taking a fresh look at Medicaid

Hospitals should examine the potential impact of Medicaid expansion on their organizations and consider various strategies for meeting the diverse needs of Medicaid patients in cost-effective ways.

The impact of Medicaid expansion is at the forefront of many hospitals’ planning agendas.

Twenty-six states have chosen to expand their Medicaid programs under the Affordable Care Act (ACA), and figures released Aug. 8 by the U.S. Department of Health and Human Services indicate that more than 7.2 million Americans have enrolled in Medicaid or the Children’s Health Insurance Program (CHIP) since Oct. 1, 2013, when the insurance marketplaces were launched. These figures include 602,210 people who enrolled in the month of June alone.

Enrollment in the 26 states that expanded Medicaid grew by an average of 18.5 percent in June, with nine of the states reporting an increase greater than 30 percent. Meanwhile, even states that did not expand Medicaid experienced an average growth in enrollment of 4 percent in June.

It is estimated that 19.5 million more individuals could become eligible for Medicaid by 2020, depending on how many states eventually opt into expansion.a

a. In June 2013, months before the launch of the insurance marketplaces and Medicaid expansion, 55 million people were enrolled in Medicaid nationally; nearly 75 percent were not disabled or elderly (An Introduction to Medicaid and CHIP Eligibility and Enrollment Performance Measures, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, January 2014).
Given the potential impact of an increased number of Medicaid patients on hospital margins, there are compelling reasons for providers to take a fresh look at their Medicaid strategies now.

For hospitals, Medicaid expansion may be a mixed blessing. On the one hand, it means that some previously uninsured patients now have coverage. On the other hand, in most markets, Medicaid payment contributes little to fixed costs, and in many cases, it does not cover variable costs. In instances where expanding Medicaid utilization displaces commercial utilization, hospitals could be worse off. In virtually all cases, hospitals face the prospect of increasing Medicaid utilization paired with a diminished ability to support Medicaid losses due to declining commercial profitability.

**Medicaid Market Segments**

The Medicaid market is complex—and physician availability can be problematic.

The elderly and the disabled, who constitute 25 percent of Medicaid enrollees, account for 42 percent of Medicaid costs. Many elderly Medicaid patients are dual eligibles who qualify for benefits under both Medicare, which pays for their health care, and Medicaid, which pays for long-term care and behavioral treatment. Treatment of dual eligibles has generally been provided in uncoordinated care systems, resulting in poor quality and costly care. In contrast, mothers and children account for the largest group of beneficiaries. Approximately 50 percent of Medicaid enrollees are children, who account for only 20 percent of the costs.

New Medicaid eligibility rules in effect in all states will result in significant demographic changes, making the enrollment profile for Medicaid patients more reflective of the general population.

Under Medicaid expansion, the new Medicaid enrollees will be:

> Younger (about 36, compared with a current average age of 39)

> Less likely to be Hispanic (59 percent will be non-Hispanic, compared with 50 percent of current Medicaid enrollees)

Medicaid patients also will be split between genders—a sharp contrast from today, when 67 percent of enrollees are female.

The new Medicaid beneficiaries will be younger and somewhat healthier—more likely to smoke and drink, but less likely to be obese or have diabetes. Some will be people drawn from a population with higher incomes than current Medicaid beneficiaries who would consider themselves more middle class, which could soften the connotation of Medicaid as a program only for the poor.\(^b\)

But the availability of physicians to treat Medicaid enrollees will continue to be an issue. According to a recent survey, 30 percent of office-based physicians do not accept new Medicaid patients, and the rate of nonacceptance is much higher in specialties such as orthopedics (40 percent), general internal medicine (44 percent), dermatology (45 percent), and psychiatry (56 percent). Physicians practicing in higher-income areas also are less likely to accept Medicaid patients than those in more economically diverse communities. Each of these factors will challenge efforts to provide care to Medicaid patients.\(^c\)

Some Medicaid managed care organizations have expressed concern that, although they currently have an adequate number of providers to treat their patients, a rapid increase in Medicaid patients in their states could prompt physicians to drop out of the program. This development would limit access to care and could prompt more Medicaid beneficiaries to seek treatment in emergency departments (EDs) or forgo care.

\(^b\) Chang, T., MD, “Potential Adult Medicaid Beneficiaries Under the Patient Protection and Affordable Care Act Compared with Current Adult Beneficiaries,” Annals of Family Medicine, September/October 2013.

entirely. For now, the ACA has increased payment to primary care providers who treat Medicaid patients; however, such increases may not continue into 2015 due to diminishing funds.

Market Transition Is Well Underway
State politics will decide the eventual extent of Medicaid expansion, but Medicaid’s transition from fee-for-service payment to value-based, risk-sharing contracts is ahead of the curve.

Medicaid was an early adopter of managed care, with large-scale state programs having been around since the 1990s. Approximately 74 percent of Medicaid beneficiaries are enrolled in some type of managed care plan, compared with about 28 percent of the Medicare market. At least 48 states are pursuing aggressive efforts to expand managed care to include new populations and are launching programs designed to improve quality of care and care coordination and to control costs.

Even states that have not opted into Medicaid expansion may see an increase in enrollment because new income eligibility rules and enrollment procedures in all states will make it easier to enroll and stay enrolled. For example, the ACA expanded the Centers for Medicare & Medicaid Services’ (CMS’s) presumptive eligibility policy, enabling “qualified entities,” such as hospitals, federally qualified health centers, and schools, to screen patients for Medicaid eligibility and temporarily enroll them in Medicaid or CHIP. Hospitals are guaranteed payment even if a patient is later found to be ineligible.

Medicaid Managed Care Initiatives Dominate Market
Enrollment of Medicaid beneficiaries in capitated, full-risk managed care plans will be the dominant business model for Medicaid expansion.

Most states require contracting Medicaid managed care organizations to have statewide or regional networks as well as the ability to administer an integrated benefits package of physical, behavioral, and long-term care services. The need for statewide or regional scale in provider networks and operations will be a barrier to market entry for providers that are not already licensed as Medicaid managed care organizations.

Although the national market remains fragmented, with the top four companies accounting for only about a quarter of enrollment, most states concentrate their contracts in a handful of large, well-financed Medicaid managed care organizations. Opportunities for new market entrants therefore may be limited.

Although states typically make monthly, capitated, full-risk payments to Medicaid managed care organizations, these organizations, in turn, may contract on a fee-for-service or per-case basis with their network providers. Given the potentially negative impact of fee-for-service Medicaid, hospitals and health systems should calibrate their strategy for selective participation in Medicaid managed care risk if they are to remain viable as eligibility expands.

For example, Optima Family Care, a 167,000-member statewide Medicaid managed care plan in Virginia—and a division of Optima Health, owned by Sentara Healthcare—contracts with the state of Virginia on a full-risk basis. However, Optima Family Care pays its network providers on a fee-for-service basis against a uniform fee schedule set by the state. The plan may change its approach as accountable care organizations (ACOs) grow in effectiveness.

Medicaid Initiatives: Taking a Closer Look
In December 2013, the TennCare Medicaid program in Tennessee gave three-year, full-risk contracts covering Tennessee’s 1.2 million Medicaid beneficiaries to three Medicaid networks already under contract with the state: AmeriGroup, BlueCare of Tennessee, and United Healthcare. This action reduced the number of

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Medicaid networks from six to three, despite the fact that several well-financed national players, such as Molina Healthcare and Centene, invested heavily in attempting to enter the market.

Presbyterian Healthcare Services in Albuquerque, N.M., which has a statewide Medicaid enrollment of 200,000, passes risk onto its own physician group as well as other provider networks and will consider shared-savings contracts based on an entity’s care management capabilities.f

Generally, states offer Medicaid beneficiaries a choice between two plans if they are to be enrolled in managed care. Nearly all states carve out at least one acute care benefit from their contracts (for example, behavioral health services) and provide that service to Medicaid managed care enrollees on a fee-for-service basis or under a separate managed care risk contract. Most states set actuarially determined managed care rates administratively, but some use a negotiated or competitive bidding process.g

With the launch of the CMS dual-eligible demonstration projects in 2013, large commercial Medicaid plans are starting to tap into the

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g. Medicaid Managed Care: Key Data, Trends, and Issues, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, February 2012.
$320 billion dual-eligible market, which is still primarily fee for service. The dual-eligible market may offer substantial opportunities for shared savings for well-organized Medicaid managed care organizations, although these opportunities are not without risk, given the complex healthcare needs of the beneficiaries.²

**Keys to Success**

Because the needs of beneficiaries are complex, the most successful Medicaid managed care organizations are specialized, with care management programs tailored to their enrollees. For example, pregnant mothers and children require different care models than dual eligibles, as will newly eligible adults who became enrolled through expansion. Many successful plans have a separate organizational structure to supervise care management protocols for Medicaid patients, but shared infrastructure for claims processing and other back-office functions.

Managed care organizations with dominant Medicaid enrollment (where Medicaid beneficiaries comprise more than 75 percent of enrollees) have been more profitable than plans with mixed-business portfolios, such as those that include Medicare Advantage or commercial products. However, the Presbyterian and Optima Medicaid plans, which are owned by full-service HMOs, both report having been consistently profitable over the past two decades. In some years, the Medicaid plans for these organizations have accounted for a majority of the health plans’ profits, contributing to the health systems’ margins.

Overall, provider-sponsored Medicaid managed care plans have frequently outperformed for-profit plans with competitive medical loss ratios and lower administrative costs. A national study of 170 plans with more than 5,000 enrollees in 2009 found that provider-sponsored plans with predominantly Medicaid enrollees attained operating margins of approximately 2 percent, slightly better than those for similarly focused for-profit, publicly traded Medicaid managed care organizations.² The study’s authors suggest that the results achieved by Medicaid enrollee-dominant plans may have been the result of more cost-effective care management, restriction of access to less costly providers, and lower rates negotiated with network providers.

**Multidimensional Strategy Needed**

Segmenting Medicaid patients by the type of care needed and the most appropriate care setting is generally seen as the most effective means of providing care. To succeed, hospitals and health systems would do well to invest in varying strategies to meet the diverse needs of Medicaid patients, depending on how their markets are segmented and their current exposure to and experience with risk products.

**Option No. 1: Continue to focus on strengthening primary care and improving cost efficiency in the current Medicaid market.** Because Medicaid utilization is a negative contributor at most hospitals, this strategy is viable only if it is pursued in conjunction with a type of managed care contracting as defined in options two and four.

**Option No. 2: Develop value-based, risk-sharing contracts with existing Medicaid managed care organizations.** The option of extending value-based risk contracting to the Medicaid market segment may be feasible for markets with established Medicaid managed care organizations. Almost eight out of 10 Medicaid beneficiaries will be enrolled in a managed care plan by 2020. As a result, the over 500 commercial and Medicare ACOs may be well-positioned to leverage their clinical networks and care management systems to subcontract for targeted Medicaid market segments.

**Option No. 3: Partner with existing Medicaid managed care organizations to develop new products for targeted market segments.** The changing demographics

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Notes: States were asked to report new initiatives in these areas. "Any Managed Care Expansions" includes states that reported expanding to new geographic areas, adding new eligibility groups, transitioning groups from voluntary to mandatory participation, implementing or expanding managed long-term care, or adopting new or enhanced quality measures. "Any Care Coordination Initiatives" includes states that reported new initiatives or expansions of patient-centered medical homes, health homes, accountable care organizations, or additional quality efforts. Dual-eligible initiatives include participation in the financial alignment model through the CMS Innovation Center and the CMS Medicare-Medicaid Coordination Office, as well as other initiatives targeting this group.

of Medicaid mean new, younger enrollees who are more attractive managed care candidates, and the public exchanges offer products suitable for people who may move in and out of Medicaid eligibility but qualify for subsidies to maintain health plan coverage.

Option No. 4: Own a health plan targeting the Medicaid market segment. This strategy could involve the expansion or acquisition of an existing health plan license or the development of a new one. Providers that are considering accepting greater Medicaid risk should have many of the same skills in place that are required for Medicare Advantage. Generally, a base of at least 10,000 patients is necessary to get started, although state contracting procedures make market entry difficult. In addition to gaining minimum scale, necessary business elements include:

> Physician alignment
> Networking and contract management
> Appropriate rate setting to avoid adverse selection
> Experience in design and implementation of care coordination initiatives
> The appropriate IT infrastructure
> Effective member communications

None of the above options is mutually exclusive. A large metropolitan or regional system might explore several approaches in moving forward.

Take a Deliberate Approach

Medicaid expansion opportunities under the ACA will vary significantly. Providers that are organizing ACOs may have a unique opportunity to leverage their clinically integrated networks to contract with established Medicaid plans or to partner with payers to develop new products for specific Medicaid market segments. Other providers will do better to limit their exposure and focus on the expansion of patient-centered medical homes, which can improve primary care access and curb unnecessary ED utilization and hospital admissions.

Before finalizing a plan to move forward, provider executives should answer a few key questions:

> Is there consensus on the likely rate of change in Medicaid enrollment that lies ahead? What impact will this change have on our organization’s finances?
> Would Medicaid expansion be a good fit with our organization’s mission?
Does our organization have the necessary physician network, IT, and behavioral and community outreach capabilities to even consider expansion?

Does the organization have sufficient experience and skills in value-based risk contracting to apply to the Medicaid market?

Is the population base large enough to support a managed care initiative of more than 10,000 enrollees?

Are there any experienced payers in the market that would make good partners?

Under what, if any, circumstances should our organization develop its own Medicaid risk arrangements versus partnering with others?

Once consensus on moving forward has been gained, the next step will be to undertake a financial feasibility assessment. Given the complexity of the Medicaid market and the need for scale in statewide contracting, securing an experienced managed care partner may turn out to be the best business option for entering the Medicaid managed care market.

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**About the authors**

Bill Eggbeer  
is managing director and co-leader of the payer-provider innovation practice, BDC Advisors, Miami, and a member of HFMA’s Maryland Chapter  
(bill.eggbeer@bdcadvisors.com).

Krista Bowers  
is managing director and co-leader of the payer-provider innovation practice, BDC Advisors, Miami, and a member of HFMA’s Florida Chapter  
(krista.bowers@bdcadvisors.com).

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