Populations and Enrollment in Medicaid Managed Care

States have expanded their use of comprehensive risk-based managed care for Medicaid enrollees, but not to the same extent for all populations. When large expansions of Medicaid enrollment into managed care began in the mid-1990s, the focus was on low-income children and families. Historically, enrollees with disabilities as well as people age 65 and older were often excluded or exempted from enrollment in comprehensive risk-based managed care; they generally received Medicaid benefits that were paid on a fee-for-service (FFS) basis, sometimes augmented with a primary care case management (PCCM) program or limited-benefit plans for certain services. More recently, states have expressed growing interest in extending managed care to enrollees age 65 and older and enrollees with disabilities—25 percent of all Medicaid enrollees—who tend to have higher costs and more complex health care needs. However, these changes present challenges as well as opportunities to states.

Non-disabled children and adults under age 65 make up the largest share of comprehensive risk-based managed care enrollees (88 percent) and account for 66 percent of total spending for comprehensive risk-based managed care (Table B-1). By contrast, individuals with disabilities account for 10 percent of total enrollees in comprehensive risk-based plans and 27 percent of spending on comprehensive risk-based plans. Overall, individuals with disabilities and those age 65 and older report poorer health status, have higher rates of specific health conditions, and use more health services than children and younger adults without disabilities (MACStats Tables 3A-5C).

This section describes:

- the populations enrolled in Medicaid managed care plans;
- the share of program expenditures among the populations enrolled; and
- the opportunities and challenges of managed care for different populations.

Managed Care Enrollment and Spending

Medicaid provided health coverage for 67 million low-income individuals in FY 2010.[1] Forty-eight percent of Medicaid/CHIP enrollees have incomes below 100 percent of poverty—a much higher share than for the population covered by private insurance. Almost three-fourths of enrollees were non-disabled children and adults (33 million and 17 million, respectively), and the remaining Medicaid enrollees were 11 million individuals with disabilities (16 percent) and 6 million individuals age 65 and older (9 percent) (MACPAC 2011). These subpopulations of enrollees vary considerably in their health care needs, service use, and spending.

Overall enrollment in Medicaid managed care increased in the last decade, although this growth varied depending on the type of managed care arrangement and eligibility group. For example, the share of non-disabled adults under age 65 in comprehensive risk-based plans grew in the first half of the decade, while the share of other Medicaid enrollees in this form of managed care was relatively stable. There was moderate growth in the share of enrollees in comprehensive risk-based managed care in the second half of the decade for all eligibility groups. In limited-benefit plans, the share of non-disabled adults under age 65 has remained stable while enrollment of other groups has increased. The share of enrollees in PCCM programs fluctuated during this period, with marginal growth overall.[2]

Enrollment by Eligibility Group

Data reported by states to CMS (Tables A-1 and B-1) show that 85 percent of all children in Medicaid are enrolled in some type of managed care; children also make up the majority of the Medicaid managed care population (60 percent). Fifty-seven percent of non-disabled adults under age 65 are enrolled in some form of managed care, making up 22 percent of the Medicaid managed care population. Persons with disabilities and those 65 and older are less likely to be enrolled in Medicaid managed care and therefore make up a much smaller share of Medicaid managed care enrollment (14 and 4 percent, respectively). Compared to child and adult enrollees, aged and disabled enrollees make up a smaller share of those in comprehensive risk-based plans (which is the main focus of this Report) and a larger share of those in limited-benefit plans (which generally cover services such as behavioral health and transportation). For more detail on the different types of Medicaid managed care arrangements, see Section C of this Report.

Spending by Eligibility Group

Total Medicaid spending varies across the different Medicaid subpopulations. Of $338.6 billion in total Medicaid benefit spending in FY 2008, 21 percent was for managed care (Table B-2). The largest share was for comprehensive risk-based plans, which accounted for 18 percent of all Medicaid benefit spending by states.[3] (See MACStats Table 12 for these data by state.) PCCM programs accounted for less than 1 percent of spending because most services provided to enrollees in PCCM programs are paid on a FFS basis; the only amounts tracked as managed care payments are the

[1] U.S. territories are excluded.

[2] MACPAC analysis of FY 2002–FY 2008 Medicaid Statistical Information System (MSIS) state summary data from CMS as of April 2011.

[3] States may also make FFS payments on behalf of individuals enrolled in these plans if they carve out certain services from the managed care plan contract. For more on this practice, see Section C of this Report.

TABLE B-1. Distribution of Managed Care Enrollees and Managed Care Spending by Eligibility Group, FY 2008

Basis of Eligibility	Any Managed Care		Comprehensive Risk-based Plans		Primary Care Case Management		Limited-benefit Plans	
	Enrollees	Spending	Enrollees	Spending	Enrollees	Spending	Enrollees	Spending
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Aged	4.4	7.3	2.2	7.3	1.4	1.0	7.1	8.6
Disabled	14.1	28.3	10.0	26.7	15.2	13.0	19.0	41.6
Children	59.6	37.7	62.9	38.1	66.5	52.3	54.7	32.8
Adults	21.8	26.7	24.9	27.9	17.0	33.8	19.1	17.0

Notes: Excludes the territories, Medicaid-expansion CHIP enrollees, and administrative costs. Benefit spending from MSIS data has been adjusted to match CMS-64 totals. Spending is for the respective type of managed care arrangement shown. 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. Includes federal and state funds. 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 and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2011

TABLE B-2. Percentage of Total Medicaid Benefit Spending on Managed Care by Eligibility Group, FY 2008

Basis of Eligibility	Total Medicaid Benefit Spending	Percentage of Total Medicaid Benefit Spending on Managed Care			
		Any managed care	Comprehensive risk-based plans	Primary care case management	Limited-benefit plans
Total	**$338.6**	**21.1%**	**18.2%**	**0.3%**	**2.6%**
Aged	70.4	7.4	6.4	0.01	1.1
Disabled	150.5	13.5	10.9	0.1	2.4
Children	68.1	39.6	34.5	0.8	4.2
Adults	49.5	38.6	34.8	0.7	3.0

Notes: Includes federal and state funds. Excludes administrative costs, 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. Benefit spending from MSIS data has been adjusted to match CMS-64 totals; see Section 4 of MACStats for methodology.

Source: MACPAC analysis of Medicaid Statistical Information System (MSIS) annual person summary (APS) data and CMS-64 Financial Management Report (FMR) net expenditure data from CMS as of May 2011

small case management fees paid to primary care providers (PCPs). Limited-benefit plans made up 3 percent of all benefit spending in FY 2008.

Beneath this aggregate spending profile, however, patterns differ dramatically by eligibility group. Compared to the average for all of Medicaid, spending on children and adults under age 65—who account for 35 percent of all Medicaid benefit spending (MACStats Figure 3 and Table 7)—is almost twice as likely to go toward managed care payments (21 percent of benefit spending for all groups, 40 to 39 percent for children and adults, respectively).

By contrast, individuals with disabilities under age 65 account for 44 percent of all Medicaid spending (MACStats Figure 3 and Table 7). This group is far less likely to be enrolled in managed care, and only 14 percent of all Medicaid benefit spending for individuals with disabilities went to managed care payments (Table B-2). Medicaid enrollees age 65 and older—representing 21 percent of all Medicaid benefit spending—are the least likely to be enrolled in managed care. Only 7 percent of Medicaid benefit spending for those age 65 and over was for managed care payments.

Opportunities and Challenges in Comprehensive Risk-based Managed Care

When implemented and monitored effectively, comprehensive risk-based Medicaid managed care programs may offer some states opportunities for improving access to and quality of care while potentially constraining program costs. Contracting with plans for comprehensive risk-based managed care may provide states with the ability to require the development of a dedicated network of providers, care management and coordination, and quality measurement standards. How these goals are achieved may vary by eligibility group, as each one presents opportunities and challenges related to managed care monitoring requirements in contracts. Although some states have chosen to implement PCCM programs or make use of limited-benefit plans alone, this section presents some of the issues that states face when moving enrollees to comprehensive risk-based managed care, then explores how some of these issues are particularly significant for different eligibility groups within Medicaid.

Issues Affecting All Enrollees in Comprehensive Risk-based Plans

Some of the issues that states address in implementing managed care for all Medicaid enrollees in comprehensive risk-based plans include:

- establishing voluntary or mandatory enrollment policies;
- educating enrollees about managed care;
- planning for adequate time to roll-out enrollment for large new populations;
- providing for plan choice and auto-assignment;
- ensuring continuity of care and access to providers;
- setting payment rates in a way that covers the cost of efficiently provided and appropriate care; and
- monitoring plans over time.

Voluntary versus mandatory enrollment. Many states have made enrollment in a comprehensive risk-based managed care plan mandatory for certain populations. Other subgroups of enrollees may be excluded (not eligible for enrollment, sometimes referred to as a population carve out) or exempt (may voluntarily enroll) from mandatory managed care. Some states exclude persons with disabilities, children with special needs, foster

children, and medically needy enrollees from enrolling in their managed care program.[4] Carved-out populations either remain in traditional FFS or may be enrolled in a specialized managed care plan with a network of providers that specializes in their specific health care needs (e.g., cystic fibrosis, cancer care, organ transplantation, end-stage renal disease, HIV/AIDS, hemophilia).

When voluntary enrollment in managed care is low, there is the chance that participating plans will not have adequate numbers of enrollees to spread out the risk of high-cost events or to cover certain administrative costs. These issues can be addressed through well-designed payment arrangements. Mandatory enrollment is an approach that has been used to ensure a large number of enrollees participate.

Outreach and enrollee education. When implementing managed care, making sure enrollees understand how managed care works and differs from FFS is a particular concern. For enrollees who have been uninsured or in FFS Medicaid, the enrollment process may be their first interaction with managed care. Thus, when enrolling individuals with Medicaid coverage, it is important to communicate:

- how to obtain services in the most appropriate manner;
- the procedures for making plan selection and the implications of those choices;
- the concept of auto-assignment for those who do not select a plan; and
- the importance of acting in a timely manner so that enrollment cards and new member materials can be issued (Gold et al. 1996).

For Medicaid enrollees, education about the managed care program is crucial. States often contract with enrollment brokers who provide outreach, enrollment, and educational services and serve as a link between managed care plans and enrollees. States may also use community-based organizations to assist enrollees with the enrollment process. States and enrollment brokers often use several strategies to inform enrollees about their managed care choices, including informational materials and instructions on how to enroll, toll-free help lines, and face-to-face counseling.

Roll-out. Successful implementation of Medicaid managed care takes time and may improve with a phased-in roll-out schedule. Implementation must take into consideration adequate time for systems development, as well as sufficient resources to ensure an effective enrollment and transition process for enrollees.

The past experiences of some states that moved quickly to design and implement new managed care programs in the mid-1990s demonstrated the issues that may emerge when rapidly implementing such programs. For example, when Tennessee initially introduced and implemented TennCare in 1994, the state's implementation schedule proved to be too short for adequate preparation by the state and participating managed care plans, including not having operating information systems by the start date of the program. Information and adequate education were not readily available for enrollees who were unfamiliar with managed care concepts; providers were delivering services without knowing whether or by whom they would get paid; and the state was not fully prepared for adequate oversight of the managed care plans (Wooldridge et al. 1996).

[4] There are also federal requirements related to the enrollment of American Indians into Medicaid managed care. For example, a state may not require tribal members to enroll in managed care or a PCCM program, except when the entity is the Indian Health Service; an Indian health program operated by a tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service; or an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service.

However, this program has matured over the years and now has 93 percent of its Medicaid enrollees in comprehensive risk-based plans (MACStats Table 11).

Plan choice and auto-assignment. For mandatory enrollment in comprehensive risk-based managed care programs, states try to enroll new Medicaid members into a managed care plan as soon as possible after their initial Medicaid eligibility determination. The timing of enrollment in a managed care plan varies across states, with some states requiring enrollees to pick a plan at the time they apply for Medicaid, while other states wait until after Medicaid eligibility has been determined. Thus some Medicaid enrollees may enroll in Medicaid and select a plan at the same time.

Medicaid enrollees are generally offered a choice among health plans and must choose one within a specific window of time (ranging from a number of days to several months, depending on the state). The amount of time may vary by Medicaid subpopulation. For example, some states allow persons with disabilities a longer amount of time to choose a plan compared to non-disabled enrollees. A state that mandates Medicaid managed care enrollment must offer a choice of at least two plans, except in certain rural areas or if the state receives a waiver for this provision (42 CFR 438.52). The number of plans from which Medicaid enrollees may choose can vary by state, county, region, or even by metropolitan area. While some Medicaid enrollees may be offered a choice of 10 managed care plans in a certain area, in other geographic areas they may only be offered two managed care plans. Communicating the differences in managed care plans offered to enrollees is critical for their ability to make informed decisions on which plan best meets their health care needs.

For some individuals, plan enrollment is initiated by a health care encounter. The clinic or hospital providing services often looks into potential eligibility and facilitates enrollment of the individual, if eligible, in Medicaid or CHIP. If the person is in an eligibility category where managed care is mandatory, this enrollment triggers the need to select a plan.

Auto-assignment is a common method of plan selection for enrollees who do not make a choice within the given timeframe. For these enrollees, the state makes the selection and assigns them to a particular health plan. While the methodology for auto-assignment varies across states, federal regulations require that the auto-assignment process try to preserve existing provider-enrollee relationships (42 CFR 438.50). Auto-assignment may also take into consideration the proximity of participating plans and providers, the plan enrollment of other family members, and the balanced distribution of enrollees across plans. Some states use auto-assignment in certain performance-based policies. For example, plans that rank higher on clinical quality outcomes may receive a higher percentage of auto-assigned enrollees. States may also use other factors for auto-assignment. For example, California gives preference in auto-assignment to plans according to their percentage of contracts with safety-net providers and certain performance measures.

Once enrolled in a managed care plan, enrollees often have the ability to switch plans within a certain timeframe (e.g., 90 days from enrollment into plan) without cause. Once the opportunity to switch ends, several states have lock-in provisions that mandate the enrollee stay with the assigned plan for a certain period of time, usually six months or one year.[5]

[5] Enrollees may request disenrollment from a plan at least once every 12 months (42 CFR 438.56).

States' capacity to smoothly enroll large populations has been an issue in the past as some states moved to mandatory managed care for large groups. High rates of auto-assignment or plan switching may signal inadequacies in the education and enrollment process. States have offset these problems by modifying enrollment procedures and increasing outreach and education among Medicaid enrollees and providers.

Continuity of care. Another consideration for states when an enrollee transitions from FFS to managed care is the need to minimize disruption in any ongoing course of treatment. States often require plans to allow a transition period during which an enrollee can continue treatment with a given provider for a given period of time, regardless of whether or not the provider is within the plan's network. This helps to ensure continuity of care until the managed care plan can develop a transition plan and identify appropriate providers within the network to meet the enrollees' needs—and also attempt to include the enrollees' provider(s) in the plan's network.

Access to providers. Some states have found it a challenge to secure provider participation in Medicaid, particularly for some specialties, such as behavioral health providers, neurologists, and oncologists. Through contract requirements, states can require managed care plans to develop broad provider networks. As described below, access to specialty care may be a concern for certain populations moving into managed care.

Payment. States must assure that the mechanisms for setting capitation payments to plans are adequate. As states' experience with Medicaid managed care has grown, methods for risk adjusting payments have improved. These considerations are especially important as states move to enroll high cost, high need populations in managed care. More information on payment issues is included in Section D of this Report.

Monitoring. By requiring managed care plans to collect and report ongoing data such as utilization measures, states can ensure that enrollees are receiving continued appropriate access to high-quality services. More information on monitoring access and quality is included in Section E of this Report.

Issues Related to Non-disabled Children and Adults

Non-disabled child and adult Medicaid enrollees under age 65 (such adults often qualify on the basis of being parents of children enrolled in Medicaid) make up 88 percent of the Medicaid enrollees in comprehensive risk-based managed care plans. These two populations are far healthier on average than the rest of the Medicaid population. Nearly three-fourths of children enrolled in Medicaid or CHIP report being in excellent or very good health. This is lower than privately insured children, but higher than adult Medicaid enrollees (MACStats Tables 3B, 4B, 5B).

However, children enrolled in Medicaid and CHIP are not uniformly healthy. About 18 percent of children enrolled in Medicaid and CHIP do not receive SSI benefits but meet the definition of children with special health care needs (CSHCN).[6] On many measures of health status and service use, this group of children is more similar to

[6] This definition, used by the federal government and states for policy and program planning purposes and by researchers for analytic purposes, includes children who "have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally." CSHCN encompasses children with disabilities, as well as those with chronic conditions (e.g., asthma, juvenile diabetes, sickle cell anemia) that range from mild to severe. Except for those who are eligible for Medicaid on the basis of a disability, CSHCN are included in the "Children" category throughout this Report. See Section 2 of MACStats for further discussion of the disabled, SSI, and CSHCN populations.

children with disabilities than to other Medicaid/CHIP children: they are more likely to report fair or poor health status and are nearly twice as likely to visit health care providers four or more times within a year (MACStats Tables 3B and 3C). In managed care statistics available from CMS, non-disabled CSHCN are not tracked separately; they are included in the statistics for all non-disabled children.

Predictable costs. Average benefit spending for non-disabled children in Medicaid was about $3,000 per full-year equivalent enrollee in FY 2008; for non-disabled adults under age 65, average benefit spending was about $4,700 per full-year equivalent enrollee (MACStats Table 8). Spending on individuals with disabilities and enrollees age 65 and older is three to five times as much. Regardless of cost, enrolling various populations in managed care may increase predictability of state spending.

Fluctuations in eligibility. One challenge of managed care for enrolling non-disabled children and adults is fluctuations in their eligibility status. Turnover in program enrollment can be a function of changes in income levels or issues with renewal. An analysis of 2006 Medicaid administrative data indicated non-disabled adults under age 65 had the lowest rates of continuous enrollment and were typically continuously enrolled for just over two-thirds of the year. Individuals age 65 and older and children had rates of continuous enrollment similar to the average, which is three-quarters of the year (Ku et al. 2009).

Interruptions in health care coverage can affect plans' ability to manage and coordinate care for Medicaid enrollees. It can also impair quality monitoring and improvement activities in the provision of health care services. One study found that extending children's enrollment in Medicaid from three months to one year reduced hospitalizations for ambulatory-care-sensitive conditions by about five percent (Bindman et al. 2008). States have used such increases in the period of time between eligibility determinations as one strategy for improving continuity of care. Federal Medicaid policies allow states to provide children with continuous eligibility in the Medicaid program for up to 12 months. As of January 1, 2011, 23 states provided 12-month continuous eligibility in Medicaid programs and 28 states provide it in CHIP (Heberlein et al. 2011).

Adequate provider networks. Enrolling large numbers of children and adults in managed care plans requires that the plans have an adequate network of appropriate providers that can serve the needs of the enrolled populations (42 CFR 438.206). Access to specialists is a particular issue for Medicaid children and adult enrollees. Plans report greater difficulty developing adequate specialty care networks while providers have reported difficulty in making successful referrals for specialty care (Gold et al. 2003).

Pregnant women require a specific set of services and providers for their health care needs. Medicaid provides coverage for pregnant women and their pregnancy-related care, including prenatal, delivery, complications that may occur during pregnancy, and postpartum-related services. Access to adequate obstetrics and gynecology provider networks and prenatal and postnatal services is a component of providing quality care to this population. The cost of care for pregnant women may vary depending on the type of delivery and whether there are any complications. Eligibility determination for this population differs from most other non-disabled adults under age 65 in that pregnant women may become eligible for Medicaid coverage based on their health condition (pregnancy status).

Issues Related to Persons with Disabilities

Persons with disabilities in the Medicaid program are individuals under age 65 (including children) who qualify for federal SSI benefits or meet similar criteria. In most states, qualifying for SSI—a federally funded, cash assistance program for certain low-income aged, blind, and disabled individuals—automatically confers Medicaid eligibility.[7] (For more on SSI eligibility, see Section 4 of MACStats.)

Children receiving SSI represent only 3 percent of non-institutionalized Medicaid/CHIP children under age 19 (MACStats Table 3B). Among non-institutionalized Medicaid adults under age 65, 21 percent receive SSI benefits (MACStats Table 4B). Together, disabled children and adults account for 17 percent of total Medicaid enrollment, but they represent a disproportionate share of program spending (44 percent of total Medicaid benefit spending in FY 2008) (MACStats Tables 6 and 7).

Medicaid enrollees on SSI, both children and adults, report poorer health status and greater presence of health conditions including chronic conditions, compared to the overall Medicaid/CHIP population in that age group (MACStats Tables 3B and 4B). Over half of Medicaid adults that receive SSI benefits report their health status as fair or poor. Both adults and children on SSI reported more visits to providers within a year, and adults reported more home care within the past 12 months, than other Medicaid/CHIP enrollees in their age group (MACStats Tables 3C and 4C).

In general, persons with disabilities are a high need, high cost group of Medicaid enrollees that can present challenges for managed care, both in terms of service delivery and costs. However, the number of states with SSI enrollees in both voluntary and mandatory managed care has grown over time (GAO 2000).

High cost population. Medicaid benefit spending for persons with disabilities averaged more than $17,000 per full-year equivalent enrollee in FY 2008, the highest of any eligibility group (MACStats Table 8). Cost savings may be a major goal for states implementing managed care for disabled enrollees, but research quantifying state savings from transitioning disabled enrollees into managed care is often limited and narrow in scope; additional data would be helpful.

Despite the potential for savings, the high costs of care for persons with disabilities can also be a barrier to managed care enrollment. Effective setting of payment rates for this population is necessary to protect access to care for high cost enrollees and equity across health plans participating in the program. (For further discussion of Medicaid managed care payment policy, see Section D of this Report).

Stable eligibility. Individuals with disabilities tend to have more stability in their Medicaid eligibility status than non-disabled children and adults under age 65. Individuals with disabilities are more likely to be continuously enrolled than all other Medicaid enrollees, likely reflecting that the income of many of these individuals is stable (Ku et al. 2009).

Voluntary versus mandatory enrollment. Many Medicaid programs that offer managed care to individuals with disabilities have started with voluntary program enrollment. In order for mandatory enrollment to be effective for individuals with disabilities, provider networks

[7] Eleven states (Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, Virginia) known as 209(b) states are allowed to use different financial and non-financial Medicaid eligibility rules from the federal SSI program for Medicaid eligibility determinations as long as the Medicaid rules are no more restrictive than the rules the state had in place in 1972 when the SSI program was enacted.

that take into account the special health care needs of the populations, as well as adequate enrollee education and outreach, are needed.

Continuity of care. Mandatory managed care enrollment of individuals with disabilities has the potential to affect established provider and care arrangements (Tanenbaum and Hurley 1995). Issues of continuity of care may arise for providers and disabled enrollees when a specialty care provider that has developed a relationship with an enrollee is not included in the managed care plan's provider network. This can be further complicated by the fact that enrollees in this group may see a wide variety of providers to address multiple co-morbid conditions. Some states offer a longer transition period for disabled enrollees than they do for managed care enrollees without disabilities, so enrollees can continue ongoing courses of treatment and managed care plans can work to ensure continuity of care. Plans may also choose to allow some enrollees to continue receiving care from an out-of-network provider for a given period of time.

Care coordination. Enrollees with disabilities often have complex medical needs that may require coordination of care across multiple physical and behavioral health providers, as well as pharmacy and dental services. In FFS, management of care is typically the responsibility of the enrollee or the enrollee's family or guardian, though some states provide care coordination services. The care for enrollees with complex chronic conditions may be improved through care management activities.

In well-designed contract provisions states can require managed care plans to coordinate services for enrollees, including scheduling appointments, locating participating providers, helping facilitate communication between providers, identifying health risks, and addressing other issues that may affect access. Plans may also be responsible for providing enrollee education that focuses on specific health needs, including disease management programs or self-management skills for a particular chronic condition. Well-executed managed care can also focus appropriate attention on care transitions (e.g., hospital to short-term nursing facility to home), which can reduce readmissions to hospitals and nursing facilities, and loss of enrollee long-term independence.

Benefit carve outs can affect care coordination for disabled enrollees. (For further discussion of carved-out benefits see Section C of this Report.) If certain services such as oral health, pharmacy, or behavioral health are carved out of managed care and provided through FFS, enrollees must navigate across multiple environments, and coordination of services becomes more complex. Even for services included in a managed care contract, plans may choose to contract out certain services, which also may raise issues with coordination of care.

Access to care. Medicaid enrollees who qualify for coverage on the basis of a disability have conditions that may include physical impairments and limitations (e.g., quadriplegia), intellectual or developmental impairments (e.g., mental retardation, cerebral palsy), and severe mental and emotional conditions, including mental illness (e.g., schizophrenia). They include children and adults residing in the community, as well as in long-term care facilities. Therefore managed care plans must ensure that their provider network consists of the right types and sufficient numbers of providers to serve this group adequately. States may require plans to allow standing referrals to specialists or designation of a specialist as a PCP.

Issues Related to Persons Dually Eligible for Medicaid and Medicare

Approximately 9 million individuals are dually eligible for Medicare and Medicaid (referred to as "dual eligibles") (MACStats Table 6). These Medicare beneficiaries receive financial assistance from their state Medicaid programs to pay for Medicare premiums, copays and/or deductibles. If their income and assets are low enough, dual eligibles may also qualify for full Medicaid benefits including long-term services and supports (LTSS).

Medicare is the primary payer for dual eligibles, covering all acute care services, outpatient and physician services, dialysis, prescription drugs, and post-acute care services (e.g., rehabilitation following hospitalization). Medicaid "wraps around" Medicare for dual eligibles, paying Medicare premiums and cost sharing (i.e., deductibles and copays) and covering services with limited or no Medicare coverage including LTSS, behavioral health, and medical transportation services.

Dual eligibles can be enrolled in varying combinations of FFS and managed care for their Medicare and Medicaid benefits. These combinations can vary by state and within market areas of individual states. Most dual eligibles, however, currently receive care for Medicare and Medicaid services in FFS settings.

High cost population. Spending on dual eligibles varies substantially according to health status, physical and cognitive impairments, and whether or not they reside in an institution. Medicaid and Medicare per enrollee spending on dual eligibles totaled $26,185 in 2005 with Medicaid spending accounting for 63 percent of the total (MedPAC 2010).[8] Dual eligibles' Medicare spending is also higher than for the average Medicare beneficiary. This has created an interest in finding better ways to coordinate and manage care for this population in both programs.

Voluntary versus mandatory managed care. For services covered by Medicare, federal law requires that a beneficiary's enrollment in managed care must be voluntary (§1802 of the Social Security Act). Incentives for dual eligibles to join Medicare managed care plans, known as Medicare Advantage (MA) plans, may be limited because some of the additional benefits and reduced cost sharing that MA plans offer to attract enrollees are already covered by Medicaid. Approximately 1.5 million dual eligibles—less than 20 percent of this population—have exercised the option to enroll in an MA plan for their Medicare benefits (Bella and Palmer 2009).

A larger number of dual eligibles—over 2 million—are enrolled in some form of managed care for their Medicaid benefits (CMS 2010). State policies determine whether dual eligibles have the option to enroll in Medicaid managed care, whether enrollment is voluntary or mandatory, and whether certain services such as behavioral health and LTSS are provided by the managed care plan or through FFS. States may also establish policies regarding simultaneous enrollment in Medicare and Medicaid managed care plans and whether dual eligibles can receive both program benefits from the same health plan or from two separate health plans (Walsh 2002).

Integrating Medicare and Medicaid. Medicare and Medicaid have different statutory provisions, administrative procedures, and payment policies, which can complicate coordination of services and payments. States, CMS, and health plans also jointly face challenges in effectively sharing information.

[8] The data predate the implementation of Medicare's drug benefit so prescription drug spending is included in Medicaid's spending.

For dual eligibles in managed care, Medicare and Medicaid services and benefits may be coordinated to different degrees under current law. Examples include:

- an MA plan with Medicaid FFS "wrap around" for acute care cost sharing and coverage of LTSS;
- an MA plan (possibly a Special Needs Plan (SNP)) and a companion Medicaid managed care plan with a primary, acute, and LTSS contract; and
- a fully integrated provider-based managed care plan that provides all Medicare and Medicaid primary and acute care services and LTSS. The Program of All-Inclusive Care for the Elderly (PACE) is a model of fully integrated Medicare and Medicaid services and financing for dual eligibles.

SNPs. SNPs are MA plans that focus on certain groups of Medicare enrollees. There are three types of SNPs: SNPs for dual eligibles (D-SNPs), SNPs for Medicare enrollees with severe or disabling chronic conditions (C-SNPs), and SNPs for Medicare beneficiaries in institutions such as nursing homes (I-SNPs). SNPs are able to target or limit plan enrollment to these specific subsets of the Medicare population.

As of April 2011, 298 D-SNPs were operating with an enrollment of approximately 1.1 million (CMS 2011a). Full integration of Medicare and Medicaid benefits requires the D-SNP to have a contract with the state for the provision of Medicaid benefits, in addition to an MA contract. Most D-SNPs currently do not have contracts with states to provide full Medicaid benefits. Only an estimated 120,000 dual eligibles, or less than 1.5 percent of the total dual eligible population, are enrolled in fully integrated managed care programs (Bella and Palmer 2009).

In an effort to improve the integration of Medicare and Medicaid benefits, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275, §164) mandates that new D-SNPs, or existing D-SNPs seeking to expand into new service areas, must enter into contractual relationships with states to provide Medicaid benefits for D-SNP enrollees. The regulations authorizing contracting requirements (42 CFR 422.107) have offered some additional guidelines on this requirement, detailing what must be contained in the contract between the state and the D-SNP, including the MA organization's responsibilities (e.g., financial obligations) to provide or arrange for Medicaid benefits, Medicaid benefits covered under the SNP, and cost-sharing protections.

PACE. The PACE program is a provider-based model for qualifying frail elderly dual eligibles that integrates Medicare and Medicaid services and financing. PACE programs—which are offered by nonprofit or public entities—provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the enrollee's needs. The PACE model of care is a permanent provision within the Medicare program, but an option for state Medicaid programs. States must include PACE as an optional Medicaid benefit in their state Medicaid plan before the state and the Secretary of the Department of Health and Human Services (HHS) can enter into program agreements with PACE providers. Currently 82 PACE organizations in 30 states have enrolled approximately 20,000 dual eligibles (CMS 2011a).

Acting as the sole source of services for enrollees, PACE providers assume full financial risk for participants' care without limits on amount, duration, or scope of services. PACE providers receive separate monthly Medicare and Medicaid

capitation payments for each eligible enrollee. Under the Medicare program, the standard risk-adjusted capitation rate that CMS pays to MA plans is adjusted to include an additional patient frailty adjustment for PACE enrollees. The monthly Medicaid capitation rate is negotiated between the PACE provider and the state agency and is specified in the contract between them. This Medicaid capitation rate is fixed during the contract year regardless of changes in the enrollee's health status.

Evaluations of PACE programs have found them to be a successful model of care for frail elderly individuals, in terms of several measures of outcomes, including health and functional status, qualify of life, and satisfaction with services (Chatterji et al. 1998). However, only about 10 percent of eligible individuals choose to enroll in PACE. Additionally, the availability of PACE programs is limited in many parts of the country, due in part to the high start-up costs to develop new delivery sites and the financial risk for organizations that choose to establish PACE programs. Some organizations are exploring the concept of "PACE without walls," which would provide options for integration of acute and LTSS in the community without the need for a single "bricks and mortar" delivery site.

CMS Activities and Demonstrations. The new Federal Coordinated Health Care Office (FCHCO) at CMS, created by the Patient Protection and Affordable Care Act (P.L. 111-148, §2602), is intended to work toward integrating care for dual eligibles and coordinating benefits between Medicaid and Medicare. FCHCO recently published a list of areas in which the two programs could better align their requirements, including coordinated care, FFS benefits, prescription drugs, cost sharing, enrollment, and appeals (CMS 2011b).

On April 14, 2011, CMS announced 15 states selected to receive design contracts as part of the agency's initiative on State Demonstrations to Integrate Care for Dual Eligible Individuals.[9] Each state will receive up to $1 million to design a delivery system and payment model to improve coordination of care across primary, acute, behavioral health, and LTSS for dual eligibles. States that successfully complete their design may be eligible to receive additional funding to implement their proposals.

[9] The states selected were California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.

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