

medicaid
and the uninsured

February 2010

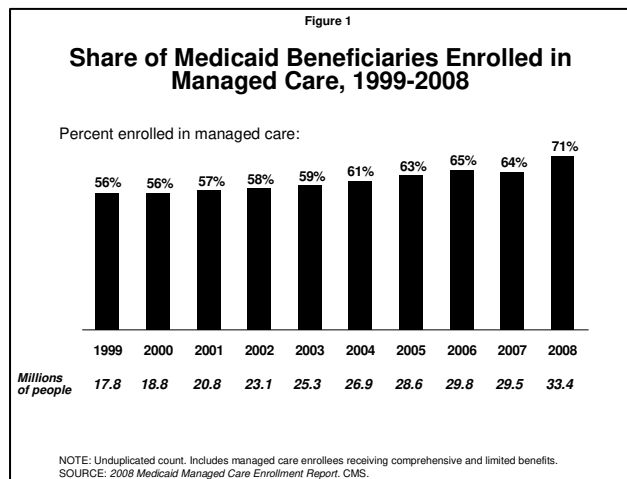
Medicaid and Managed Care:
Key Data, Trends, and Issues

Medicaid provides health and long-term care coverage to nearly 60 million low-income individuals, or roughly 1 in 5 Americans.¹ Since the 1990s, state Medicaid programs have increasingly relied on different forms of managed care to organize and deliver services to their Medicaid beneficiaries. Currently, about 70% of Medicaid enrollees receive some or all of their services through managed care.

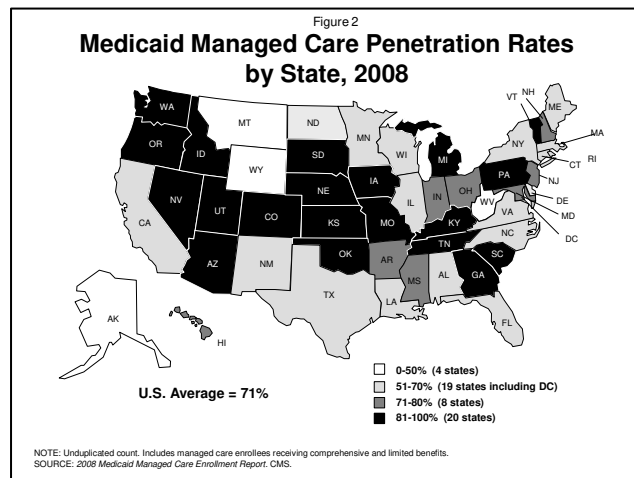
Managed care is an approach to delivering and financing health care that is aimed at both improving the quality of care and saving costs. The fundamental idea is to improve access to care and coordination of care by assuring that enrollees have a “medical home” with a primary care provider, and to rely more heavily on preventive and primary care. As distinct from the fee-for-service system, in which individual providers are paid for each service they furnish, traditional risk-based managed care systems put networks of providers at financial risk, paying them a fixed monthly “capitation” rate for each enrollee to provide all or a defined set of Medicaid-covered services. This payment arrangement provides different financial incentives to providers, and ideally, supports an approach to practice that emphasizes early identification and treatment of health problems and coordinated management of patients’ conditions. Capitation also gives states more cost predictability and control, and contracts with managed care plans offer states a mechanism, through quality measurement and improvement requirements, for holding plans accountable for the quality of care they provide to Medicaid enrollees.

Medicaid managed care enrollment

The number of Medicaid beneficiaries in managed care, which rose significantly during the 1990s, nearly doubled in the most recent decade, growing from 17.8 million as of June 30, 1999 to 33.4 million as of June 30, 2008.² Over this period, the share of Medicaid enrollees in managed care arrangements also increased substantially, from 56% to 71% (Figure 1). Following fairly steady growth of 1 to 2 million annually since 1999, Medicaid managed care enrollment was flat between 2006 and 2007. Between 2007 and 2008, reflecting major expansions of Medicaid managed care in several states, enrollment grew by nearly 4 million, and the percentage of Medicaid beneficiaries in managed care rose from 64% to 71%.³



All states except Alaska and Wyoming have some portion of their Medicaid population enrolled in managed care, and managed care is the dominant care delivery system in most state Medicaid programs. Forty-six states and DC have more than half their enrollees in managed care (Figure 2); in 20 of these states, over 80% of the Medicaid population is enrolled in some form of managed care.



Medicaid managed care spending

Reflecting the ongoing growth in managed care enrollment, Medicaid managed care spending has also grown, both in total dollars and as a share of Medicaid spending. From 2000 to 2007, Medicaid managed care expenditures more than doubled, rising from \$27 billion to \$61 billion, and managed care spending as a proportion of all Medicaid spending for acute care (including prescription drugs) rose from 26% to 34%.⁴ Still, managed care spending as a share of total Medicaid spending on services is low (20% in 2007) compared to the roughly two-thirds of Medicaid beneficiaries who are enrolled in managed care. This reflects the fact that managed care enrollment is dominated by families and children, whose costs tend to be low, and that many of the highest-cost Medicaid beneficiaries (i.e., the elderly and disabled) and services (e.g., long-term care) remain in the fee-for-service sector.^{5 6}

State options to use Medicaid managed care

State Medicaid programs have long had authority to give beneficiaries an option to enroll in managed care plans on a *voluntary* basis. Until the late 1990s, however, states had to have a federal waiver to *mandate* managed care enrollment. Over half the states (27) have 1915(b) waivers that permit them to mandate managed care in certain regions of the state, for certain categories of beneficiaries, or for certain services (e.g., behavioral health care). Seventeen states have implemented statewide mandatory managed care under section 1115 waivers, as part of comprehensive health reform demonstrations (AR, AZ, DE, FL, HI, IN, KY, MA, MD, MN, NY, OK, OR, RI, TN, UT, and VT).

The Balanced Budget Act (BBA) of 1997 gave state Medicaid programs new authority to mandate managed care enrollment without a waiver, except for children with special needs, Medicare beneficiaries, and American Indians. Twenty states and DC now operate at least some of their managed care program under this new option – up from 10 states in 2002.⁷ At the same time the BBA granted states this new authority, the law established standards for managed care plan quality and solvency and added new protections for beneficiaries in Medicaid managed care. The BBA also eliminated Medicaid’s longstanding “75/25” rule, which, to help ensure quality, required that 25% of a Medicaid plan’s enrollment be commercially insured. This change paved the way for the emergence of Medicaid-dominated and Medicaid-only managed care plans.

Medicaid managed care models

States use an array of managed care arrangements in Medicaid, but the two basic forms, described below, are risk-based plans and primary care case management programs. Between

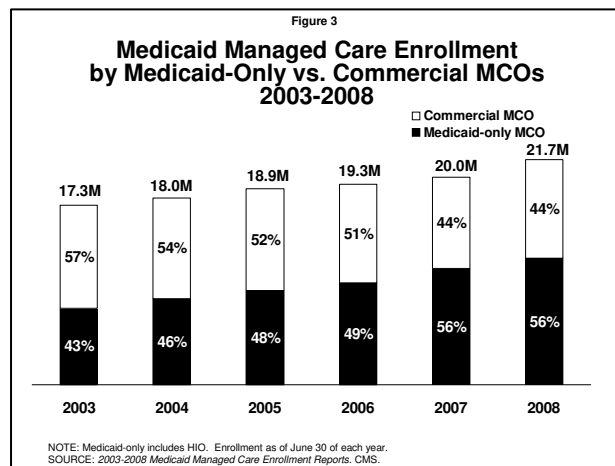
full-risk plans and primary care case management programs stretches a continuum of managed care arrangements that borrow, adapt, and blend different aspects of the two approaches. Medicaid managed care continues to evolve as states try out new models of care organization, delivery, and financing.

Risk-based. Risk-based managed care organizations (MCO) are paid a fixed monthly fee per enrollee (capitation) and assume the financial risk for delivering a set of services. Some MCOs are at risk for comprehensive services (full-risk); others contract on a prepaid basis for a limited scope of services, such as ambulatory care, inpatient care, dental care, mental health care, or transportation (prepaid, partial-risk). Beneficiaries may be enrolled in multiple managed care arrangements, receiving different kinds of services in different plans. As of June 30, 2008, 21.7 million Medicaid beneficiaries – 49% of all beneficiaries that month, and 65% of all those in managed care – were enrolled in 307 full-risk plans in 34 states and DC.⁸

Primary Care Case Management (PCCM). PCCM programs are a blend of fee-for-service and conventional managed care. The state contracts with a provider – usually the Medicaid beneficiary’s primary care physician – to provide basic care and to coordinate and authorize any needed specialty care or other services furnished by other physicians or managed care plans. The primary care physician is paid a small case management fee per person per month, and other services are usually paid on a fee-for-service basis. As of June 30, 2008, 29 states operated 35 PCCM programs with enrollment of 6.7 million Medicaid beneficiaries. In rural areas, where low population density and limited availability of providers make MCOs less likely to operate, PCCM is the predominant form of Medicaid managed care.⁹

Growth of Medicaid-dominated MCOs

Following substantial exit by commercial MCOs from Medicaid beginning in the late 1990s, Medicaid-only and Medicaid-dominated MCOs – plans whose enrollment is at least 75% Medicaid, CHIP, or other publicly insured individuals – have become an increasingly important factor in Medicaid managed care. Many of these MCOs are owned by safety-net hospital or clinic systems that have traditionally served the low-income population, while others are multi-state, publicly traded corporations that have chosen to specialize in the Medicaid market. While Medicaid enrollment in commercial MCOs has been essentially level since 2003 (the earliest year for which data are available), enrollment in Medicaid-only MCOs has climbed steadily and, in recent years, has exceeded Medicaid enrollment in commercial plans. As of June 30, 2008, enrollment in Medicaid-only MCOs totaled 12.1 million and accounted for over half of all Medicaid enrollment in full-risk plans (Figure 3).¹⁰



Emerging trends in Medicaid managed care

Until relatively recently, mandatory managed care was largely limited to children and families in Medicaid. However, many states now mandate or offer managed care for more complex Medicaid populations, including children and adults with disabilities and chronic illnesses, persons with

HIV/AIDS, and “dual eligibles” – low-income seniors and severely disabled individuals who are covered by both Medicare and Medicaid. As of June 30, 2008, nearly one-third of dual eligibles received at least some services through Medicaid managed care. As states have extended Medicaid managed care to higher-need populations, they have pioneered different models of managed care. Two major innovations, discussed in more detail below, are enhanced PCCM programs and plans that integrate the delivery and financing of health and long-term care services for dual eligibles.

Enhanced PCCM. A growing number of states are building additional features into their PCCM programs that enhance the ability of primary care providers to coordinate and manage care for beneficiaries with chronic physical and mental illnesses and disabilities. The idea is to enable PCCM programs to improve care for high-cost, high-risk enrollees and save costs by performing the same kinds of care coordination and management functions that are associated with MCOs. Some states target their enhanced PCCM programs to individuals with specific conditions, while others target individuals with multiple conditions. States use different resources to conduct care coordination and management, including state staff, community-based networks, contractors, and physician practices; they also use different mixes of clinical and social services staff. To support intensive care coordination and management, states are using provider payment incentives, provider profiling focused on quality and access, and performance monitoring and reporting.¹¹ An evaluation of enhanced PCCM programs in five states (OK, NC, PA, IN, AR) indicates that they may perform as well as or better than capitated MCOs on measures of access, cost, and quality if sufficient resources are devoted to their design, implementation, management, and funding. At the same time, lack of direct control over hospital use – primary care providers were not at financial risk for hospitalization and the programs had no contracts with hospitals to give them leverage over utilization – was an obstacle to achieving savings.¹²

Integration of Medicare and Medicaid services for dual eligibles. Dual eligibles, whose health care needs are complex and costly, often face fragmented care because Medicare and Medicaid, the two programs that cover them, are not coordinated in terms of either services or financing. Some state Medicaid programs mandate managed care for dual eligibles under a waiver, while others have voluntary managed care for dual eligibles. In Medicare, managed care is voluntary. Although there is not large-scale enrollment of dual eligibles into fully integrated programs, states are trying to improve coordination of their care through different approaches to integrating Medicare and Medicaid under managed care. Some approaches rely on capitation, while others rely on fee-for-service with alternative payment systems that foster coordination.

Medicare Advantage Special Needs Plans (SNP), which were authorized by federal law to serve targeted Medicare subpopulations, including dual eligibles, offer one vehicle for facilitating Medicare/Medicaid integration. However, while nearly 1 million dual eligibles were enrolled in dual eligible SNPs as of August 2009, most of the plans were providing only Medicare services to them. Few states had Medicaid contracts with dual eligible SNPs to provide some level of integration across the two programs.¹³

The Program of All-Inclusive Care for the Elderly (PACE) integrates both acute and long-term Medicare and Medicaid services under a coordinated set of federal rules outlined in Medicare and Medicaid law and regulations. PACE is limited to people who need a nursing-facility level of care and services are provided at a site that is also an adult day center.¹⁴ There are about 50 PACE programs nationwide and total enrollment is only about 16,000.¹⁵

Several states have developed other integration projects, which vary in design and in the scope of services covered. Some states require MCOs that participate in their Medicaid/Medicare integration projects to be certified as SNPs plans as well, to support integrated care and delivery. In other cases, Medicaid MCOs may offer a companion Medicare plan for dual eligibles, with integration occurring at the plan level. In some state projects, MCOs integrate all Medicaid and Medicare services for dual eligibles, while in others the plans integrate all Medicare and Medicaid acute care services, with some or all long-term care services remaining in Medicaid fee-for service.^{16 17}

Two new demonstration authorities offer possible additional approaches to integration. Under “gainsharing” demonstrations, physician networks, integrated health systems, and others would join to provide services to dual eligibles on a fee-for-service basis, with Medicare/Medicaid integration supported by a care management fee paid to the provider network and the reinvestment of Medicare savings. Under “Medicaid Duals Demonstrations,” states could receive Medicare funding and assume risk for managing both Medicare and Medicaid benefits.

Assuring access and quality in Medicaid managed care

Standards and protections. Although no comparable standards or monitoring procedures are required in Medicaid fee-for-service arrangements, including PCCM, states are required by the BBA to develop and implement access standards and have a written strategy for assessing and improving quality in MCOs. MCOs must have ongoing quality assessment and improvement programs that include certain elements. The BBA maintained the requirement for external quality review of Medicaid MCOs and specified minimum criteria for the entities that can perform this function. Federal rules also provide enrollee protections related to access to emergency and specialist care, specify information that states or plans must provide to potential enrollees, and outline grievance and appeal processes that Medicaid-participating MCOs must develop and implement. Although not required by federal law, some states have developed quality monitoring initiatives for their PCCM arrangements.

Measurement and public reporting. Important tools have evolved to measure quality in Medicaid managed care. The Health Plan Employer Data and Information Set (HEDIS) is a national set of quality, access, and effectiveness-of-care measures for managed care that has been adapted to include measures applicable to the Medicaid population. The Consumer Assessment of Health Plans Survey (CAHPS), a set of surveys to capture consumers’ experience and satisfaction with MCOs, includes surveys designed for children and adults in Medicaid managed care. In FY 2009, 36 states used HEDIS or similar measures to monitor quality in MCOs, while 18 states used such measures in PCCM; 34 states used CAHPS or similar surveys in MCOs, and 17 did so in PCCM.¹⁸

In FY 2009, 29 states reported that they published data on health plan performance on a website, in a report, or in the form of a report card, to help Medicaid enrollees choose a health plan.¹⁹ A 2007 study of publicly reported plan performance on eight HEDIS measures showed that quality tended to be better in non-profit versus for-profit plans, in provider-owned versus other Medicaid-dominated plans, and in larger versus smaller plans. No patterns were found regarding Medicaid-dominated versus commercial MCOs.²⁰ Other research indicates that states are much less likely to collect and report performance data for PCCM programs than for MCOs, and that states tend to emphasize utilization results over quality-measure results for PCCM.²¹

Evidence. Managed care aims to improve access to primary care and use of preventive care. Research on the relationship between Medicaid managed care and beneficiary access has produced mixed evidence. Some studies show improved access and reduced avoidable hospitalizations in managed care relative to fee-for-service, other studies show worse results in

managed care, and still others show no consistent effect of managed care on access. Findings also vary based on the access measures and type of managed care studied.

Issues in Medicaid managed care

Interruptions in Medicaid enrollment. Continuous coverage is fundamental to the potential of organizations to improve care quality and outcomes through better management of care. Churning in Medicaid eligibility is thus a major challenge. Overall, Medicaid enrollees receive Medicaid coverage for about three-quarters of the year.²² Coverage periods are somewhat longer for those with disabilities, the elderly, and children, but shorter for non-disabled, working-age adults. Some states require more frequent Medicaid recertification than federal law requires, as a means of dampening enrollment. This short-term cost-cutting measure causes interruptions in Medicaid eligibility, a result at odds with the conceptual framework for managed care.

Data needs for analysis and evaluation. The only data that CMS currently produces on Medicaid managed care is an annual enrollment report that is limited to national summary data and state- and entity-specific enrollment statistics. While federal law and CMS require states to collect and report encounter data from MCOs – data necessary to analyze and monitor MCO utilization and access levels, variation, etc., and to track costs and support rate-setting efforts – CMS has not enforced this requirement, issued standards, or provided states with technical assistance.²³ As a result, there is no national database that can be used to analyze important Medicaid managed care measures. Current federal reporting systems (i.e., the Medicaid Statistical Information System or MSIS) capture only the lump-sum payments made to capitated plans on behalf of Medicaid beneficiaries, and lack the utilization, access, and spending data necessary to track and evaluate the care that Medicaid enrollees in capitated plans receive.

Although the states collect encounter data from plans, they generally lack adequate budget and analytic resources to maximize their use of them. Without a national database, there is no ability to develop a comprehensive picture of Medicaid managed care or support proper oversight and policymaking. As more, and more medically complex, Medicaid beneficiaries are enrolled in managed care, the need for data becomes more pressing. Without new federal resources, data infrastructure, and analytic investments, the utilization experience of beneficiaries in managed care will remain a “black box,” hobbling efforts to evaluate and ensure access and quality in Medicaid managed care and increase plans’ accountability for the Medicaid payments they receive.

Some efforts are underway at the federal level to collect HEDIS results from as many Medicaid MCOs as possible, to develop benchmark data that the federal government and states can use to monitor, compare, and drive quality improvement in Medicaid plans.²⁴ Benchmark data can also help policymakers, researchers, and others understand variation and trends in managed care plan performance.²⁵

Appropriate payment. Federal Medicaid rules require that capitation rates be “actuarially sound” – sufficient to ensure that plans can provide appropriate access and care for their Medicaid enrollees. This requirement has largely protected MCOs from reductions that some states, under recessionary pressures, have made in other Medicaid provider payment rates. The adequacy of Medicaid rates is uniquely important to Medicaid-focused MCOs, which cannot cross-subsidize their Medicaid enrollment with premiums from commercial enrollees.²⁶

To shield plans from excessive risk, most contracts now include formal risk adjustment based on the health status and resource use of their enrollees, risk corridors, or stop-loss provisions. Rate-setting for managed care arrangements that integrate Medicare and Medicaid services is particularly complicated by issues including coordination challenges, limited state experience

with rate-setting for long-term care, and setting rates to promote policy goals such as community-based delivery of long-term care.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established a new Medicaid and CHIP Payment and Access Commission (MACPAC), charged with reviewing Medicaid and CHIP payment policies (which include managed care payment policies) and examining their impact on access to and quality of care for children. MACPAC must also assess the implications of health care delivery and marketplace changes for beneficiaries' access, and develop an early warning system to identify provider shortage areas and other threats to access. Funding for MACPAC has not yet been provided.

Looking ahead

As efforts to broaden coverage advance, Medicaid will likely be the primary vehicle for expanding coverage to millions of low-income, uninsured Americans – primarily working-age adults. It seems likely that many states would rely on managed care to deliver services to their new Medicaid beneficiaries, and the current Medicaid managed care market could change sharply depending on how plans respond.

The possibility of a major expansion of Medicaid underscores both the opportunities and challenges associated with Medicaid managed care. Managed care could translate into access to needed care for a long-underserved adult population. Alternatively, if plan or provider participation is inadequate, Medicaid eligibility is unstable, or the unique needs of the Medicaid population are overlooked, concerns about access could grow.

The potential role of Medicaid in coverage expansions heightens the need for federal investments to collect and use data on Medicaid managed care strategically, to monitor and safeguard beneficiary access and care, hold plans accountable for performance improvement, and promote value-based purchasing with state and federal Medicaid dollars.

¹ www.statehealthfacts.org Data downloaded January 5, 2010.

² 2008 Medicaid Managed Care Enrollment Report, Summary Statistics as of June 30, 2008. 2009. Centers for Medicare and Medicaid Services (CMS).

³ Ibid.

⁴ Holahan et al. 2009. *Medicaid Expenditures Increased by 5.3% in 2007, Led by Acute Care Spending Growth*. Kaiser Commission on Medicaid and the Uninsured.

⁵ *Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies*. 2009. The Lewin Group, for AHIP.

⁶ Herz. 2006. *Medicaid Managed Care: An Overview and Key Issues for Congress*. Congressional Research Service.

⁷ Kaye. 2005. *Medicaid Managed Care: Looking Forward, Looking Back*. National Academy for State Health Policy; 2008 Medicaid Managed Care Enrollment Report.

⁸ 2008 Medicaid Managed Care Enrollment Report.

⁹ Silberman et al. 2002. "Tracking Medicaid Managed Care in Rural Communities: A Fifty-State Follow-Up." *Health Affairs*.

¹⁰ 2008 Medicaid Managed Care Enrollment Report.

¹¹ Verdier et al. 2009. *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*. Center for Health Care Strategies.

¹² Ibid.

¹³ Bella and Palmer. 2009. *Encouraging Integrated Care for Dual Eligibles*. Center for Health Care Strategies.

¹⁴ Stone and Tritz. 2007. *Integrating Medicare and Medicaid Services Through Managed Care*. Congressional Research Service.

¹⁵ 2008 CMS Enrollment Report.

¹⁶ Stone and Tritz.

¹⁷ Edwards et al. 2009. *Integrating Medicare and Medicaid: State Experiences with Dual Eligible Medicare Advantage Special Needs Plans*. AARP Public Policy Institute.

¹⁸ Smith et al. 2009. *The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession, Results of a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010*. Kaiser Commission on Medicaid and the Uninsured.

¹⁹ Ibid.

²⁰ Felt-Lisk et al. 2007. "Public Reporting of Quality Information on Medicaid Health Plans." *Health Care Financing Review*.

²¹ Schneider et al. 2004. "Quality Oversight in Medicaid Primary Care Case Management Programs." *Health Affairs*.

²² Ku et al. 2009. *Improving Medicaid's Continuity of Coverage and Quality of Care*. 2009. George Washington University Department of Health Policy, for Association for Community Affiliated Plans.

²³ *Medicaid Managed Care Encounter Data: Collection and Use*. 2009. USDHHS Office of Inspector General.

²⁴ Ku et al.

²⁵ Felt-Lisk. 2000. *Monitoring Quality in Medicaid Managed Care: Accomplishments and Challenges at the Year 2000*. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*.

²⁶ Catterall et al. 2006. *Rate Setting and Actuarial Soundness in Medicaid Managed Care*. 2006. The Lewin Group, for Association for Community Affiliated Plans and Medicaid Health Plans of America.

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