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Incentivizing Care Coordination in Managed Care

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Care coordination for children remains one of the least-understood, widespread practice and policy interventions in pediatrics. In "Medicaid Managed Care Structures and Care Coordination: A National Cross-Sectional Analysis," Gilchrist-Scott and colleagues examine the degree to which state penetrance of Medicaid managed care structures (specifically, health maintenance organizations [HMOs] versus primary care case management [PCCM]) may incentivize care coordination. They find that states with lower HMO and higher PCCM penetrance exhibited greater care coordination on 2 parent-reported National Survey of Children's Health (NSCH) metrics: access to care coordination and receipt of care coordination when needed. Given that NSCH data were cross-sectional and penetrance data were aggregated by state, no causal inferences can be made, but the findings are intriguing nonetheless.

From low to high quintiles of HMO penetrance (and, conversely, from high to low quintiles of PCCM penetrance), access to care coordination fell roughly 5 percentage points, and receipt of care coordination when needed fell roughly 10 percentage points. This finding is not subtle and suggests that the choice of incentive structure may matter.

Nor is this finding surprising, given the incentive structures themselves. Unlike PCCM, fully capitated HMOs incentivize care coordination indirectly. The incentive exists only if there is a belief that care coordination creates downstream cost savings for the organization. However, over the entire population of children (even when restricted to Medicaid-insured children), this belief is largely evidence-free. Although one might justifiably argue that care coordination improves important processes of care and patient experiences, whether these improvements create general reductions in health care use is unknown. For children who have few or noncomplex health problems, short- to intermediate-term financial savings seem unlikely to materialize. For them, the most defensible justification for care coordination may be quality for its own sake: adherence to principles and practices that maximize health care's ability to contribute to lifelong health. Furthermore, some HMO care coordination practices aimed at reducing use may not even be visible to patients (eg, recommendations to physicians about patients who frequently use emergency department services). These efforts would not be captured in this study's patient-centered care coordination measures. Therefore, the finding that care coordination is lower in states with high HMO penetrance seems entirely logical, given the populations being considered, the care coordination being measured, and the incentives in play.

The same is not necessarily true, however, for children with special health care needs (CSHCN), especially children with medical complexity (CMC). A growing body of literature suggests that care coordination, in conjunction with other components of the patient-centered medical home, not only may improve health outcomes for CMC and some CSHCN but may also produce substantial health care cost

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savings in capitated environments.[1–4] For these children, HMO incentives may align with care coordination much better than for children as a whole.

For HMOs, then, the most cost-effective system might entail targeted care coordination for CMC and certain CSHCN who frequently use emergency departments and are admitted to hospitals; in a typical Medicaid HMO, this group might constitute only 5% to 10% of children. Depending on how PCCM incentives are structured, similar targeting in PCCM systems might also prove cost-effective.

In practice, care coordination in most systems may already be aimed at chronically ill children. The growing number of complex care programs, for instance, suggests not only that care coordination is increasingly being directed toward the most complex patients but also that it is increasingly being directed away from noncomplex ones. Gilchrist-Scott and colleagues may have inherently incorporated some of this targeting into their own study; they used 2 NSCH care coordination measures that were legitimately skipped by more than half of respondents because of a lack of parent-expressed need for care coordination.

If a care coordination system built on a goal of cost savings will, for now at least, funnel HMOs (and perhaps some PCCMs) into care coordination targeted at patients who frequently use emergency departments and are admitted to hospitals, then we must advance the national discussion regarding long-term goals of care coordination policies. What are we trying to achieve, and for whom? Is care coordination for patients who frequently use emergency departments and are admitted to hospitals the best use of limited resources? Or is it an intermediate way station on the road to a universal patient-centered medical home? If so, then what outcomes outside of health care cost savings should we measure to justify that larger investment? Or does the patient-centered medical home mean something different for different groups of children? Should care coordination for other children revolve instead around coordination between health care providers and social service providers, education providers, legal aides, or financial counselors? If so, then any cost savings will accrue far outside the boundaries of any traditional health care structure, and an entirely different set of financial incentives will be needed.

It is one thing to say that states with high PCCM penetrance provide more access to care coordination than states with high HMO penetration. It is another thing to say that such states are better able to provide the right types of care coordination to the right people in the right ways to improve population health.

ABBREVIATIONS

CMC: children with medical complexity
CSHCN: children with special health care needs
HMO: health maintenance organization
NSCH: National Survey of Children's Health
PCCM: primary care case management

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