Honoring Accountability in Medicaid and Medicare

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Examples of Where the FFS Setting Offers No Accountability for Improving Person's Lives

1. Persons with numerous recent hospitalizations (e.g., 3+ within past 1-2 years) obtain excellent inpatient care that stabilizes them. Unfortunately, the FFS setting offers no assurance that anything will be done to address the underlying circumstances causing the repeated clinical crises to occur.
2. Many high-risk pregnant women do not adequately engage with the health care system (sometimes not until in labor), often leading to birth related complications. These circumstances can create higher short-term costs as well as lifelong disabling conditions.
3. Persons with a complex mix of behavioral health and physical health conditions often receive treatment in various "silos", driven by these individuals' (often compromised) decisions regarding from whom and when they seek care.
4. Many persons with a chronic condition obtain quality care treatment, but receive little or no outreach to support them during the 99+% of their lives when they are not interacting with health care providers.
5. Persons forced to obtain care at a physician's office or clinic (and sometimes emergency departments) in situations where adequate clinical care/guidance can occur via the phone, email, etc.

Accountable Care Organization Designers/Implementers Are Often Ducking -- Instead of Honoring -- the "A"

- To date, the "A" in ACO could easily be changed from accountable to aspirational
  - There need to be requirements against which accountability is measured/enforced. Minimal requirements exist for Medicare ACOs to coordinate care effectively and comprehensively.
  - Financial incentives have been slanted towards rewards if medical costs come in under a pure FFS cost target; if costs come in above this generous target there is no downside risk. Moving in the opposite direction warranted, CMS is extending the date at which downside risk will occur in the Medicare ACO program.
  - Without full medical cost risk, ACOs have a disincentive to invest in outreach and other administrative efforts that will likely yield a more than offsetting reduction in health costs.
- Nothing has been preventing providers who are interested in operating a comprehensive care coordination program from forming a truly accountable MCO
  - Several dozen provider-sponsored MCOs operate in both the Medicaid and Medicare arenas, competing successfully on a level playing field with other MCOs.
  - Politically anointing inexperienced provider-sponsored care coordination entities to play this role is questionable public policy
  - Most comprehensive care coordination organizations are not provider-sponsored. Policymakers should avoid disqualifying experienced, capable entities from serving any Medicaid or Medicare subgroup simply because they are not provider-sponsored.

Capitated MCO Model Creates True Accountability in Medicaid and Medicare

- A vast set of contract requirements are in place for Medicaid and Medicare MCOs to ensure they deliver a comprehensive coordinated care program.
  - Medicaid MCOs must typically meet the further standard of being selected as one of the "best" partners for the State through a competitive procurement.
- MCO model creates a "fishbowl" where extensive monitoring can occur.
  - Government oversight personnel -- as well as the advocacy community -- can identify and address problem areas that occur within the MCO setting. In the FFS setting the same problems are largely invisible. Even if problems are identified in FFS, this setting provides no individual or organization who can be held accountable for a remedy.
  - Quality can be measured far more effectively in the capitated MCO setting.
- Enrollees/caregivers concerned with their health plan can seek recourse within their MCO and/or can switch to another MCO.
  - MCO member services departments typically feature sophisticated information systems and extensive staff resources. In contrast, persons served under an ACO are usually unaware the ACO program exists; typically no member services function exists in an ACO.
- Dollar-for-dollar medical cost risk strongly motivates innovation and activity to proactively keep enrollees healthy and address health problems cost-effectively.

Summary

- Injecting accountability to facilitate access, measure and improve quality, and avoid unnecessary costs is an important health policy priority
  - most Medicaid and Medicare expenditures still occur in an outdated FFS setting that is detrimental both to our high-need beneficiaries and to the country's taxpayers
- Notwithstanding its name, the Medicare ACO model is compromised in its ability to deliver accountability – unless and until it morphs into the comprehensive MCO care coordination model that we already have available
- The more that policymakers and advocates value accountability in identifying and addressing the key challenges high-need subgroups face, the more they should embrace the capitated MCO model as the core framework through which Medicaid and Medicare coverage occurs

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