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Beyond the HMO: Managing Care through Integrated Care Models in Medicaid

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Key Resources

Publications

- *Health Advocate* volume 5 (September 2012), available here.
- *Health Advocate* volume 6 (October 2012), available here.

Issue Briefs

- Accountability and Stewardship in Medicaid Managed Care (June 2007), available here.

Fact Sheets

- Medicaid Managed Care: Enrollment and Education, available here.
- Medicaid Managed Care: Services, available here.
- Medicaid Managed Care: Financing, available here.
- Medicaid Managed Care: Grievances and Appeals, available here.

Coming in March's Health Advocate:

NHeLP's Response to the Federal Budget Proposals

In this issue of the Health Advocate, we discuss emerging models of integrated care, how they relate to existing Medicaid managed care options, and recent federal guidance on implementing integrated care models in a variety of Medicaid systems.

As the population ages and the prevalence of disabilities and chronic conditions increases, public and private insurers are struggling to contain rising costs. State Medicaid agencies face an especially daunting challenge because they bear a disproportionate share of the responsibility for long term care services (LTCS) – over 43% percent of LTCS costs are paid by Medicaid.[1] An increasing number of states have turned to capitated managed care provided by HMO-type plans. In the past eight years, the number of individuals receiving LTCS through capitated managed care programs more than doubled from 105,000 to 389,000.[2] As implementation of the Affordable Care Act (ACA) proceeds, it is anticipated that states will expand the use of managed care even further as they enroll increasing numbers of individuals who require LTCS.

In capitated managed care, plans receive a set payment based on the number of enrollees. If the cost of serving those enrollees is less than the capitated payments, the plan keeps the difference. But, if it the costs of serving the population exceeds the amount of the payment, the plan takes a loss. Because serving people with disabilities and chronic conditions is expensive, there is an obvious incentive for plans to deny coverage of services. Advocates are concerned that this trend will lead to denials of necessary services in the name of cost control.

While the expansion of capitated managed care causes concerns, the fee-for-service (FFS) system does not necessarily serve those with long term care needs well. Services can be fragmented and duplicative in FFS systems, which is not only a costly enterprise, but it also poorly serves patients. Thus, policy makers, state Medicaid agencies, advocates, and patients have sought delivery system reforms that would coordinate and integrate care in a way that is beneficial to patients and improves health outcomes.

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[1] Kaiser Commission on Medicaid and the Uninsured, *Medicaid's Long Term Care Users: Spending Patterns Across Institutional and Community-based Settings* 1 (Oct. 2011), *available at* http://www.kff.org/medicaid/upload/7576-02.pdf (figures from 2007).

[2] Paul Saucier, et al., *The Growth of Managed Long Term Services and Supports (LTSS) Programs: A 2012 Update* (July 2012).

There are a number of delivery and payment alternatives that are gaining popularity, spurred in part by the availability of options offered through the ACA. Last summer, the Centers for Medicare & Medicaid Services (CMS) issued guidance to State Medicaid agencies describing several initiatives for care delivery and payment reforms that they refer to as Integrated Care Models (ICMs).[3] ICMs include Accountable Care Organizations and medical and health homes. Advocates should familiarize themselves with these entities and the opportunities and challenges they offer.

Accountable Care Organizations (ACOs). These entities are provider organizations that provide coordinated care to enrolled patients and have the potential to share in any savings that result from the way in which they serve enrollees. The ACO model has been widely used in Medicare but, until recently, much less frequently in Medicaid programs. Encouraged in part by a new option under the ACA to offer Pediatric Accountable Care Organizations, some states have begun to implement ACOs in their Medicaid programs.[4] Currently, at least 12 states are engaged in efforts to implement Medicaid ACOs.[5]

There is no standard definition, so the characteristics of these ACOs vary widely. States are, however, primarily considering models that include capitation and risk-based arrangements.[6] But, ACOs are not required to employ such arrangements.

Health Homes. The ACA created a new option that enables state Medicaid programs to offer coordinated care to eligible individuals with chronic conditions through "health homes." These health homes are based on the concept of a medical home, which has existed for more than 40 years.[7] In a medical home model, a patient has an ongoing relationship with a primary care provider, who has an ongoing responsibility for coordinated, quality care. While health homes and ACOs have some essential similarities, one primary distinction is that ACO's always include the ability to share in savings obtained by the way in which they provide care.

The ACA health homes option authorizes coverage of care from a designated provider, team of health professionals, or other health team. A team of health care professionals includes physicians and other professionals (such as nurses, nutritionists, or home health agencies). The health team has the same definition as a "community health team," which is authorized by Section 3502 of the ACA and is an interdisciplinary team that must include a variety of health professionals.[8] Eligible individuals include those who have:

- At least two chronic conditions,
- One chronic condition and is at risk for a second chronic condition, or
- One serious and persistent mental health condition.

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[3] CMS, *Dear State Medicaid Director* (# 12-002) (July 10, 2012).
[4] ACA § 2706.
[5] National Ass'n of State Health Policy, "State Accountable Care Activity Map," http://nashp.org/state-accountable-care-activity-map (last visited January 31, 2013).
[6] CHCS, *Core Considerations for Implementing Medicaid Accountable Care Organizations* (Nov. 2012)), *available at* http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261462. *See generally* Kaiser Comm'n on Medicaid and the Uninsured, *Emerging Medicaid Accountable Care Organizations: The Role of Managed Care* (May 2012), *available at* http://www.kff.org/medicaid/8319.cfm.
[7] CMS, *Dear State Medicaid Director* (# 10-24) (Nov. 16, 2010). http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.
[8] CHCS, *Implementing Health Homes in a Risk-Based Managed Care Delivery System* 2 (June 2011), *available at* http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261271

"Chronic conditions" are defined as a mental health condition, substance use disorder, asthma, diabetes, heart disease, or being overweight with a BMI greater than 25. Services that can be covered include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow up;
- Patient and family support;
- Referral to community and social support services; and
- Use of health information technology to link to services.[9]

According to CMS, there are ten approved state plan amendments for health homes, in eight states.[10] Many other states are exploring this option.[11] CMS encourages states to integrate health homes into their existing systems but to make sure not to duplicate services – for example, if a managed care plan is contractually obligated to provide care coordination.[12]

In addition to describing various ICMs, CMS explained how states can implement these options. States can, for example, create capitated, risk-based ACOs. Or existing HMO plans can contract with these entities. CMS also explains, however, that states may implement these models through a type of managed care that has long existed in the Medicaid Act, known as Primary Care Case Management (PCCM).[13]

As the name indicates, PCCM arrangements are based on a primary care provider who coordinates, manages, and provides primary care for enrollees. In Medicaid PCCM arrangements, the state Medicaid agency pays a primary care provider a per-person case management fee to coordinate care. Services that are provided are reimbursed on a fee-for-service basis. The provider can be a physician, physician group practice or similar entity. If a state chooses, it can also be a nurse practitioner, certified nurse midwife, or physician assistant. Primary care includes health care and laboratory services usually provided through a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. PCCMs must locate, coordinate, and monitor health care services. When operating PCCMs, states must ensure that the state agency, among other things:

- Ensures that the PCCM has adequate hours of operation, including emergency information, referral, and services available on a 24-hour basis;
- Ensures that the PCCM makes arrangements with sufficient numbers of physicians and health care professionals to ensure prompt service delivery;
- Limits enrollment to individuals residing near the service delivery site;
- Prohibits discrimination in enrollment on the basis of health status.
- Provides for disenrollment.[14]

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[9] 42 U.S.C. § 1396w-4.
[10] The states are ID, IA, MO, NY, NC, OH, OR, RI. Integrated Care Resources, "Approved Medicaid Health Home State Plan Amendments, http://www.integratedcareresourcecenter.com/hhapprovedplanamendments.aspx (last visited Feb. 5, 2013).
[11] In 2011, a survey revealed that 42 states were considering implementing health homes. Nat'l Ass'n of State Health Pol., *Developing and Implementing the Section 2703 Home Health State Option: State Strategies to Address Key Issues* 18 (July 2012) *available at* http://nashp.org/sites/default/files/health.home_.state_.option.strategies.section.2703.pdf.
[12] *See also* Integrated Care Resource Ctr., *Health Home Considerations for a Medicaid Managed Care Delivery System: Avoiding Duplication of Services and Payments: Technical Assistance Tool* (Feb. 2012), *available at* http://tinyurl.com/b4d4nb9.
[13] CMS, *Dear State Medicaid Director* (# 12-002) (July 10, 2012).
[14] 42 U.S.C. § 1396d(t)(1)-(4); 42 C.F.R. §§ 438.2, 438.6.

The benefits of PCCMs have been widely recognized, particularly for Medicaid beneficiaries with complex needs. For example, North Carolina's extensive network of PCCMs, known as Community Care North Carolina, is widely considered to be a success and credited with greater coordination of care, improved health outcomes, and cost savings.[15] In Oklahoma, PCCMs are credited with saving millions for Oklahoma's Medicaid Program.[16] Advocates should be aware of this option and consider the potential for it to work in their states.

Conclusion

As states move forward with ICMs, advocates must understand how these entities work and what their risks and benefits are. It is important to remember, as CMS has instructed, "[t]he goal of any successful and approvable ICM, regardless of authority, is not to lower costs through the reduction of services or access to care, but through improvement in the quality of the beneficiary experience."[17] While the evidence so far suggests that medical and health home models may help meet this goal, the potential for ACOs to improve care rather than simply cut costs is less clear. For example, it remains to be seen whether ACOs with risk-based models just perpetuate longstanding problems in capitated managed care. In addition, if HMOs simply contract with medical or health homes, it is important to ensure that these entities do not simply impose an additional layer of administration without actually adding value. Advocates should work to get out in front of this trend and be prepared to take an active role in their state's plans to implement ICMs.

[15] *See generally* Community Care of North Carolina: Building Medical Homes, 70 N.C. MED. J. 197-286 (May/June 2009).
[16] Okla. Health Care Auth'y, "SoonerCare Choice: Oklahoma's PCCM Program (Jan. 2008) (power point presentation), *available at* http://tinyurl.com/aow26wy. *See also* Sheldon V. Toubman, *Primary Care Case Management: The Medical Home Future in Medicaid*, 75 CONNECTICUT MEDICINE 43 (Jan. 2011).
[17] CMS, *Dear State Medicaid Director* (# 12-002), at 5.

About Us

The National Health Law Program protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

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