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Medicaid Managed Care: Background, Issues, and Options

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Background, Issues and Options

What is Managed Care?

Managed care is a payment method that provides incentives for health plans to improve care outcomes and reduce unnecessary use of high cost services. Under a managed care program, states pay health plans a pre-established amount for each person enrolled in the plan and in exchange the plans provide all the necessary medical services to members. This payment method provides greater budget predictability for states and gives providers incentives to coordinate and manage services in a cost effective way.

Managed care has become a leading model for the delivery and payment of health care services in state Medicaid programs across the county. The number of Medicaid beneficiaries in some form of managed care doubled from 17.8 million in 1999 to 33.4 million in 2008. The percentage of Medicaid members in managed care also increased from 56% to 71% during this time (Kaiser Commission, 2010). All states except Alaska and Wyoming have Medicaid members enrolled in some kind of managed care.

Although nationally more than two thirds of Medicaid members are in some form of managed care program, only about 20% of state Medicaid dollars are spent in managed care. This reflects the fact that most states have focused their managed care initiatives on parents and children, where costs are lower. Fewer states have included many of the higher cost Medicaid beneficiaries (e.g. older adults and adults with disabilities) and services (e.g. long term care services such as nursing home care) (Kaiser Commission, 2010). Many members in this higher cost group are also dually eligible for Medicaid and Medicare services. Designing managed care programs for dually eligible members presents more challenges to states.

Why Managed Care? State Goals

States implement managed care programs to meet multiple policy goals. Initially states moved to managed care programs to increase access to care for Medicaid beneficiaries. As programs grew and became more popular in the 1990s, cost control became a more prominent reason for managed care expansions. States have since used managed care to meet a number of other policy goals, including:

- Improve access to networks of qualified providers;
- Increase use of primary and preventive care services for members;
- Reduce inappropriate use of services (such as emergency room and inpatient services);
- Better integrate and manage care for children and adults with chronic illnesses, disabilities and complex care needs across medical, behavioral and social services;
- Improve outcomes of care by providing incentives to meet certain quality goals; and
- Publicly report on outcomes (Somers et al., 2000).

What are Common Models for Managed Care?

There are two primary types of Medicaid managed care programs – Primary Care Case Management and Risk-Based Contracting.

Primary Care Case Management (PCCM)

Under PCCM each Medicaid member chooses a primary care physician who provides basic medical care and who authorizes referrals to other specialty care services (e.g. mental health services, other medical specialists). Each primary care provider is paid a small monthly fee to act as the central source of medical care for each member and to coordinate and manage other specified services.

The physician and other providers continue to be paid the Medicaid rate for each visit or other unit of service provided (fee-for-service basis). State Medicaid programs measure and monitor the quality and outcomes of the medical providers.

Risk Based Managed Care

In a risk based managed care program, each Medicaid member chooses a managed care organization (MCO) as the source of all medical and other designated services. As part of choosing a managed care organization, members can review the list of physicians and other providers who are part of that plan's provider network. Depending on the program design, members must have a choice of two or more managed care organizations; or a choice between the traditional fee-for-service system and a managed care option. In certain instances (e.g. rural areas) and with permission from the federal government, states may limit choice in an area.

In a risk based model, Medicaid pays each managed care organization a monthly, per member per month (PMPM) amount -- called the capitation rate -- for each member enrolled in the plan. Actuaries develop these rates and certify that they are sufficient to cover all the costs of caring for all members over the month. Some members may not use any services in that month; others may use a lot of services. The managed care organization is responsible for managing the overall use of services by all members and the cost of services within this predetermined amount. The managed care plan is at financial risk if the total cost of services provided to all enrollees is greater than the amount generated from the capitation rates. If the managed care plan spends less than the amount in the capitation rate, the plan is able to retain the savings.

Almost half (49%) of all Medicaid beneficiaries across the U.S. were in some form of risk based managed care in 2008. At that time, thirty-four states had risk based managed care plans with members enrolled in 307 different plans (Kaiser Commission, 2010)

Design Decisions

Medicaid managed care plans vary greatly from state to state. The major design decisions that state Medicaid agencies face are:

- *Populations:* Who will be enrolled in managed care?
- *Services:* What services will be included in the managed care benefit or capitation rate?
- *Voluntary/mandatory enrollment:* Will members be able to choose to enroll or be required to enroll in managed care?
- *Capitation:* What is the structure and amount of risk in the capitation rate?
- *Regional or statewide:* Is the program statewide or limited to substate regions?

Populations: Medicaid managed care programs serve a wide range of eligibility groups including poor families, children with disabilities, older adults, and adults with disabilities. Most states started their managed care programs by enrolling parents and children. More recently states have begun to enroll populations with more complex health needs (Kaye, 2005). These groups include older adults (e.g. people over 65) and people with physical or other chronic disabilities.

Services: Most states include basic medical and hospital care as part of a managed care benefit. States use a wide range of approaches with respect to inclusion of other more specialized services, such as mental health services, substance abuse services and dental services, in a managed care program. Some states "carve out" certain services (e.g. mental health) and continue to pay for these services on a fee-for-service basis; other states have contracted with plans that specialize in these services. Still others integrate all services into one managed care plan. Only a few states have implemented managed care programs that include long term care services (such as nursing home care or other home based care services) and serve people who are eligible for both Medicaid and Medicare. (See section on managed long term care).

Voluntary versus Mandatory Enrollment: States design their managed care programs such that members may either voluntarily enroll in a managed care plan or are required to enroll in a managed care plan. Under voluntary enrollment, members may choose a regular fee-for-service program (where the member may choose any provider and change providers at any time) or may choose to join a managed care plan. With mandatory enrollment, members must have a choice of at least two managed care organizations.

Capitation Rates: Under risk based managed care programs, health plans are paid a monthly capitation rate for each member enrolled in the plan. The capitation rates vary based on the age, sex and category of Medicaid eligibility. Rates are also adjusted for high cost chronic conditions and other levels of acuity.

Quality Incentives: Medicaid programs also develop quality outcome goals for the managed care plans. If the managed care organizations meet these goals, Medicaid may pay an additional amount as a reward or incentive for meeting these goals.

Statewide or regional: States can request permission from the federal government to implement managed care in discrete areas such as counties or other regional areas. This is more common in larger states and/or in states that have implemented managed long term care where the populations are higher cost and the challenges of implementation are more complex.

Quality Standards in Medicaid managed care programs

States that implement Medicaid managed care programs are required to develop standards and processes that the managed care plans must meet before services are delivered. These standards cover the adequacy of the provider network; the credentials of providers; geographic/distance and timeliness standards; member rights appeal and grievance processes; and internal quality management systems.

The development and use of quality measures to monitor plan performance and consumer outcomes is an important component of managed care programs. It is common for states to publish data on the performance of health plans on public websites and to hold plans accountable for meeting certain quality goals.

Managed Care for Long Term Care Populations

States have been slower to develop risk-based managed care programs for people who need long term care services. A high percentage of people who need long term services and supports are dually eligible for Medicare[1] and Medicaid.[2] Coordinating Medicare and Medicaid financing and developing provider networks and services that include both medical care and long term care and social support services present special challenges in developing risk-based managed care programs for the dually eligible population. Despite the challenges of designing managed long term care programs, integrating Medicaid and Medicare services and payments offers a number of advantages and opportunities including: (a) improved care and service coordination; (b) potential to share savings between programs; (c) improved quality of care and outcomes; (d) increased flexibility in services; (e) greater focus on prevention and coordination of services; and (f) greater budget predictability (Tritz, 2006).

While many states have engaged in extensive planning efforts to develop managed long term care programs, only thirteen states have actually implemented such programs.[3] Of these states, three have mandatory enrollment (Arizona, Texas, and Wisconsin). Three states have integrated Medicaid and Medicare payments (Wisconsin, Minnesota and Massachusetts).

People who are dually eligible rely on two sources of funding to pay for their care. Medicare pays for basic medical, hospital, and prescription drug costs and Medicaid pays for long term care services including home care, personal care, residential care/assisted living and nursing home services. Efforts to integrate services and payment into single managed care programs have faced a number of challenges including (a) administrative and operational inconsistencies between Medicaid and Medicare; (b) financial misalignment between Medicare and Medicaid that limits states' ability to share in any savings from greater care coordination and (c) low enrollment in programs (Bella and Palmer, 2009). Other issues that States must grapple with when designing long term managed care programs include: mandatory versus voluntary enrollment; population/program eligibility; payment rates; quality assurance and legal authority (Saucier et al., 2005).

Success Factors

In the spring of 2010, the Department of Health and Human Services prepared a report on the feasibility of implementing risk based managed care in Maine (Maine DHHS, 2010). This report identified five key factors to implementing a successful managed care program:

Cultivate long term collaborative relationships with contractors – Medicaid programs that nurture collaborative partnerships are best prepared to respond to future developments and improve the program over time.

Measure performance – States where managed care outperforms fee-for-service systems are those that have been able to aggressively manage quality and have systems to collect and use performance data to manage contractors and report to stakeholders.

Engage stakeholders early and continuously – States emphasize the need to engage stakeholders in the design, development, implementation and oversight of the managed care programs. Stakeholders include consumers, advocates, providers, contractors and legislators.

Build effective administrative infrastructure – States with little or no prior experience with Medicaid managed care, need to recruit or build skill sets (e.g. quality measurement) necessary to operate in fundamentally different program environment from bill paying and claims processing.

Adapt to local conditions – Successful programs take advantage of and respond to local conditions, provider environments and other state characteristics.

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1. Medicare is federally administered program for people over age 65, certain people with disabilities under age 65 and people of all ages with end-stage renal disease. Medicaid is a means-tested program, administered by each state.

2. In Maine, about approximately 90% of older adults; two-thirds of people with developmental disabilities; and half of the people with severe and persistent mental illness are dual eligibles.

3. These states include Arizona, California (selected counties), Florida, Massachusetts, Minnesota, New Mexico, New York, Texas, Washington, and Wisconsin, Tennessee, Hawaii and Pennsylvania.

How Well Do Medicaid Managed Care programs Perform?

The literature on the outcomes of risk-based Medicaid managed care is mixed to favorable. The evidence indicates that risk-based Medicaid managed care:

- Increases the likelihood of beneficiaries having a usual source of care,
- Reduces the use of emergency departments and admissions to hospitals,
- Is associated with smoking cessation among pregnant women,
- Increases the likelihood that members will receive prenatal care, well-child care, and childhood immunizations.

For those using long term services, it has been associated with reduced use of emergency rooms, hospitals and nursing home care and increased use of community based services including homemaker services, home delivered meals and outpatient rehabilitation (Saucier and Fox-Grage, 2005; Kane et al., 2003).

Authority for Medicaid Managed Care

All major changes in Medicaid eligibility and service delivery require federal approval. Federal approval options include 1) State Plan Amendments, 2) a Managed Care Waiver called a 1915(b) waiver or 3) a "Demonstration" waiver called an 1115 Waiver.

State Plan Amendment: States can use this authority to mandatorily enroll members in managed care except children with special needs, dually eligible members, or American Indians. States can include all or some services in the managed care plan. Members must have a choice of at least two managed care plans.

Managed Care Waiver 1915(b): States can require all members to enroll in a managed care plan **including** children with special needs, dually eligible members and American Indians. All members must have a choice of a managed care plan.

Demonstration Waiver 1115: States can mandatorily enroll members in managed care. Dually eligible members must continue to have a choice of provider for Medicare services. States generally use this authority to waive more rules and propose large scale innovations that could not be accomplished under the usual Medicaid authority.

Summary

Managed care is a fundamental shift from the historical fee-for-service payment systems. It provides opportunities for states to transform the delivery and financing of Medicaid financed services and promote and reward improved care outcomes. Implementation of such programs requires thoughtful planning, active stakeholder engagement and an effective administrative infrastructure to manage and operate in a value based purchasing environment.

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