Issues Facing Medicaid and CHIP Managed Care

Medicaid managed care arrangements differ from those in the private sector and in Medicare in part due to differences in the populations served. Enrollment of low-income populations (e.g., at or below 133 percent of the federal poverty level or $24,645 a year for a family of three) with limited resources and often complex health needs affects Medicaid managed care program design. The role of provider networks, the use of cost sharing as a tool for managing utilization, the enrollment process and the types of organizations sponsoring managed care plans in different markets differ from private sector and Medicare managed care plans. These distinct differences can affect whether and how states use managed care in Medicaid to deliver quality care.

Managed care in Medicaid has taken on many forms: comprehensive risk-based plans, primary care case management (PCCM) programs, and limited-benefit plans. These arrangements are a major part of Medicaid programs in many states and their role is likely to expand over the coming years. In a recent survey, 20 states said they anticipated some expansion in Medicaid managed care in FY 2011 (Smith et al. 2010). While the focus of this report has been on Medicaid managed care, managed care plays a significant role in CHIP programs as well, though evaluation, analyses, and data are limited.

States have pursued managed care strategies as a way to improve care management and care coordination, secure provider networks for enrollees, lower spending or make it more predictable, and improve program accountability. All of these goals will continue to be important as states work to improve the health of Medicaid enrollees, both in managed care and fee for service (FFS), while addressing budget constraints. However, state strategies are likely to differ based on factors such as population characteristics, population density, provider availability, plan participation, state goals, and existing managed care arrangements in each state.

Managed Care in Medicaid Today

Since states first began testing managed care as a part of Medicaid in the early years of the program, much has changed. Approximately 49 million Medicaid enrollees receive care through some form of Medicaid managed care. This Report presents the current status of managed care in Medicaid as it continues to evolve. As this Report shows, at this point in the evolution of Medicaid managed care:

Trends in Enrollment (See MACStats Tables 9 and 11). Comprehensive risk-based managed care enrollment in Medicaid is growing nationwide, and the population covered is expanding to enrollees with disabilities.

- Medicaid enrollment in comprehensive risk-based programs has increased to 47 percent of enrollees in 2009, up from 15 percent in 1995.
- Low-income children and non-disabled adults under age 65 were most likely to be enrolled in comprehensive risk-based managed care (60 percent and 44 percent respectively) in FY 2008 than other groups.
- Individuals with disabilities were enrolled in comprehensive risk-based programs in 39 states and the District of Columbia in FY 2008; 28 percent of all Medicaid enrollees with disabilities are enrolled in comprehensive risk-based managed care. However, the percentage of this group's enrollment in comprehensive risk-based managed care varies significantly by state—from less than 1 percent to over 90 percent.
- Low-income individuals age 65 and older, mostly with primary coverage through Medicare, were the least likely to be enrolled in comprehensive risk-based managed care: 11 percent of all Medicaid enrollees age 65 and older were enrolled in comprehensive risk-based managed care programs in FY 2008.

Managed Care Arrangements (See MACStats Table 9 and 10). States choose managed care arrangements and/or FFS depending on their unique populations, provider base, benefits, geography, and state goals.

- Thirty-four states and the District of Columbia had comprehensive risk-based Medicaid managed care programs with 21 states and the District of Columbia enrolling more than half of their total Medicaid population in such programs.[1] Many of the 16 states without comprehensive risk-based plans are largely rural.
- Thirty states used PCCM programs to coordinate care in FFS and 34 states and the District of Columbia used limited-benefit plans to provide selected services (such as behavioral health and oral health) in managed care and FFS settings.
- Thirty-seven states and the District of Columbia used a combination of two or more managed care arrangements and 13 states used all three managed care approaches in their Medicaid programs.[2]
- Using the CMS definition, 71 percent of Medicaid enrollees in FY 2009 were enrolled in some form of managed care in 48 states and the District of Columbia. Most Medicaid enrollees still receive at least some services through FFS arrangements.

[1] Seven additional states have Program for All-inclusive Care for the Elderly (PACE) programs but no other comprehensive risk-based managed care.

[2] Excludes PACE programs.

Payment Policy. There is considerable variation in the way states pay managed care plans.

- States with comprehensive risk-based managed care generally use forms of administered pricing or competitive bidding to establish payment rates for plans. Rates are required to be actuarially sound.
- States use different methods of adjusting payments to reflect the health and demographic characteristics of enrollees. More work is needed on risk adjustment models for complex, low-income populations.
- For some states, moving populations into managed care has implications for certain supplemental payments.

Access, Quality, and Program Accountability. Monitoring program integrity, quality, and access to care is challenging due to a lack of data and up to date analyses.

- The consistency, availability, and timeliness of the data submitted by managed care plans to states and subsequently from states to CMS vary considerably, creating challenges for analyzing and monitoring managed care programs and policies at the national level. This limits the ability to create baseline data and compare states.
- Multistate data and analyses on managed care arrangements would better enable monitoring of program integrity, appropriate utilization of health care services, and access to care.

Current and Future Issues

In this context of existing growth and variety in managed care arrangements, three overarching questions exist for policymakers as managed care continues to evolve in Medicaid and CHIP:

1. How can current managed care programs in Medicaid be improved for the low-income populations currently served? How can these lessons be applied to CHIP?
2. How can care management best address the high health care needs and costs of low-income populations including children with special health care needs, individuals with disabilities, and dual eligibles who are increasingly likely to be enrolled in managed care in the future?
3. How can managed care meet the needs of new adult populations potentially enrolling in Medicaid starting in 2014?

Key issues stemming from these three questions include: enrollment, plan participation, benefit design, payment, access to care and care quality, and data for program accountability and program integrity. Building on the baseline information in this Report, the Commission will seek to provide a better understanding of these issues as the basis for future work on how health care delivery and financing can work even more effectively for Medicaid and CHIP enrollees.

Enrollees

Historically, the Medicaid managed care environment has primarily focused on children and parents, but increasingly states are moving to cover enrollees with more complex health care needs to manage costs and improve care management. With implementation of the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148), the populations that states seek to enroll in managed care will increase further.

Much more could be known about what program features work best for different populations, and how to adapt managed care programs as states continue to extend them to additional populations. For example, individuals with complex, chronic medical needs may benefit from particular methods of care management and may need a different mix

of providers in a provider network. Individuals dually eligible for coverage through Medicare and Medicaid bring an additional set of complexities because of the need to coordinate with benefits covered and financed by the Medicare program.

States may also need to fine-tune their existing managed care enrollment processes to serve an increasing—and increasingly diverse—number of enrollees in managed care. For example, to ensure continuity of services and coordination of benefits, mandatory enrollment and auto-assignment processes might differ for enrollees with disabilities as compared with the processes states have typically used for low-income children and families. In addition, the health insurance exchanges expected to be implemented in 2014 will likely change program enrollment for Medicaid and CHIP because states are required to create an eligibility and enrollment process that integrates Medicaid and CHIP with the exchanges. Under current law, income eligibility levels for Medicaid will rise to 138 percent of poverty[3] ($15,028 for one person) for most adults in 2014—an expansion of Medicaid to new groups of eligibles in most states. This will be a diverse group, ranging from healthy young adults to older low-income individuals with multiple chronic conditions. Many of these newly eligible individuals will have little to no experience with Medicaid or other forms of health insurance.

The use of managed care for these new Medicaid enrollees will undoubtedly continue to vary substantially across the country as states adopt arrangements that meet their particular environments and state goals. For states that are already experienced with rate setting and contracting issues in comprehensive risk-based managed care arrangements, enrolling additional populations into comprehensive risk-based plans represents more of an incremental change. Other states with less managed care experience or capacity may find it easier to continue to rely on FFS or arrangements like PCCM to serve these additional enrollees.

One additional consideration for states is how to manage care for a population whose incomes fluctuate from month to month. A recent study estimated that under the new eligibility rules, as many as half of adults with incomes under 200 percent of poverty ($21,780 for one person)—approximately 28 million people—can be expected to experience changes in income that could change their Medicaid eligibility status within a single year (Sommers and Rosenbaum 2011). In this respect, these new eligibles will be similar to the non-disabled adults under age 65 who are currently enrolled in Medicaid, who are covered on average for just two-thirds of the year (Ku et al. 2009). This level of turnover will continue to be a challenge for states and plans seeking to manage care for part-year enrollees.

Plan Types and Benefit Designs

The Medicaid managed care market is a mix of comprehensive risk-based plans (in 34 states plus the District of Columbia), PCCM programs (in 30 states), and limited-benefit plans (in 34 states plus the District of Columbia). All but two states use at least one of these arrangements, and 13 states use all three types of managed care (MACStats Table 10). Because insurance markets vary from state to state, arrangements that work best for Medicaid managed care or even for a certain type of enrollee are likely to vary across states. Policymakers would benefit, however, from more systematic analyses of how use of different managed care models

[3] For individuals whose eligibility is determined using modified adjusted gross income starting in 2014, the eligibility limit is 133 percent of the federal poverty level (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.

and types of plans affect costs and outcomes for different populations. For example, states have very different experiences with carving out benefits from comprehensive risk-based managed care plans, but little research has been done on the effects of those different carve-out policies.

The landscape of comprehensive risk-based plan sponsors across the overall health system is likely to change with the introduction of insurance exchanges under PPACA, with potential ripple effects on plan participation in Medicaid and CHIP managed care. Concurrent with these changes, states and other players in the health care arena will likely continue to explore new options for care management outside the context of the managed care plans that exist today, including employing new models such as health homes and accountable care organizations (ACOs).

Payment

Payments for both FFS and managed care are likely to be under fiscal pressure as states continue to struggle with budget challenges. Some states may seek additional savings through experimenting with delivery models such as ACOs and health homes; others may focus on lowering costs for existing managed care programs or moving enrollees into managed care.

States' ability to find savings through managed care may vary depending on the availability of providers, the existing practice patterns of those providers, the patterns of service use by Medicaid and CHIP enrollees, and current FFS payment levels. For example, plans in states with a large number of providers likely have more capacity to establish networks and negotiate payment rates than do plans in states with provider shortages. Factors such as these will affect states' decisions on which kinds of managed care to pursue or whether to pursue managed care at all.

Much more could be known about how states set payment rates and use risk adjustment and risk sharing. Many states with more mature risk-based managed care systems, and particularly those that have moved to enroll high need populations such as individuals with disabilities, have developed systems to adjust plan payments based on the health status of low-income enrollees. However, there is no comprehensive source of information on the methodologies states use to risk adjust their managed care payments. Other states have not yet worked out the payment issues for these more complex, higher cost populations.

Access and Quality

Under both FFS and managed care arrangements in Medicaid and CHIP, enrollee access to appropriate services and care quality will be ongoing issues. Although many states have systems for monitoring the impact of Medicaid managed care on access to providers, use of services, and quality, systematic studies are limited and dated. Collecting more recent evidence across states will help inform both state and federal policymakers about the impact of managed care on access to appropriate care and cost for serving vulnerable populations.

Improved information and analyses would inform the assessment of access to care over time in both FFS and managed care.

Program Accountability

CMS sets broad operational and administrative requirements but gives states flexibility in how they determine operational methods, contract with plans, administer the program, and monitor participating plans. Federal and state agencies overseeing the Medicaid and CHIP programs are responsible for ensuring that mechanisms to promote access, quality, and program efficiency are

in place to prevent fraud, waste, and abuse and to identify problems when they occur.

Contracting with managed care plans may shift some responsibilities in these areas onto the plans, but it also creates new responsibilities for states. When states move from primarily staffing for FFS claims processing and operations to staffing to implement managed care programs by contracting with plans, new staff skill sets are often required to focus on plan oversight and monitoring.

Federal and state oversight of managed care in Medicaid and CHIP likely will continue to change as these programs evolve. For example, CMS is currently working with states to improve the submission of encounter data from comprehensive risk-based plans. As enrollment in managed care continues to grow, this will be an essential source of information not only for program accountability but also for research on other issues related to access and quality.

Data

Evaluating managed care's impact on access, quality, and program spending at the national level is limited by lack of timely and accurate data. Data already exist in many states, but they generally are not standardized or gathered together in a way that facilitates analyses across states. Most research examining managed care in Medicaid and CHIP is old and thus less relevant to current programs. For populations currently enrolled in managed care and for those likely to be enrolled in the future, it will be essential to improve the data available at both the state and the national level to address policy questions and provide timely program assessments.

Next Steps

The Congress established MACPAC as a nonpartisan advisor to provide technical and analytic assistance, and to be a source of current, reliable information to guide policies related to Medicaid and CHIP. MACPAC's future analytic agenda will continue to focus on managed care as well as FFS in these programs.

Just as this Report has looked at the evolution of managed care in Medicaid, in the future MACPAC will look at the evolution of managed care in CHIP. Children in stand-alone CHIP programs are even more likely than children in Medicaid to be enrolled in managed care: 81 percent are enrolled in a comprehensive risk-based managed care plan. Analyzing how managed care is working across states and for diverse populations in both Medicaid and CHIP will help state and federal policymakers understand how programs can be improved to promote appropriate access and quality while controlling costs.

Managed care currently plays a central role in many state Medicaid programs, with nearly half of all enrollees nationwide in comprehensive risk-based plans. That role may broaden in the future, as states consider managed care arrangements to cover a more diverse mix of low-income enrollees including high need, high cost populations. Moving forward, states will continue to evaluate which managed care or FFS arrangements work best for their populations now and in the future.

References

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