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THE HENRY J. KAISER FAMILY FOUNDATION

A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey

EXECUTIVE SUMMARY

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September 2011

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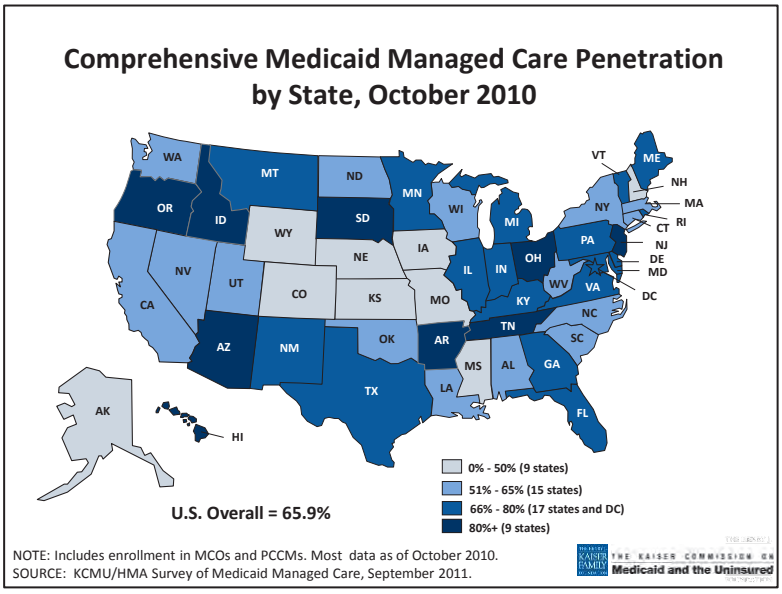
The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

EXECUTIVE SUMMARY

Medicaid, the public insurance program for low-income Americans, is the single largest health care program in the United States. In calendar year 2011, average monthly Medicaid enrollment is projected to exceed 55 million, and a projected 70 million people, or roughly one in five Americans, will be covered by the program for one or more months during the year. Beginning in 2014, the Patient Protection and Affordable Care Act (ACA) will expand Medicaid eligibility to cover nearly all non-elderly Americans with incomes below 133 percent of the federal poverty level ($14,404 for an individual), providing coverage to 16 million additional people – mostly, uninsured adults – by 2019.

A growing phenomenon since the early 1980's has been states' use of various models of managed care to deliver and finance care for Medicaid enrollees, with the goals of increasing access to care, improving quality, and, in some cases, reducing costs. Whereas in the traditional fee-for-service system, Medicaid beneficiaries must find providers willing to accept new (or any) Medicaid patients, states with managed care purchase or establish a network of providers for their Medicaid enrollees through contracts with health plans and/or providers who agree to accept Medicaid patients and to meet certain requirements to ensure timely access to care. These contracts give states a mechanism for holding plans or providers accountable for Medicaid enrollees' overall experience with the health care system, through performance standards related to access to care, quality of care, data reporting, and other patient care goals.



At the same time, managed care can fail as a strategy for improving patient care if capitation payment rates are not adequate or they overpay, transitions from fee-for-service are not well-conceived, provider networks are not sufficient to meet the care needs of the enrolled population, or state oversight of managed care programs is lacking. The history of Medicaid managed care provides evidence of the promise of managed care, but also shows that the details of how it is structured and implemented are consequential for Medicaid beneficiaries.

The share of Medicaid beneficiaries enrolled in some form of managed care has increased every year except one for over two decades, reaching 71.7 percent as of June 30, 2009 according to CMS. This trend has heightened both policy interest and needs for information about Medicaid managed care, and three dynamics are focusing even more attention on how Medicaid managed care is developing. First, many state policymakers are eyeing managed care as a Medicaid cost containment tool and a means to address concerns about access and quality, particularly as states are facing severe budget pressures from the recession and the slow recovery. Second, many states are expanding managed care to more medically complex and fragile populations, for whom the stakes may be greatest. Third, states are

expected to rely heavily on managed care to serve the millions of adults who will become newly eligible for Medicaid in 2014.

In light of the large and growing role of managed care in Medicaid, and the implications for Medicaid beneficiaries, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) conducted a special survey of Medicaid programs to assess the state of Medicaid managed care, identify current issues, and gain perspectives on the directions Medicaid managed care may take in the coming years. This report presents data and findings based on that survey.

Key Findings

Nearly all states operate comprehensive Medicaid managed care programs. Across all 50 states and DC, only three states (Alaska, New Hampshire and Wyoming) reported that they did not have any Medicaid managed care as of October 2010. Of the 48 states with comprehensive managed care programs, 36 reported contracting with risk-based managed care organizations (MCOs) and 31 reported operating a primary care case management (PCCM) program.

Nearly two-thirds of all Medicaid beneficiaries are enrolled in comprehensive managed care arrangements. Over 26 million Medicaid beneficiaries are enrolled in MCOs and 8.8 million are enrolled in PCCM programs. Together these beneficiaries in comprehensive managed care represent 65.9 percent of all Medicaid beneficiaries. However, managed care penetration varies considerably from state to state – in nine states (including three with no managed care), the rate is 50 percent or less, while in another nine states, at least 80 percent of Medicaid beneficiaries are enrolled in these programs.

Half the states with MCOs and/or PCCM programs also contract with non-comprehensive prepaid health plans (PHP) to provide specific categories of services. The types of services most commonly provided by non-comprehensive PHPs, which are risk-based, limited-benefit plans, are inpatient and outpatient behavioral health services and substance abuse treatment. A number of states also contract with non-comprehensive PHPs to provide dental care, non-emergency transportation, or prescription drugs – all services that are frequently carved out of MCO contracts.

States are increasingly mandating managed care for previously exempt or excluded Medicaid beneficiaries. States have long mandated that most children, pregnant women, and parents and other caretaker adults in Medicaid enroll in managed care. A majority of states reported that, for at least one Medicaid managed care program and/or geographic area, they also mandate enrollment in managed care for children with disabilities receiving Supplemental Security Income (SSI), children with special health care needs, and seniors and people with disabilities who are not dually eligible for Medicare and Medicaid.

Risk-based comprehensive managed care

Almost two-thirds of Medicaid MCO enrollees are in health plans that primarily or exclusively serve Medicaid. In addition, for-profit plans account for a little over half of all Medicaid MCO enrollment. Roughly 60 percent of Medicaid MCO enrollees are in non-publicly traded plans. Medicaid MCO enrollment is distributed about evenly between local and national plans.

Auto-assignment rates appear to vary widely. Auto-assignment rates may provide a useful signal of how well Medicaid beneficiaries understand the managed care system and their choices within it. Across the 26 states that reported auto-assignment rates, half (13 states) reported rates of 20 percent or less;

four states reported rates higher than 50 percent. More than two-thirds of states with MCOs use third-party enrollment brokers to provide plan information to beneficiaries and assist them in choosing an MCO; a small number of vendors dominate the market. Most states allow MCOs to conduct outreach and marketing to Medicaid beneficiaries within federal rules.

Most states set MCO capitation rates administratively and risk-adjust their rates. Three-quarters of the states with MCOs reported that they used administrative rate-setting with actuaries to establish MCO rates. Other approaches states reported using are negotiation and competitive bidding, and some states combine multiple methods. Most states adjust their capitation rates for age and eligibility category, and about two-thirds adjust for health status. Risk-sharing arrangements with MCOs, such as stop-loss/reinsurance or risk corridors, are in place in half the states.

Over half the states with MCOs include a pay-for-performance (P4P) component in their payment to plans. Capitation withholds and bonus payments were reported most frequently. Examples of other approaches are shared savings, auto-assignment preference, and enhanced capitation.

A limited number of states have a minimum medical loss ratio (MLR) requirement for MCOs participating in Medicaid. Eleven states indicated that they have a minimum MLR requirement for plans, 21 states reported that they do not, and three states said they plan to establish one in the future. Minimum MLRs ranged from 80 percent in three states to 93 percent in one state for MCOs serving aged and disabled Medicaid beneficiaries. Three states plan to establish a minimum MLR requirement.

All states but one "carve out" at least one acute-care benefit from their MCO contracts, but several states are carving some benefits back in. More often than not, dental care and outpatient and inpatient behavioral health care are carved out and provided either on a fee-for-service basis or by a non-comprehensive prepaid health plan (PHP) – a risk-based, limited-benefit plan. Other common carve-outs are outpatient substance abuse treatment, non-emergency transportation, and pharmacy services. Some states that previously carved out the pharmacy benefit or other Medicaid services are carving them back into their MCO contracts or plan to do so.

States use a variety of network adequacy standards. States typically use provider-to-population ratios and distance and travel-time maximums as standards to ensure that MCO networks are adequate. They generally apply different standards for primary and specialty care and frequently apply different standards for rural and urban areas. The standards states use vary widely. In most states, in addition to primary care physicians, providers such as ObGyns, nurse practitioners, federally qualified health centers, and physician groups/clinics are recognized as primary care providers (PCP) for MCO enrollees.

Many but not all states report that Medicaid MCO enrollees sometimes face access problems. Over two-thirds of responding states with MCOs reported that Medicaid beneficiaries enrolled in MCOs sometimes experience access problems. Problems with access to dental care, pediatric specialists, psychiatrists and other behavioral health providers, and other specialists (e.g., dermatologists, ear-nose-throat doctors, orthopedists and other surgeons, neurologists, cancer and diabetes specialists) were all cited. At the same time, improved access to care – both primary and specialty care – was the most frequently cited perceived benefit of managed care relative to fee-for-service. Some states indicated that where an access problem existed, it usually paralleled a similar problem encountered by persons with other types of insurance, for example, due to provider shortages and other market factors. The survey, however, did not directly collect information on access problems in fee-for-service Medicaid.

Primary care case management (PCCM) programs

Nearly as many states have a PCCM program as have contracts with MCOs. Thirty-one states operate PCCM programs, in which PCPs, by contract with the state, agree to provide, manage, and monitor the primary care of Medicaid beneficiaries who select them, or, in some cases, are assigned to them. In addition to serving as a medical home for primary and preventive care, PCPs are contractually responsible for authorizing referrals when specialty care is needed. Most states pay PCPs a small monthly fee for case management in addition to regular fee-for-service payments. A quarter of states include a pay-for-performance element in their payments to PCPs.

Many states contract for PCCM administrative services. Over half the states with PCCM programs reported that they have PCCM administrative services contracts and, in a few cases, the administrative fees are at risk. The services provided under these contracts range from case or care management to enrollment broker services to claims administration.

Nine states operate Enhanced PCCM (EPCCM) programs. These programs incorporate strengthened quality assurance and care management and coordination. Enhancements include disease management services, coordination/integration of physical and mental health care, case management for high-cost/high-risk enrollees, and linkages between primary care and community-based services for targeted groups.

Non-comprehensive managed care

Half the states contract with non-comprehensive PHPs, separate from their MCO and PCCM programs, to provide some services. The services most commonly provided by these PHPs are inpatient and outpatient behavioral health care and substance abuse treatment, followed by dental care, non-emergency transportation, and prescription drugs – all services that are frequently carved out of MCO contracts.

Nearly all Medicaid beneficiaries receiving behavioral health care through a PHP were in plans that specialize in Medicaid. Not-for-profit, non-publicly traded, and local plans were strongly dominant. By comparison, Medicaid beneficiaries receiving dental care through a PHP were more likely to be in plans with mixed enrollment, for-profit plans, and plans affiliated with a national company.

Measuring, monitoring, and improving quality in Medicaid managed care

Sixteen of the 36 states with MCOs require plans to be accredited. All states with MCOs but one, and most states with PCCM programs, require HEDIS© and CAHPS© data or state-specific measures of performance and patient satisfaction. Required measures focus heavily on Medicaid priority areas such as prenatal and post-partum care, child health preventive care, management of chronic diseases, and access to care. A quarter of the states with MCOs and/or PCCM programs also assess quality in their fee-for-service delivery system.

Three-fourths of states with MCOs publish reports on MCO quality, and half the states with PCCM programs publish quality reports on their PCCM programs. A smaller number of states also publicly report on PHPs' performance, allowing a look at quality across all their managed care arrangements, and a few extend quality reporting to the non-managed fee-for-service component of their program. Fifteen states with MCOs and one PCCM-only state reported that they prepare a quality report card using

HEDIS©, CAHPS©, and state-specific measures, which Medicaid beneficiaries can use to compare and choose health plans. Two states publicly reported on quality performance for the first time in FY 2011.

Quality improvement activities in the states with MCOs reveal a breadth of state priorities. MCOs must conduct "performance improvement projects," and all states must contract with External Quality Review Organizations (EQRO) to provide an independent assessment of the quality of care provided by Medicaid MCOs. States reported wide-ranging quality improvement activities, including, for example, projects focused on improving birth outcomes, increasing access to pediatric subspecialists, identifying high-risk individuals for case management, and increasing coordination between behavioral health and medical providers. Four PCCM-only states reported contracting with EQROs.

Special initiatives to improve quality and care coordination

All but a small number of states have undertaken initiatives to reduce inappropriate use of ERs; many report initiatives to reduce obesity. States often include a focus on ER utilization in their Medicaid contracts with MCOs, and ER use is a factor in some pay-for-performance systems. MCOs may use data on ER use to target high-users for case management or care coordination, and to profile providers and work with medical directors to improve their utilization patterns. Systems that notify PCPs when their Medicaid patients use the ER and 24-hour nurse consultation lines are among the ER diversion strategies in PCCM programs. Initiatives to monitor and reduce obesity were also reported by most states, with Medicaid MCOs often playing a leading role.

About half the states reported current or planned initiatives in Medicaid to address racial and ethnic disparities, including participation in broader state efforts. Numerous states reported formal Medicaid performance improvement projects focused on reducing racial and ethnic disparities in certain measures (e.g., adolescents' use of well-child visits, breast or cervical cancer screening rates), or on cultural competency. Some states calculate or publish quality measures by race/ethnicity. Several states reported broader public health efforts to reduce disparities, with Medicaid participating in interagency and community task forces and statewide collaboratives.

States reported a broad spectrum of other, special managed care quality initiatives. Many states reported managed care quality initiatives in a host of additional areas, such as perinatal care and depression screening; improved care management for individuals with both behavioral health diagnoses and chronic conditions; identification of high-risk enrollees for intensive case management; dental utilization: and improving the data available to providers to benchmark their performance.

Many states have initiatives to improve primary care and to better coordinate care for Medicaid beneficiaries with more complex needs. Medical home initiatives are underway or in development in 39 states. The same number of states reported disease management or care management programs, which, in many instances, are integrated into their MCO or PCCM programs. Twenty-two states reported plans to elect the new "health home" option established by the ACA. Nine states reported that they have an Accountable Care Organization (ACO) initiative underway, planned, or under development.

Managed long-term care and managed care initiatives for dual eligibles

Over half the states operate PACE sites, and 11 states reported operating additional managed long-term care (MLTC) programs. A total of 29 states operate PACE sites, which are paid on a risk basis to provide and coordinate the full range of medical and long-term services and supports for Medicaid enrollees; however, total PACE enrollment nationally is only about 20,000. Eleven states reported

operating non-PACE MLTC programs as of October 2010, with aggregate enrollment exceeding 400,000. Some of these programs encompass only long-term services and supports, but others include acute medical care as well. Most include only Medicaid services, but programs in three states also include Medicare services. States highlighted numerous operational challenges associated with MLTC programs, such as contracting with Medicare Advantage Special Needs Plans, coordination with physical health MCOs, slow enrollment growth, and plan difficulty contracting with Boarding Homes.

Half the states reported enrollment of dual eligibles in non-PACE Medicaid managed care arrangements, on either a voluntary or mandatory basis. Overall, 25 states reported that they enroll dual eligibles in some kind of non-PACE Medicaid managed care arrangement, on either a voluntary or a mandatory basis. In some states, dual eligibles are enrolled in comprehensive managed care; in others, dual eligibles may be enrolled in non-comprehensive PHPs for specific categories of services, but remain in fee-for-service for all other Medicaid-covered services.

In many states, broader efforts focused on dual eligibles are expanding or getting underway. Twenty-one states reported on plans to expand or modify current programs or initiate new programs focused on dual eligibles, including 15 states that received grant funding under the ACA initiative, "State Demonstrations to Integrate Care for Dual Eligible Individuals," administered by the new Medicare-Medicaid Coordination Office in CMS, to design new approaches to better coordinate care for dual eligibles and integrate Medicare and Medicaid financing. Twenty-one states reported that they contract with Medicare Advantage Special Needs Plans to provide care for dual eligibles.

Medicaid managed care and health reform

States expect to rely increasingly on managed care in the near term. Continued budget pressures and interest in improving service delivery and payment systems are fueling plans in many states to expand the use of managed care in Medicaid, including mandatory managed care for additional Medicaid populations and in new geographic areas.

Key health reform implications for Medicaid managed care are yet to come into focus in many states. A little over half the states with MCOs (20) reported that their plans had or could develop sufficient network capacity to handle increased Medicaid enrollment expected under health reform, while one state said its plans could not. Nine states reported that they did not know whether or not their MCOs could develop the capacity, and six states did not respond to this question. Uncertainty was wider regarding Medicaid MCOs' interest in becoming Exchange plans, and especially concerning state intentions to require Medicaid MCOs to participate in the Exchanges or Exchange plans to participate in Medicaid. The widespread uncertainty may be an indication that more immediate issues and pressures still eclipse health reform in many Medicaid programs.

Severe budget pressures remain a key challenge for states, and new demands associated with health reform also emerge as issues. The lingering effects of the recession – reduced tax revenues, high unemployment, and high demand for Medicaid and other human services – all continue to generate intense pressure on states already struggling to meet competing needs with limited resources. States cited additional challenges stemming from health reform, in particular, increased Medicaid enrollment, adequacy of provider networks, Exchange development, and development of systems for claiming the proper federal matching rate. Some states also cited a need for more flexibility to integrate care for dual eligibles. More general pressures, including required implementation of new procedure codes (ICD-10) and strains on state administrative capacity, were raised as well.

Conclusion

For over 30 years, Medicaid programs have relied increasingly on managed care arrangements to deliver and finance care for Medicaid beneficiaries, and both the number and share of beneficiaries in managed care have grown steadily. Medicaid managed care is expected to continue to expand, driven by budget pressures to contain Medicaid spending and by the influx of millions of new Medicaid enrollees when the ACA takes full effect in 2014. As individual states look for new ways to improve care and achieve greater value for state dollars, there is much to be learned from the wide and evolving variety of Medicaid managed care program designs and experiences that can be found across the country.

This survey documents the diversity in current state Medicaid managed care approaches and activity, and captures state policymakers' perspectives on the value of managed care as a strategy to improve access, quality, and accountability and to promote cost-effective care and better health outcomes. As such, it provides a baseline against which to measure and monitor what are likely to be important developments and trends in the coming years.

However, an assessment of the impact of Medicaid managed care was beyond the scope of this project, which surveyed state policy officials alone and gathered largely descriptive information. Particularly as states expand managed care to beneficiaries with more complex needs and shape the delivery systems that will serve millions more low-income Americans in the future, rigorous evaluative research, including investigations of beneficiary and provider experiences and perspectives, is crucial to identify the characteristics of managed care programs that are associated with gains for Medicaid beneficiaries and that advance state goals. Robust federal and state oversight is important, as well, to ensure that the design of managed care programs translates into access to high-quality care for the Medicaid enrollees they serve.

The Kaiser Family Foundation, a leader in health policy analysis, health journalism and communication, is dedicated to filling the need for trusted, independent information on the major health issues facing our nation and its people. The Foundation is a non-profit private operating foundation, based in Menlo Park, California.

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This publication (#8220-ES) is available on the Kaiser Family Foundation's website at www.kff.org.