Quality Matters

Health & Medicine
POLICY RESEARCH GROUP

Policy Brief #3: Selective Contracting as an Inequity Reduction Strategy in Managed Care

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Capitated managed care was introduced into Illinois Medicaid with two stated goals—improving quality and reducing costs. A key selling point for managed care was the flexibility to use capitated payments to pay for services to address non-clinical issues that impact people's health—the kinds of services that are not covered in fee-for-service. Under fee-for-service, Medicaid pays again and again for emergency room visits but is unlikely to pay for an exterminator to eliminate the root cause of ongoing asthma attacks, for example. Other examples of MCO using flexible spending to address environmental and behavioral factors include housing supports and wraparound services for people transitioning from homelessness or from institutions, career counseling and job training, and in one case direct employment of members with HIV as peer specialists, book clubs for children, distributing healthy food and sponsoring classes on meal preparation, and targeted community health education.[1]

Because those kinds of non-clinical issues are a major driver of racial and ethnic health inequities[2], these kinds of interventions by managed care organizations may play a role in reducing or eliminating those inequities and potentially reduce per capita costs. The persistence of racial health inequities in Illinois make the relative success or failure of those interventions a key measure of the effectiveness of managed care overall.

Earlier managed care programs in Illinois had ended in disappointment, and sometimes scandal[3], and a non-capitated primary care case management program

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[1] The Menges Group, "Positively Impacting Social Determinants of Health: How Safety Net Health Plans Lead the Way," prepared for the Association of Community Affiliated Plans, June 2014. http://www.communityplans.net/Portals/0/Fact%20Sheets/ACAP_Plans_and_Social_Determinants_of_Health.pdf

[2] We distinguish "disparity," which merely indicates indicates a difference, from "inequity," a difference that is unfair, unjust, remediable, and that harms disadvantaged groups.

[3] For example, see Department of Justice Press Release "Amerigroup Settles Federal & State Medicaid Fraud Claims for $225 Million," August 14, 2008 https://www.justice.gov/archive/opa/pr/2008/August/08-civ-723.html

had shown some promise to cut costs[4]. However, the ACA's Medicaid expansion brought added urgency to get managed care right. Illinois estimated an additional 780,000 people would become eligible for Medicaid under the ACA. The new ACA eligibles had not been in a category (like pregnant women or people with disabilities) covered by traditional Medicaid, but like all Medicaid enrollees, they are poor and therefore subject to the inequities in health status that we know impact low-income people in the United States. After the 100% federal match for the new enrollees expires, Illinois could face a potential cost bomb: non-elderly adults with unmanaged chronic health conditions, barriers to accessing quality, timely care, and environment and social factors stacked against their health and wellness. Other states were making (often specious) arguments against accepting the Medicaid expansion based on dire cost predictions at even 90% federal match. Illinois chose a different path, expanding Medicaid to the new ACA eligibles residing in Cook County a year early, along with a plan to manage their care.

The first wave of enrollees under the Medicaid expansion joined CountyCare, an HMO-like 'managed care community network[5]' operated by Cook County Health and Hospital System. CCHHS has long been the backbone of the health safety net in and around Cook County. I talked with CountyCare CEO Steven Glass in May 2016 to find out how the still-young health plan was approaching health inequities.

This paper will summarize our conversation with Glass and dig deeper into a surprising managed care strategy to combat disparities that he highlighted—selective contracting with high quality providers.

Managed Care and Health Inequities

Any discussion of disparities in Medicaid needs to be clear about whether "disparities" refers to the gap in access and outcomes within the Medicaid population—differences between African-American and White Medicaid members, for example—or between Medicaid and non-Medicaid populations. Glass's focus was on a key defining feature of the Medicaid population as a whole, regardless of race, ethnicity, education, language, or other demographic status: "inter-generational poverty. " Given the enrollment requirements, Medicaid enrollees are generally impoverished and many have been so for generations. However, CountyCare may only have one year of membership for any given individual to

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[4] Robert L. Phillips, Meiying Han, Stephen M. Petterson, Laura A. Makaroff, and Winston R. Liaw, "Cost, Utilization, and Quality of Care: An Evaluation of Illinois' Medicaid Primary Care Case Management Program," Annals of Family Medicine, Vol. 12, No. 5: 408-417, September/October 2014, doi: 10.1370/afm.1690.
http://www.annfammed.org/content/12/5/408.full

[5] Managed Care Community Networks are defined in Title 89 IAC 143.200
http://www.ilga.gov/commission/jcar/admincode/089/089001430001000R.html

tackle decades of impact from economic inequity, lack of access to high-quality nutrition, and inequitable housing and education systems.

Given these harsh realities, combined with the chaos at the State level, Glass suggests a pragmatic approach to what can be done in the short- to medium-term. Collecting data on social determinants like housing stability and food security is already challenging, and CountyCare is focusing on those issues for their entire membership. Member-level data collected during care coordinator assessments can be cross-referenced with utilization and HEDIS data. But research isn't the priority for CountyCare. We have ample research demonstrating associations between social determinants and health status, and the clear disparities in access and outcomes for African Americans and Latinos. The role Glass sees for CountyCare is to follow the lead of that existing research and implement strategies that have the strongest impact on mortality.

Even a successful strategy to improve preventive care and reduce mortality in the Medicaid population will collapse if it is not financially sustainable, however, and CountyCare faces what Glass called a "structural problem" in Medicaid managed care—to coordinate care well, plans must address social determinants of health, but they are not paid for those interventions. Therefore, targeting high utilizers and high risk members is doubly imperative because high utilization and risk indicates an opportunity for powerful impact on morbidity and mortality and also produces the most cost savings that can be reinvested in unreimbursed social interventions. High utilizers can be easily identified in claims data, while assessing more subtle risk factors requires more outreach and engagement work from community-based care coordinators along with data analytics.

Community engagement and data mining to identify individual-level risk factors is an important tool for managed care organizations; however, focusing on the individual factors can obscure important institutional drivers of disparities. Furthermore, MCOs have limited control over membership retention, and an individual who is a CountyCare member one year may be in a different plan the next. So there are barriers to individual-level interventions in managed care as it is currently set up. But we know that the site of care is another important factor driving health outcomes, and Medicaid plans have significantly more control over provider networks than the State has in a fee-for-service system.

That's why CountyCare is also looking at the site of care for its members as well as individual-level data on utilization and social determinants like food security and housing stability. Tracking the type and quantity of services helps identify members who are missing screenings and immunizations, on the one hand, or over-relying on emergency rooms, on the other. Members may seek the right service at the right time, but from a provider with a history of low quality and poor outcomes. This is an especially important consideration for the goal of health equity when white and non-white patients tend to go to different sets of providers, and those settings vary in quality.

Care coordination may create some improvement in quality, and interventions that target social determinants can reduce risk factors for poor health and impaired functioning. But differences between sites of care that provide most of the care to non-white patients and sites that treat very few non-white patients also contribute to racial and ethnic health disparities.[6] Recent attempts to incentivize improvements in post-discharge hospital-community collaboration by penalizing hospitals with high readmission rates have come under criticism for disproportionately penalizing safety-net hospitals that treat patients more complex environmental and psycho-social needs upon their return to the community. Karen Joynt led a study that considered the impact of site of care on readmissions and found that patients of any race were more likely to be readmitted if they received care at hospitals that served the highest proportion of African American patients in a community. Adjusting for mortality, patients' prior hospitalizations, and the in-hospital procedures patients received eliminated the racial disparity in readmissions at non-minority-serving hospitals. The study concludes that "the hospital at which a patient receives care appears to be at least as important as his/her race."[7]

The disparities in quality among providers for white and non-white patients reflects a structural inequity in the healthcare system for which there is no 'quick fix.' However, managed care plans are tasked with coordinating care for their patients, which includes monitoring and managing the provider network available to their members.

A question for payers managing provider networks is whether care at providers predominantly serving people of color can be improved or whether such patients would be better served by shifting their site of care to higher quality providers. The challenge facing the former strategy is feasibility: Can providers with a history of poor quality be improved quickly and does a managed care plan have the tools to incentivize what quality improvement is possible? The challenge facing the latter strategy is on the one hand practical—is it realistic to change long-standing utilization patterns and convince plan members to accept new providers that may be outside their communities? On the other hand, a strategy to change the site of care in order to improve quality will have to face the complexity of defining 'quality.' If 'high quality' providers have achieved that designation precisely by avoiding more

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[6] Peter Bach, "Racial Disparities and Site of Care," *Ethnicity and Disease,* Vol. 15, Spring 2005 http://www.ishib.org/journal/ethn-15-2s-31.pdf

[7] Karen Joynt, E. John Orav, and Ashish Jha, "Thirty-day readmission rates for Medicare beneficiaries by race and site of care," Journal of the American Medical Association 305(2011): 675-681, doi: 10.1001/jama.2011.123 http://www.ncbi.nlm.nih.gov/pubmed/21325183

vulnerable patients, for example, then they are unlikely to maintain their performance when they are compelled to accept more of those patients.

Identifying high-performing providers in a market as well as the root causes of poor performance are both data-intensive tasks. In our conversation, Steven Glass acknowledged the lack of reliable, actionable quality measures. HEDIS outcome measures are problematic because providers can't control the behaviors that affect them most. Without more granular quality data dashboards for monitoring providers, attempts to measure and improve quality anywhere near to real time are bound to be clumsy and ineffective. Glass shared a successful example of case-by-case provider monitoring, in which a network hospital identified a community substance use disorder treatment center as the source of many ED referrals. CountyCare was able to locate the real problem, which was not so much the quality of the SUD treatment provider as its limited capacity to address medical issues with its existing staff. The non-medical SUD provider could be a more effective partner with the hospital if it had an on-site nurse practitioner, so the hospital agreed to provide that staffing.

That kind of case-by-case investigation and intervention into provider networks is not a systematic approach to building a quality network for the plan's members, however. For that, Glass looks to third party accreditors, such as Joint Commission and NCQA accreditation of patient-centered medical homes, Metropolitan Breast Cancer Task Force members, and AIDS Foundation of Chicago-endorsed providers. Given the state of quality measurement, the capacity of managed care plans to monitor and intervene, and the relative trust that consumers have in third party accreditation over insurers of any kind, and the culture change that the accreditation process can stimulate, an approach that relies on third party accreditation to ensure quality could be more immediately implementable than more data-intensive strategies, while also having a long-term effect on both quality and cost.

Ideally, selective contracting with high-quality, cost-effective providers is a service to health plan members as well as a benefit to payers. If consumers know they can trust their health plan to only contract with the best providers, they can avoid the time-consuming and complex task of shopping for the right provider themselves. For some health care consumers, this would be a straightforward value-add from their health plan. For others, selective contracting looks more like a penny-pinching restriction on their choice.

Decades ago Walter McClure introduced the "buy right" principle according to which purchasers of large group insurance should provide their employees with "the means, and the incentives to identify and choose good providers over poor providers."[8] Research showing better outcomes for commercially insured kidney

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[8] J, K. Iglehart, "A Conversation with Walter McClure: Competition and the Pursuit of Quality," Health Affairs, 1988 7(1):79–90.

transplant patients at in-network hospitals than out-of-network hospitals suggests there is a real trade-off between offering a broad choice of providers and ensuring quality care.[9] A major complaint about Medicaid managed care in Illinois has been the disruption in continuity of care and limitations on choice of physicians and other providers, particularly for people with disabilities. Consumers justifiably suspect that secret negotiations between plans and providers are driven primarily by cost and profit considerations. Meaningful engagement with consumers and movement toward more transparency in provider quality and prices may be helpful to overcome consumer distrust of selective contracting.[10] Developing network adequacy standards that allow for flexibility to implement value-based purchasing but maintain strong consumer protections for access and continuity of care present an enormous policy challenge, but could provide an important accountability tool to ensure that selective contracting is implemented in the interest of consumers.

The Need for State-Level Policy Change

Even if selective contracting can be a truly valuable service for plan members that is responsive to their needs and preferences while maintaining high quality at sustainable costs, Medicaid managed care will still need longer-term policy changes to meaningfully affect quality and disparities.

No matter what a single plan does within its membership and its provider network, there is always the risk that the outcomes and savings that their investment produces will land in the "wrong pocket." For example, if one health plan invests in treating Hepatitis C with a newer drug like Sovaldi and that member switches plans, then the reduced spending on long-term management of the disease is realized by the new plan, not the plan that paid for the Sovaldi prescription. Risk adjustment and stop-loss insurance have weak spots that leave health plans bearing unmanageable risk for high cost benefits, like specialty drugs and power wheel chairs. Steven Glass suggested a few policy changes that would create more opportunities for CountyCare to coordinate care and invest in social determinants of health.

- Carve out the cost of the highest priced drugs, while continuing to let plans manage their utilization, and include high cost conditions, like hemophilia, in stop-loss insurance. These reforms could allow plans to manage the comprehensive Medicaid benefit package without balking at high-spend

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[9] David Howard, "Hospital Quality and Selective Contracting: Evidence from Kidney Transplantation," Forum on Health Economics and Policy. 11(2): 2, December 2008

[10] Romy Bes, Sonja Wendel, Emile C. Curfs, Peter P. Groenewegen, and Judith D. De Jong, "Acceptance of selective contracting: the role of trust in the health insurer," BMC Health Services Research, 13:375, March 2013. DOI: 10.1186/1472-6963-13-375. http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-375

treatments that create savings for the overall healthcare system but only losses for individual plans.

- Coordinate state and federal rules for redetermination and open enrollment so that plans have less risk of losing members as a result of administrative processes (rather than true, informed choice of members). Open enrollment periods can be aligned with redetermination so that choice and redetermination occur at the same time, for example.

- Illinois could also apply for a waiver to lock in members with certain conditions for longer periods. We note that such a waiver would, of course, need to include protections for consumers to switch plans with cause.

- Allowing expenses for addressing social determinants in Medical Loss Ratio calculations. Plans are discouraged from spending on services that facilitate stable housing, food security, and other social determinants of health if that spending is not categorized as a service to members the way spending on, say, an emergency room visit would be.

Conclusion

The interaction between sites of care and disparities, especially in Chicago, where de facto segregation is visible in hospitals as well as in schools and neighborhoods, has preoccupied Health & Medicine for some time. We regard ourselves as advocates, and sometimes activists, for health equity and also as staunch defenders of the health care safety net. It won't surprise many readers to hear that Health & Medicine approaches managed care with skepticism. Therefore, a strategy for health equity that relies on selective contracting—a market-based solution that could cut off safety net providers from Medicaid contracts and restrict choice for already marginalized populations--is intriguing and challenging, which is why we chose to write about it.

Selective contracting may bring narrow networks that control costs while producing barriers to access to consumers. Or it can become a valuable service to consumers who are faced with opaque, confusing choices in the health care market. Health & Medicine has argued that the role of the State Medicaid agency (and its sister agencies, DHS, IDOA, and IDPH) must change to effectively monitor and guide Medicaid managed care organizations. [cite OASAC recs report] Reviewing selective contracting arrangements as part of an overall strategy to track access, quality, and patient experience in managed care plans could be an important role for the State administration of Medicaid managed care.