ENTRY POINT

Primary care: Nurse Igor Berman takes a patient’s vital signs at San Francisco General Hospital and Trauma Center’s General Medicine Clinic, which provides primary care to adults with complex chronic illnesses. As part of Medicaid’s Delivery System Reform Incentive Payment waiver, the hospital has invested in primary care Complex Care Management Teams, which aim to improve outcomes and reduce hospital stays among high-risk patients.

DOI: 10.1377/hlthaff.2015.0552

Once A Welfare Add-On, Medicaid Takes Charge In Reinventing Care

States around the country have seized on Medicaid as a force for health system transformation.

BY ROB CUNNINGHAM

It is no secret that Medicaid has grown up in a big way. From its origins fifty years ago as a modest expansion of state welfare medicine programs, it has become a dominant presence in the US health system, through the gradual accumulation of a huge portfolio of responsibilities for both mainstream and hard-to-serve populations. The program began as an add-on to cash welfare, covering poor single parents and children, with eligibility and benefits that varied widely from state to state. It has grown incrementally with coverage for people with disabilities and mental illness, and it has steadily expanded coverage for children and pregnant women. Now, in what may be the most ambitious leap of all, Medicaid has undertaken the expansion of coverage to ten million or more previously uncovered low-income adults.

Similarly, it seems self-evident that Medicaid’s capacity for adaptation and growth owes everything to the pragmatism and flexibility of its federalist structure. Health care, like politics, is largely local, and Medicaid programs have earned their keep by meeting their states’ specific needs and harnessing the unique capabilities of their provider communities, all on the tightest of budgets.

Equally notable, if less noticed, is this: At a time when unprecedented efforts are under way to forge a more coherent care delivery system, Medicaid has also quietly established a track record of exploiting opportunities for innovative approaches to finance and delivery. The better-resourced segments of the health sector—Medicare and private insurance—have had the luxury of dallying with reform ideals such as integrated care organization. Medicaid has no choice. It has to get results. And it does so, not always but often, despite the perpetual drag on its potential from chronic underfunding and the indifference of many state policy makers.

Managed Care: Making A Virtue Of Necessity

The emergence of Medicaid as a force driving delivery system transformation follows roughly the pattern of accretive growth that is observed in the gradual expansion of the populations and services it covers. As with any kind of large-scale change, the beginnings can be very messy. The foundation of many current initiatives, for example, was laid in the teeth of the managed care backlash of the mid-1990s, and at the time engendered distrust and resistance.

By the time low-budget, jerry-built commercial plans had alienated con-
From Managed Care To Medical Homes
A legal guarantee of access was understandably not enough to ensure that Medicaid managed care enrollees would establish stable and proactive relationships with their primary care providers. The need for deeper engagement fed a growing interest in the idea of medical homes in the mid-1990s, with state Medicaid programs in the lead. From 1996 to 2012 twenty-five states created new payment programs to support enhanced connections with patients, emphasizing the use of teams and treatment protocols tailored to the needs of specific, at-risk patient populations.

The medical home approach lent itself to a wide variety of applications as state planners marshaled cost and epidemiological data to identify priority needs: at-risk pregnancies, mental health, HIV/AIDS, diabetes, and a host of other chronic conditions. The team approach enables even small practices to maintain consistent contact with patients with chronic illnesses to help them manage their conditions and provide additional support when they are in danger of falling out of compliance with their treatment regimes. Information technology, in most cases, provides invaluable assistance in keeping care team members on the same page with each other and in maintaining lines of communication with patients.

Medicaid offers several forms of support for the medical home approach. The most common is a per member per month care management fee, which may range from just a few dollars for routine services to nearly a hundred dollars for especially complex and demanding patients. The payments may come directly from Medicaid or through managed care plans contracting with providers. A handful of states have helped practices pay for costs of starting up a medical home. More than a dozen states pay performance bonuses to practices when they reduce costs, usually in the form of some type of shared savings arrangement. More than twenty states have programs of “transformation support,” to provide training, coaching, and “learning communities” for practices seeking a medical home designation.3

Support Networks
Arkansas offers a good example of Medicaid’s adaptability at work. After the state legislature expanded eligibility for prenatal care in 2001, a shortage of obstetrical specialists in rural areas became apparent. Medicaid responded by financing a telemedicine network to connect rural providers with urban specialists to manage high-risk pregnancies, and it initiated provider reimbursement for these teleconsultations.

Before the term “medical home” became widely familiar, Arkansas Medicaid was developing a medical home without walls: virtual teams with the ability to coordinate services for specific high-risk and costly patient populations. Arkansas Medicaid’s decision to reimburse providers for telemedicine consultations enabled a rapid expansion of the model’s application to pediatrics, asthma care, cardiology, oncology, mental health, HIV/AIDS care, and more.4 Telemedicine reimbursement is now the norm for Medicaid in all but a few states.5

Information technology was and still is a key component in the development of medical homes, facilitating care coordination, patient engagement, and population health management. It has also contributed to the formation of support networks, or learning communities, to diffuse lessons from successful programs and shore up the capabilities of beleaguered Medicaid providers, stretched thin by bulging caseloads, low reimbursement rates, and patients with complex conditions.

In North Carolina, a twenty-year history of Medicaid support networks laid the foundation for medical home efforts. Since 1998 the state has nurtured local collaboratives providing mutual support and sharing of expertise for providers caring for the Medicaid population in each of the state’s 100 counties. Nurse specialists may help train staff at small practices and clinics. Consultations with specialty physicians may be available. Technical assistance with information systems is also available. As in Arkansas, North Carolina Medicaid officials were concerned about poor birth outcomes, so they created a Medicaid pregnancy medical home project in 2011. The project uses community collaboratives to deploy specially trained

consumers and providers, it seemed like cruelty for states to inflict managed care’s various expected abuses on the most vulnerable by contracting with private plans. But beneficiaries had less to lose than it first appeared. The providers they saw were already receiving only Medicaid’s rock-bottom reimbursement rates, and narrow provider networks were already the de facto norm.

“Sensitivity about relinquishing freedom of choice seemed overstated, because Medicaid beneficiaries in many states had always found only limited providers willing to treat them, given low payment rates and other program requirements,” wrote Robert Hurley in 2003.1 Pioneering states “discovered that by embracing managed care, they gained contractually guaranteed access to health plans or primary care physicians.” Managed care’s “focus on cost-conscious consumption and provision of services seemed to make an especially good match for Medicaid.”2

In response to the overwhelming financial pressures of the 1980s, Medicaid managed care surged in the following decade. The access guarantee nudged beneficiaries toward more stable relationships with their providers. State-to-state variation made comprehensive evaluation difficult, but coordination of care improved, cost savings were reported, and overuse of emergency departments dropped, in Hurley’s account. To curtail cut-rate “Medicaid mills”—for-profit ambulatory care facilities filing suspect claims for often unnecessary services—rules were added to require Medicaid plans to include at least some commercial enrollees, although Medicaid-only plans are now allowed.

Over time, states gained experience in private-plan contracting and absorbed lessons in value purchasing from the employer community, paving the way for performance evaluation and, eventually, reimbursement incentives for quality improvement. The process for obtaining state waivers for managed care experiments remained cumbersome and contentious into the 1990s, but the number of waivers continued to grow. By 2002, 58 percent of Medicaid beneficiaries were in some type of managed care plan. By 2016, the total is expected to grow to 76 percent.2
obstetrics nurse coordinators to help train local providers, win the trust of physicians, and use the collaboratives’ analytical capacity to identify quality improvement targets.7

Many other states have used the network model, such as that used by Arkansas and North Carolina, to expand medical home projects beyond the limited scope of their early, narrowly targeted experiments. “Shared teams” may include behavioral health providers, pharmacists, nutritionists, health coaches, or community health workers, as well as nurses, who make themselves available to small and underresourced providers. Early adopters of the network approach included New York, Oklahoma, Vermont, Alabama, Maine, Michigan, and Minnesota, according to a 2012 report by Mary Takach of the National Academy for State Health Policy.7

The Next Frontier: Multipayer Collaboration

Public and private payers alike are counting on performance incentives to drive innovative cost and quality improvements that the health system is generally believed to need. Medicaid, Medicare, and commercial insurers are cultivating a teeming garden of pay-for-performance programs for clinics, hospitals, and health plans from Maine to California. But it is also generally acknowledged that the impact of these programs is severely diluted by their diversity of measures and payment mechanisms. Providers who face multiple reporting requirements and reward systems are swamped with administrative hassles and unable to focus their quality improvement efforts within a coherent framework. A 2013 study looked at criteria in twenty-three health plans and found 546 distinct measures.7

Multipayer collaborations are the logical response to a landscape with so many reporting requirements and reward systems. But obstacles have been formidable, making Medicaid’s role as a convener of payers and health systems increasingly indispensable. Antitrust concerns have checked some efforts among private payers to align rewards. However, involving states as partners, typically through their Medicaid programs, can bestow antitrust immunity on private payers attempting to agree on common standards and quality metrics. Established Medicaid performance measurement and reporting programs, often built into medical home initiatives, give aspiring collaboratives a leg up on achieving concordance of measures—often a difficult stumbling block.

Similarly, patient data from Medicaid help create a robust foundation for accurate risk adjustment to level the field for providers who treat sicker and poorer patients, although it remains a challenge for collaboratives to distinguish adequately between Medicaid and commercial plan populations. Payment mechanisms differ among pay-for-performance programs, from monthly management fees to partial capitation to shared savings. But as the largest payer in most prospective initiatives, Medicaid may have established payment methods that offer a convenient starting point for alignment.

In Oregon, a state quality alliance anchored by Medicaid has been collecting and reporting performance data on primary care providers since 2000, setting a precedent for data sharing that competitors, looking for any advantage, would typically resist. Alliance data now cover 80 percent of the state’s primary care providers; in recent years the alliance has added small groups of four or fewer physicians—a rare advance into the frontier of small-practice quality improvement. Eight commercial plans participated in the reporting project, according to a 2012 report.9

In Wisconsin, Medicaid led an effort to align ambulatory and hospital performance measures that began in 2011; by 2014 it had enlisted the assistance of representatives from thirty-five plans, providers, employers, and consumers. The Wisconsin initiative began with an initial inventory of 200 measures but ultimately whittled that list to fourteen condensed sets of measures.9 A 2014 study by National Academy for State Health Policy researchers found that seventeen Medicaid multipayer medical home initiatives were launched in the United States between 2008 and 2014. Twelve were led by state agencies, and sixteen included Medicaid as an anchor payer. Medicare participated in eleven.10

Localized But Scalable

Much of the activity described in this review seems to point toward a future scenario in which the much-ballyhooed accountable care organizations (ACOs) play a central role in shaping how care is delivered and paid for. By 2012 ten states were moving toward ACOs in their Medicaid programs, building on their experience with medical homes, support networks, data sharing, and multipayer arrangements. In waiver arrangements with the Centers for Medicare and Medicaid Services (CMS), Medicaid ACOs are not required to use shared savings methods, as those in Medicare must. But according to Tricia McGinnis of the Center for Health Care Strategies, “this payment model has nonetheless served as a catalyst and guide,” along with other tools such as management fees and partial capitation.11(p13)

But in a larger sense, Medicaid’s history and accumulated experience of supporting primary care practice at the grassroots improves the chances that ACOs will work for Medicare and commercial payers as well. The ACO concept has little chance of lasting success if it is built around just those large and established organizations that have already climbed their way well up the quality improvement learning curve. The pro-mulgation of locally focused medical homes and other initiatives spearheaded by Medicaid has begun to create a solid floor on which the visionaries’ cathedral can be constructed.

“Conceptually, ACOs are seen as a vehicle for encouraging providers to build connectivity and collaboration across the full spectrum of health services that rests on a strong primary care foundation,” says a 2012 Center for Health Care Strategies report. “States seek to leverage existing investments in primary care by incorporating ACOs within current delivery reform initiatives,” such as...
A few brave souls have suggested that Medicaid is the place to look for the model of a desirable future health system.

System Reform Incentive Payment, offering states bonus payments for achieving measurable quality improvements chosen from a flexible menu of performance objectives.12 The Medicaid and CHIP Payment and Access Commission reports that states are beginning to tinker with premium support arrangements, in pursuit of consumer-driven incentives for quality improvement and parsimoniousness in Medicaid managed care plans.13 New regulations seek to create stricter quality standards for the care of managed care enrollees with disabilities. The ACA pushes efforts to integrate behavioral services into primary care by including services for mental health and substance abuse disorders among the “essential health benefits” that plans are required to provide and by mandating parity between mental and physical health benefits.

A few brave souls have suggested from time to time that Medicaid is the place to look for the model of a desirable health system for the future.14,15 Single-payer idealists used to say that they wanted a “Canadian-style single-payer system.” For many, the mantra is now “Medicare for all.” What is lost in these formulations and reformulations is that the Canadian system, so popular with the citizenry up north, is a federalist, province-based structure that resembles Medicaid much more than a Washington-based program such as Medicare. Nor do either of these paradigms reflect the extent to which both Medicare and Medicaid are interwoven with private-sector health care financing and organization, chiefly through their extensive contracting with private health plans.

Setting aside such theoretical considerations, it is incumbent on sapient observers of the health policy scene to recognize that in fulfilling its very difficult mission over the years, Medicaid has become a sturdy vehicle for the kind of ground-level improvements in the organization of care necessary to make fundamental change possible.

Rob Cunningham (rcunningham44@gmail.com) is a consulting editor for Health Affairs. He is based in Gaithersburg, Maryland.