



Payers Ready for Explosion of Medicaid Beneficiaries with Chronic Conditions?

Although the recession has begun to loosen its grip on the U.S., states are faced with helping 6 million new Medicaid beneficiaries who joined the government health program during the economic downturn. As unemployment rises nationwide, so, too, do the Medicaid rolls as the long-term unemployed give up employer-sponsored health benefits.

In December 2009, the country counted 48.6 million Medicaid beneficiaries, including the 6 million beneficiaries who became eligible during the recession. As more people join Medicaid, spending increases. In 2010, Medicaid enrollment growth of about 9% pushed Medicaid spending growth to approximately 9%. In 2008, the country's total Medicaid spend was \$339 billion. While spending increases in a recession, states still must find ways to serve the Medicaid population in the spite of falling tax revenue. It was just two years ago that state tax revenues plummeted an astonishing 17%; by the first quarter of 2010 revenues recovered slightly, pushing up approximately 3% before dropping again.

It's clear states need help managing the costs and continuity of care of the entire Medicaid population, including the additional 16 million people expected to gain coverage as a result of health reform. States want more value and efficiency from their health care programs, and they continue to look to commercial payers for support and answers, especially when it comes to managing the long-term, chronic illnesses of these beneficiaries.

Care management's role in Medicaid managed care

Now, even more than in the past, Medicaid turns to commercial payers to increase enrollment in current programs or start new Medicaid managed care programs. States typically implement Medicaid managed care programs to increase the beneficiary's access to care and contain costs. In fact, more than 70% of Medicaid beneficiaries already receive care in a commercial setting through Medicaid managed care. And in 2010, 20 states adopted policies to expand Medicaid managed care.

In the Medicaid population, care management programs—chronic disease management and nurse advice line services—can make a significant impact on the cost and outcomes generated by this population. Forty-five percent of Medicaid beneficiaries with disabilities have three or more chronic conditions, according to 2009's "The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions." Medicaid beneficiaries with co-morbid conditions also generate significant costs: 45% of those with three or more chronic conditions account for 75% of costs, according to the report. The group most often shifted to Medicaid managed care is the ABD, or "Aged, Blind and Disabled,"

population; this group, while making up a relatively small 25% of the total Medicaid population, drives 70% of its costs. We rely on care management programs to teach beneficiaries new ways to manage acute and chronic issues, and ultimately contain costs.

Although Medicaid beneficiaries are shifted to commercial payers through Medicaid managed care, their costs and demographics remain the same as when they participate in state programs. Medicaid beneficiaries often have:

- Low income;
- Literacy barriers;
- Less access to reliable transportation;
- Fewer childcare options;
- Lower levels of education; and a
- Lack of shelter and food.

These significant issues are themselves barriers to successfully implementing—much less meeting operational and financial goals—a commercial payer-based care management program for Medicaid members. Barriers to care must be addressed before a member considers taking a real look at managing his or her health. When a member can't pay the gas bill, the last thing he or she thinks about is the best time to take asthma controller medication. Commercial payers wading into the Medicaid managed care market must navigate these issues and many others before they can realistically consider rolling out a program to help beneficiaries rein in costs by managing acute and chronic health issues.

Can care management drive Medicaid managed care savings?

Working with the right vendor, one with experience providing services directly to Medicaid beneficiaries, can be the difference between a program that meets its goals and one that falls short. As discussed in The Lewin Group report, Medicaid managed care plans do have an opportunity to "achieve savings through a number of mechanisms." These include improving access to preventive care; using outreach and education to promote the use of preventive services and healthy behaviors; and providing disease and case management services. Case management, as typically executed, often overreaches while only brushing the surface of need. While counter-intuitive at first glance, case management often takes too broad a stroke at the highest level by including those who don't need this intensive help because the condition doesn't warrant the additional attention, yet fails to reach down into the population to assist those who on the surface may not appear to need the extra service, but do. Care management can complement these programs

and balance this inequity by better serving specific members who need the most help.

Commercial payers have expertise in many of the areas outlined in the Lewin report and have successfully implemented these programs in the commercial population. This is certainly a strength among commercial members. But Medicaid beneficiaries have virtually none of same characteristics as commercial members, making the possibility of repeating this success minimal without the right partner.

Care management as competitive strategy

Care management doesn't always come to mind as a competitive strategy in Medicaid managed care. But those payers who do recognize the advantages and partner with organizations possessing core Medicaid expertise can impact the market. Organizations familiar with the Medicaid population understand how to overcome the barriers that keep participation low.

Now that you've decided to partner with a care management vendor, what do you need to know? What are the basic requirements a vendor should fulfill? The following list isn't exhaustive, but a good place to start. Your care management vendor should be able to accomplish the following and, importantly, tell you how to:

- Identify and stratify the at-risk population to ensure the program makes an impact
- Find and engage the population

- Generate holistic assessments resulting in multidimensional care plans addressing psychosocial issues, barriers to care and gaps in care
- Engage members and providers for better overall care complemented by an on-the-ground care team
- Generate savings and improve outcomes

It's time to find a new partner if a care management vendor hasn't thought carefully about everything in this list and isn't willing or able to provide in-depth, real-world examples of how their programs work. If your vendor can't articulate this information, they simply don't have the experience necessary to manage this complex population and will likely fail at doing so. Working with a partner that has Medicaid experience and new ideas about engaging this complex population ensures the care management program will drive savings while improving the health and wellness of Medicaid managed care members. **CDHC**

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