capabilities to appropriately select, identify, and stratify appropriate populations can be instrumental in optimizing the care model.

- **Social determinants of health (SDOH).** SDOH are "conditions in the environments in which people are born, live, learn, work, play and worship, and age that affect a wider range of health, functioning, and quality-of-life outcomes and risks."[20] Evident in newer models is the recognition that 1) social determinants can contribute significantly to an individual's overall health; 2) some populations, such as those with low income or of certain racial and ethnic groups, are disproportionately affected by SDOH; and 3) an individual's ZIP Code can play a significant role in their well-being. The environmental and socioeconomic factors directly linked to a beneficiary's local area can account for up to 50% of overall health outcomes, while clinical care accounts only for up to 20%.[21] In 2020, of the 41 states with Medicaid managed care systems, 35 states were "leveraging MCO contracts to promote at least one strategy to address social determinants of health."[22]

FIGURE 1: SOCIAL DETERMINANTS OF HEALTH



Adapted from: County Health Rankings Model.

- **Expanded health assessments.** Initial health screenings, health risk assessments (HRAs), and comprehensive assessment tools may require additional data elements under new models of care. For example, current assessments might include factors such as SDOH, functional status, mental health and substance use, depression, suicide risk, exposure to adverse childhood experiences (ACEs), legal involvement, and need for community support services, which weren't always reviewed before. Furthermore, some states may require use of a standardized HRA tool by all contracted Medicaid health plans. Effective use of the additional data elements can help MCOs to identify target populations and tailor the model of care and interventions to the specific needs of their populations.
- **Person-centered care.** A whole-person, holistic approach is central to new care models, though it's certainly not a new concept. The Institute of Medicine (IOM) 2001 report "Crossing the Quality Chasm" defined patient–centered care as "providing care that is respectful of and responsive to the individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions."[23] In 2010, the Case Management Society of America revised its standards of practice for case management to include "addressing the total individual, inclusive of medical, psychosocial, behavioral and spiritual needs…increasing involvement of the individual and caregiver in the decision-making process…minimizing fragmentation of care within the health care delivery system," and "expanding the interdisciplinary team."[24] A person-centered care model requires a mindset shift from a traditional medical model of condition-focused interventions, care plans, and goals developed by healthcare professionals for a member. Although the health outcomes may be the same (e.g., reduced hemoglobin A1C for a person with diabetes, continued SUD treatment following release from jail), the goals and path to get there are centered around and targeted to the individual member.
- **Medical/behavioral integration.** Whole-person care also means making the connection between physical and mental/behavioral healthcare needs. In addition to care coordination and integration to address members' needs across medical and behavioral health services, structural changes may also be involved. Collaborative bidirectional care models, colocation of medical and behavioral providers, embedding plan staff locally, and expanding interdisciplinary care teams (ICTs) to include, for example, behavioral health specialists, social workers, and peer supports, may be appropriate or even required.

- **Community-based care**. Connecting the dots between medical, behavioral, and social components of health, care models increasingly call for community-based "boots on the ground"—whether from MCOs or other entities, such as contracted patient-centered medical home (PCMH) providers or accredited PHM organizations. The care can include face-to-face visits with members, a primary point of contact for care navigation, coordination and advocacy, a local ICT, and collaborative partnerships within the local care delivery system. At a minimum, this may require a health plan with a centralized care team to build extensive local knowledge, connections, working relationships, and agreements with community-based organizations (CBOs) and the local providers. Also noteworthy for community-based care is the increasing emphasis on coverage and provision of long-term services and supports (LTSS). Depending on membership size, communities and populations served, state contract requirements, and the contract relationships with local providers, plans may consider "build versus buy," "build and buy," or formal partnerships for local field-based roles such as community health workers (CHWs), social workers, peer supports, care coordinators, and care managers.

Tailoring these key components of the care model to the populations and communities served can help meet contract requirements and accreditation standards, improve the efficiency and effectiveness of the MCOs' care models, and improve health outcomes for populations.

CONSIDERATIONS AND CHALLENGES FOR IMPLEMENTING NEW CARE MODELS

Translating contract requirements and accreditation standards into the "must haves" for an MCO's care model, even for accredited plans, may result in extensive redesign of a plan's existing framework, and may include added investment with or without additional funding. Some considerations and challenges plans may face in implementing new care models include the following:

- **Technology/system changes**. Required changes may start with system, process, and reporting alterations to promote the successful identification and stratification of beneficiary populations. Changes to HRAs and comprehensive assessment requirements may lead to extensive rework of key care model components, including the clinical management system configurations, data capture and reporting methods, referral processes, and program design and interventions. For example, national plans operating in multiple states may have different requirements in each local market and MCOs may need to make design and workflow changes to effectively collect and use International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Clinical Modification (ICD-10-CM) z-codes related to SDOH.
- **Operationalizing the care model.** Key components of new care models may require substantial internal program changes. Integrating medical and behavioral care processes may require significant operational redesign and changes to staff mix, capabilities, training, and workflows. Overcoming staff inertia and establishing a cohesive internal care team that leverages their combined medical/behavioral experience can be a challenge. Linking SDOH to community supports and care interventions can be conceptually easier than designing, integrating, and operationalizing them in new care models.[25]
- **Local knowledge**. Building local knowledge of services and resources may be a heavy lift, particularly for health insurance plans with centralized, telephonic care models. Plans with well-established local connections and/or their own "boots on the ground" (e.g., community health workers, embedded staff, nurses or social workers doing home visits, emergency room visit follow-up or post-discharge follow-up) may enjoy both a performance and competitive advantage.
- **Local service agreements**. Whether a "buy" decision is required by contract or made by choice, plans need to determine the appropriate pricing/payment model, service standards, and vendor oversight. Some states are requiring a progressive transition to care management deployed, for example, to local care management agencies (CMAs), accountable entities (AEs), or local care management entities (LCMEs). Plans may also need to evaluate and manage any internal staffing changes accordingly.
- **Local supply and demand.** Adequate supply to meet increasing demand for specific roles—such as community health workers, housing specialists, and mental health professionals—can be a challenge to MCOs and local care delivery systems alike. Limited supply can increase competition for hiring key roles and increase the administrative cost. Moreover, a limited supply of key personnel may also contribute to heightened competition among plans as they secure state-required service agreements with local community organizations and agencies. The increasing coverage for nontraditional health services may also increase demand and competition for limited resources further. Designing, implementing, and maintaining cross-organization collaboration may require ongoing relationship management.

OPTIMIZING NEW MODELS OF CARE

Meeting the requirements for change can have its rewards. MCOs can take action in several ways to meet transitional challenges and optimize new models of care. Whether a plan is just beginning the journey or already operates a well-adapted care model, a focus on improvement can yield better design, operational efficiencies, and outcomes. For care management programs and clinical operations that "run quietly in the background," this can be an opportunity to rediscover and redeploy valuable assets to do more, starting with the basics.

- **Start with the basics**. Conduct a deep-dive assessment of the current care model design, platform(s), processes, and performance, including an evaluation of the overall clinical, financial, and quality performance outcomes. This step alone may reveal opportunities for performance improvement, innovation, and efficiencies. Compare the current model assessment to contract requirements and accreditation standards to identify gaps and update the design accordingly. A systematic approach, adequate resources, and a comprehensive project plan often yield the best results. Though simple, conducting a thorough self-assessment can be a critical step. MCOs may consider engaging external expertise to assist with the process.
- **Approach the design as a whiteboard opportunity**. MCOs can create a whiteboard opportunity to look beyond required changes and address persistent or perplexing challenges with their current care models and utilization trends. A whiteboard approach can also help reduce natural barriers and overcome inertia. For a plan's care management team, the prospect of transitioning from traditional case management programs to a person-centered, community-based care model can inspire innovative thinking and solution-focused action.
- **Identify the flex points for innovation and leading practice development**. Look to success stories from the growing number of care management pilots and demonstration projects, as well as insights from within the care management team. Consider the role that technology can play to better identify, connect, and engage with members. The heightened demand for telehealth, fitness apps, and wearables, for example, can be a springboard to explore or expand use of available technologies.
- **Update the staffing model.** Look for administrative cost savings and efficiencies. Take stock of the current model, staff mix, capabilities, and capacity. Traditional care management models generally rely on a core of nurse care managers who, even with operations support, often are not working at "top of license." Furthermore, a typical care management team may have limited experience addressing behavioral health and mental health needs such as suicide ideation, posttraumatic stress disorder, and autism spectrum disorder. New care models offer an opportunity to reconsider skill mix and reconfigure staffing models. Selectively introducing behavioral health specialists, social workers, peer supports, community health workers, and/or education and housing specialists into the mix to meet contract requirements, for example, can garner many benefits. Such benefits may include reduced overall administrative costs, better use of valuable resources, expanded breadth of experience and expertise of the team, more person-centered care, and improved health outcomes.
- **Train for success**. Build a core knowledge base, knowledge sharing, and learning culture across the care team. Health insurance plans may also assess, prioritize, and address training gaps. Just as care managers and care coordinators may feel unprepared to ask members about suicide ideation, behavioral health specialists may be unfamiliar with the basics of diabetes or asthma. Tap into plan expertise, community organizations, or external resources to supplement the aggregate team's understanding. Training for new care models may include assessment tools or key topics such as trauma-informed care, ACEs, motivational interviewing, suicide assessment and prevention, substance use disorder, and prevalent chronic conditions and comorbidities identified within the membership.
- **Build community presence, relationships, partnerships, and expertise**. Provide active support, leadership, and collaboration. Note that hospitals and providers are also including PHM and key elements, such as SDOH and community connections, in their strategies and care models with a focus on improving quality of care, managing costs, achieving value-based performance (VBP) targets, and meeting accreditation standards. MCOs that leverage the full extent of their care models are often seen as "valued partners" in connecting the population health dots to collectively achieve the Triple Aim and improve the care of the populations served.
- **Manage, monitor, and improve**. Ensure operational and outcomes reporting is well-designed, working, and used. Plans may consider performance dashboards and quality improvement processes, such as Plan-Do-Study-Act (PDSA) cycles, to monitor and improve the care model on the go. Doing so requires plans to commit the necessary time and resources for consistent and effective management oversight, both internally and for contracted CBOs and providers. The result of continuous model of care improvement is a plan that can identify gaps, address them, and celebrate the success of growth.

While each listed action warrants in-depth review, these steps can serve as a good place for a health plan to start, or continue, along the path to managing the challenges of change, optimizing the new care models, and managing improvements in the future. As Medicaid programs seek to improve care and lower costs, state contract requirements and accreditation standards may continue to drive change.

Summary

The structural and process changes needed to design and implement a new care model may be a major undertaking for many Medicaid health plans, and action may no longer be optional. Planning and managing successful change require time, vision, and expertise. Engaging external expertise can provide the additional knowledge and resources needed to get there. Whether or not action is optional, optimizing the value of a new model of care can be a planned, deliberate, and strategic choice and the rewards for an MCO can be substantial.

CONTACT

Penny Edlund
penny.edlund@milliman.com

ENDNOTES

[1] CMS (December 16, 2020). CMS Office of the Actuary Releases 2019 National Health Expenditures. Press release. Retrieved November 2, 2021, from https://www.cms.gov/newsroom/press-releases/cms-office-actuary-releases-2019-national-health-expenditures.

[2] Commonwealth Fund (June 6, 2020). International Health Care System Profiles: United States. Retrieved November 2, 2021, from https://www.commonwealthfund.org/international-health-policy-center/countries/united-states.

[3] Commonwealth Fund (July 14, 2017). Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care. Retrieved November 2, 2021, from https://www.commonwealthfund.org/publications/fund-reports/2017/jul/mirror-mirror-2017-international-comparison-reflects-flaws-and.

[4] CMS, 2019 National Health Expenditures, op cit.

[5] Statista (September 8, 2021). Total Medicaid Expenditure from 1966 to 2019. Retrieved November 2, 2021, from https://www.statista.com/statistics/245348/total-medicaid-expenditure-since-1966/.

[6] Ibid.

[7] Stolyar, L. et al. (June 24, 2021). Growth in Medicaid MCO Enrollment During the COVID-19 Pandemic. Kaiser Family Foundation. Retrieved November 2, 2021, from https://www.kff.org/coronavirus-covid-19/issue-brief/growth-in-medicaid-mco-enrollment-during-the-covid-19-pandemic/.

[8] Corallo, B. & Mehta, A. (October 29, 2021). Analysis of Recent National Trends in Medicaid and CHIP Enrollment. Kaiser Family Foundation. Retrieved November 2, 2021, from https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/.

[9] Ibid.

[10] AHIP. The Value of Medicaid Managed Care: States Transition to Managed Care. Retrieved November 2, 2021, from https://www.ahip.org/wp-content/uploads/Medicaid_Managed_Care_States_Research_2020.pdf.

[11] Ibid.

[12] Kaiser Family Foundation. Medicaid Managed Care Market Tracker. Retrieved November 2, 2021, from https://www.kff.org/data-collection/medicaid-managed-care-market-tracker/.

[13] AHIP. The Value of Medicaid Managed Care: Improving the Quality of Care in Medicaid. Retrieved November 2, 2021, from https://www.ahip.org/wp-content/uploads/AHIP-MMCResearch-QualityofCare-2020.pdf.

[14] Ibid.

[15] Berwick, D.M., Nolan, T.W., & Whittington, J. (May/June 2008). The Triple Aim: Care, Health, and Cost. Health Affairs. Retrieved November 2, 2021, from https://www.healthaffairs.org/doi/10.1377/hlthaff.27.3.759.

[16] CMS. Overview of the CMS Quality Strategy. Retrieved November 2, 2021, from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy-Overview.pdf.

[17] Hisashige, A. (March 2013). The Effectiveness and Efficiency of Disease Management Programs for Patients with Chronic Diseases. Global Journal of Health Science. Retrieved November 2, 2021, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4776791/.

[18] NCQA. Health Plan Accreditation. Retrieved November 2, 2021, from https://www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/.

[19] Population Health Alliance. PHA Framework. Retrieved November 2, 2021, from https://populationhealthalliance.org/research/understanding-population-health/.

[20] NCQA. Population Health Management: Roadmap for Integrated Delivery Networks. Retrieved November 2, 2021, from https://www.ncqa.org/wp-content/uploads/2019/11/20191216_PHM_Roadmap.pdf.

[21] University of Wisconsin Population Health Institute. County Health Rankings Model. County Health Rankings & Roadmaps. Retrieved November 2, 2021, from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model.

[22] Institute for Medicaid Innovation (January 2019). Innovations and Opportunities to Address Social Determinants of Health in Medicaid Managed Care. Retrieved November 2, 2021, from https://www.medicaidinnovation.org/_images/content/2019-IMI-Social_Determinants_of_Health_in_Medicaid-Report.pdf.

[23] Institute of Medicine (U.S.) Committee on Quality of Health Care in America (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Retrieved November 2, 2021, from https://pubmed.ncbi.nlm.nih.gov/25057539/.

[24] Case Management Society of America (2010). Standards of Practice for Case Management. Retrieved November 2, 2021, from https://www.abqaurp.org/DOCS/2010%20CM%20standards%20of%20practice.pdf.

[25] Livingston, S. (August 25, 2018). In Depth: Payers Can't Control Costs Without Social Determinants of Health Model. Modern Healthcare. Retrieved November 2, 2021, from https://www.modernhealthcare.com/article/20180825/NEWS/180829956/in-depth-payers-can-t-control-costs-without-social-determinants-of-health-model.