Managing Medicaid for Better Results

Much public attention has been focused on the question of whether Alabama should take advantage of federal incentives provided under the Affordable Care Act and expand its Medicaid program to support health insurance for low-income individuals up to 138 percent of the poverty level.

While that debate continues, it is important to understand how Alabama is making major changes in its existing Medicaid system, changes designed to improve health outcomes for recipients and stabilize costs to the state. In 2012, the Governor created the Alabama Medicaid Advisory Commission, chaired by State Health Officer Don Williamson, to assess the financing and structure of Alabama's Medicaid program and to recommend ways of improving it.

In 2013, the Commission delivered a report to the Governor, which served as the basis for legislation adopted that year and updated in 2014. The reforms will accelerate a shift of Medicaid from a health coverage system in which providers are paid on a fee-for-service basis, toward one in which Medicaid enrollees are cared for through a system of coordinated, managed care. Shifting payments for providers from a volume basis to a system based on outcomes is intended to improve quality of care as well as cost-effectiveness. This new system is currently under development with full implementation expected in 2016. According to the Medicaid Advisory Commission report, the new approach is projected to save between $148 and $320 million over five years when compared to baseline spending projections.

Where are we now?

Medicaid is a fundamental part of Alabama's healthcare economy, accounting for over 16 percent of all healthcare expenditures in the state. A federal and state cooperative program, Medicaid pays for the health care of low-income pregnant women, children, a limited number of very low-income adults with children, disabled individuals, and qualifying nursing home residents.

In 2013, more than 1 million Alabamians qualified for services under Medicaid for at least a portion of the year. The program paid for 53 percent of all births and covered 43 percent of Alabama children as well as almost two-thirds of nursing home residents. Over 60 percent of patient days at Children's Hospital are paid for by Medicaid. Other hospitals, particularly in rural areas, are highly dependent on payments from Medicaid for their survival. Alabama's Medicaid Agency is budgeted to spend over $6 billion in 2015.

The federal government provides about 68 percent of the funding. The state's share amounts to about $1.8 billion, with about a third of this coming from the state's General Fund. The $685 million Medicaid appropriation from the General Fund in 2015 represented 37 percent of the total appropriated from that Fund, by far the largest single investment of General Fund dollars.

The state has struggled to pay its share of Medicaid's rising costs. The program's requirements have grown much faster than General Fund revenues, due both to increases in medical costs and growth in the number of eligibles. In addition, Medicaid's expenses rise when the economy experiences a downturn, as people lose jobs and health insurance, which is also when the state's revenues stagnate or even fall. And the complex flow of money between the state, the federal government, and providers sometimes leads to inaccurate estimates that can produce unexpected expenses.

The urgency of developing a stable and sustainable approach to paying for Medicaid is indicated by the fact that the General Fund faces a shortfall in 2016 reported to be more than $250 million. At the same time, Medicaid may be required to repay $43 million in 2016 (a total of $129 million over three years) to the federal government due to past estimating errors.

In addition to the General Fund, Alabama relies heavily on taxing provider groups to pay its share of Medicaid costs. The entire hospital program, Medicaid's biggest expense at $2 billion a year, is financed by provider taxes plus federal payments based on the volume of uncompensated care. Since provider-based revenues vary with the

volume of services provided, there is little incentive to reduce utilization of the services taxed because that also would reduce revenue to pay for the program.

Alabama has only a limited ability to control Medicaid costs by curtailing eligibility or services. While the state has some options for limiting eligibility, for the most part, it covers only those who fall within federal mandates, and it maintains some of the strictest eligibility requirements in the nation. Alabama also limits the services it offers mainly to federal minimums. Cutting the few optional services offered, like kidney dialysis, hospice, and pharmacy benefits for example, would likely lead to increased costs and more critical health problems for recipients. The state has resorted to cutting payments to providers, but those cuts can result in limiting the number of providers willing to treat Medicaid patients.

As a result of the limits to eligibility and coverage, Alabama spends less per Medicaid enrollee than every other state except Georgia and Nevada.

However, reform of the reimbursement system for providers appears to provide opportunity for improvement. Alabama's Medicaid program currently pays providers on a fee-for-service basis that rewards volume. This system lacks incentives for providers to decrease utilization, reduce length of hospital stays, minimize emergency room care, or coordinate care to produce better outcomes. Over-reliance on hospital and emergency room care is a problem in Alabama generally. According to figures from the Kaiser Family Foundation, Alabama is the second highest state in hospital admissions per 100,000 residents. The state's rates of emergency room utilization and days spent in the hospital are also significantly higher than the national average, while outpatient visits are more than 20 percent lower than the national average.

Indicators per 100,000 (2012)	United States	Alabama	Percent Differential
Admissions	110	135	23%
Emergency Room Visits	424	488	15%
Inpatient Days	591	672	14%
Outpatient Visits	2,150	1,689	-21%

Where do we want to go?

Considering the limited options available to control costs and improve patient care, the Medicaid Advisory Commission chose to focus on reform of the methods for delivering and paying for care within the Medicaid program. The Commission's report described the goals as follows:

> *"A reformed Medicaid delivery system will improve patient outcomes through integration and coordination of care. Unnecessary hospitalization and emergency room use will be reduced with care shifted to the primary care setting … Payment reform will shift payment from a volume basis to an outcome and quality of care basis."*

Across the U.S, states are increasingly turning to the use of managed care and other integrated care models in serving their Medicaid beneficiaries. According to the Centers for Medicaid and Medicare Services (CMS), more than 70 percent of the national Medicaid population is enrolled in some form of managed care.

The Advisory Commission considered the option of contracting with a commercial managed care company to administer the program, as some states have done. Instead, the Commission opted to support the creation of what will be known as Regional Care Organizations (RCOs). These are new Alabama-based, managed care organizations, which typically involve existing providers, health-related companies and insurers. These newly formed coalitions will then be responsible for paying for and managing the care of Medicaid enrollees assigned to them.

Acting on the advice of the Commission, the Legislature, in 2013 and 2014, passed legislation authorizing the creation of RCOs and setting the ground rules under which they will operate.

How can we allocate resources to carry out our strategies?

To realign the incentives under the new system, Medicaid will put a cap on Medicaid expenditures per enrollee. The new RCOs will receive an allocation from Medicaid based on how many Medicaid enrollees they serve. With that money, the RCOs will pay for the care of their patient populations.

The cap on expenditures per enrollee will give the state more certainty over how much it will spend on Medicaid coverage. It will also shift the risk of poor patient outcomes and expensive overutilization from the state to the RCOs. This will give hospitals and other care providers an incentive to keep their patients healthier, to decrease hospitalization and emergency room visits, and to track patients after they leave the hospital to ensure successful recovery. The RCOs are scheduled to begin operation in 2016.

What are our strategies for getting there?

The new RCO system will build on and, in some cases, incorporate existing features of managed care already present in Alabama's Medicaid program.

RCOs will provide a variety of services to their Medicaid clients in hopes of increasing the number of enrollees who are seen by their primary care physician, a more efficient and less costly approach than the emergency room or hospital. The RCOs will build care networks that will organize and increase communication among service providers so that care of individuals can be better coordinated, in order to avoid such problems as duplication of tests and conflicting diagnoses and medications. The RCOs will also reach out to patients, following up on care, helping patients manage their medications, encouraging vaccinations and other lifestyle changes known to improve and maintain health.

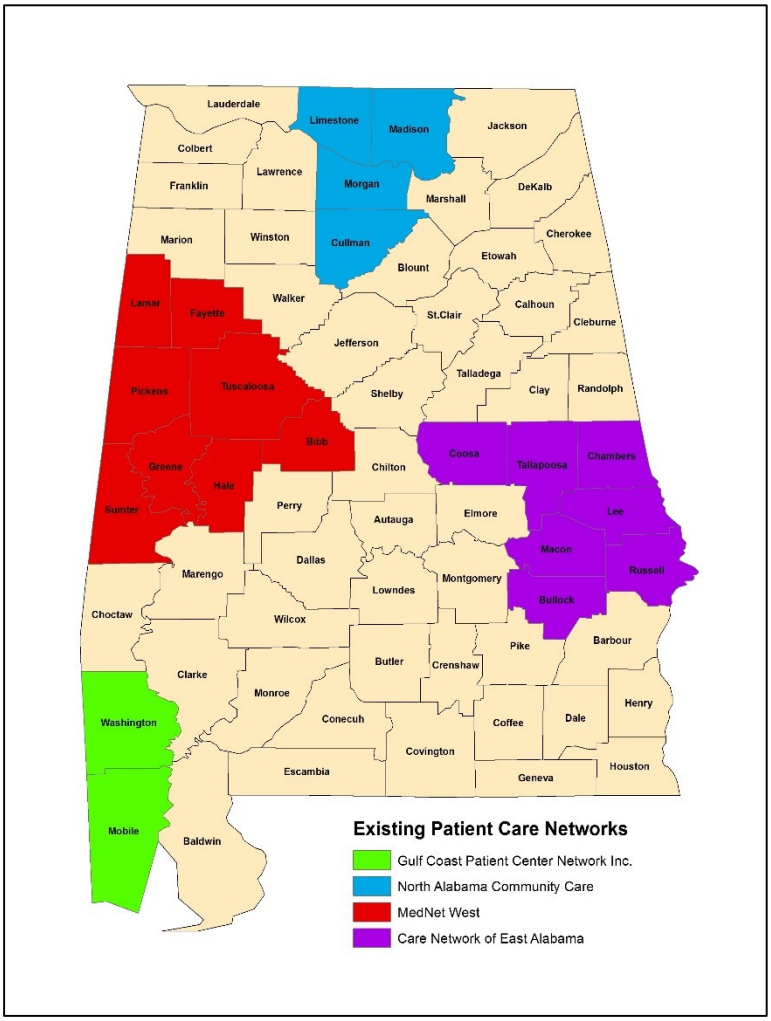
A significant portion of Alabama Medicaid recipients are already enrolled in what is known as the Patient 1st program, which serves children, low-income families, and individuals who are aged, blind or disabled. Patient 1st members are assigned to contracting primary care providers who are paid a small case management fee to cover the cost of coordinating care and referrals to specialty care. In 2012, that system was augmented in select parts of the state with what is known as a Patient Care Network, in which primary care doctors can contract with an outreach network. That network in turn builds a close relationship with high-risk individuals, helping them manage their conditions.

Alabama's Patient Care Networks were modeled on North Carolina's Community Care Networks. Patient Care Networks provide intensive case management for high-risk patients, reviewing service utilization data, monitoring referrals and medications, and providing additional education and outreach. Once RCOs are operational, the existing services provided by Patient Care Networks will be delivered by RCOs.

What measurable successes should we expect to see?

To get an idea of what results we might expect from the transition to a statewide system of managed and coordinated care, one can look at the early results being reported from Alabama's existing Patient Care Networks. Four are now operating: MEDNET West, serving Tuscaloosa and eight surrounding West Alabama Counties; the Care Network of East Alabama, serving Lee County and six others in east Alabama; North Alabama Community Care, which serves Madison and three other counties in north Alabama; and the Gulf Coast Patient Care Network, serving Mobile and Washington counties.

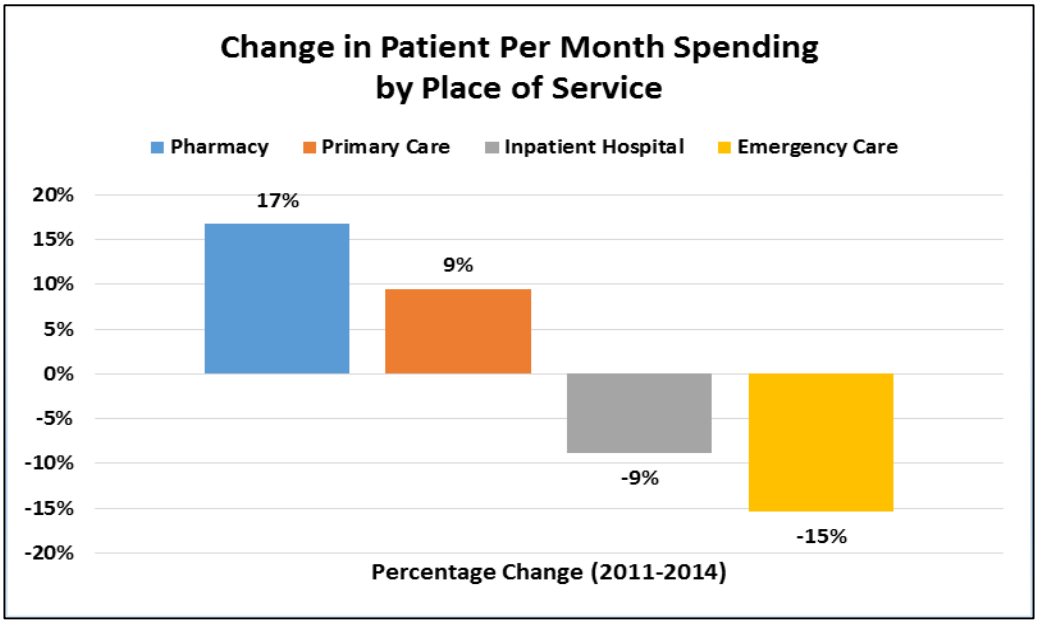
Care networks employ social workers, nurses, and pharmacists who work with patients and providers to increase care coordination and management of medications. They connect with and monitor patients in need of mental health service and provide transitional nursing for chronically ill patients moving from the hospital to home. By working with patients in home and family settings, care network specialists are able to identify underlying conditions that interfere with health improvement. Examples include lack of transportation to appointments, poor housing conditions, lack of food, and confusion over medical instructions.



Using information provided by Medicaid, the care networks are able to identify high risk and high cost patients and target those most in need of help. Care network employees are assigned to offices of primary care doctors, creating a channel of communication and familiarity with particular patient populations.

Care network transitional care coordinators visit Medicaid patients who are hospitalized in order to understand discharge instructions and patient needs, then visit patients at home after discharge. They follow the patient's progress for 30 days after discharge, ensuring appointments are kept and prescriptions are understood and followed.

Results from patients served by the Care Network of East Alabama indicate that the approach may be having some desired effect. Patient spending on medicine and visits to the offices of their primary care doctors have increased over time, while spending for inpatient hospital and emergency room care have decreased. While there may be



other factors at work (including enhanced reimbursement rates for doctors), there is at least some indication that patients are more consistently visiting their doctor, filling prescriptions, and taking their medication, cutting the utilization of expensive emergency rooms and inpatient hospitalization.

Case studies from the Care Network of East Alabama provide real-life examples of how this dynamic works in the lives of patients. The first involves a 54 year-old male with diabetes and heart disease. He was referred to the Care Network because he was not regularly taking medication for his conditions and often ended up being treated in the hospital after suffering acute episodes.

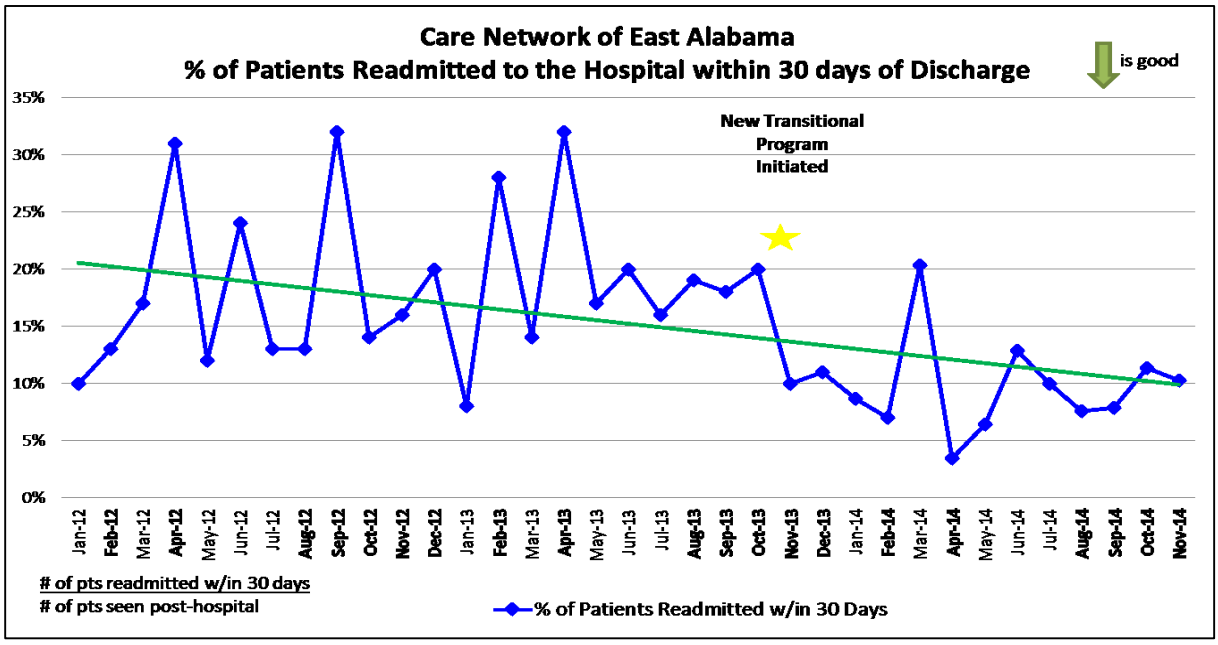
The Care Network provided the man with transitional nursing care after hospitalization and assigned a social worker to manage his care. Care Network representatives visited the man at home to educate him on the importance of his medications and encourage him to stay on them. They stayed in close touch with the patient and helped him monitor his glucose levels.

In 2013, before receiving services from the Care Network, the patient's treatment over the course of the year totaled $19,546. In 2014, after receiving case management from The Care Network, his cost dropped to $3,854 for the year. He didn't visit the ER or have a hospital stay.

In a second example, a 61 year-old male with conjestive heart failure and hypertension was referred to the Care Network after multiple hospitalizations. A transitional nurse was assigned to him and visited his home. The nurse found that the man was trying to manage eight different medications. He was illiterate and could not read instructions on his medication. He lived alone and depended on a friend to transport him to physician appointments.

The Care Network provided the man with a pill box and filled it on a weekly basis. Care Network staff helped the patient schedule his doctor visits.

In 2013, the man had incurred $10,395 in medical expenses. In 2014, after working with the Care Network, his annual costs had been cut to $3,362. He had not been to the hospital or the emergency room over the course of the year.



Source: The Care Network of East Alabama