The District's Dime
Going Beyond the Budget Book

The DC Fiscal Policy Institute blog
www.dcfpi.org

November 10, 2014

Stronger Oversight of Medicaid Managed Care Could Mean Better Health Outcomes for Residents

By Wes Rivers

The District could be doing a better job of connecting residents on Medicaid with basic health services, which would improve health outcomes and avoid costly services that do not improve patient care. A recent report on the managed care organizations (MCOs) that serve 175,000 DC Medicaid participants suggests that better oversight and monitoring is needed to contain health care costs and improve health outcomes for DC residents.

In the District, most Medicaid recipients are assigned to one of three MCOs. The District pays each MCO a fee for each enrollee and in return the company reimburses doctors and hospitals for health care services used. Since the rate the District pays is fixed, the companies have an incentive to connect members with the services that will manage and improve their health.

Yet a report from the Department of Health Care Finance suggests that the three managed care organizations could be doing a better job. The share of Medicaid patients who see a primary care doctor each year has fallen steadily over the last nine months and is now at 70 percent. Seeing a primary care doctor regularly makes it more likely to manage health needs and reduces the likelihood of needing more costly services.

The inadequate basic care means that DC's Medicaid managed care organizations incur millions in costs associated with poorly coordinated care. Over three-fifths of emergency room visits by DC Medicaid recipients are for basic care that could be avoided by regular visits to a primary care doctor. In addition, many Medicaid recipients who seek hospital care end up being re-admitted, and the new report shows that half of those readmissions could be avoided through better service delivery and follow-up care.

The District needs stronger oversight and performance evaluation of the Medicaid managed care program. Stronger performance standards will to lead to improved health outcomes among residents and fewer avoidable costs. Three areas that should be addressed to improve patient care include:

- **Ensuring a sufficient network of doctors.** A major barrier to routine care is a lack of doctors available to see patients. The District can improve access to care by making sure that the MCO networks have a large number of providers available for patients, and that those providers are located throughout the community.

- **Providing access to a care coordination program.** Care coordination means that patients' needs are identified and that they are referred to an appropriate service provider. Many

primary care clinics take on a care coordination role by acting as a "medical home" to their patients, providing on-going care, and storing and sharing electronic health records. It is important that MCOs attach their enrollees to a medical home and make sure they are getting this level of comprehensive care.

- **Establishing outcome-based benchmarks of performance.** The District has already begun to establish standards for the MCO's financial performance and how well they manage the care of their enrollees. Those standards should be subject to public input and should be tied to improved health outcomes – especially outcomes related to health disparities that exist in the District.