Anthem
Public Policy Institute

Hidden Benefits: The Value of Medicaid Managed Care Networks

Medicaid managed care plans have a strong track record of delivering services and supports that meet high standards of quality while increasing access for beneficiaries. As an ever growing number of Medicaid beneficiaries are enrolled in managed care, health plans, working with their state partners, are seeking new and innovative ways to ensure that beneficiaries have access to the full array of services needed to help keep them healthy.

Recently, the Centers for Medicare and Medicaid Services (CMS) proposed new Medicaid rules that states must establish time and distance standards for a range of provider types, including primary care, OB/GYN, behavioral health, and other specialists and facilities, to ensure enrollees in Medicaid managed care plans have timely access to covered services.[1]

- Traditional measures are an important component of assessing network adequacy, but they paint an incomplete picture of access to quality care. Further, CMS's proposal does not extend to plans greater flexibility to ensure access to the most appropriate providers or providers in short supply, such as those practicing in certain sub-specialties and/or in rural or underserved areas.
- These measures also do not reflect how Medicaid managed care plans, working with their provider and state partners, are developing innovative strategies to enhance access and the delivery of high quality care for their members. Nor do the measures recognize the particular efforts directed at members with multiple or complex conditions or efforts that support members who are geographically isolated.

State and federal **policymakers can support the development and proliferation of innovation in Medicaid managed care networks** by ensuring that regulations provide enough flexibility to recognize innovative and effective network-enhancing strategies that improve access to care.

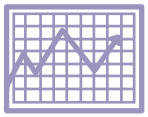
Medicaid Managed Care Employs Network Enhancing Strategies

Technology-Based Innovations. Medicaid health plans use tele-health, tele-monitoring, and technology-supported PCP-to-specialist consults to increase access, leverage provider expertise, and improve convenience for members. In both rural and urban areas, tele-health can reduce the need for some face-to-face specialty visits and expand access to services, such as psychiatry, that have traditionally had an inadequate supply of providers. **Technology-based innovations are helping to address a key "root cause" of physician access issues in rural and some urban markets – limited physician capacity.**

- In Georgia, where nearly half the counties do not have any psychiatrists, the Amerigroup Georgia health plan is collaborating with the Georgia Partnership for TeleHealth (GPT) to expand access to behavioral health and other health care services through tele-health. When specialists are unavailable in a member's community, the member's provider or a health plan care manager can schedule a "remote consult" appointment at one of GPT's sites located throughout the state. This has greatly increased the number of members receiving behavioral health services.[2]

Innovations in Provider Collaboration. Medicaid managed care organizations (MCOs) are critical partners in the development and proliferation of a range of new delivery and payment models including medical and health homes as well as effective care coordination strategies. Examples of these efforts include:

- The "Clinic Days" program, which works with network providers to reserve appointment times for members with identified gaps in care to ensure their health care needs are met, as well as coordination of transportation for those members who need it.[3]
- The PC-INSITE program, which places a behavioral health provider within primary care practices to carry out behavioral health screenings and integrate behavioral health into the primary care setting.[4]



Value-Based Payment. MCOs report that **value-based payment is becoming an increasingly powerful network recruitment and retention tool,** as providers look for reimbursement that supports the practice transformation they are undertaking. Value-based payment can also help to address one of the underlying reasons why some providers limit their participation in Medicaid – low reimbursement rates – by providing opportunities to earn additional payments.

Physician Extenders and Non-Traditional Providers. MCOs have adopted a range of initiatives that empower providers to work at the top of their license and that support the use of non-traditional providers, physician extenders, and patient access models, such as group visits or plan-operated health centers. **Medicaid health plans have embraced mid-level and non-traditional providers as key partners in ensuring access for vulnerable populations.** At the same time, several plans have established their own plan-operated health centers with care models designed specifically around the needs of their members.

- The CareMore model in Memphis, Tennessee relies on physician extenders to address the care needs of its more medically complex members. Clinicians referred to as "extensivists" assume responsibility for the most ill and frail members, while physician extenders provide care for members with less complex needs. An array of enabling service providers, including pharmacists, nutritionists, and social service professionals, expand and coordinate services and supports across the full continuum of care.[5]

Broadening the Dialogue Around Network Access

These and other innovative strategies should be part of an expanded dialogue as Medicaid programs continue to seek ways to ensure that beneficiaries have access to the right services at the right time.

- State and federal policy makers can support the expansion of these strategies by reducing regulatory barriers that further inhibit network access, such as overly restrictive scope-of-practice policies and requirements that inhibit full implementation of tele-health and tele-outreach programs.
- Medicaid programs can facilitate the delivery of highly accessible, high-quality care by supporting access-enhancing programs and initiatives by their contracting health plans. This will help supplement traditional measures of network adequacy, presenting a more complete picture of how beneficiaries access services in the modern Medicaid program.

1. Federal Register, Vol. 80, No. 104 (file code CMS-2390-P).
2. Program information and data from the Amerigroup Georgia Health Plan, May 29, 2015.
3. Health Management Associates telephone interview with Anthem's affiliated health plans' subject matter experts, April 6, 2015.
4. Internal health plan materials and Health Management Associates interview with Anthem's affiliated health plans' subject matter experts, May 4, 2015.
5. The CareMore Model, PowerPoint presentation, February 2015, and Health Management Associates interview with CareMore subject matter experts, April 27, 2015.