What is managed care?

• Managed care, in general, refers to efforts to coordinate and rationalize the provision and utilization of services to achieve desired access to care, service, and health outcomes, while controlling costs.

• Risk-based managed care describes contractual arrangements in which:
  – Health plans receive a monthly premium, or capitation rate, from the insurer for each enrollee and are at financial risk for services in the contract.
  – Enrollees select a primary care provider in the plan network who coordinates their specialist and other care (in-network).
  – Out-of-network care is not covered, except for emergency services.
  – Plans use various strategies to manage utilization and control costs.

• Fee-for-service payment raises concerns about provider-generated over-utilization, while capitation payment raises concerns about under-service.
Medicaid has three major models of managed care.

- **Comprehensive risk-based managed care:** States contract with managed care organizations (MCOs) to provide Medicaid-covered benefits to enrolled beneficiaries.

- **Primary care case management (PCCM):** The state pays contracted fee-for-service physicians or practices a small additional per member per month fee to provide case management services for enrollees assigned to them. PCCM is considered a form of comprehensive managed care, although no financial risk is involved.

- **Limited benefit plans:** Many states contract with MCOs to provide limited types of services, such as prescription drugs, dental care, or inpatient and/or outpatient behavioral health care.
What motivates states to adopt managed care in Medicaid?

- Increased predictability in state Medicaid spending and potential savings
- Privatization efforts
- Plan provider networks may improve beneficiaries’ access to care
- Emphasis on preventive and primary care, chronic care management, and care coordination may lead to better outcomes and lower costs
- Selective contracting can give states leverage to secure high-performing plans and obtain favorable rates
- Plan and provider standards, incentives and penalties, and other contracting terms allow states to measure, monitor, and drive performance
States can use State Plan Amendments or seek waivers to mandate enrollment in Medicaid managed care.

- **Section 1932(a)** – **State plan authority** for mandatory and voluntary enrollment in MCOs or PCCM; selective contracting allowed; certain groups exempt from mandatory enrollment

- **1915(b)** – Renewable 2-year **waiver authority** for mandatory enrollment (for all groups) in MCOs or PCCM
  - Choice of two or more MCOs or PCPs required
  - CMS approves contracts and payment rates

- **Section 1115**: **Research and demonstration waiver authority** to test innovations to further the objectives of Medicaid
  - State must have a hypothesis and evaluate using data from demo
  - Must be budget-neutral
Almost all states operate comprehensive Medicaid managed care programs.

Note: MCO is Managed Care Organization and PCCM is Primary Care Case Management.

SOURCE: CMS Medicaid Managed Care Enrollment Report, July 2011
Two of every three Medicaid beneficiaries are enrolled in comprehensive MCOs or PCCM.

July 2011

- MCO 29.1 million (51%)
- PCCM 8.9 million (16%)
- Traditional FFS 19.1 million (33%)

Total = 57.1 million Medicaid beneficiaries

Note: MCO is managed care organization, PCCM is Primary Care Case Management, and FFS is fee-for-service.

SOURCE: CMS Medicaid Managed Care Enrollment Report, July 2011
NOTE: Comprehensive risk-based managed care includes Health Insuring Organizations, comprehensive managed care organizations (MCOs), and Program of All-Inclusive Care for the Elderly (PACE).

Source: Medicaid Managed Care Enrollment Reports, 2003-2011, CMS.
More than half of Medicaid beneficiaries nationally are enrolled in managed care plans.

Share of Medicaid beneficiaries enrolled in comprehensive risk-based plans, July 2011

U.S. Overall = 51%

NOTE: Includes Health Insuring Organizations (HIOs), comprehensive commercial and Medicaid managed care organizations (MCOs), and Program of All-Inclusive Care for the Elderly (PACE).

Payments to managed care plans account for more than one-quarter of total Medicaid expenditures.

**FY 2012 Total = $415.15 billion**

NOTE: Excludes administrative spending, adjustments and payments to the territories.
SOURCE: Urban Institute estimates based on FY 2012 data from CMS (Form 64), prepared for the Kaiser Commission on Medicaid and the Uninsured.
Medicaid-only plans dominate and more than half of MCO enrollees are in for-profit plans.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.
States are expanding their use of Medicaid managed care through a range of actions.

NOTE: States were asked to report new initiatives or expansions in these areas; this does not reflect ongoing state efforts in these areas.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2012 and September 2013.
NOTES: Data are as of August 28, 2014. *AR, IA, MI, and PA have approved Section 1115 waivers for Medicaid expansion. In PA, coverage will begin in January 2015. NH is implementing the Medicaid expansion, but the state plans to seek a waiver at a later date. IN has a pending waiver to implement the Medicaid expansion. WI amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid, but did not adopt the expansion.

SOURCES: Current status for each state is based on data from the Centers for Medicare and Medicaid Services, available here, and KCMU analysis of current state activity on Medicaid expansion.
In 8 states that expanded Medicaid as of January 2014, managed care enrollment rose by over 1.7 million from Dec. 2013-May 2014.

Note: Michigan expanded Medicaid as of April 1, 2014.
Ten of the 11 states with approved dual eligible financial integration demos are using capitated models.

As of July 2014

NOTE: MN is testing the integration of administrative functions, but without financial integration.

States must (among other responsibilities):
- Pay actuarially sound rates;
- Ensure that plan networks are adequate and appropriate, and that plan capacity is sufficient to provide timely access to covered services;
- Ensure plan compliance with federal regulations on marketing activities;
- Have written strategy for assessing and improving quality of plan services and ensure plan compliance with state standards; and
- Ensure that plans’ grievance and appeal systems meet federal requirements.

CMS reviews and approves all contracts and capitation rates.

CMS engagement on Medicaid managed care issues is increasing.
- Direct technical support is available to help states develop, implement, enhance, and evaluate managed care programs.
- CMS is expected to propose revised Medicaid managed care regulations soon.

Federal regulations on Medicaid managed care operate largely through State Plan requirements and state oversight of plans.
Government reports have raised concerns about oversight of Medicaid managed care programs.

- A 2014 GAO reported cited need for increased oversight to ensure the integrity of growing managed care expenditures.

- A 2010 GAO report found CMS was inconsistent in reviewing states’ rate-setting for compliance with actuarial soundness requirements, and CMS’ limited efforts do not ensure the quality of data used to set rates.

- A 2009 HHS/OIG report found that, while all states with MCOs were collecting and using Medicaid encounter data internally, CMS was not enforcing the requirement that states submit the data to the agency, limiting the usefulness of the data for federal oversight of Medicaid managed care programs.

“Because of the gap... between state and federal program integrity efforts in managed care, neither state nor federal entities are well positioned to identify improper payments made to managed care organizations...” (GAO, 2014)
Requiring plans to report quality data can help states assess and performance and assist beneficiary choice

- All MCO states and over half of PCCM states require reporting of HEDIS©, CAHPS©, or state-developed measures of access, clinical quality of care, and patient experience.

- Three-quarters of states with MCOs publicly report on the quality of their health plans, and half of PCCM states publish quality reports on those programs.

- Fifteen states with MCOs and one PCCM-only state prepare quality “report cards” for beneficiaries to use when choosing a plan or a provider.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.
What are the major opportunities and concerns presented by Medicaid managed care?

- **Access and continuity of care**
  - (+) Could improve if plans deliver robust networks of providers
  - (-) Could be limited or disrupted if provider networks are inadequate, beneficiaries’ regular providers are not in-network, or plans limit access to specialists

- **Incentives**
  - (+) Incentives to promote appropriate use of preventive and primary care and chronic care management to achieve better outcomes and reduce long-run costs
  - (-) Incentives to cherry-pick or underserve to maximize short-term profits

- **Accountability**
  - (+) Contracts and performance measurement are important levers for achieving accountability
  - (-) Privatization without adequate state oversight and enforcement weakens accountability; beneficiary navigation of grievance and appeals processes may be complicated by multiple layers of accountability (i.e., provider, plan/insurer, state)

- **Federal and state Medicaid spending**
  - (+) Potential savings from improved access to primary care and better chronic care management, with lower downstream costs
  - (-) Potential overpayment to plans not delivering services or under-performing
What does the research evidence on Medicaid managed care show?

- Research findings on access and quality in Medicaid managed care are mixed.
  - Results depend on specifics of state programs and populations studied.
  - Lack of fee-for-service measures of access and quality to serve as benchmarks.

- Findings on savings are also mixed, reflecting, in part, differences among states’ baseline Medicaid programs (i.e., savings compared to what?), details of their managed care programs, and study design.

- Savings can come from two sources – price and utilization:
  - Savings on price depend on state’s underlying FFS rates: states with high FFS rates may have room to negotiate lower capitation rates, while states with low FFS rates will have trouble extracting savings.
  - Savings from improved utilization patterns are unlikely in short-term; budget-driven efforts to achieve savings could lead to reduced access to care.

- Non-publicly traded plans perform significantly better than Medicaid-focused publicly-traded plans on clinical quality measures and consumer experience, and have lower administrative costs and higher medical loss ratios.
Managed care presents special concerns regarding people with disabilities and complex care needs.

- Both the potential for improvements in access and care and exposure to under-service and quality problems are heightened for people with complex needs for medical care and long-term services and supports.

- Managed care experience with people with disabilities and others with special needs is still limited and evidence from research is scant.

- Standard measures of access, quality, and outcomes may not be appropriate or adequate for people with disabilities.

- Few standard measures of access and quality exist for long-term services and supports exist and evidence on impact of managed LTSS on costs or outcomes is limited and inconclusive.
States are testing other new approaches to delivering care, in addition to managed care.

NOTES: States reported new initiatives in these areas; this does not reflect ongoing state efforts in these areas.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2013.
Looking ahead

- Medicaid expansion creates large new markets for plans and firms.

- Growing strains on primary care capacity and shortages in some specialties raise concerns about access to care.

- Increasing industry consolidation has uncertain implications for beneficiary access, competition and choice, plan performance, and state and federal costs.

- New federal regulations are on the horizon.

- Watch for a new Medicaid Managed Care Tracking tool on [www.kff.org](http://www.kff.org).
For more information on the Medicaid and managed care, visit...

www.kff.org
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