Winning in the Medicaid and “Duals” Markets
Navigating Uncertainty and Planning for Successful Growth
The authors thank Booz & Company senior associates Steffen Gnegel and Samir D’Sa and associate Ian Ellis for their contributions.
EXECUTIVE SUMMARY

The Supreme Court’s recent decision to allow individual states to opt out of the Medicaid expansion provision of the Affordable Care Act (ACA) has created a flurry of speculation about which states will opt in and which will opt out. However, it’s already clear that Medicaid rolls will soon expand by millions of people. Indeed, this decision is just one element of the changing Medicaid landscape. Regardless of the Supreme Court’s ruling, many states will continue to shift their current Medicaid populations to managed care organizations (MCOs). What’s more, the Centers for Medicare & Medicaid Services (CMS) is encouraging states to switch more of their “Duals” populations—those who qualify for both Medicare and Medicaid—to managed care (in the form of MCOs, Accountable Care Organizations [ACOs], or primary care case management) as a cost-saving measure. Together, these developments are creating enormous opportunities for MCOs, with millions of patients and hundreds of billions of dollars in play. But there are serious challenges and complexities that MCOs must consider before committing themselves to this market. The costs of providing healthcare to the old, sick, and disabled can spiral out of control and wreck razor-thin margins; at the same time, revenue is under pressure thanks to a very competitive environment and uncertain reimbursement from the states. Finally, managing these complex populations will require an integrated and holistic “life management” approach that goes beyond the conventional medical management models in place at traditional health plans. For MCOs that decide to take the plunge, we propose a multistep approach:

- Identify the states with the greatest growth opportunities for Medicaid patients and Duals, paying particular attention to which states have chosen or may choose to expand Medicaid under the ACA.
- Choose one of four value propositions to take to market (that is, find a “way to play”).
- Build or enable five differentiating care management capabilities necessary to effectively and cost-efficiently serve both the Medicaid and Duals populations.
- Design a new, coherent operating model in which these converging capabilities can be leveraged across the Medicaid and Duals populations, as well as Medicare and individual exchange market segments.
The Supreme Court’s late June decision to uphold most of the Affordable Care Act (ACA) while allowing states to opt out of the Medicaid expansion provision surprised many and will certainly affect the program’s growth. Originally, the ACA would have expanded the Medicaid market by at least 16 million new enrollees (primarily by expanding coverage for non-elderly adults to those living at or below 133 percent of the poverty level). But the Court’s ruling has led to intense speculation about each state’s potential expansion. As of early July, five states—Texas and Florida among them—had formally declared their intention to opt out, reducing the potential market size by 4 million new enrollees. In contrast, more than a dozen others (including California, Illinois, and a number of Northeast states), representing 4.4 million potential new enrollees, have affirmed their interest in opting in to the Medicaid coverage expansion. Still, the majority of states, representing 7.7 million potential new enrollees, remain undecided. Although many political considerations will influence their decisions, our analysis, based purely on budget considerations (i.e., the incremental burden on state budget deficits from potential expansion), suggests

States representing 4.4 million potential new enrollees have affirmed their interest in opting in.
the Medicaid market could expand by almost 10 million Medicaid enrollees.

Wherever the tally ends up, the Medicaid population is still going to expand very quickly by millions of people in those states that decide to participate in the program. And this is just half of the Medicaid growth story. Concurrent with ACA expansion, many states are planning to shift their current Medicaid populations to managed care organizations (MCOs) in order to better manage their own costs. Together, these two developments create not only enormous opportunities, but also significant uncertainties and complexities that MCOs must weigh carefully before entering the fray.

According to Booz & Company estimates based on extensive interviews with state Medicaid directors, policy analysts, health plan executives, and state-level projections and modeling, Medicaid rolls in the U.S. will likely surge to 68 million, by 2019. Approximately 10 million of the new enrollees will be in states opting in to the ACA's coverage expansion (see Exhibit 1). At the same time, 100% color

Exhibit 1
Medicaid Enrollment Growth

many states are looking to shift their current Medicaid populations from a fee-for-service (FFS) model (whereby the state pays health-care providers directly for treating individual Medicaid patients) to a managed care model (whereby the states contract with a managed care organization, which is then responsible for financing healthcare services to individual Medicaid patients). We estimate that by 2019 the number of Medicaid enrollees in risk-based managed care could grow from 26 million to 47 million, and the overall market size will likely catapult from US$104 billion to $360 billion.

One subsegment of the Medicaid population in particular—those who qualify for Medicaid and Medicare—could offer the biggest, most immediate growth opportunity for health plans. These patients, known as Duals, incur $300 billion in costs through Medicare and Medicaid, only about 10 percent of which is currently handled through managed care. But that may change rapidly. The Centers for Medicare & Medicaid Services (CMS) believes that working with states and coordinating between Medicare and Medicaid on funding and care issues can lead to significant cost savings and better outcomes.

To this end, CMS—in conjunction with individual states—recently introduced two demonstration programs. In the first demonstration program, CMS awarded federal grants to 15 states to organize proposals for integration of Duals. In the second demonstration program, a three-way contract that involves the state; CMS; and either MCOs, ACOs, or primary care case management organizations will cover healthcare for Duals. So far, more than 23 states have applied to participate, and more than 1 million Duals could be covered. Booz & Company estimates the managed care organization market size for Duals-eligibles to be between $86 billion and $183 billion in the next five years, largely depending on state preferences for managed care models and CMS’s decision on which states will be included in the second demonstration program (see Exhibit 2, page 5).

The markets for Medicaid patients and Duals may be a compelling opportunity, but they are also fraught with risk and uncertainty. Even MCOs experienced in delivering services to the poor and disabled must carefully assess the new cost and revenue pressures embedded in the emerging landscape for Medicaid and Duals. On the cost side, broader ACA eligibility and CMS initiatives will change the mix of the Medicaid population to higher proportions of aged, blind, and disabled patients. These patients have complex care
needs and will test MCOs’ razor-thin margins. On the revenue side, health plans must realistically assess state budget constraints. Some states may eventually target Medicaid reimbursement levels to reduce costs. What’s more, there will be stiff competition for Medicaid patients and Duals among multi-segment managed care organizations, Medicaid pure plays, local care-delivery systems, and third-party care coordination/management entities. This will invariably force very competitive pricing.

Given this complex backdrop, how should MCOs tackle the new Medicare marketplace? We propose a multistep approach. First, health plans need to perform a state-by-state analysis of the MCO Medicaid opportunity because opportunities vary significantly, especially given the Court’s ruling allowing individual states to opt out of Medicaid expansion. An MCO must then choose a “way to play” in the market, which will depend on the company’s current strengths, state-level preferences, and competitive environment. Finally, the MCO must identify and acquire the capabilities necessary to support that way to play, and then redesign its operating model to create coherence when serving the Medicaid and Duals populations.

Exhibit 2
Likely Dual MCO Market Opportunity 2016

<table>
<thead>
<tr>
<th></th>
<th>Demos in States Pursuing MCOs Only</th>
<th>MCO Market Potential (High End)</th>
<th>MCO Market Potential (Low End)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300</td>
<td>$79</td>
<td>$57</td>
<td>$28</td>
</tr>
<tr>
<td>$38</td>
<td>$22</td>
<td>$15</td>
<td>$43</td>
</tr>
<tr>
<td>$22</td>
<td>$43</td>
<td>$15</td>
<td>$64</td>
</tr>
<tr>
<td>$15</td>
<td>$64</td>
<td>$33</td>
<td></td>
</tr>
<tr>
<td>Healthcare spending</td>
<td>Spend in demo states pursing MCOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>on Duals today</td>
<td>states not covering managed care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$300</td>
<td>$22</td>
<td>$43</td>
<td></td>
</tr>
<tr>
<td>$38</td>
<td>$43</td>
<td>$64</td>
<td></td>
</tr>
<tr>
<td>$22</td>
<td>$64</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Bank of America Merrill Lynch “Dual Eligible Primer: Quantifying the Opportunity,” March 2012; Booz & Company analysis
PERFORMING A STATE-BY-STATE ASSESSMENT

According to our research, states fall into four categories with respect to managed care: those with a mature managed care market; those aggressively shifting to managed care; those with a hybrid model encompassing elements of both managed care and fee for service (FFS); and states with an FFS model.

As noted previously, states vary in their preference for managed care and their willingness to work with MCOs. Another factor to consider in an assessment is whether a state is going to opt in to Medicaid expansion, a decision that will be driven by political and budgetary factors. By understanding where each state stands on all these issues, MCOs can better target their efforts (see Exhibit 3).

The best opportunities for MCOs are in big states where an aggressive shift to managed care is under way and the Medicaid program will expand. Not only is the ACA increasing the Medicaid rolls in these states, but these states are actively looking...

Exhibit 3
State Attractiveness Heat Map for Medicaid Managed Care Opportunities
to convert their current Medicaid population to the MCO model. If, in addition, these states participate in CMS demonstrations to integrate care delivery and financing for Duals-eligibles, the opportunities for MCOs will be even greater.

Time is of the essence for players seeking to capture this potential growth. The Medicaid expansion of the ACA occurs in 2014, and many states are planning to rebid their Medicaid contracts this year and next. MCOs must act nimbly or risk missing out on this opportunity. In 2012, 16 states are issuing bids covering more than 7 million Medicaid customers and close to 1.5 million Duals. Next year, additional states will issue RFPs to cover an additional 4 million Medicaid customers and 1 million Duals. Winning these bids is crucial to establishing market share in the new landscape of Medicaid and Duals.

Choosing a Way to Play
After deciding where to target its efforts, an MCO must define a clear value proposition to take to market in order to compete with some well-established players. Multi-segment national players (including UnitedHealth Group, Aetna, and WellPoint—particularly with its recent Amerigroup acquisition announcement) as well as multi-state Medicaid pure plays (such as Centene, Molina, and WellCare) can leverage their low-cost platforms; they also have valuable experience managing the complex care needs of the Medicaid population. Medicaid pure plays have won most recent state contracts. They’ve done so by balancing cost competitiveness, quality of care management, and a good understanding of local Medicaid populations.

To win against these formidable institutions, MCOs will need to choose their way to play carefully on the basis of their own strengths in enabling care delivery, state-level preferences, and competitive environment. With this in mind, we have defined four possible ways to play:

1. Low-Cost, High-Quality Administrator: These health plans leverage a low-cost administrative platform, network, and specific care programs. Care management is very focused on quick ROI (e.g., shifting care from ERs to primary care clinics). For the most part, Medicaid pure plays, with their inherent cost-structure advantages relative to multi-segment national players, have used this approach successfully. Given Medicaid’s low margins, MCOs will need to continue to focus on low-cost, high-quality administration. However, in a departure from the past, this approach will not create a sustainable advantage for those competing broadly in all the Medicaid segments. To pursue Duals and emerging Medicaid subsegments, all players—including pure plays—will need to build a different set of care management capabilities to capture the expanded market opportunity.

2. Care-Delivery Enabler: These health plans support medical groups, hospitals, health systems, and other community-based providers with data, informatics, process guidance, intervention design, and implementation. In this model, health plans delegate the majority of care management activities—including ownership of care-delivery assets, employment of nurses and care coordinators, and so on—to their delivery system partners.

3. Hands-On Care Coordinator: These health plans go a step beyond enabling care delivery by directly owning or partnering with the care coordinators to engage providers and consumers. In some cases, these MCOs go even farther and offer their own clinics, primary care providers, and home health nurses.

4. Integrated Payor–Provider (Facilities+): These MCOs own and manage a network of provider groups and facilities, and they integrate care management across the payor and provider sites. These MCOs offer a broader spectrum of care-delivery assets than the Hands-On Care Coordinators, including specialists. This approach can help align incentives (e.g., shared savings programs, quality-of-care bonuses), organization, and information systems to drive care coordination.

The Medicaid expansion of the ACA occurs in 2014; MCO’s must act nimbly or risk missing out on this opportunity.
The Medicaid population in general, and Duals-eligible patients specifically, are quite different than the commercial population. The traditional Medicaid population is more transient with limited access to transportation and communication. Because of frequent changes in location and eligibility, preventive care is often not continuous. Chronic medical conditions and behavioral health issues are exacerbated by lifestyle challenges. On average, Duals-eligible patients have higher levels of chronic illness than other Medicare and Medicaid enrollees. They are more likely to be disabled and have higher rates of diseases such as diabetes, pulmonary disease, and stroke. They make up over half of all nursing facility residents. They have low incomes and relatively low levels of education and family and community support.

As a result, these populations must be managed differently than patients in the commercial business. For Medicaid participants and Duals, MCOs can’t take a “one size fits all” approach. They need a more flexible, tailored approach in order to identify heavy users of healthcare services and to work aggressively to manage costs associated with these patients (e.g., steering them to a clinic before they go to a hospital emergency room).

Consider that just 4 percent of the Medicaid population is responsible for 48 percent of the spending. Successful MCOs require a set of core “table stakes” capabilities to compete in the markets for Medicaid patients and Duals (see sidebar, “Identifying Table Stakes Capabilities”, page 11). In addition, MCOs need five key care capabilities to enable or deliver whole-person care to the Medicaid and Duals populations effectively and cost efficiently (see Exhibit 4, page 9).

Integrated Care Coordination: Many Medicaid and Duals-eligible members suffer from multiple chronic conditions (both medical and behavioral). Care coordination across the provider spectrum (including primary care providers, specialists, hospitals, outpatient clinics, long-term-care facilities, behavioral health providers, and substance abuse treatment centers) improves health outcomes and prevents redundancies in care and treatment. MCOs may employ or contract nursing care coordinators or provide extra reimbursement to providers for the care coordination and patient/family-engagement services.

Engagement and Outreach: To encourage Medicaid and Duals-
eligible members to adopt healthy behaviors, seek preventive care, and comply with care plans, MCOs must enable or develop the capability to engage members in more personal ways than traditional telephone outreach. Many emerging care models include a tiered outreach strategy, giving more personal service to higher-cost members with more complex health and life conditions. These include in-person home visits, provider office visits, and phone conversations.

Relationships with Care Collaborators: Many Medicaid and Duals-eligible members must cope with nonmedical issues in order to stay healthy. MCOs can help by coordinating with state agencies, social service organizations and community groups, and churches to give patients nonmedical assistance that will improve their quality of life. For instance, some organizations can arrange for meal delivery,}

**Exhibit 4**
**Whole-Person Care Model for High Utilizers**

---

**WHOLE-PERSON CARE MODEL FOR HIGH UTILIZERS**

**Behavioral Healthcare**

- Specialists
- Dietitian & Fitness Consultant
- Primary Care

**Long-Term-Care Facilities**

**Pharmacy**

**Care Collaborators**

- Community Groups
- Social Services
- State Agencies

**Aligned Incentives for Providers and Care Coordinators**

(Mission, Culture, Rewards)

**Data/Informatics-Based Claims, Clinical Data, and Consumer Engagement Data**

---

**DIMENSION OF DIFFERENCE**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A</strong> Integrated Care Coordination</td>
<td></td>
</tr>
<tr>
<td>- Care coordination across provider spectrum; specialists, hospitals, long-term-care facilities</td>
<td></td>
</tr>
<tr>
<td>- Integrated with behavioral health specialists and substance abuse organizations</td>
<td></td>
</tr>
<tr>
<td><strong>B</strong> Engagement and Outreach</td>
<td></td>
</tr>
<tr>
<td>- Encouragement of member to improve own health</td>
<td></td>
</tr>
<tr>
<td>- Multiple in-person touch points by care team, with phone calls to subset of members</td>
<td></td>
</tr>
<tr>
<td><strong>C</strong> Relationships with Care Collaborators</td>
<td></td>
</tr>
<tr>
<td>- Establishment of extended care teams that include state agencies, social service organizations, associations, etc. to supplement medical interventions</td>
<td></td>
</tr>
<tr>
<td><strong>D</strong> Incentives</td>
<td></td>
</tr>
<tr>
<td>- Alignment of care coordinator, provider incentives to ensure “active” management of cases; development of incentives for members, other care collaborators</td>
<td></td>
</tr>
<tr>
<td><strong>E</strong> Informatics</td>
<td></td>
</tr>
<tr>
<td>- Stratification of high utilizers, ability to predict the future high-risk members and track related care interventions</td>
<td></td>
</tr>
</tbody>
</table>

---

*Source: Booz & Company*
offer transportation, and help those with disabilities apply for low-income housing.

**Aligned Incentives:** To ensure proper management of cases, MCOs need to align the incentives of the care coordinator and all care providers. It’s also important to incentivize the patients themselves with food, stipends, and transportation to participate in their own healthcare.

**Informatics Provision:** MCOs should also provide patient data and analytics to identify and segment at-risk members, develop target interventions, and track the success of interventions.

**Designing a New Operating Model**
The capabilities necessary to serve the Medicaid and Duals populations will also be increasingly critical to serving subsidized individuals who are likely to “churn” between Medicaid and the new healthcare exchanges enacted by the ACA. In other words, many of the capabilities necessary for serving all three of these populations are converging. This has significant implications for an MCO’s operating model.

Today, health plans with a Medicaid business and a commercial group business run them as separate entities with few overlapping capabilities. However, in the future, the Medicaid side of the business may be reorganized to facilitate capability sharing and coherence across Medicaid, Duals, Medicare, and individual segments. (Coherence is the extent to which capability systems are shared among the different segments and services that a health plan participates in. We have observed that companies that have higher coherence tend to outperform their competitors.)

As part of the operating model redesign, an MCO must identify which capabilities it needs but does not possess and determine how to acquire those capabilities: whether to buy them, build them, or partner with someone to access them. Each method has trade-offs in terms of cost, complexity, and time to market. Developing an internal solution might be the least expensive route, but development time might be too long or uncertain; buying the capability might be a quick go-to-market strategy, but the cost might be too high; and partnering might be relatively quick and cheap, but integration issues could be daunting.

---

**As part of the operating model redesign, an MCO must identify which capabilities it needs but does not possess.**
Identifying Table Stakes Capabilities

No matter what the chosen way to play, to compete in the Medicaid and Duals marketplaces, an MCO must develop and tailor a large set of “table stakes” capabilities that span the Medicaid value chain—activities in the front, middle, and back offices, as well as corporate/shared-services functions.

In the front office (e.g., product development and pricing, sales and marketing, account management, and setup eligibility), critical capabilities include an ability to tailor products to state program needs, competitive pricing and bids based on market and state intelligence, continuous reevaluation of products on the basis of regulatory changes, and strong embedded government relationship/sales team work on RFP bids.

In the middle office (e.g., network management, pre-certification and pre-authorization, care coordination, medical cost management, and disease case management), critical capabilities include an ability to manage the Medicaid population; data, tools, and processes to pre-authorize care in a flexible manner; ability to identify high-risk individuals proactively and coordinate care across medical and behavioral health providers; ability to interact with patients in a culturally appropriate manner; development of a low-cost network of providers; collaboration to improve efficiency and results; and ability to network with state agencies, community groups, and social services.

In the back office (e.g., customer service, claims processing, accounts receivable/payable, and enrollment and fulfillment materials), critical capabilities include highly automated, lean, and flexible claims operations and customer service functions that are tailored to state-specific needs; integrated infrastructure linked to claims systems; tools and platforms that support high-frequency activities; and platforms and channels that redirect common questions from patients to interactive voice response and Web portals.

Within the corporate/shared-services functions (e.g., legal compliance, information analytics, and IT platform), critical capabilities include translation of state program requirements into business rules and operations; process controls and testing protocols that can identify areas of risk and potential noncompliance; data analytics and tools that can support complex scenario analysis and predictive modeling; and platform flexibility that can support basic requirements that may differ by state and that can be easily reconfigured.
These are significant strategic decisions, and the answers will be different for each company. But one thing is certain: MCOs do not have the luxury of time. Most major elements of the ACA go into effect in 2014, many states are rebidding their Medicaid contract this year and next, and the CMS is pushing forward with its Duals demonstrations.

Not all MCOs will want to participate in the Medicaid and Duals markets. That’s understandable given the serious challenges inherent in serving the poor, old, and disabled populations—not to mention the competitive pricing environment and uncertainties regarding reimbursement levels from budget-strapped states.

However, for those MCOs that do want to work in these markets, there is no time to lose. They must act nimbly to choose their way to play, put the necessary capabilities in place, and align operations to create coherence for the converging needs of the Medicaid, Duals, and subsidized individual segments. The challenges are significant, but the growth opportunity is enormous.
Sanjay B. Saxena, M.D., is a partner with Booz & Company based in San Francisco, where he co-leads the firm’s North American hospital and health systems practice. He advises healthcare clients on strategy development and capability building, specializing in payor–provider collaboration, next-generation payment models, and care-delivery innovation.

Sundar Subramanian is a principal with Booz & Company based in New York. He co-leads the firm’s Medicaid/Medicare Center of Excellence and specializes in developing strategy and operating models for health plans and services companies.

Jennifer Yaggy is a senior associate with Booz & Company based in New York. She specializes in strategy in the payor and provider sectors, with a particular focus on care management and consumer engagement.
Booz & Company is a leading global management consulting firm focused on serving and shaping the senior agenda of the world’s leading institutions. Our founder, Edwin Booz, launched the profession when he established the first management consulting firm in Chicago in 1914. Today, we operate globally with more than 3,000 people in 60 offices around the world.

We believe passionately that essential advantage lies within and that a few differentiating capabilities drive any organization’s identity and success. We work with our clients to discover and build those strengths and capture the market opportunities where they can earn the right to win.

We are a firm of practical strategists known for our functional expertise, industry foresight, and “sleeves rolled up” approach to working with our clients. To learn more about Booz & Company or to access its thought leadership, visit booz.com. Our award-winning management magazine, strategy+business, is available at strategy-business.com.

©2012 Booz & Company Inc.