Executive Insights

Volume XVIII, Issue 11

Payer Implications of the Medicaid Revolution

The Medicaid managed care market is exploding: Between 2010 and 2017, managed care market revenue is expected to more than triple, from approximately $90 billion to $290 billion. While the industry is grappling with myriad challenges — such as Affordable Care Act requirements, exchange implementations and supporting accountable care — managed care organizations (MCOs) with strong Medicaid service lines are enjoying the fruits of market expansion. But it's not all easy street for these payers.

In this *Executive Insights*, L.E.K. Consulting highlights what Medicaid payers must do in order to win and avoid being left behind in a growing but increasingly competitive industry.

Sources of growth

The unprecedented Medicaid managed care expansion is the result of three primary drivers:

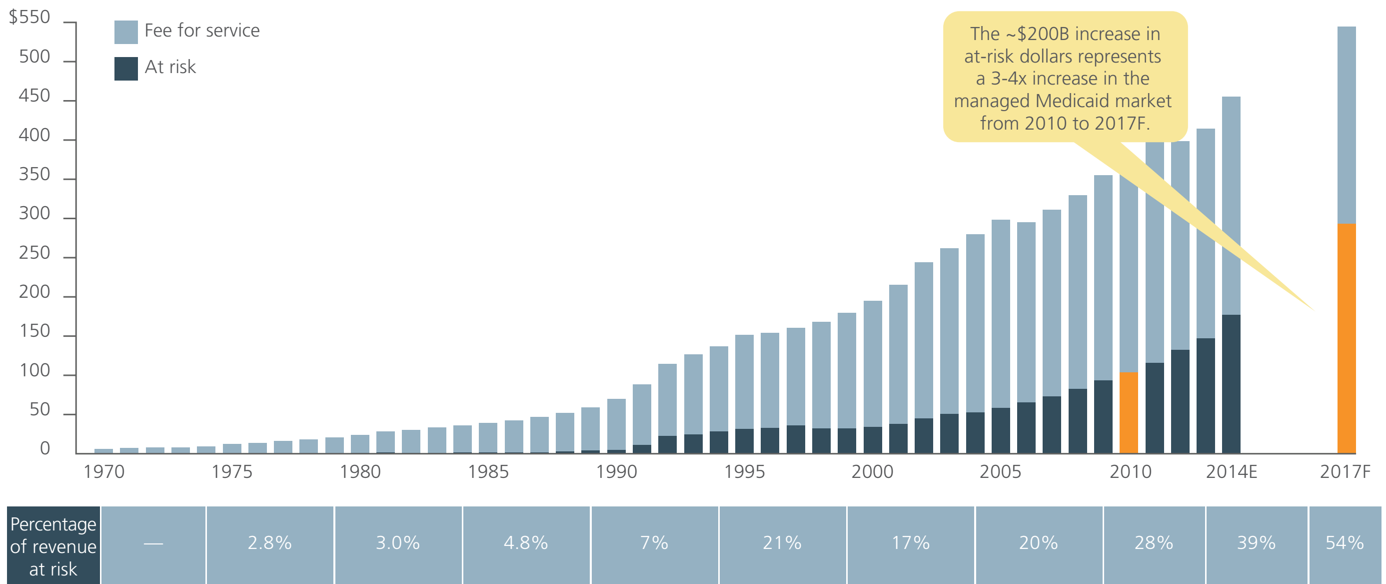
1. **Massive increase in managed care penetration:** From approximately 56% of Medicaid-eligible people in 2010 to 83% in 2017. States have partnered with MCOs to operate Medicaid programs since the 1980s, but advocacy groups successfully dissuaded states from large-scale adoption until the early 2000s. Since then, a combination of strong MCO performance, acute state budget pressures and improved budgeting has unleashed a flood of conversions to managed care. Thirty-nine states currently have risk-based managed care contracts, and more than half of these made policy changes to increase enrollment in MCOs in either 2015 or 2016.
2. **Rapid increase in the number of people eligible for Medicaid:** 38% increase, from approximately 54 million beneficiaries in 2010 to 74 million in 2017. Medicaid expansion under the Affordable Care Act has been the largest driver of growth in beneficiaries. At the time of printing, 31 states and the District of Columbia had already opted to expand Medicaid coverage to all adults who earn less than 138% of the federal poverty level, thereby adding roughly 11 million new beneficiaries — and accounting for 56% of growth since 2010. Additionally, population growth of about 1% per year since 2010 and a stable poverty rate of approximately 15% since the recession have contributed about 9 million new beneficiaries to the growing Medicaid rolls, accounting for the remaining 44% of growth in the number of people eligible for Medicaid.
3. **Shift in populations served:** approximately 65% increase in average annual cost per member, from about $3,100 in 2010 to $5,100 in 2017. The population that the managed portion of Medicaid serves is quickly changing. Whereas the program once served primarily mothers and children, it now serves the most complex, difficult-to-care-for and costly populations, including

Payer Implications of the Medicaid Revolution was written by **Bill Frack**, Managing Director, **Andrew Garibaldi**, Principal, and **Jerry Coil,** Executive-in-Residence, in L.E.K. Consulting's Healthcare Services practice. Bill is based in Los Angeles, Andrew is based in Boston and Jerry is based in San Francisco.

For more information, please contact healthcare@lek.com.

L.E.K.
INSIGHTS@WORK®

Figure 1
History of Medicaid (1970-2017F)



Sources: USDHHS 2014 Actuarial Report on the Financial Outlook for Medicaid, 2002 Medicare and Medicaid Statistical Supplement, L.E.K. forecast and analysis.

dual-eligible beneficiaries and individuals requiring long-term services and supports (LTSS). Ten states reported plans to carve at least some portion of LTSS or home- and community-based services (HCBS) into MCO contracts in 2015 or 2016. Seven states have reported plans in 2016 to incorporate some portion of inpatient mental health, outpatient mental health and/or substance abuse services into MCO contracts. Some states, such as Iowa and Kansas, have converted virtually all populations from entirely fee-for-service Medicaid programs to managed care overnight with one RFP. Such changes in the populations that Medicaid serves have necessarily increased the complexity of the program and changed the distribution of available funds.

Winning in today's managed medicaid environment

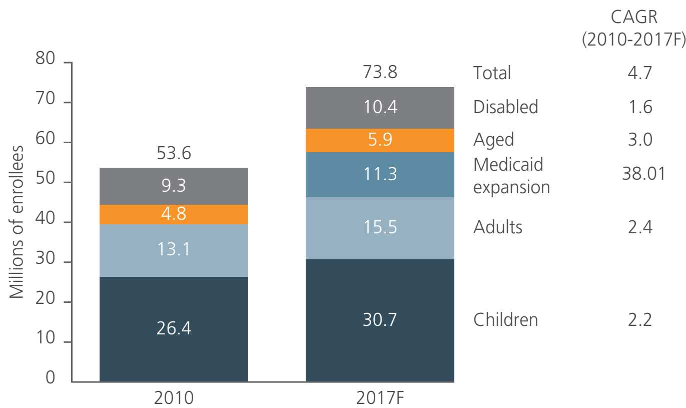
To survive and thrive under this new world order, payers must move aggressively to meet the drastic shift in state program requirements. Based on our experience, we have identified six points Medicaid payers should focus on in order to win RFPs and maximize profit potential in this rapidly evolving new era of Medicaid managed care.

1. **Depth and breadth of expertise are increasingly important.** Recently, RFPs have required MCOs to have experience and expertise serving nearly all Medicaid populations and meeting increasingly complex member segments' needs. For example, bidders in Iowa's recent 2015 RFP were required to demonstrate comprehensive capabilities across such areas as behavioral health, LTSS, foster care, health homes and seven distinct HCBS waiver populations. Similarly, Kansas's 2013 RFP required bidders to demonstrate capabilities across multiple special populations and programs, including Aged, Blind or Disabled (ABD), Severe Mental Illness (SMI), Children's Health Insurance Program (CHIP), Intellectual Disability/Developmental Disability (ID/DD), foster care and LTSS. As RFP requirements become more comprehensive, MCOs that lack capabilities across the wide gamut of needs will be left out of the running.

2. **Care models must be optimized by subpopulation.** Population-driven care models and their supporting infrastructure must tailor delivery of care to specific subpopulations' needs and rapidly identify changes in health status and eligibility. As managed populations become more complex and a growing number of complex members consume a disproportionate share of costs, such optimization improvements will become ever more important. Care models need to be member-centric and use a multidisciplinary, coordinated team approach to manage medical, behavioral and social components. More specifically, MCOs need to be well-versed in assigning the right care coordinator to each patient,

 INSIGHTS@WORK®

Figure 2
Total Full-Benefit Medicaid Enrollment (2010-2017F)



Note: Dual-eligible beneficiaries were pulled out of ABD, and LTSS users were pulled out of all categories. 138.0 CAGR from 2014 to 2017F.

Source: DHHS 2014 Actuarial Report on the Financial Outlook for Medicaid.

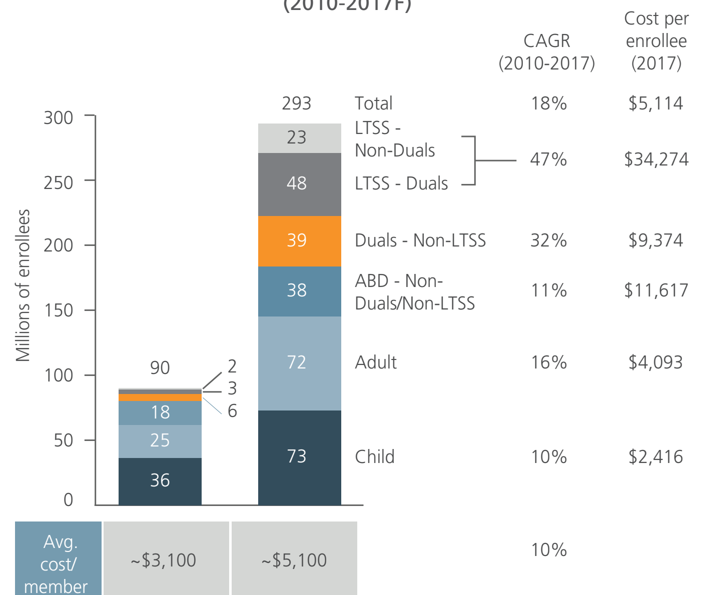
based on the member's primary need; coordinating across all patients' needs; building member relationships; and creating a seamless experience for members. Behavioral health has become a particular point of emphasis in recent RFPs, so MCOs that fully integrate behavioral health in their care models have a significant advantage over those that outsource behavioral health to specialized providers.

3. **State RFPs increasingly expect MCOs to address members' social needs.** Given Medicaid expansion and the increasing penetration of managed LTSS, winning MCOs must have capabilities that go beyond the traditional functions of a healthcare payer. They must also be able to coordinate social services; integrate community resources; support nonmedical providers; and develop care plans that address the social determinants of health, such as housing, nutrition and education. To provide effective care management, MCOs are finding they must address members' social needs as a routine part of every healthcare encounter. For example, MCOs need to evaluate social determinants of health through their screening tools and health risk assessments, and they must be adept at identifying and leveraging government and community programs (e.g., through well-developed databases and referral tools) to support members' social needs and promote healthy lifestyles.

4. **MCOs must innovate to fill gaps in care delivery.** Provider partnerships or embedded providers can help close gaps in care, thereby controlling costs and better supporting members' needs. Amerigroup's embedded CareMore Care Centers in Tennessee are an example of effective innovation. These centers provide direct medical care for many of Amerigroup's sickest and frailest members in Memphis, thereby improving management of chronic conditions, reducing hospital admissions and readmissions, keeping members healthier, and decreasing overall cost. A non-location-specific example of delivery innovation is telehealth, which can help close gaps in access to care, especially in rural, low-income neighborhoods.

5. **COs must have a best-in-class RFP response process.** Given the high volume of state RFPs and the increasingly shorter turnaround times, MCOs must not only communicate and quantify their experience delivering high-quality outcomes for specific Medicaid populations, but also craft compelling stories underpinned by resonant win themes and strong data-based support for state decision-makers. In our experience, MCOs are becoming more adept at writing program descriptions, but they tend to lack data-driven support of program efficacy.

Figure 3
Comprehensive Risk-Based Managed Medicaid Revenue (2010-2017F)



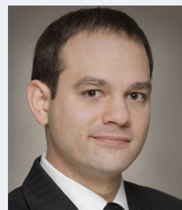
Source: L.E.K. research and analysis; MACPAC 2013 & 2012 Report to Congress on Medicaid and CHIP; DHHS – 2012; Actuarial Report on the Financial Outlook for Medicaid – March 2013.

6. **Cost-effectiveness is still the bottom line.** To help states bend the cost curve and validate the value proposition of managed care, payers must find the elusive balance between localization and scale. Although care delivery, network relations, community engagement and partnerships, and other plan elements derive value from being local, MCOs can realize cost-reducing benefits by scaling up in such areas as program design and innovation, claims payment, IT and care models.

The rapidly changing Medicaid managed care landscape has made it difficult for payers to take full advantage of — let alone keep up with — recent drastic shifts. MCOs must position themselves now to stay ahead of the game, capitalize on emerging opportunities and ultimately win RFPs.

About the Authors

Bill Frack is a Managing Director and Partner, and he leads L.E.K.'s Americas Healthcare Services practice. He has more than 28 years of consulting experience in strategy, organization, cost-effectiveness, and mergers and acquisitions. He has provided strategic advice to a wide range of leading U.S.-based healthcare, media, entertainment and technology companies.



Andrew Garibaldi is a Principal in L.E.K. Consulting's Boston office and is dedicated to the firm's Healthcare Services practice. He joined L.E.K. in 2008 and has worked extensively on corporate strategy, commercial due diligence, and other transactions and engagements.

About L.E.K. Consulting

L.E.K. Consulting is a global management consulting firm that uses deep industry expertise and rigorous analysis to help business leaders achieve practical results with real impact. We are uncompromising in our approach to helping clients consistently make better decisions, deliver improved business performance and create greater shareholder returns. The firm advises and supports global companies that are leaders in their industries — including the largest private and public sector organizations, private equity firms and emerging entrepreneurial businesses. Founded more than 30 years ago, L.E.K. employs more than 1,200 professionals across the Americas, Asia-Pacific and Europe. For more information, go to www.lek.com.

L.E.K. Consulting is a registered trademark of L.E.K. Consulting LLC. All other products and brands mentioned in this document are properties of their respective owners.
© 2016 L.E.K. Consulting LLC

L.E.K.
INSIGHTS@WORK®