Medicaid Managed Care in 2010: Highlights from the KCMU/HMA 50-State Survey

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FIGURE 1

About the KCMU/HMA Survey

- Survey of Medicaid directors in 50 states and DC regarding their managed care programs operating as of October 2010.
  - Survey fielded in late December 2010; data collected through Spring 2011.
- Scope of survey:
  - States' current managed care programs (MCOs, PCCM programs, non-comprehensive PHPs)
  - Special initiatives to improve quality and care coordination
  - Managed long-term care and managed care initiatives for dual eligibles
  - Expectations related to health reform.
- Findings are based on information as reported by state Medicaid officials.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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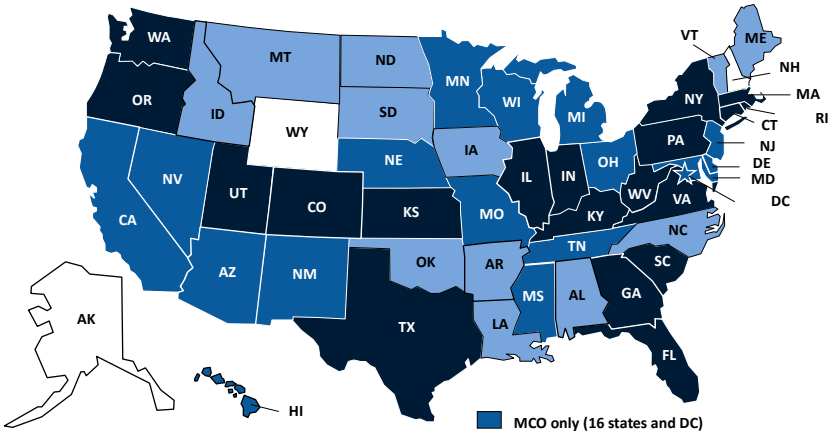
FIGURE 2

Comprehensive Medicaid Managed Care Models Operating in the States, 2010



Comprehensive Medicaid Managed Care enrollment = 66%

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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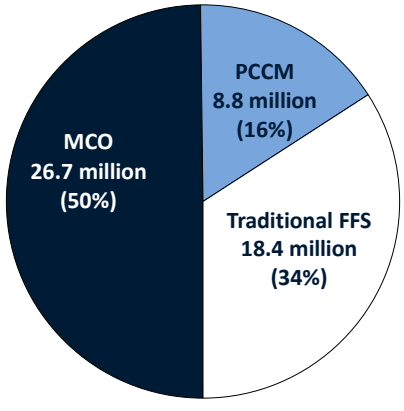
FIGURE 3

Medicaid Enrollment in Comprehensive Managed Care, October 2010



Total = 53.9 million Medicaid beneficiaries

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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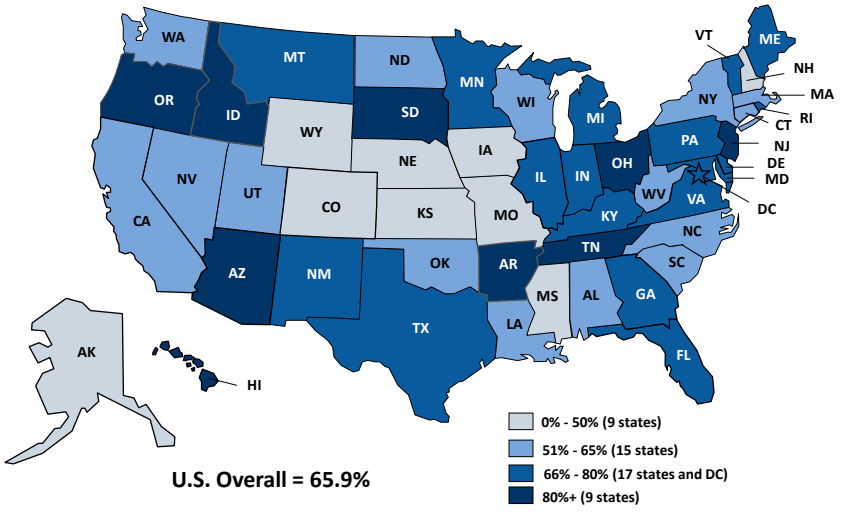
FIGURE 4

Comprehensive Medicaid Managed Care Penetration by State, October 2010



NOTE: Most data as of October 2010. Includes enrollment in MCOs and PCCMs.
SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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FIGURE 5

Mandatory Managed Care for Beneficiaries with More Complex Health Care Needs

- In all, 46 states mandate managed care for most children, and 44 do so for pregnant women, and parents and other caretaker adults.
- A majority of states mandate enrollment in some managed care program and/or geographic area for children with disabilities receiving SSI, children with special health care needs, and seniors and people with disabilities. Several states plan to mandate enrollment for additional populations.
- Half the states report some enrollment of dual eligibles in a managed care arrangement, on either a mandatory or voluntary basis.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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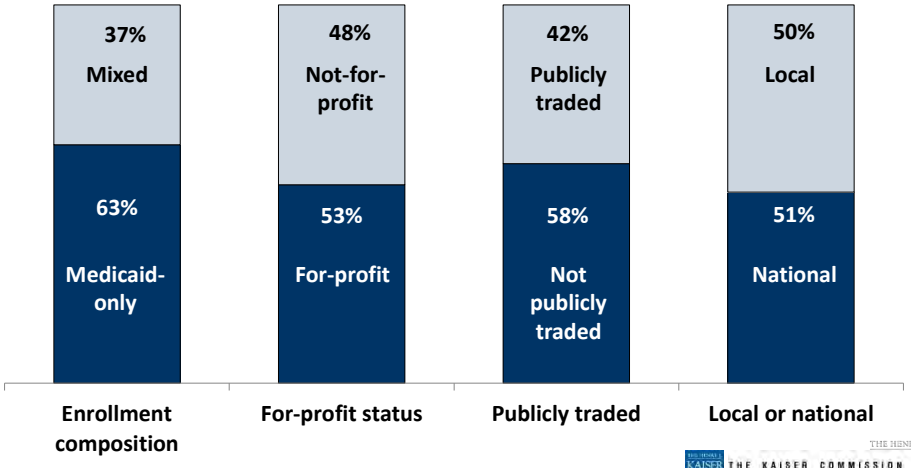
FIGURE 6

Distribution of Medicaid MCO Enrollment by Selected MCO Characteristics



SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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FIGURE 7

MCO Outreach and Marketing and Plan Selection

- Most states (28) allow MCOs to conduct outreach and marketing activities within federal rules; six prohibit this.
- A substantial majority of states with MCOs (25) use an enrollment broker to provide plan information to beneficiaries and assist them with plan selection.
- Auto-assignment rates varied widely among the 26 MCO states that provided this information.
  - Rates ranged from 3% in WA to 80% in OR and VA; half the states reported rates of 20% or less, while five reported rates exceeding 50%.
  - State auto-assignment criteria may reflect beneficiary considerations (e.g., assignment of other family members, geographic proximity) and/or state policy objectives (e.g., reward high-performing plans, balance plan enrollment).

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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FIGURE 8

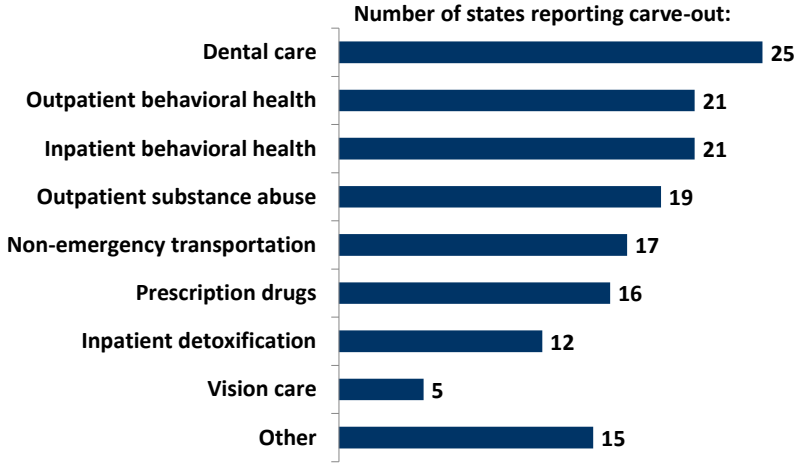
Capitation Rate-Setting, P4P, and Medical Loss Ratio Requirements

- Three-quarters of states with MCOs (27) set capitation rates administratively using actuaries.
  - Smaller numbers of states reported setting rates by negotiation (11), by competitive bid within ranges (10), and by simple competitive bid.
- Most states risk-adjust their capitation rates for age and eligibility category, and about two-thirds adjust for health status.
- More than half the states with MCOs (19) have a P4P element in their payment to plans, such as withholding a portion of the capitation, which can be earned back through performance, or bonus payments.
- Eleven states have minimum medical loss ratio (MLR) requirements for their MCOs, ranging from 80% to 93%. Three states plan to require minimum MLRs in the future.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 9

Acute-Care Benefit Carve-Outs in Medicaid MCOS



SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 10

MCO Network Adequacy and Access to Care

- States use a variety of network adequacy standards to ensure beneficiary access to needed care in MCOs.
  - States often apply different standards for primary and specialty care; standards may be expressed as minimum provider-to-population ratios or distance or travel-time maximums, and they frequently differ for urban and rural areas.
- Many but not all states with MCOs (25) reported that Medicaid enrollees sometimes face access problems.
  - Gaps in access to dental care, pediatric specialists, psychiatrists and other mental health providers, and other specialists were all cited.
  - At the same time, the vast majority of state officials perceived managed care to improve access, relative to FFS, significantly in some cases. (The survey did not directly collect information on access problems in FFS.)

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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FIGURE 11

Key findings from States with PCCM Programs

- Most of the 31 states with PCCM programs pay PCPs a small fee such as $3 PMPM for case management in addition to regular FFS payments.
- A large majority of states with PCCM programs require PCPs to provide 24/7 coverage and about half limit PCP panel size.
- 13 states require PCPs to participate in state quality initiatives, and 8 states have a P4P element in their payment to PCPs.
- Enhanced PCCM programs in 9 states include enhancements such as disease management, coordination/integration of physical and mental health care, and case management for high-cost/high-risk enrollees.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

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FIGURE 12

Quality Standards and Performance Measurement in MCOs and PCCM Programs

- 16 of 36 states with MCOs require plans to be accredited to participate in Medicaid.
  - Some other states recognize or encourage accreditation, and some that do not require accreditation deem accredited plans to meet certain state and federal requirements.
- All MCO states require HEDIS©, CAHPS©, and similar state-developed measures of access, clinical quality of care, and patient satisfaction in their plans. Median number of required HEDIS© measures is 32.
  - Top measures reflect Medicaid priorities, e.g., prenatal and postpartum care, childhood immunization status, appropriate asthma medication, comprehensive diabetes care, care following hospitalization for mental illness.
- Over half the states with PCCM programs use similar measures for these programs. Median number of HEDIS© measures used is 16.
- 16 states reported that they also use HEDIS© to measure performance in traditional FFS.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 13

Public Reporting of Quality Performance Data and Performance Improvement

- Three-quarters of states with MCOs publicly report on the quality of their health plans, and half of states with PCCM programs publish quality reports on those programs.
- 15 states with MCOs and one PCCM-only state prepare quality "report cards" for beneficiaries to use when choosing a plan or a provider.
- State "performance improvement projects (PIPs), required by federal standards for Medicaid MCOs, focus on a broad range of topics, such as improving birth outcomes (DC, VA), access to pediatric subspecialists (SC), appropriate ER use (OK), and improving coordination between behavioral health and medical providers (AZ).

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 14

Special Initiatives to Improve Quality

- 43 states report initiatives to reduce inappropriate use of ER.
  - E.g., ER data to PCPs, 24-hour nurse line, beneficiary education, case management for heavy users.
- 34 states report initiatives to reduce obesity, with Medicaid MCOs often playing a leading role.
  - E.g., weight reduction programs, disease management, health nutrition education, health promotion.
- Almost half the states report Medicaid initiatives to reduce racial and ethnic disparities
  - E.g., focus on well-child visits, screening for cancers for women; cultural competency; data on race/ethnicity provided to MCOs for analysis of use patterns.
- Other quality initiatives target dental care, depression screening, behavioral health, persons needing care coordination.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 15

Special Initiatives to Improve Care Coordination

- 39 states have a medical home initiative in place or under development, and the same number report disease management or care management programs, which are often integrated into MCOs or PCCM programs.
- 22 states plan to elect the new “health home” option for beneficiaries with chronic conditions.
- Nine states reported having an ACO initiative in some stage of development, and three states indicated proposed legislation in 2011 to begin a pilot or require Medicaid payment to ACOs.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 16

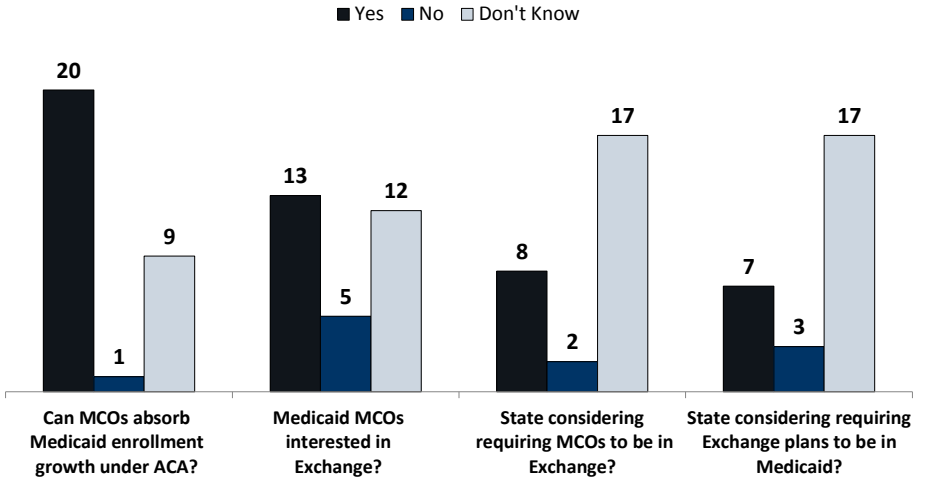
Medicaid Managed Long-Term Care (MLTC) and Managed Care Initiatives for Dual Eligibles

- Half the states have PACE sites with total enrollment of about 21,000. Eleven states also reported capitated, non-PACE MLTC programs with total enrollment of over 400,000.
  - Some programs include LTC only, but others encompass acute care as well.
  - Programs generally include only Medicaid services, but programs in MA, NY, and WI also include Medicare services.
- 25 states reported enrollment of dual eligibles in some form of (non-PACE) Medicaid managed care in 2010, on a voluntary or mandatory basis.
- 21 states reported plans to expand or modify current programs, or broader efforts focused on dual eligibles, including 15 states that received grants from CMS to design approaches to better coordinating and financing care for dual eligibles.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 17

Medicaid MCOs and Health Reform (27-30 states responding)



Note: 36 states contract with MCOs.

SOURCE: KCMU/HMA Survey of Medicaid Managed Care, September 2011.

FIGURE 18

Looking Ahead

- High level of managed care activity in Medicaid programs is likely to continue or even build, given ongoing state budget pressures, focus on improving care for people with complex needs, the Medicaid expansion, and industry interest in a growing Medicaid market.
- Expansion of managed care to more medically complex and fragile beneficiaries elevates the importance of measuring and monitoring access and quality, and of robust oversight of managed care.
- Growing stakes in Medicaid managed care translate into increased policy needs for data, analysis, and evaluation across current and emerging managed care approaches.

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