kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

POLICY BRIEF

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Medicaid Managed Care: Key Data, Trends, and Issues

Medicaid, the public health insurance program for low-income people, covered nearly 60 million Americans, or about 1 in 5, for at least some time during FY 2008. Under the Patient Protection and Affordable Care Act (ACA), beginning in 2014, Medicaid will expand to cover nearly all Americans with income below 133% of the federal poverty level, reaching an estimated 16 million uninsured people, mostly adults, by 2019. Since the early 1980s, states have relied increasingly on managed care arrangements to serve their Medicaid beneficiaries. Two-thirds of Medicaid enrollees now receive most or all of their benefits in managed care, and many states are expanding their use of managed care to additional geographic areas and Medicaid populations. Given Medicaid's large and growing coverage role and the increasing dominance of managed care in the program, this current profile of Medicaid managed care (MMC) offers a key policy resource.

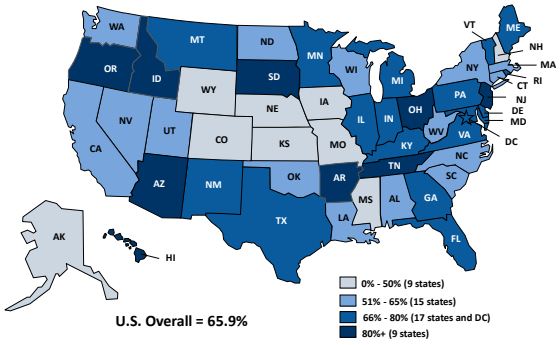
Prevalence of managed care in Medicaid

In a recent 50-state survey, all states except Alaska, New Hampshire, and Wyoming reported operating comprehensive MMC programs as of October 2010.[1] Thirty-six states (including DC) contract with managed care organizations (MCOs) on a risk basis and 31 operate a Primary Care Case Management (PCCM) program. In addition, half the states, including those with MCOs and/or PCCM programs, contract with health plans that provide only specific categories of services, such as behavioral health care, dental care, non-emergency transportation, or prescription drugs.

Nationally, over 26 million Medicaid beneficiaries are enrolled in MCOs, and another 8.8 million are enrolled in PCCM programs. Together, these beneficiaries represent 65.9% of all Medicaid beneficiaries, but managed care penetration varies considerably by state (Figure 1). Although half of Medicaid beneficiaries are enrolled in MCOs, payments to MCOs account for only about 20% of total Medicaid spending on services. This is because disabled and elderly beneficiaries, who account for most Medicaid spending, largely remain in fee-for-service (FFS), and because expensive services, such as nursing home care, are typically excluded from MCO contracts.

Figure 1

Comprehensive Medicaid Managed Care Penetration by State, October 2010



NOTE: Includes enrollment in MCOs and PCCMs. Most data as of October 2010.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Medicaid beneficiaries enrolled in managed care

Many states have long mandated managed care for most children, pregnant women, and parents, who make up a large majority of both total Medicaid enrollment and total MMC enrollment. As of 2008, a large majority of Medicaid children were enrolled in either risk-based MCOs (60%) or PCCM (19%). The MCO and PCCM shares among non-disabled Medicaid adults were 44% and 9%, respectively; disabled and aged beneficiaries were far less likely to be in managed care, especially in risk-based MCOs.[2] Notably, more and more states are expanding mandatory MMC to include beneficiaries with greater health care needs, a development that raises special issues.[3] A majority of states now report that, for at least one MMC program or geographic area, enrollment is mandatory for children with disabilities, children with special health care needs, and/or seniors and adults with disabilities who are not dually eligible for Medicare and Medicaid. In addition, half the states enroll individuals

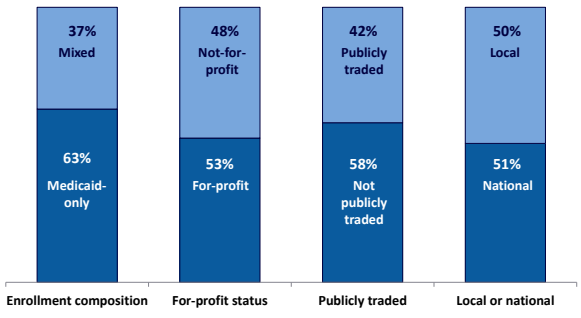
who are dually eligible for Medicare and Medicaid ("dual eligibles") in MMC for some or all Medicaid services, on either a voluntary or mandatory basis.[4] Over the next few years, under its "Bridge to Reform" waiver, California will enroll up to 400,000 non-dually eligible seniors and people with disabilities in MMC. CMS recently approved Texas' plan to mandate managed care for the 1.1 million of its 3.3 million Medicaid beneficiaries who remain in FFS. New York Medicaid officials have also outlined plans to move in this direction. These three states already account for a third of all Medicaid MCO enrollees.

Risk-based Medicaid managed care

Over 300 MCOs provide comprehensive Medicaid benefits on a risk basis. MCOs that serve Medicaid primarily or exclusively, including plans built around safety-net hospitals and health centers, have played an increasing role over time and now account for almost two-thirds of all Medicaid MCO enrollees. Over half of Medicaid MCO enrollees are in for-profit plans, some of which specialize in Medicaid and some of which have a mix of Medicaid and commercial enrollment. About 40% of Medicaid MCO enrollees are now in publicly traded plans (Figure 2).

Figure 2

Distribution of Medicaid MCO Enrollment by Selected MCO Characteristics



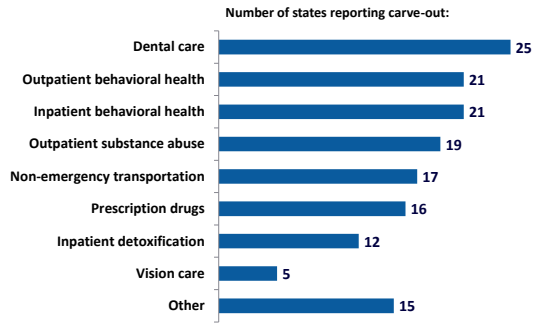
Note: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

Generally, when MMC is mandatory, beneficiaries have a choice of at least two plans. Most states contract with an enrollment broker to help beneficiaries select a plan. States "auto-assign" beneficiaries who do not choose a plan, based on factors such as which plan the person's primary care provider participates in, the plan assignment of other family members, or geographic considerations. Auto-assignment rates, which may signal how well beneficiaries understand managed care and their options, vary widely by state.

Almost all states carve out at least one acute-care benefit from their MCO contracts and provide that care to MCO enrollees on a FFS basis or under a separate risk contract with a plan that provides only those specific services. Dental care, behavioral health care, and substance abuse treatment are the most common carve-outs (Figure 3). Responding to several factors – a growing emphasis on person-centered, integrated care; the high rate of mental health co-morbidities among Medicaid enrollees; and the ACA's extension of the Medicaid drug rebate program to MCOs – some states now are revisiting or reversing their pharmacy and behavioral health carve-outs.

Figure 3

Acute-Care Benefit Carve-Outs in Medicaid MCOs



NOTE: 36 states contract with MCOs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

States pay MCOs a fixed, monthly "capitation" rate for each Medicaid enrollee. Federal law requires states to pay actuarially sound rates. Most states set rates administratively using actuaries, but others negotiate rates, set them by competitive bid, or combine approaches. Most states risk-adjust rates based on beneficiary age, sex, eligibility category, geographic location, and health status. About half also have risk-sharing arrangements with plans, such as reinsurance.

Unlike FFS, risk-based MMC is subject to extensive federal statutory and regulatory requirements regarding access to care, quality, collection of encounter data, beneficiary protection, and oversight. Many states have used managed care contracting to drive improvements in quality, holding plans accountable for measurable performance and aligning payment incentives with care delivery goals. At the same time, weaknesses in monitoring and oversight of risk-based MMC have also been documented.[5]

PCCM programs

In PCCM programs, states contract directly with primary care providers (PCPs) to provide, manage, and monitor the primary care of beneficiaries who select or are assigned to them; PCPs are also generally responsible for authorizing referrals when specialty care is needed. Most states pay PCPs a small fee to perform these functions, such as $3.00 per-member-per-month (PMPM), as well as regular FFS payments. Partial capitation and other payment arrangements also exist.

States may operate PCCM programs alongside or instead of risk-based managed care programs in Medicaid. They may use PCCM in rural areas with insufficient population to attract MCOs, or because they prefer contracting directly with providers, rather than with insurers, and have the administrative capacity to do so. Oklahoma, and more recently Connecticut, have both dropped earlier MCO contracting programs in favor of PCCM, citing issues including higher costs associated with MCO contracting, plan turnover, and comparable or better performance by PCCM on measures of quality and enrollee satisfaction.

Some states are using their PCCM programs as a platform for enhanced PCCM (EPCCM) programs or patient-centered medical homes, which incorporate features and mechanisms to strengthen care coordination, management, and integration, such as disease management, case management for high-cost/high-risk enrollees, and linkages between primary care and community-based services for targeted groups.

Managed long-term services and supports (MLTSS)

Over half the states operate risk-based PACE programs, which provide the full range of Medicare and Medicaid primary and acute medical, behavioral health, and social services, and long-term services and supports (LTSS), to frail elders who would otherwise need nursing home care. PACE enrollment totals only around 21,000. In addition to PACE, 11 states report operating additional capitated, managed long-term care programs, in which enrollment may be voluntary or mandatory. Some of these programs encompass only LTSS, often including both institutional and community-based care, while others encompass medical care, too. Most are limited to Medicaid services rather than also including Medicare services.

Managed care for dual eligibles

Half the states report enrollment of dual eligibles in non-PACE, capitated managed care arrangements, on either a voluntary or mandatory basis. CMS data indicate that about 800,000 dual eligibles were enrolled in comprehensive risk-based MCOs as of July 1, 2010.[6] For the most part, LTSS are provided outside the MCO contract, either on a FFS basis, or through a separate capitated, managed care plan. Like other Medicaid beneficiaries, dual eligibles may also be enrolled in other limited benefit plans for services, such as behavioral health care, dental care, or non-emergency transportation.

The rate of physical and mental health co-morbidities among dual eligibles is high, and they account for a large share (39%) of total Medicaid spending, underscoring the importance of coordinating and improving their care, but also compounding the challenges associated with integrating Medicare and Medicaid benefits, and acute and long-term care. The vulnerability of dual eligibles – they are both poorer and in worse health than other Medicare beneficiaries – and the lack of plan experience serving people with their needs raise special concerns about the pace of movement toward enrolling this population in capitated managed care. The CMS initiative to demonstrate models, including risk-based models, for integrating Medicare and Medicaid benefits and financing for dual eligibles, is designed to catalyze innovation in this area, but it calls for testing models rather than wide-scale implementation in the near-term.

Access and quality measurement and initiatives

All states with MCOs and most with PCCM require reporting of HEDIS©, or other performance measures, and CAHPS©, or other surveys of patient experience. Required measures focus on Medicaid priority areas, such as prenatal care, child health, preventive care, and chronic disease management. Most states with MCOs and half of

states with PCCMs publicly report on the quality of these programs. Some states prepare a MCO quality report card that beneficiaries can use to compare plans. In addition, federal rules require that states contract for independent assessments of MCO performance. These assessments focus on a wide array of topics that reflect diverse priorities across states, such as improving birth outcomes, reducing emergency room use, and improving coordination between behavioral health and medical providers. In addition, MMC programs are integral to broader initiatives in many states to address such issues as obesity, racial and ethnic disparities in care and outcomes, and non-emergency use of emergency rooms.

While access and quality measurement related to acute care and patient experience has evolved considerably, few quality measures for long-term services and supports have been developed or tested, and no national standards exist.[7] Population-specific measures are needed, as appropriate utilization patterns may vary for groups with different underlying care needs. In addition, in the context of dual eligibles, both Medicare and Medicaid data are needed to develop complete measures of access and quality.

Evidence on savings

Studies investigating the savings impact of MMC have produced mixed results. Findings appear to depend on many factors related to the specifics of states' baseline Medicaid programs and their MMC programs, and the analytic strategy used in the research. There are two potential sources of savings from MMC: reduced use of hospital and other high-cost care due to improved primary care access and care management, and lower unit prices relative to FFS payment rates. A recent national study found that the impact of mandatory MMC on Medicaid spending is a function of how generous a state's Medicaid FFS payment rates are compared to commercial rates. Where Medicaid FFS payment rates are very low, it is difficult for states to negotiate capitation rates that garner plan participation but also yield savings, and the study showed that MMC contracting in such states did not reduce spending. On the other hand, in states with relatively high Medicaid FFS rates, MMC did reduce spending below what it would otherwise have been.[8]

While managed care may be able to generate savings over time by improving access to preventive and primary care and more effective management of chronic conditions, savings from improved utilization patterns are unlikely in the short-term, and budget-driven efforts to achieve savings from managed care could have adverse consequences for beneficiaries' access to needed care.

Looking Ahead

Greater use of managed care in Medicaid is likely to continue, fueled by interest in improved care delivery and payment systems, a sharpened focus on high-cost/high-need beneficiaries, ongoing state budget pressures, and federal funding opportunities that promote person-centered systems of care, such as the Medicaid "health homes" option, and demonstrations to integrate care for dual eligibles. In addition, states preparing to serve millions more Americans when Medicaid expands in 2014 are widely expected to look to managed care for this purpose. Managed care companies are also planning for 2014, positioning themselves to participate in the large new markets created by the Medicaid expansion as well as the new health insurance exchanges.

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[1] *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, September 2011.
[2] *MACPAC Report to the Congress: The Evolution of Managed Care in Medicaid* (Table A-1), June 2011.
[3] *People with Disabilities and Medicaid Managed Care: Key Issues to Consider*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, February 2012.
[4] *A Profile of Medicaid Managed Care Programs in 2010*, op.cit.
[5] See, for example, *Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement*, Government Accountability Office, August 2010; and Burns ME, *Medicaid Managed Care and Health Care Access for Adult Beneficiaries with Disabilities,* Health Services Research, October 2009.
[6] *CMS Medicaid Managed Care Enrollment Report*, data as of July 2010.
[7] Summer L, *Examining Medicaid Long-Term Service and Support Programs: Key Issues to Consider*, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, October 2011.
[8] Duggan M and T Hayford, *Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates,* Working Paper 17236, National Bureau of Economic Research, July 2011.

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