ALABAMA POLICY INSTITUTE

GUIDE TO THE ISSUES

# Orienting Medicaid toward Outcomes

## Background

One of the most startling aspects of Alabama's current Medicaid system is that it provides a relatively limited array of health services at skyrocketing costs. Alabama provides very few services that are not required by the federal government and has among the strictest qualification limits in the country, yet still faces budgets and enrollment far outpacing the growth of available resources.[1]

According to Medicaid Director, Dr. Donald Williamson, Alabama Medicaid is facing a potential budget shortfall of $100 million for fiscal year 2013, and even the current proposal of enhancing the regionally-divided Patient Care Networks (PCN) will not make the substantive changes needed to make the program solvent over the next few years.[2]

While Medicaid needs to control its short-term budget, the long-term *fiscal* health of the program must be tied to the long-term *physical and mental* health of its enrollees.

## Policy Considerations

There are five major cost drivers for Medicaid: utilization, federal match rate changes, benefit changes, enrollment growth, and medical inflation.[3] Alabama saw a 25 percent increase in enrollment from 2008-2012, corresponding with the nationwide economic downturn,[4] but Alabama also has rates of emergency room and inpatient use that are significantly higher than the rest of the country.[5]

### ISSUE SNAPSHOT

Alabama has seen a 25 percent increase in Medicaid enrollees since 2008.

Currently, Medicaid in Alabama focuses on delivery of health care services rather than patient outcomes.

Managed Care Organizations (MCOs) have the financial incentives to take a comprehensive look at Medicaid beneficiaries' healthcare and ensure improved outcomes.

| Per 1,000 Population | Alabama | US | % Difference |
|---|---|---|---|
| ER visits | 482 | 411 | 17.27% |
| Hospital Admissions | 134 | 114 | 17.54% |
| Inpatient Days | 697 | 613 | 13.70% |
| Outpatient Visits | 1839 | 2106 | -12.68% |

In order to effectively control costs and improve outcomes, 38 other states have implemented some form of managed care.[6] Under a managed care program, private providers called Managed Care Organizations (MCOs) contract with the state Medicaid agency to provide, at a minimum, the federally mandated coverage for an agreed-upon, per-person or "capitated" amount.

Under this model, the MCOs assume *all the financial risk* of coverage, and are thus incentivized to provide this healthcare in the most economically efficient way possible. Some beneficiaries might be concerned that those financial incentives really mean that "managed care" is "rationed care." But the truth is that MCOs only realize a financial benefit when patients are healthy. Denying care until it becomes necessary for the beneficiary to be admitted to a hospital or emergency room is generally far more expensive than routine visits to a primary care physician or ongoing wellness care. From a cost and care standpoint, the state, the MCO, and the Medicaid patient benefit from early detection and treatment of health concerns before they have the chance to develop into major medical issues.

As an added benefit, MCOs in other states have developed programs that incentivize good health practices in order to holistically improve the health of Medicaid beneficiaries. For example, in Bayou Health, Louisiana's managed care service, members of some plans are offered unlimited visits to their primary care physician (PCP) as well as free Weight Watchers memberships, emergency-use cell phones, free fitness and nutrition program, family classes, and nicotine replacement products and coaching programs to help smokers quit.[7] These types of benefits not only improve patient health, but they also lower long-term healthcare utilization.

Rather than Alabama's current "faceless" Medicaid, MCOs work at a community level to ensure effective delivery of care, thus providing jobs and economic stimulus to the local economy, and even possibly hiring current and former Medicaid enrollees familiar with the system.[8]

## Conclusions & Recommendations

As Alabama evaluates potential Medicaid reforms, it should pursue options that align economic incentives with patient outcomes. MCOs and similar organizations that can be held accountable for improving the overall health of Medicaid beneficiaries offer a better option than the current Medicaid which simply pays for a finite range of services and does little to promote healthy lifestyles for Medicaid beneficiaries.

In short, Alabama will only be able to solve the budget challenges posed by Medicaid if the State is willing to move towards a new Medicaid that simultaneously improves the long-term health of those served by the program.

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[1] Donald E. Williamson, M.D., *Report of the Alabama Medicaid Advisory Commission*, January 2013, www.medicaid.alabama.gov/documents/2.0_Newsroom/2.2_Boards_Committees/2.2.1_Med_Adv_Comission/2.2.1_DRAFT_Commission_Report_1-29-13a.pdf.

[2] Kim Chandler, *Alabama Medicaid will get through '14 with prayer and luck, but faces potential crisis in '15, says state health officer*, available at: http://blog.al.com/wire/2013/02/alabama_medicaid_will_get_thro.html.

[3] *Id.*

[4] *Id.*

[5] *Alabama Hospital Utilization*, 2010, STATEHEALTHFACTS.ORG, available at www.statehealthfacts.org/profileind.jsp?cat=8&sub=217&rgn=2.

[6] *Medicaid: States' Use of Managed Care*, UNITED STATES GOVERNMENT ACCOUNTABILITY OFFICE, available at: http://www.gao.gov/assets/600/593781.pdf.

[7] *Amerigroup Real Solutions in Healthcare*, (pamphlet), available at http://new.dhh.louisiana.gov/assets/docs/BayouHealth/HealthPlanBrochures/AGP_LAMKT-003-11-Health_Plan_NetworkBro_ENG.PDF.

[8] *About Us*, Centene Corporation, available at: http://www.centene.com/about-us/.