

Issue Brief #1:

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Date: February 12, 2010
To: Washington State Legislators
From: Wilson Strategic Communications
Re: Medicaid 'Healthy Options' and Coordinated Care

Generally speaking, Medicaid has two payment models for coverage of low-income individuals: a fee-for-service model and a managed, or coordinated, care model.

A brief survey of lives versus resources in the two models can best be shown here in Table 1. The Medical Assistance Administration houses both Medicaid operations.

The fee-for-service model essentially compensates physicians and hospitals based upon procedures or exams provided. Quality of care is not a factor in this model. Rather, it is the procedure itself that is paid for by the State, which pays physicians and hospitals through contracts between providers and DSHS. While the State sets the rate at which physicians and hospitals are compensated, in this model, there is no limit to the amount of money that the state might be billed. It is dependent on the number of procedures provided. Because the State is financially responsible, this rate of compensation or "reimbursement rate" is kept very low.

The coordinated care payment model exists in a program called "Healthy Options" (HO). In this model, the DSHS contracts with health plans to be responsible for patient care. As part of the agreement, the State pays health plans a fixed amount per patient enrolled (capitation) in each plan. Unlike the fee-for-service model, the total financial liability for the State is fixed. The two largest plans with HO patients are Community Health Plan of Washington (CHPW) and Molina Healthcare.

In this case, the State also sets "reimbursement rates" for physicians and hospitals. However, there is no incentive for physicians and hospitals to do the extra work of care coordination at

the same reimbursement rate as fee-for-service. Consequently, plans must pay slightly more than “straight Medicaid” rates.

CHPW works primarily with its member community health clinics, and affiliated specialists, to provide the care. Molina contracts with independent groups across the state to provide care. NPN is a contracted provider for Molina “Healthy Options” patients, and cares for more than 13,000 low income patients in Pierce County.

Table 1

MAA	Lives	%	\$\$\$	%	\$/Live
Coordinated Care	764,766	59.8	\$1.048 bn	34.7	\$1370
Everything Else in MA	513,942	40.2	\$1.971 bn	65.3	\$3835

Source: DSHS Client Services, 2006-2007

In the coordinated care model, when a physician or hospital provides medical care, they are paid by the health plan, not the State. Because the total amount a health plan has to pay for care is fixed, there is an incentive to actively coordinate and manage patient care. Health management and preventive care are less expensive alternatives to emergency care. This incentive leads plans to better and more coordinated care among providers, which increases the likelihood that care will be timely and appropriate.

In “Healthy Options,” health plans have the financial liability for costly care, not the State. This means plans seek to treat basic medical needs in a clinic exam room rather than a hospital emergency room. It means that the model provides a financial benefit to closely manage chronic diseases like diabetes, congestive heart failure or depression. Those incentives do not exist in the fee-for-service model.

In some cases, a plan can pass on the financial risk for care to provider groups, in the same way the State passes on that risk to plans in the first place. That is the case with NPN. Northwest Physicians Network assumes all financial risk for its 13,000 “Healthy Options” patients, and receives a fixed sum per patient from Molina (after deducting an administrative fee from the State’s initial payment).

Any money left over from the initial annual capitation, after patient care has been rendered and compensated, is money that is typically reinvested in health information technology, chronic disease management systems, and tools that can help coordinate care.

Coordinated care offers incentives for quality care, limiting the State’s financial liability,

When the state increases premiums for HO patients, it increases the likelihood that there will be financial resources to reinvest in improving care systems. When the state increases “reimbursement rates” to physicians, hospitals, or other providers, it decreases the likelihood that there will be money for this reinvestment.

When the State increases reimbursement rates without any commensurate increase in overall premiums, it becomes likely that plans (or physician groups that have assumed financial risk) will lose money. When that occurs for an extended period, the State is likely to see an end to the managed, coordinated care model. This is the situation we are in today. Preserving adequate reimbursement levels for systems that actively manage and coordinate care for patients, and even increasing the proportion of Medicaid patients who receive their care under a managed, coordinated benefit, will save State funds both in the short and long term.

Table 2

Model	Fee For Service	Managed Care
Discourages unnecessary care	No	Yes
Pays for all necessary services in an episode	No	Yes
Encourages coordination among providers	No	Yes
Facilitates comparison of costs of different providers	No	Yes
Encourages high-quality services	No	Yes
Avoids penalty for taking sicker patients	Yes	No
Discourages unnecessary episodes	No	Yes

Source: “From Volume to Value: Better Ways to Pay for Health Care.” Health Affairs, Sept/Oct 2009.