

HEALTH CARE**Medicaid Managed Care**

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The Medicaid program was enacted in 1965 as a joint federal and state government program to provide health care for the nation's poorest people. Rising health costs over the three decades since its implementation have caused policy-makers repeatedly to examine ways to rein in expenditures. State governments began experimenting with managed care programs for their Medicaid populations decades ago, but due to greater federal government flexibility in recent years, the number of state Medicaid managed care programs has exploded. Less than 10 percent of the Medicaid population was enrolled in some form of managed care before 1992. Over 54 percent of the Medicaid population is now enrolled in managed care, according to the most recent Health Care Financing Administration figures.

While some policy-makers saw Medicaid managed care as the magic answer to double-digit increases in health-care costs, others feared that the emphasis on cost savings hurt the quality of care provided to Medicaid beneficiaries. Critics say that managed care, with its use of fixed payments prior to care, contains an inherent incentive to deny care and underserve patients. Due to the amount of money states spend on Medicaid and the special needs of many Medicaid enrollees, policy-makers have been particularly concerned with providing adequate protections for Medicaid recipients enrolled in managed care plans.

Many state and federal agencies as well as private organizations have developed methods to assess the quality of care provided to patients enrolled in managed care, both private and government-funded. As a way to deal with concerns about quality, states are using quality assurance techniques from other organizations and supplementing them with their own quality measures

and programs.

These quality assurance/improvement programs for the Medicaid managed care population are fairly new, and there are tremendous differences between state programs. These differences, coupled with the ever-changing landscape in the field of quality assurance, make describing, analyzing and comparing the quality assurance efforts of Medicaid managed care programs difficult. Like measuring the course of a river, the study of Medicaid managed care quality assurance is the study of a system constantly in flux.

CSG surveyed the states about Medicaid managed care. The results showed that states use a number of different measures in their quality assurance programs for Medicaid managed care, including:

- Reviewing and approving plans' quality assurance/improvement programs.
- Requiring periodic plan reports of utilization information, performance measures/quality indicators, health outcomes measures, enrollment/disenrollment figures, consumer satisfaction information, and/or financial information (e.g., information on solvency).
- External quality reviews.
- Random medical audits/chart reviews.
- Focused quality of care reviews.
- Site visits.
- Provider feedback.
- Consumer satisfaction surveys.
- Monitoring enrollment and disenrollment figures.
- Monitoring and investigation of complaints and grievances.
- Dissemination of information to plan members about procedures and rights.
- Consumer participation on plan boards.
- Toll-free hotlines for complaints and grievances.

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- Advocate/ombudsman services.
- Certification of plans.
- Accreditation of plans.

Each state uses some combination of the above measures. These practices may be carried out in conjunction with one another and may be performed by a state agency, a health plan or other entity that contracts with the state agency responsible for the Medicaid program.

From the analysis of original data and the use of existing studies of Medicaid managed care, several conclusions emerge. First, one of the biggest obstacles to assessing the quality of care in Medicaid managed care is the tremendous difference between state quality assurance programs. It is difficult to provide a nationwide analysis of Medicaid managed care without commonly accepted benchmarks of quality used by all programs.

Despite this problem, stakeholders in the debate over quality — government officials, health plans, providers and consumer groups — are working on the foundational elements of what constitutes quality care and how to measure it for Medicaid populations. Collaborative efforts between the National Committee on Quality Assurance and the National Association of State Medicaid Directors, as well as initiatives by the Health Care Financing Administration are steps toward the development of some common measures of quality.

In addition, the overarching consensus from studies on Medicaid managed care is that it provides comparable quality to traditional fee-for-service Medicaid. While this is encouraging on one hand, on the other, the hope was that managed care would actually improve care for Medicaid recipients because they would see the same doctors that individuals with private insurance see. Also, there are several features of Medicaid that make any comparisons of fee-for-service and managed care Medicaid preliminary in nature, including short enrollment times of recipients and differing reporting requirements among states.

Based on the analysis and findings of this report, adopting one or more of the following recommendations could improve the quality of care for Medicaid recipients enrolled in managed

care:

- Adoption of 12-month continuous eligibility for Medicaid enrollees.
- Offering user-friendly, easily accessible guides on plan performance and provider qualifications for Medicaid beneficiaries to use in selecting a plan and a primary care provider. Funds should also be provided to translate educational materials for non-English speakers. Plans also need to provide user-friendly, culturally sensitive information on accessing care and on patient rights.
- An ombudsman/advocate and/or a well-publicized multiple-language hotline should be available to assist Medicaid beneficiaries with questions regarding selection of providers, access to care, negotiating managed care arrangements, and the resolution of complaints and grievances.
- Adequate funding, recruitment of staff and competitive pay for quality assurance programs.
- Broad dissemination of consumer-friendly, easy-to-understand comparative reports of plan quality based on plan performance information.
- Periodic objective assessments of the reasons some providers do not participate in Medicaid managed care programs as well as the level of satisfaction of participating providers with the programs
- Aggressive steps to address any provider concerns raised through the assessments.
- Carefully scrutiny of the causes of commercial plan exits from the Medicaid market. Low plan participation rates may indicate that payments to plans are too low and/or administrative requirements too burdensome.
- Review of capitated payments to providers and plans and increases in payments where necessary to maintain provider and plan participation, program competitiveness and quality of care.
- Established procedures and adequate personnel to investigate complaints promptly. When a pattern of poor quality care appears, states must take appropriate and prompt action to protect Medicaid recipients.

The tables that follow this article highlight Medicaid managed care plan types by state and

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state use of assurance techniques to measure the quality of Medicaid managed care. They are part of *Measuring the Quality of Medicaid Managed Care: An Introduction to State Efforts - 2000*,

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