The Academy
The Health Management Academy

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Strategic Survey Q2 2019: Medicaid Managed Care

June 2019

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Medicaid Managed Care

Introduction

Beginning in the 1990s, states began implementing Medicaid Managed Care programs to provide health benefits to their Medicaid beneficiaries. Under this model, state Medicaid agencies pay a fixed monthly fee to Managed Care Organizations (MCOs), which are tasked with managing cost, quality, and utilization of services for beneficiaries. Presently, nearly all state Medicaid programs contract with MCOs, with the majority of Medicaid beneficiaries receiving benefits via these arrangements nationwide.[1]

In an era where government payers are responsible for an increasingly greater share of health system revenue, Leading Health Systems (LHS) must consider how Medicaid Managed Care fits into their overall payer strategy and plans for financial viability in the future.

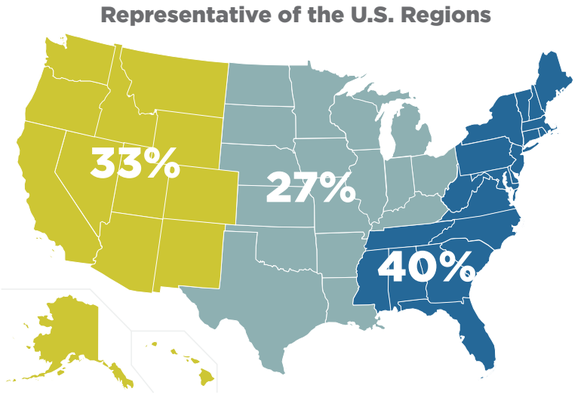
Methodology

In May 2019, The Academy conducted the nineteenth round of phone interviews for its quarterly strategic survey among LHS executives, including: CEOs, COOs, CFOs, CMOs, and CSOs.

The survey for the interview consisted of:

1. A tracking section that provides insight into trends around primary strategic areas; and
2. A special topic area that allows for an in-depth look into a timely developing issue.

Profile of Participating Health Systems



MEDIAN REVENUE

$3.4 BILLION

OWN OR OPERATE **193 HOSPITALS** WITH **37,964 BEDS**

SINGLE-STATE SYSTEMS: **60%**
MULTI-STATE SYSTEMS: **40%**

[1] Centers for Medicare & Medicaid Services. 2017 Managed Care Enrollment by Program and Population, 2019. Retrieved from: https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/vcjc-yq9z/data

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Key Findings

1

Managed Care

Medicaid Managed Care is the predominant care delivery model for Medicaid beneficiaries among 87% of health systems. However, few of these systems consider Medicaid Managed Care to be a part of their overall risk portfolio.

2

Prioritization

Health systems that place a high priority on Medicaid Managed Care tend to have a higher proportion of their patient revenue attributed to government payers.

3

Challenges

The top challenges health systems encounter in managing Medicaid Managed Care beneficiaries are the effective use of data analytics (39%) and patient engagement (31%).

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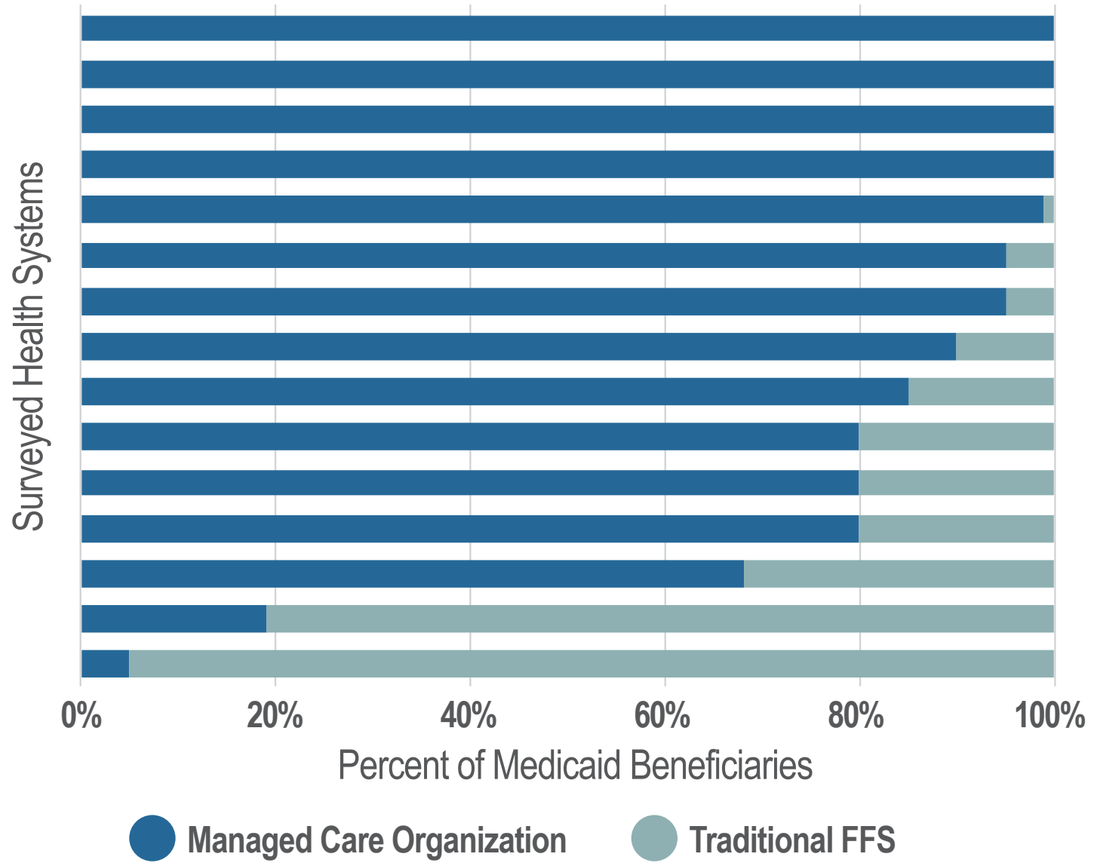
Managed Medicaid is Dominant, But Few Taking Risk

All of the health systems surveyed have some portion of their Medicaid population enrolled under Managed Care Organizations (MCOs). For a majority of these health systems (87%), Medicaid Managed Care, also known as Managed Medicaid, is the predominant arrangement for Medicaid beneficiaries receiving care within the system. This is reflective of national Medicaid enrollment trends.[1]

However, relatively few health systems consider Medicaid Managed Care to be a means for assuming financial risk because they are still paid on a fee-for-service (FFS) basis for these patients. Several health systems are paid on a capitated per-member per-month basis by the MCOs with which they contract, and these health systems in turn consider this population to be "at risk". Others receive some shared savings dollars back on these patients, but ultimately this is a negligible amount compared to their overall revenue at risk. Only one health system has a Managed Medicaid population that makes up more than 20% of its total risk portfolio. Notably, several health systems intend to take full risk on their Medicaid contracts over the next 12 months.

> We're not thinking about Medicaid in the same way we're thinking about our other risk programs. We don't consider it risk at this point because we're still getting paid on a per-unit basis for a majority of these beneficiaries." (COO)

CONTRACT TYPE AMONG MEDICAID BENEFICIARIES



[1] Centers for Medicare & Medicaid Services. 2017 Managed Care Enrollment by Program and Population, 2019. Retrieved from: https://data.medicaid.gov/Enrollment/2017-Managed-Care-Enrollment-by-Program-and-Popula/vcjc-yq9z/data

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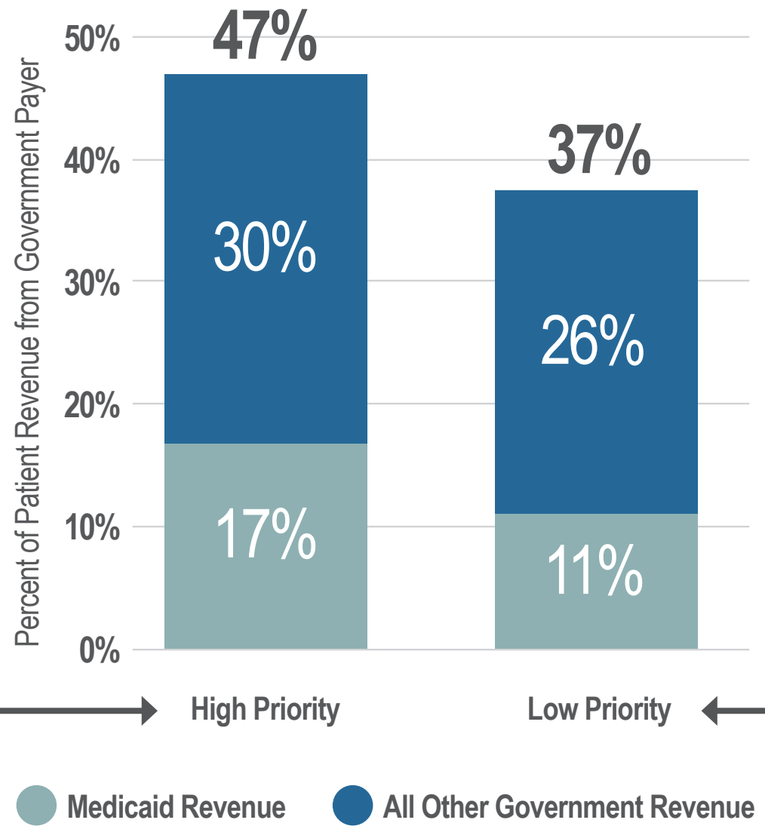
Priority Level for Managed Medicaid is Predictive of Revenue from Government Sources

"We believe that the path to sustainability in a high government penetration environment is maintaining control of the premium dollar." (COO)

Nearly half of the health systems surveyed (43%) indicate a high priority level for participating in Medicaid Managed Care. These "high prioritizers" see value-based care contracts, such as Medicaid Managed Care, as a vehicle for fulfilling their organizational mission to deliver value to their communities. Interestingly, this group tends to have a higher proportion of their patient revenue tied to government payers – 47% on average – compared to low prioritizers. Since reimbursement from government payers is lower than commercial payers, health systems with greater revenue coming from government payers must be better prepared to assume risk on these patients and manage their service utilization appropriately to control associated costs.

REVENUE FROM GOVERNMENT PAYERS BY PRIORITY LEVEL FOR MANAGED MEDICAID



"There is an acknowledgment that taking more risk on the Medicaid population is something we need to do, but we're not necessarily driving that. The payers have control of what those contracts look like." (CFO)

For 20% of the sample, participating in Medicaid Managed Care is a low priority or not a current priority for their health system. For these health systems, payers within their market are by far the largest factor inhibiting their participation. These health systems tend to be in small states with few payers controlling the market. For some of these health systems, other payer arrangements in which they are actually assuming financial risk take a higher priority. However, these systems anticipate Managed Medicaid will become a higher priority in the near future when they are taking more risk on this population.

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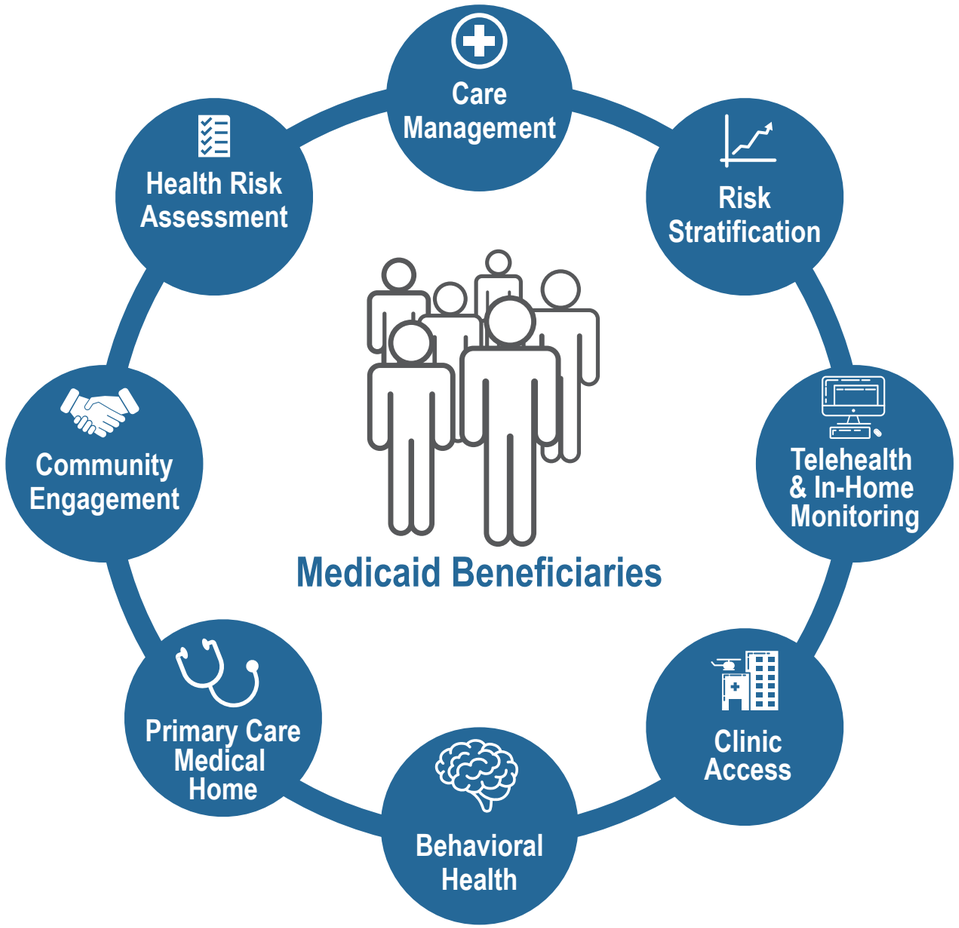
Medicaid-Specific Initiatives Help Control Utilization

While all health systems surveyed have created initiatives to control utilization among patient populations for which they are at risk, less than half of them have created initiatives specific to the Medicaid population. Unsurprisingly, health systems are not as far along at creating initiatives for this population as other populations because they are not assuming much risk in Medicaid at present. Some systems that have seen success with their Medicare Advantage (MA) patients have begun adapting those programs for Medicaid patients. Medicaid-specific initiatives include using data analytics to identify at-risk individuals and heavy utilizers, digital health tools to prevent costly urgent care and emergency room visits, the creation of outpatient clinics in Medicaid-dense areas, the integration of behavioral health resources into ambulatory care settings, and connecting patients with a primary care medical home.

> "We know how to do this very well with our MA patients. We're trying to take those learnings and infrastructure and move them into the Medicaid side, but we're not at the same level of interventions yet." (CFO)

With regard to managing Medicaid patients with complex and chronic conditions, health systems are working to provide additional resources to clinicians. These resources include care coordinators that monitor duplication of services and opportunities for medication substitutions, decision support tools and practice alerts in the EMR, and data analysis and processing of claims data to identify undiagnosed conditions and early symptoms of disease. One commonly identified gap in this area is communicating the right level of data to physicians without overloading them with noncritical information. Also, the high churn rate within the Medicaid population poses a unique challenge for clinicians and care managers.

INITIATIVES CONTROLLING UTILIZATION AMONG MEDICAID POPULATION



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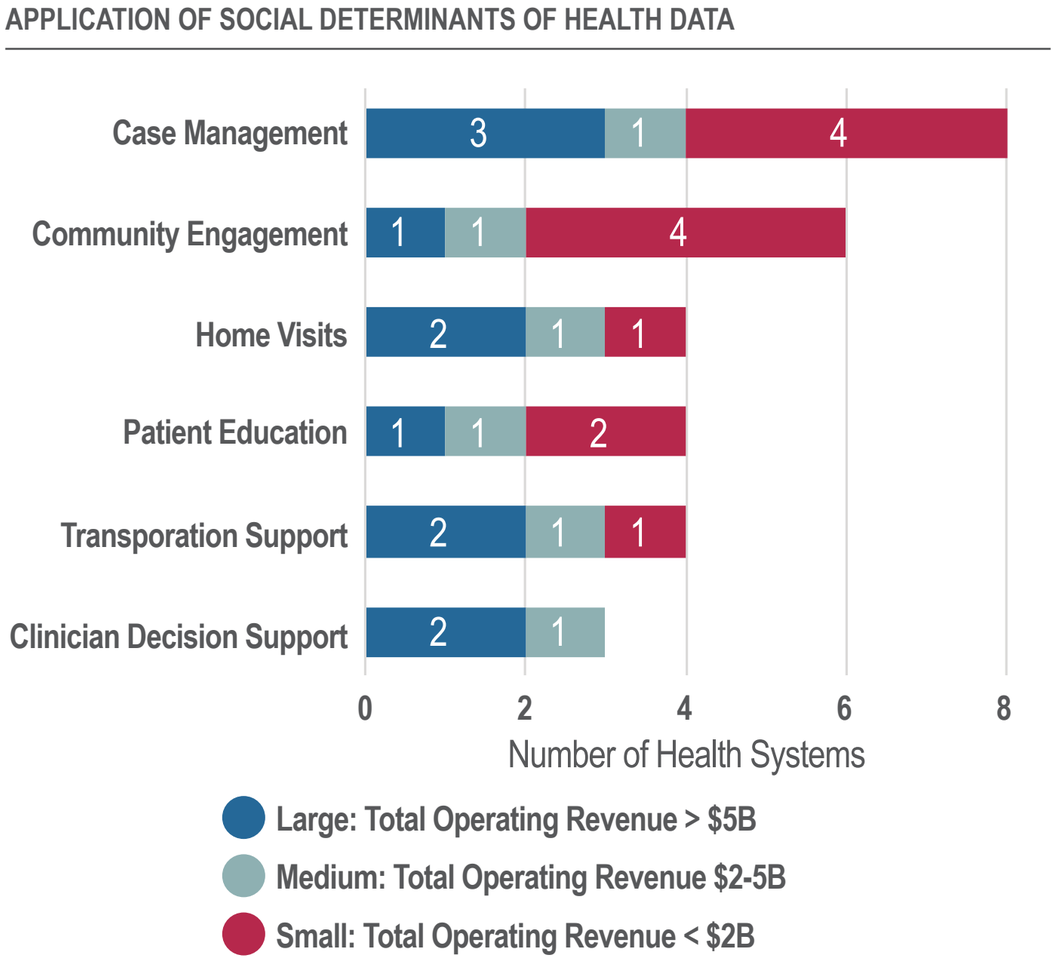
Case Management is Most Common Use for SDOH



In addition to creating initiatives to control utilization among the Medicaid population, health systems have begun collecting and aggregating Social Determinants of Health (SDOH) data to better understand the various factors that affect the health of these patients. Ultimately, health systems hope to use these data to more appropriately target interventions and resources to their most vulnerable groups. However, nearly half of health systems (47%) are not currently using SDOH data in any meaningful way and are in preliminary stages of operationalizing the use of these data.

Among health systems that have begun leveraging SDOH data, the most common application is case management. SDOH data allows them to more adeptly identify at-risk patients in need of additional resources and support. Of note, no small health systems (total operating revenue (TOR) <$2 billion) have begun using SDOH data for clinician decision support; rather are much more likely to use these data for community engagement than large and medium health systems (TOR >$2 billion).

Additional resources available to Managed Medicaid patients include dental care, dietary support, housing support, and community-based education support.

> "We use SDOH for patients engaged in care management. We are building a program for universal SDOH screening for all patients." (COO)

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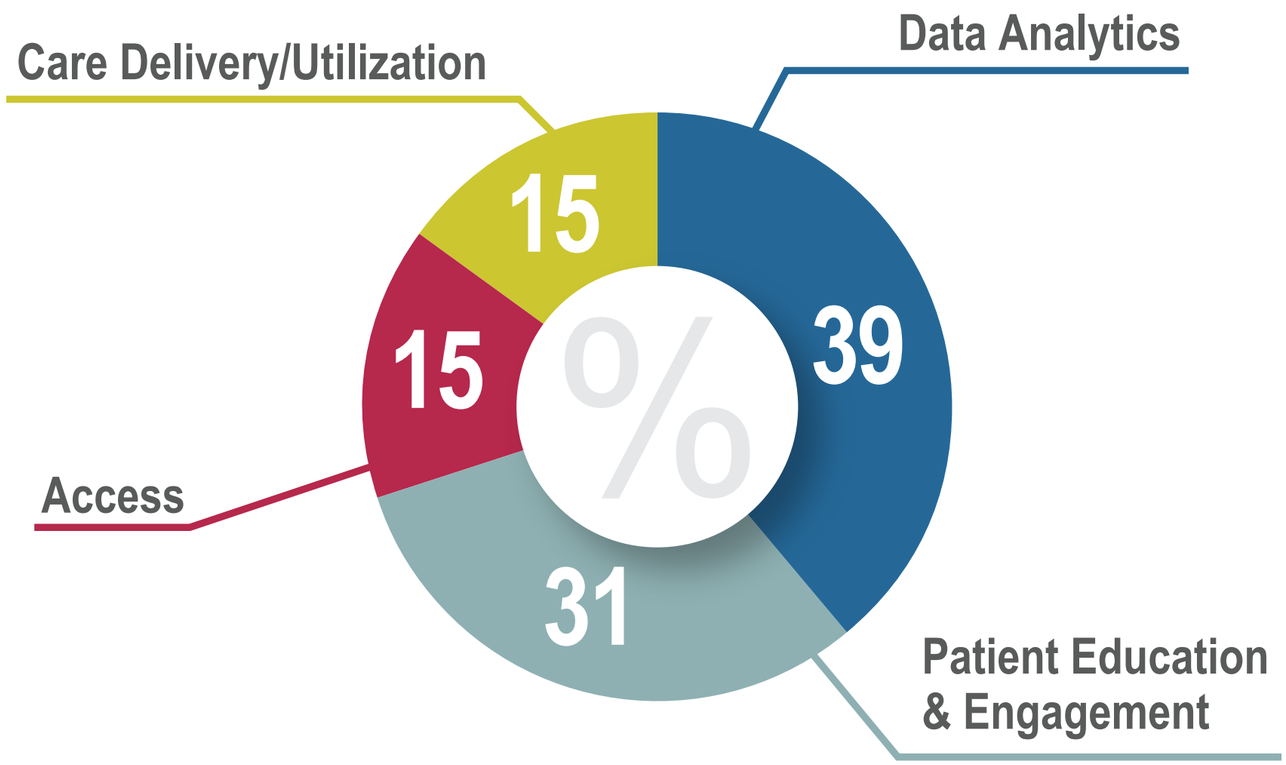
Data and Patient Engagement are Top Challenges

TOP CHALLENGE FOR PROVIDING CARE TO PATIENTS IN CAPITATED PAYMENT MODELS



"Data management is a real challenge. Even though we have a good platform for care management, making sure everything is accounted for and costed appropriately is a challenge as we transition from volume to value. In an uncertain regulatory and payer landscape, it's tough to know how to make investments into the things that matter." (CSO)

Looking to the future, health systems are seeking to solve challenges in delivering care for patients in capitated payment models in order to maintain financial stability and viability. LHS identify data analytics and patient engagement as their top challenges in providing care for Medicaid patients, particularly those for which they are taking financial risk.

For data analytics, the challenge is integrating disparate IT systems for the purposes of data aggregation and tracking the proper analytics to appropriately target resources toward distinct patient cohorts. From the patient perspective, health systems are challenged with helping Medicaid patients understand care plans, particularly following a hospitalization, and pre-emptively engaging beneficiaries before they end up in the ER.

As Managed Medicaid becomes a larger organizational priority for more health systems, LHS will need to find solutions and strategic partners to address these challenges.

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About the Academy

The Health Management Academy (The Academy) is a membership organization exclusively for executives from the country's Top-100 Health Systems and most innovative healthcare companies. The Academy's learning model identifies top priorities of health system leaders; develops rich content based on those priorities; and addresses them by convening members to exchange ideas, best practices, and information. The Academy is the definitive trusted source for peer-to-peer learning in healthcare delivery with a material record of research and policy analysis. Offerings include C-suite executive peer forums, issues-based collaboratives, leadership development programs, research, advisory, and media services. The Academy is an accredited CE provider. More information is available at www.academynet.com

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About Lumeris

Lumeris is a value-based care managed services operator for health systems and providers seeking extraordinary clinical and financial outcomes. Lumeris aligns providers and payers across populations with technologies, processes, behaviors and information to achieve high-quality, cost-effective care with satisfied consumers — and engaged physicians. For the past eight years, Essence Healthcare, Lumeris' inaugural client and learning laboratory with more than 65,000 Medicare members in Missouri and Illinois, has received 4.5- to 5-Star Ratings from the CMS and produced the highest consumer and physician satisfaction scores in the industry along with significantly better clinical outcomes and lower costs. For more information, go to www.lumeris.com.

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