



Context and Overview of Medicaid Managed Care

Medicaid is a source of health care coverage for 67 million people, over a fifth of the U.S. population. Approximately 49 million Medicaid enrollees receive care through some form of managed care.

Managed care may encompass many different arrangements for financing or delivering health care. As described later in this section, managed care arrangements range from comprehensive risk-based plans and primary care case management (PCCM) programs in Medicaid to preferred provider organizations (PPOs) and traditional health maintenance organizations (HMOs) in employer-sponsored plans. In one form or another, these health plan arrangements have grown to be the dominant approach to delivering and financing health care services in the United States. However, fee for service (FFS) continues to be an important component of Medicaid program design and spending.

A few states have been using managed care in Medicaid since the early years of the program, but enrollment has expanded more rapidly in the last 15 years. In 2009, 47 percent of all Medicaid enrollees were enrolled in comprehensive risk-based managed care plans, up from 15 percent in 1995 (CMS 1996, CMS 2010). These comprehensive risk-based plans are responsible for providing a varying but relatively inclusive set of Medicaid benefits for a fixed per member per month amount.¹

Within Medicaid, the term “managed care” has come to include a broader array of arrangements beyond comprehensive risk-based plans. About 15 percent of Medicaid enrollees are in PCCM programs that build on FFS arrangements using

¹ In this Report, the term “comprehensive risk-based plans” refers to what federal Medicaid regulations generally call a managed care organization, which covers comprehensive services (42 CFR 438.2). In the federal Medicaid regulations, comprehensive services are defined as (a) inpatient hospital services and at least one of the following nine services, or (b) any three of the following nine services: (1) outpatient hospital services; (2) rural health clinic services; (3) federally qualified health center (FQHC) services; (4) other laboratory and X-ray services; (5) nursing facility (NF) services; (6) early and periodic screening, diagnostic, and treatment (EPSDT) services; (7) family planning services; (8) physician services; and (9) home health services.

care coordination and care management.² To complement FFS and managed care arrangements, under which enrollees may receive most of their benefits, many states use limited-benefit plans (i.e., prepaid ambulatory health plans (PAHPs) and prepaid inpatient health plans (PIHPs)) to provide a particular service such as behavioral health, transportation, or oral health.

Although most Medicaid managed care programs primarily enroll low-income³ children and their parents, some states use managed care arrangements for populations with more extensive medical needs, including persons with disabilities. As they seek to control costs and better coordinate care for these enrollees, states may rely more on managed care in the near future. In addition, changes in Medicaid eligibility rules in 2014 will potentially bring new populations and new issues for the use of managed care in Medicaid.

Identifying payment, access, quality, and other strategies for improving managed care is important for current Medicaid and State Children's Health Insurance Program (CHIP) populations and for future enrollees in these programs. Critical to the success of these improvement strategies is the availability of data. While states may have the data they need to operate their programs, insufficient information is available at the national level to conduct data-based analyses across states of what works and what could be improved.

Comprehensive risk-based managed care programs are the primary focus of this Report. However, we also provide information on the PCCM programs states use as an alternative when comprehensive risk-based managed care is less feasible or desirable, such as for certain geographic areas or

populations. Limited-benefit plans are considered mainly from the perspective of which benefits are carved out of the comprehensive risk-based managed care plan benefit package.

This Report establishes baseline information about the use of managed care in Medicaid today, including data on populations and enrollment, types of Medicaid managed care plans, payment policy, access and quality issues, and program accountability. A program statistics supplement, MACStats, is also included in the Report and provides state-level data on Medicaid managed care including data on plans as well as enrollment and spending by eligibility group. In addition, MACStats provides information on the historical growth in Medicaid spending as well as the demographic and health characteristics of individuals enrolled in Medicaid and CHIP, as compared to other sources of coverage and among subgroups within the Medicaid and CHIP populations.

A Focus on Managed Care in Medicaid

The Commission's authorizing language directs the Commission to focus its June report to the Congress on "issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs." Understanding managed care's use in Medicaid and CHIP is essential to understanding how these two programs—which together account for approximately 15 percent of U.S. health care spending—fit into the larger health care delivery system (MACPAC 2011).

² See MACStats Table 9.

³ Based on 2010 estimates from the National Health Interview Survey, 48 percent of Medicaid enrollees had incomes below 100 percent of poverty; 32 percent had incomes between 100 and 199 percent of poverty; and 20 percent had incomes above 200 percent of poverty (March 2011 MACStats Table 18). One hundred percent of poverty using Census' poverty threshold was \$17,098 for a family of three.

States and the federal government have pursued Medicaid managed care for a number of reasons. When designed and implemented well, effective managed care programs may:

- ▶ promote care management and care coordination;
- ▶ provide greater control and predictability over state spending; and
- ▶ improve program accountability for performance, access, and quality.

However, for some states, FFS may still provide advantages for certain populations and certain geographic areas.

Despite the widespread use of Medicaid managed care, most research is dated or narrowly focused on single states. It is essential to develop a new generation of in-depth research that addresses how states are meeting their goals for Medicaid managed care and identifies how programs can be updated and strengthened as states move to enroll more individuals.

The Commission's work will provide a foundation needed to examine the trends, opportunities, and challenges in fundamental policy areas including the impact of payment policy, access to care, and appropriate utilization of services. Over time, our analyses will aim to identify potential ways for the federal government and states to improve managed care payment, enrollment processes, quality improvement activities, and program integrity.

BOX A-1. Key Facts on Managed Care in Medicaid

Enrollees (Table B-1)

- ▶ Percent of Medicaid managed care enrollees, by eligibility status, who are in any form of managed care (including comprehensive risk-based, PCCM, or limited-benefit arrangements):
 - Non-disabled children: 60%
 - Non-disabled adults under age 65: 22%
 - Persons with disabilities: 14%
 - Individuals age 65 and over: 4%

Enrollment (Table 9 in MACStats)

- ▶ Number of Medicaid enrollees in any form of managed care: 49 million (71%)
- ▶ Number of Medicaid enrollees in comprehensive risk-based managed care: 23 million (47%)
 - States with highest percent of Medicaid enrollees in comprehensive risk-based managed care: Hawaii (97%), Tennessee (94%), and Arizona (90%)

Spending (Table B-2)

- ▶ Share of Medicaid benefit spending for any form of managed care: 21%
- ▶ Share of Medicaid benefit spending for comprehensive risk-based managed care: 18%

States (Table 9 in MACStats and CMS 2010)

- ▶ Number of state Medicaid programs with:
 - Comprehensive risk-based managed care plans: 34 states and DC
 - PCCM programs: 30 states
 - Limited-benefit plans: 34 states and DC
 - No managed care: 2 states (Alaska and Wyoming)

Notes: See Section 4 of MACStats for further explanation of methodology and differences in data sources. Data are from 2009 except spending and enrollee data, which are from FY 2008.

TABLE A-1. Percentage of Medicaid Enrollees in Managed Care by Type of Arrangement, FY 2008

	Children	Adults	Disabled	Aged
Any managed care	84.6%	57.1%	58.4%	32.9%
Comprehensive risk-based plans	60.0	43.8	27.9	10.9
Primary care case management (PCCM)	19.0	8.9	12.6	2.1
Limited-benefit plans	36.6	23.6	37.0	25.2

Notes: Managed care types do not sum to total because individuals are counted in every category for which a payment was made on their behalf during the year. Excludes the territories and Medicaid-expansion CHIP enrollees. Children and non-aged adults who qualify for Medicaid on the basis of a disability are included in the disabled category. Enrollees are counted as participating in managed care if at least one managed care payment was made on their behalf during the fiscal year; this method underestimates participation somewhat because it misses enrollees who entered managed care late in the year but for whom a payment was not made until the following fiscal year. See Section 4 and Tables 11 and 12 in MACStats for more information on how MSIS data used for this table differ from Medicaid Managed Care Enrollment Report data used throughout this Report.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data from CMS as of May 2011

As it continues to evolve, managed care in Medicaid will continue to be dependent on effective working relationships between federal and state governments, states and managed care plans, and managed care plans and participating providers. This Report touches on all of these relationships and identifies the roles and responsibilities of each entity.

Medicaid and Managed Care

Three different types of arrangements in Medicaid are often referred to as managed care: comprehensive risk-based plans, PCCM programs and limited-benefit plans.

Comprehensive risk-based managed care plans are the most common type of managed care arrangements in Medicaid. States typically use a HMO model in which enrollees must use a network of providers. States pay plans on a capitated basis—a set amount per member per month that covers all benefits and services under the plan contract—but may mitigate some of the plans’ risk through risk corridors or other

arrangements designed to limit plan losses. In 2009, 23 million Medicaid enrollees (47 percent of all enrollees) were in comprehensive risk-based plans (MACStats Table 9).

PCCM programs typically assure that enrollees have a primary care provider (PCP) who receives a small monthly per capita payment to coordinate each enrollee’s care. All services are still paid on a FFS basis. In 2009, 7.3 million Medicaid enrollees (15 percent of all enrollees) were in PCCM programs (MACStats Table 9).

Limited-benefit plans include a diverse assortment of plans that typically cover only a single type of benefit. Generally paid on a capitated basis, these arrangements can be used in conjunction with either of the other two types of managed care programs or with FFS Medicaid. Among Medicaid enrollees in limited-benefit plans, 4.3 million were in plans covering inpatient mental health services and 3.1 million were in plans with combined inpatient mental health and substance abuse benefits; 6.1 million enrollees were in plans that provided transportation services only. Dental

limited-benefit plans accounted for 1.2 million enrollees in five states (CMS 2010).

States differ considerably in the populations they enroll in managed care, the roles and responsibilities they assign to managed care plans, the level of oversight and management they retain at the state level, and the maturity of their programs. For example, in 2009, four states had at least three-fourths of their Medicaid enrollees in comprehensive risk-based managed care plans, while 13 other states with comprehensive risk-based managed care used that arrangement for less than half of their enrollees (MACStats Table 9). Some states mandate managed care enrollment of certain enrollees while others maintain only voluntary programs that allow enrollees to choose between enrolling in managed care or remaining in FFS. Furthermore, different geographic regions of a state may be treated differently; even in states that rely heavily on managed care, some geographic regions may not be included, especially in rural areas.

States typically have implemented managed care on a population-by-population basis. Low-income children and their parents were the first

population that states began enrolling in managed care on a regular basis, and they are by far the most commonly enrolled population in all three types of managed care arrangements (Table A-1). Sixty percent of all children in Medicaid are enrolled in a comprehensive risk-based plan. Non-disabled adults under age 65—typically parents of Medicaid-eligible children—are the next most likely to be enrolled in comprehensive risk-based managed care (44 percent). Only 28 percent of enrollees with disabilities and 11 percent of enrollees age 65 and older are in comprehensive risk-based managed care. These two groups are more likely to be in a limited-benefit plan (such as those for behavioral health) than any other arrangement (Table A-1).

CHIP and Managed Care

With the creation of CHIP in 1997, states were given the option to administer their CHIP programs through Medicaid (called a Medicaid-expansion program), as a separate, stand-alone program, or by using a combination of the two programs (see March 2011 Report for additional details).

TABLE A-2. Child CHIP Enrollment in Managed Care Plans, FY 2010

	Medicaid-expansion CHIP		Separate CHIP		Total	
Comprehensive risk-based	1,241,441	57%	4,503,711	81%	5,745,152	75%
Fee for service (FFS)	450,253	21	778,354	14	1,228,607	16
Primary care case management (PCCM)	474,256	22	257,708	5	731,964	9
Total	2,165,950	100%	5,539,773	100%	7,705,723	100%

Note: In the CHIP Statistical Enrollment Data System (SEDS), information is not obtained on limited-benefit plans.

Source: MACPAC analysis (February 2011) of SEDS, as reported by states, based on their definitions

Comprehensive risk-based plans are prominent in both separate CHIP programs and Medicaid-expansion CHIP programs. In 2010 three out of four CHIP enrollees were in such plans, including 81 percent of children in separate CHIP programs (Table A-2). Medicaid-expansion CHIP programs typically use the same plans as a state's overall Medicaid program and are more likely than stand-alone CHIP programs to use PCCM or FFS arrangements.

Relatively little research compares managed care in separate CHIP programs to Medicaid-expansion CHIP programs. In CHIP, managed care is less than one-fifth the size of the Medicaid managed care market. However, a 2007 study found that CHIP managed care enrollees were served by a slightly larger percentage of commercial plans: 35 percent of all commercial plans participated in CHIP compared to 29 percent in Medicaid (Barrett and Felt-Lisk 2008). A 2001 study comparing six states with stand-alone programs to five states with Medicaid-expansion CHIP programs found that the plans participating in both Medicaid and CHIP overlapped substantially (Gold et al. 2003).

Beyond these general statistics and limited studies, little information is currently available on the managed care arrangements states use in their stand-alone CHIP programs. Additional data are helpful to better understand these CHIP programs, their enrollment processes, the plans that participate and payment policies. Further, little is known about how CHIP stand-alone programs perform compared to Medicaid. The Commission intends to focus more on managed care in CHIP as part of our future work.

Medicaid Managed Care in the Context of U.S. Health Care

Managed care arrangements in Medicaid, in the private sector and in Medicare differ in several ways. These differences stem in large part from the differences in the populations served, how the programs are designed, statutory requirements for the programs, and their history. Key differences include:

- ▶ the role of provider networks;
- ▶ the role of cost sharing as a tool for managing utilization; and
- ▶ the process for enrolling in a managed care plan and the plan choices available at enrollment.

This section provides further background on how design features of managed care in Medicaid are similar to and different from those most commonly used in the private sector and Medicare markets.

The role of provider networks. Historically, managed care plans have generally sought to control costs by establishing a network of providers to provide health services to plan members. Contracts between the plan and participating providers typically stipulate the negotiated payment amount and how those payments will be administered. Providers may accept payments lower than their usual rates in exchange for having access to the plan's enrollees.

In 2010, most individuals in employer-sponsored plans were enrolled in PPOs (58 percent). PPOs encourage the use of network providers, but often cover services from non-network providers if enrollees pay an extra charge. Persons with employer-sponsored insurance were also enrolled in HMOs (19 percent), high deductible health plans with a savings option (13 percent), and point-of-service plans (8 percent) (KFF and HRET 2010).

Most Medicare enrollees have FFS coverage; in 2011 about one-fourth of beneficiaries are enrolled in Medicare Advantage (MA) managed care plans. Within MA, HMOs are the most common plan type, covering about 64 percent of enrollees in MA. PPOs account for about 20 percent of MA enrollment. Approximately 9 percent of MA enrollees are individuals who are dually eligible for Medicaid and Medicare and enrolled in Special Needs Plans—usually HMOs—specifically designed to serve that population (MedPAC 2010).

Cost sharing as a management tool. Cost sharing is a tool managed care plans use to influence enrollee behavior, but it is less commonly used in Medicaid because of the low-income population the program serves. The PPO model emphasizes cost sharing as a tool for managing the use of services.

Cost sharing in traditional Medicare is generally set as a percentage of a fixed fee schedule once the applicable deductible is met. MA plans are allowed to vary cost sharing from that of traditional Medicare as long as the cost sharing remains actuarially equivalent to FFS Medicare. This allows plans such as PPOs to vary cost sharing to encourage the use of provider networks.

The ability to use cost sharing in Medicaid managed care is limited (March 2011 MACStats Table 13). In Medicaid, most cost sharing is restricted to nominal levels and deductibles are rarely used.⁴ The nominal cost-sharing plans might be allowed to charge for out-of-network providers may not be enough to drive enrollee behavior. Thus Medicaid managed care plans create defined networks to ensure beneficiaries will use the providers with whom they have negotiated in-network payment rates.

Plan choice and the enrollment process.

For participants in employer-sponsored health insurance, selecting a health plan is typically overseen by the employer's benefits office. Only about 52 percent of covered employees work for a firm that offers more than one health plan type; a choice of plans is more common in large firms than small firms (KFF and HRET 2010). Where a choice of plan exists, employees commonly select a plan option during an annual open enrollment period where employees consider the available array of plans using information packages, health fairs, and other tools made available by the employer or their representative.

Similarly, Medicare holds an annual open enrollment period and offers various printed and online information resources for beneficiaries interested in choosing an MA plan. However, the default option is that beneficiaries will receive benefits (other than outpatient prescription drug benefits under Medicare Part D) through traditional FFS Medicare. Medicare beneficiaries are enrolled in FFS unless they actively choose a managed care plan.

In Medicaid, states are required to provide their enrollees with a choice of at least two plans if enrollment in managed care is mandatory (except in certain rural areas) (42 CFR 438.52). Compared to both employer-sponsored insurance and Medicare, Medicaid enrollees are far more likely to move frequently in and out of managed care plans, usually due to changes in income that affect their eligibility for Medicaid (Ku et al. 2009).

⁴ The Deficit Reduction Act (P.L. 109-171) authorized states to implement, at state option, alternative premiums and cost sharing (e.g., for non-preferred prescription drugs) for certain populations whose incomes exceed specified levels.

BOX A-2. Major Medicaid Managed Care Legislative Milestones and Key Provisions

- 1962** Public Welfare Amendments of 1962 (P.L. 87-543) establish Section 1115, which gives broad authority to the Secretary to “waive compliance to any of the requirements” of a number of sections of the Social Security Act (the Act) for any “experimental, pilot or demonstration” projects.
- 1965** Medicaid is enacted (P.L. 89-97) as Title XIX of the Act.
- 1973** Health Maintenance Organization Act of 1973 (HMO Act of 1973, P.L. 93-222) establishes requirements for health maintenance organizations (HMOs).
- 1976** Health Maintenance Organization Amendments of 1976 (HMOA 1976, P.L. 94-460) mandate that no more than 50 percent of enrollees in plans participating in Medicaid could be comprised of Medicaid or Medicare beneficiaries, known as the “50/50” rule.
- ▶ Requires entities seeking risk contracts under Medicaid to meet federal HMO requirements.
 - ▶ Amends the definition of “HMO” in the Act to coordinate with HMO Act of 1973; also re-defines “basic health services” as referring to mandatory Medicaid services.
 - ▶ Prohibits payments to organizations providing inpatient hospital services or any other mandated Medicaid services on a prepaid risk basis that are not qualified as an HMO.
- 1981** Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) establishes Section 1915(b) freedom-of-choice waivers to allow states to pursue mandatory managed care enrollment of certain Medicaid populations.
- ▶ Replaces the “50/50” rule of HMOA 1976 with the “75/25” rule, which allows Medicaid participation by plans with 75 percent Medicaid or Medicare enrollees.
 - ▶ Requires Medicaid capitation payments to be actuarially sound.
- 1997** Balanced Budget Act of 1997 (BBA, P.L. 105-33) permits states to require most Medicaid beneficiaries to enroll in managed care plans without obtaining a Section 1115 or 1915(b) waiver. This change shifts the role of Section 1115 waivers to broad program development and redesign.
- ▶ Eliminates the “75/25” rule which had required that 25 percent of a Medicaid plan’s enrollment be privately insured.
 - ▶ Requires states to develop and implement a quality assessment and improvement strategy, specifically assuring coverage of emergency services, creating a system to address complaints, demonstrating adequate capacity and services, and meeting certain quality assurance standards.
 - ▶ Calls for independent review of managed care organization performance.
- 2005** Deficit Reduction Act of 2005 (P.L. 109-171) permits states to use “benchmark” coverage instead of the regular Medicaid benefits package for certain populations; and gives states more flexibility to require cost sharing for Medicaid enrollees.
- 2010** Patient Protection and Affordable Care Act (P.L. 111-148) extends the Medicaid Drug Rebate Program (established by the Omnibus Budget Reconciliation Act of 1990, P.L. 101-508) to Medicaid managed care plans effective March 23, 2010.

The Evolution of Managed Care within Medicaid

Medicaid has evolved from an entirely FFS program to include managed care in an increasing role. Box A-2 presents some of the key legislative milestones in this evolution within the Medicaid program.

The first statutory authority used to implement managed care in Medicaid actually predated the program's 1965 passage. The Public Welfare Amendments of 1962 (P.L. 87-543) created Section 1115 of the Social Security Act, providing the federal government authority to grant waivers for broad, structural changes to federal aid programs operated by states on a demonstration basis. In Medicaid, this came to include waiving Medicaid enrollees' free choice of participating providers and permitting mandatory managed care enrollment.

Most states that enrolled Medicaid beneficiaries in managed care during the first decade of the program were seeking to achieve lower and more predictable costs (Gold and Mittler 2000). However, concerns were raised that plans did not provide needed care or took advantage of capitated payments by enrolling only people who rarely used care. California's Medicaid program first started contracting with comprehensive risk-based managed care plans (then called prepaid health plans) on a pilot basis in 1968 (GAO 1995). When the state rapidly expanded enrollment in these plans in the 1970s, controversies arose around questionable marketing practices, poor delivery systems, and plan financial stability (Freund and Hurley 1995). This may have slowed the implementation of Medicaid managed care in other states. The Health Maintenance Organization Amendments of 1976 (P.L. 94-460) followed these experiences and tightened certain rules for HMOs in Medicaid.

In 1981 the Congress enacted the Omnibus Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35), adding another option for state-level experimentation. It added Section 1915(b) waivers to permit states to limit enrollees' choice of participating providers, another way of allowing states to implement mandatory managed care for their Medicaid populations. However, states were required to limit their waivers to a certain geographic area or certain populations. The legislation also included controls on programs created with waiver authority, to address some of the problems seen in the earliest Medicaid managed care programs. Table FA-1 in the Section F Annex of this Report summarizes key federal authorities allowing Medicaid managed care.

Using primarily Section 1915(b) waiver authority, by 1990 about 2.3 million Medicaid enrollees were enrolled in managed care (Freund and Hurley 1995). Still, by 1991, fewer than 1 in 10 Medicaid enrollees were in any form of managed care (Holahan et al. 1998).

In 1993 states began using Section 1115 research and demonstration authority (Section 1115 waivers) to implement programs that combined managed care and eligibility expansions (Rowland and Hanson 1996, Hurley and Somers 2007). These waivers allowed states to create statewide programs and waived the requirement that at least 25 percent of enrollees in participating plans be from outside the Medicaid and Medicare programs.

During this time period, as some states moved to implement statewide, broad-based managed care programs with ambitious deadlines, issues arose around the adequacy of provider networks, education and marketing practices, payment, data systems, and oversight. However, by 1997 the federal government had approved 14 Medicaid statewide waivers, all of them mandatorily enrolling some individuals in managed care, with a total enrollment of 8 million enrollees. Most states used

comprehensive risk-based plans as their primary model of managed care (Smith and Moore 2008).

The Balanced Budget Act of 1997 (BBA, P.L. 105-33) included three changes with implications for Medicaid managed care. The first was the creation of CHIP. Children had already been a focus of managed care enrollment in Medicaid programs, and states continued to expand managed care for children enrolled in this new program.

Second, the BBA made it possible for states to implement mandatory enrollment in managed care programs through amendments to their state plans, rather than just through waivers (except for dual eligibles, American Indians, and children with special needs). In exchange, states were required to meet specific managed care program requirements that included standards of access and procedures for monitoring the quality and appropriateness of care. Lastly, the legislation allowed the creation of Medicaid-only plans and repealed the “75/25” rule from OBRA 1981 requiring plans to have a minimum share of private insurance enrollees.

Over the 12 years between 1997 and 2009, enrollment in Medicaid managed care increased from 8 million to 49 million, with 23 million in comprehensive risk-based plans (CMS 2010). In some states, interest continues to grow in expanding managed care to additional enrollees, especially high cost, high need populations.

The Future of Managed Care within Medicaid

The trend toward the use of managed care in Medicaid is likely to continue. The incentives for some states to expand their use of Medicaid managed care—both for managing costs and for improving coordination of care—are not changing and may well grow stronger as states continue to face serious budget pressures (NGA and NASBO 2011). In a recent survey, 20 states said they anticipated some expansion in Medicaid managed care either geographically or to additional subgroups of enrollees in FY 2011, with additional enrollment in both comprehensive risk-based plans and PCCM programs (Smith et al. 2010).

Historically, mandatory use of Medicaid managed care has focused mostly on low-income children and parents. While these two populations of Medicaid enrollees are generally less healthy than individuals in the same age range who are enrolled in private insurance, their health care costs are far lower and more predictable than the costs of Medicaid enrollees with disabilities and enrollees age 65 and older. This made them an attractive population for managed care enrollment.

As managed care oversight and payment systems have matured, more states have considered mandating enrollment of children with special health care needs and adults with disabilities or offering these enrollees more options for enrolling in managed care. Many states have also sought out better ways to coordinate care for dual eligibles, often under separate initiatives. Because these populations typically have high health care costs, states facing budget pressures are examining whether managed care arrangements might better manage health care spending for these populations (Bella et al. 2008).

Federal officials reviewing new managed care expansion requests from states will likely do so in the context of anticipated changes in Medicaid in 2014. In particular, the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) requires states to establish coverage for nonelderly parents, childless adults, and adults with disabilities with incomes up to 138 percent of poverty.⁵ For most states, this represents an expansion of coverage for most, if not all, of these population groups. Among the newly eligible groups, parents and childless adults are likely to be a prime focus for managed care.

The introduction of state health insurance exchanges as required by current law may also have effects on Medicaid and CHIP with respect to enrollment and eligibility determination, and the introduction of new standards for minimum benefits for private plans. PPACA (§1413, §2101(e), and §2201) requires a streamlined eligibility and enrollment process across Medicaid, CHIP, and the health insurance exchange in each state, to ensure that applicants are screened for eligibility for all programs and referred for enrollment in the appropriate program without the need to go through multiple application procedures.

Other policy provisions in PPACA, together with ongoing state initiatives, may encourage use of managed care for persons with disabilities and dual eligibles. For example, PPACA created a new office in CMS for dual eligibles to examine the feasibility of more integration of services between Medicaid and Medicare. PPACA also calls for the creation of accountable care organizations (ACOs)—networks of hospitals, doctors, and other health professionals that agree to share responsibility for the care received by patients.

These statutory changes underscore the usefulness of developing reliable data and analyses on Medicaid managed care policies within the dynamic context of the U.S. health care system.

⁵ For individuals whose eligibility is determined using modified adjusted gross income starting in 2014, the eligibility limit is 133 percent of the FPL, plus states will apply an income disregard equal to 5 percent of the FPL. This means that an individual whose total income equals 138 percent of the FPL will only have 133 percent of the FPL counted when his or her Medicaid eligibility is determined.

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