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CURRENT AND EMERGING ISSUES IN MEDICAID RISK-BASED MANAGED CARE: INSIGHTS FROM AN EXPERT ROUNDTABLE *Executive Summary*

Half of all Medicaid enrollees receive care through comprehensive risk-based managed care organizations (MCOs). Most Medicaid MCO enrollees today are low-income children and parents, but states are increasingly moving beneficiaries with more complex needs into MCOs. Enrollment of high-need groups in managed care may grow more rapidly as states work with the Centers for Medicare & Medicare Services (CMS) to implement initiatives to better integrate Medicare and Medicaid benefits and care for dual eligibles.

In light of the increasingly significant role of risk-based managed care in Medicaid, the Kaiser Commission on Medicaid and the Uninsured (KCMU) convened a roundtable meeting in Washington, DC on May 30, 2012 to learn more about how Medicaid MCOs are currently organized, to consider issues that the enrollment of higher-need populations in MCOs raises, and to discuss the implications for MCOs of the expansion of Medicaid under the Affordable Care Act (ACA). The meeting provided insights that complement the findings from a 50-state survey of Medicaid managed care that KCMU conducted in late 2010 in partnership with Health Management Associates. This brief summarizes key issues identified and discussed by the invited participants. Highlights include:

Provider networks, care delivery, and payment arrangements in Medicaid MCOs today

- Medicaid MCOs' current provider networks and care management features are designed to meet the needs of their current enrollees—mainly, low-income families and children. Community health centers and other safety-net providers are often integral to their networks.
- System-wide gaps in access to care are exacerbated in Medicaid, and current pressures are likely to grow as states expand managed care to higher-need beneficiaries, and coverage expands in 2014.
- MCOs are increasingly focusing on care management, and adoption of models that involve more linkages across providers is increasing.
- Physician payment approaches in MCOs are diverse, ranging from FFS to capitation, often with incentives for quality and efficiency. Some MCOs pay provider rates that exceed Medicaid FFS levels to garner more provider participation.

Expanding managed care to individuals with disabilities and dual eligibles

- Today's MCOs provide a foundation for serving people with disabilities and dual eligibles, but plan networks and care models will have to evolve to meet the specialized needs of these enrollees.
- Separate funding streams for community-based services and acute medical care, and for acute medical and mental health services, can complicate integration and coordination of care. This challenge is more important to address as more people with mental and behavioral health needs are moved into MCOs.
- Risk-adjustment developed primarily for children and parents will require change to take into account the needs of populations with more disease and disability. Risk-adjustment that relies

primarily on diagnostic factors may not work well for those whose functional status and long-term care needs drive their costs. Non-medical factors like homelessness may need to be incorporated.

- Developing enrollee trust is important to the effective implementation of new managed care programs for individuals with different kinds of disabilities and dual eligibles. Many people with severe mental illness or physical disabilities want to be engaged in directing their own care. They need to be “met where they are” and represented at the table when managed care initiatives are being developed.
- New care models offer the potential to improve care for beneficiaries with complex needs, but implementing such systems requires a long-term commitment and that potential can be undermined if managed care is undertaken primarily as a means to plug immediate budget holes.
- Managed care contracts are a critical policy tool for states. Contract requirements should be specific, “smart,” and outcomes-oriented.
- Data are essential to manage and oversee care. The growing interest in bundled payment systems that provide incentives for more effective and efficient care is a positive development. But the loss of transaction-level data needed for measurement, monitoring, and plan and provider accountability, is a major concern. Also, data siloes pose barriers to care integration and oversight.

Looking forward to the 2014 expansion of coverage under the ACA

- The coverage expansion under health reform is an opportunity to streamline and integrate coverage through a single entry point. The challenge is to design systems that foster smooth transitions and continuity between Medicaid and exchange coverage and care. Effective HIT infrastructure and real-time access to federal data to determine eligibility are crucial to bridge Medicaid and the exchanges.
- Many MCOs are interested in participating in exchanges, but many plans built around safety-net providers would find it difficult to meet the reserve requirements. They also face capital and other resource constraints.
- Some states are developing models (e.g., bridge product and Basic Health Plan) to limit the disruptive impacts of coverage transitions on care and provider access. Potentially different benefit packages in Medicaid and the exchange, and even within Medicaid, could contribute to disruptions. The Medicaid-CHIP experience when CHIP was first implemented offers helpful lessons.
- Expanded coverage will increase demands on the health care system. Provider willingness to participate in MCOs could rise or fall in response to the expansion. While the new enrollee market may be attractive to providers, concerns about payment rates could deter participation.
- States have considerable experience implementing reforms in Medicaid, but implementing the ACA at a time when economic and political conditions have limited the financial and human resources available to them poses challenges. They need as much support as possible to develop and operate managed care programs that advance the goals of the ACA.

CURRENT AND EMERGING ISSUES IN MEDICAID RISK-BASED MANAGED CARE: INSIGHTS FROM AN EXPERT ROUNDTABLE

Half of all Medicaid enrollees receive care through comprehensive risk-based managed care organizations (MCOs).¹ Most Medicaid MCO enrollees today are low-income children and families, but states are increasingly moving beneficiaries with more complex needs into MCOs. In almost 20 states, at least some beneficiaries who are dually eligible for Medicare and Medicaid are required or can elect to enroll in MCOs to receive their Medicaid-covered services. Managed care enrollment among these high-need beneficiaries may grow more rapidly as states work with the Centers for Medicare & Medicare Services (CMS) to implement initiatives to better integrate Medicare and Medicaid benefits and care for dual eligibles.²

In light of the increasingly significant role of risk-based managed care in Medicaid, the Kaiser Commission on Medicaid and the Uninsured (KCMU) convened an expert roundtable meeting in Washington, DC on May 30, 2012 to learn more about how Medicaid MCOs are currently organized, to consider issues that the enrollment of higher-need populations in MCOs raises, and to discuss the implications for MCOs of the expansion of Medicaid under the Affordable Care Act (ACA). The meeting provided insights that complement the findings from a 50-state survey of Medicaid managed care that KCMU conducted in late 2010 in partnership with Health Management Associates.³

A goal of the meeting was to obtain state policy perspectives on Medicaid MCOs, as well as “on-the-ground” strategic and operational insights from industry, with a focus on both present and future opportunities and challenges. Thus, the participants included state Medicaid officials and insurance regulators, consumer advocates, executives from a diversity of firms operating MCOs, and other key stakeholders. The roundtable discussion was designed to shed light on important managed care-related practices and concerns, but not to quantify or capture their prevalence in industry or the nation on any statistical basis.

The first part of this report on the roundtable focuses on MCOs’ current provider networks, care delivery approaches, and payment arrangements. The second part reviews issues associated with the expansion of Medicaid managed care to people with disabilities and dual eligibles. The final section covers the conversation about the expansion of health coverage in 2014 through both Medicaid and the new insurance exchanges established by the ACA.

Provider networks, care delivery, and payment arrangements in Medicaid MCOs today

Medicaid MCOs’ provider networks and care management features are designed to meet the needs of their current enrollees—mainly, low-income children and families. Community health centers and other safety-net providers are integral to many of these health plans’ networks. Systemic gaps in access to care are exacerbated in Medicaid, and existing pressures are likely to grow as states expand Medicaid managed care to more medically complex beneficiaries and coverage expands broadly in 2014. Increasingly, MCOs are focusing on care management and models of more comprehensive coordination and integration of services. Physician payment approaches in MCOs are diverse, ranging from fee-for-service to capitation, often with incentives for quality and efficiency.

Medicaid MCOs’ provider networks and care management features are designed to suit their current enrollees—mainly, low-income children and families. Although many Medicaid MCOs are mature, the shape of the provider networks that health plans engage and pay to provide care to their enrollees continues to evolve, with important differences across and within states.⁴

Safety-net providers are often critical to adequate networks. Executives of both commercial and Medicaid-dominant MCOs indicated that safety-net providers with a tradition of providing care to low-income populations often play a key role in their networks and are critical to supporting accessible care. Federally Qualified Health centers (FQHCs), in particular, are important to many networks. Under the federal Medicaid statute, FQHCs receive rate protection,⁵ which provides important support for FQHC participation in Medicaid MCOs and also makes FQHCs attractive to plans.

The nature and extent of differences between commercial and Medicaid provider networks is variable across markets. The role that FQHCs play is a fundamental aspect of the differences that exist in many cases between the provider networks for Medicaid and commercial MCOs, respectively. But the networks for Medicaid and commercial plans – sometimes, even for MCOs owned by the same managed care company – may also be dissimilar because of differences between the demographic profiles of their enrollee populations, or due to provider preferences. And while a robust commercial network can be an asset in marketing a Medicaid MCO, in some local markets, the geographic location of providers in a commercial network may simply not be congruent with the location of most Medicaid beneficiaries. On the other hand, local market conditions and features of medical care organization can also be factors that contribute to overlap between the provider networks of Medicaid and commercial MCOs. To illustrate, it was noted that, in Texas, because small office-based practices dominate the delivery of pediatric and ob-gyn care, these practices typically serve both Medicaid and privately insured enrollees. Texas' relatively high Medicaid fee-for-service payment rates have also helped to support MCO participation in the program, although rates are under increasing pressure.

Access to specialty care and dental services can be problematic. Panelists tended to agree that inadequacies in access to specialist care, stemming from system-wide shortages of specialists and the maldistribution of the specialist workforce, can be worse in Medicaid. Particularly in rural areas, long distances to reach providers and public transportation patterns can create barriers to adequate access; indeed, patients may have to travel 50–100 miles to see a specialist. Access to dental services is often especially challenging, and more so in rural areas. Gaps in access to specialty care may grow even wider if MCOs enroll more beneficiaries with complex needs, who may rely on specialists as their primary care providers or make more use of selected specialized services, such as mental health care. If plans are unable to secure contracts with providers, they may at least want to enter into some kind of written agreement with them. Plans need to monitor enrollee experience and address barriers to obtaining access to needed care.

As MCOs evolve, they are paying more attention to care management. Many MCOs now encourage or require primary care providers in their networks to be medical homes, through preferential contracting, contract requirements, additional support, or other mechanisms. MCOs may mine their own or others' data to learn what approaches work and how to manage care most effectively. MCO payment to providers often incorporates incentives tied to access or quality metrics. Roundtable participants representing large provider systems with which some MCOs contract said they have adopted advanced models of shared savings, electronic health records, and home visiting, among other strategies to improve care, although the payments they receive may not necessarily compensate them for doing so. Some MCOs that conduct care management centrally are now looking at how to better connect and integrate with community-based services and medical practices. State oversight can reinforce these new directions. For example, Pennsylvania has incorporated into its monitoring efforts a required plan report that shows how the plan is using its care managers, how many staff it deploys, and whether the care managers have connected with patients by telephone or in person, and in which settings. States with experience in this area indicated that it is important to define expectations of plans and specify desired outcomes.

Physician payment methods vary. Within provider networks, MCO payment arrangements with physicians range from fee-for-service to capitation, often with additional incentives for quality, access, and efficiency. When physicians receive capitated payment, it is typically for primary care, not a full global capitation payment that puts them at risk for all or most services. Some MCOs prefer to pay on a fee-for-service basis (with quality incentives) because they believe that it makes more sense with small practices and because it makes it easier to capture encounter data. At the same time, in other MCOs, half of all network providers are capitated. MCO executives also indicated that they vary their payment arrangements with providers to accommodate individual provider preferences, or to conform to the prevailing payment practices in different markets. They said it is not clear how large a share of providers are willing to be at financial risk; in any case, when plan executives establish their payment arrangements, they may consider not just providers' preferences, but also their capacity to manage risk. Some panelists expressed concern about transferring too much risk to providers and took the view that the appropriate entity to bear extensive financial risk is the MCO or the large health system(s) under contract to the plan.

Historically, low fee-for-service rates have limited the willingness of providers to participate in Medicaid. The relationship of Medicaid rates to other payers' rates varies across states and even within states by specialty. In one state, for example, Medicaid physician payment rates are generally above the average Medicaid rates paid by other states, but the differential is greater for pediatricians than for adult medicine physicians because a lawsuit required the state to raise its pediatric rates.

To attract providers who have been reluctant to participate in Medicaid, MCOs may structure their payment methods and levels in ways designed specifically to appeal to these providers. In some cases, MCOs pay providers rates that exceed the Medicaid fee schedule. In areas where a few large provider systems dominate, MCOs may have difficulty contracting for services because of the economic power of these systems. State budget strains are leading some states to cut rates to plans and providers, raising concerns, the discussants said, that access could be hampered and that plans could be penalized for becoming more efficient.

Expanding managed care to individuals with disabilities and dual eligibles

Today's MCO provider networks and care delivery approaches will have to evolve to meet the specialized needs of people with disabilities and dual eligibles, which encompass acute medical care, mental and behavioral health care, and community-based services and supports. Separate funding streams and data systems in these spheres make coordination and integration challenging. States' risk-adjustment methods will also need to be modified. Individuals with disabilities want to be engaged in directing their own care and need to be represented at the table when managed care initiatives are being developed. Data are essential to manage and oversee care. The desirability of bundled payment systems, which provide incentives for more effective and efficient care, has to be balanced against the loss of transaction-level data needed to measure, monitor, and hold plans and providers accountable for performance and outcomes.

Today's MCO provider networks and care delivery approaches provide a foundation for serving people with disabilities and dual eligibles, but they will have to evolve to meet their greater and more specialized needs. MCOs seeking to serve disabled and other special needs populations can build on their existing systems, but they will also need to adapt them to meet the more diverse and complex needs of these individuals. Typical MCOs will have to expand their networks to include additional types of providers and enlarge their capacity to provide specialist care. Also, people with complex and chronic needs may be more likely to rely on academic medical centers for their care, rather than on the safety-net providers that are the backbone of many Medicaid MCOs serving primarily children and mothers.

Because individuals with extensive health needs often have important non-health needs, too, in addition to providing medical management of chronic conditions, MCOs will need to contract or otherwise coordinate with community-based organizations knowledgeable about the environments in which patients function, relevant psychosocial issues, and the array of services and supports individuals may require. Also, it is likely that patient navigators – people trained to help patients negotiate the health care system – will have an important role to play in facilitating enrollees’ transitions across care settings. Discussants suggested that there may be value in imagining and developing approaches to delivering primary care that do not currently exist, such as connecting to and serving people in their homes, or basing primary care in community mental health centers, as ways to reach significant subpopulations. Also, MCOs cannot assume, just because they offer a service such as care coordination, that enrollees will realize the service is available or access it. Roundtable participants who had experience with transitions of new populations into managed care indicated that extensive outreach will likely be required.

Separate funding streams can complicate integration and coordination of care. Community-based services and acute medical care have typically been funded under different authorities, making coordination between them challenging. Coordination between acute medical care and mental health services – generally financed under a separate state mental health authority and delivered through a separate system – presents similar difficulties. Further, health services supported by different funding streams have separate data systems and use different data sources, complicating the synthesis and use of data to support coordinated, person-centered care for patients using services in different spheres. These coordination challenges are particularly important to address as populations with greater mental and behavioral health care needs are moved from the fee-for-service environment into MCOs. A number of states are reevaluating current behavioral health and other benefit carve-outs that make it harder to provide coordinated care to MCO enrollees and may also fail to align financial incentives properly across providers.

Current risk-adjustment systems will require change. The risk-adjustment methods now used in Medicaid managed care were developed to deal with risk primarily among children and adults in low-income families. These methods will need to be modified and refined to take into account the medical needs associated with populations with higher rates and diverse types of disability and chronic disease. Meeting discussants suggested that risk-adjustment that relies on diagnostic factors probably will not work very well for individuals whose costs of care largely reflect their functional status or frailty and their needs for long-term services and supports. Risk-adjustment may also need to incorporate non-medical factors, such as homelessness, that affect the cost of care. While risk-adjustment appears to work well in accounting for variation in medical needs, studies of how it performs in the Medicaid context have been limited. Also, more work on risk-adjustment systems is needed to get incentives right and to ensure that the systems are not vulnerable to gaming. Because risk-adjustment methods are likely to remain imperfect, it may be helpful to moderate expectations and to design policies that can be applied flexibly. For example, Pennsylvania operates a high-risk pool that it can use to adjust payments if some plans enroll a disproportionate share of the highest-risk enrollees. Also, at least initially, there could be value in considering methods that take into account the experience of patients in both the MCO and fee-for-service environments.

Developing enrollee trust is important. Individuals with severe mental illness or physical disabilities want to be engaged in directing their own care. Many social service agencies that serve these individuals share that orientation. While care integration may be a desirable goal, top-down initiatives that mandate new care models are likely to encounter barriers to success because they are not trusted. There is a need to honor beneficiaries’ perspectives and life experiences and meet them “where they are.” Consumer advocates working at the state level said that affected beneficiary groups need to be

represented at the table when managed care initiatives are developed and shaped, but that often this does not occur. Also, managed care systems enrolling people with special needs may benefit from providing these individuals with access to independent enrollment assistance instead of contacting them directly, as the MCOs may not be trusted. Ombudsmen and plan navigation support can be important. Confidentiality concerns, particularly related to mental illness, are also important, but will not be simple to address.

Moving complex populations into Medicaid managed care requires a long-term commitment. Progress in enhancing care and limiting cost growth can be undermined if managed care is undertaken primarily as a means to plug immediate budget holes. There is tension between the desire of states to shift risk to health plans as much as possible in order to contain the (state) costs of caring for complex populations, and the many uncertainties about how best to provide care for these individuals. Shifting risk even further down, to providers, may expose them to too much risk, particularly where populations with special needs (as opposed to the current MCO population) are concerned. While potential for cost savings may exist, some currently under-used but valuable care, such as community-based services and primary care, may be used more in managed care, increasing some costs, at least in the near-term. A separate issue is the risk that moving dual eligibles and individuals with disabilities into MCOs will lead to the medicalization of important non-medical elements of their care, such as community-based long-term services and supports. MCOs need to have or build expertise to serve people with diverse non-medical as well as medical needs, and much remains to be learned about how best to do so. States need the flexibility to learn and respond to emerging issues, and mechanisms to help them learn from one another will be very valuable.

While challenges exist, new delivery system models offer the potential to improve care. It is important to remember that the care received by dual eligibles and others with special needs in the traditional fee-for-service environment suffers from important problems related to access, fragmentation of care (i.e., of acute and long-term care, physical and mental health care, and Medicaid and Medicare services), and other issues. Transitions to managed care present an opportunity to address these problems – for example, through greater use of measurement and increased accountability for access and quality, which are advantageous features of more organized delivery systems. Also, the flexibility inherent in capitated managed care strategies can promote innovation, whereas the traditional Medicaid program is more constrained by federal rules. State procurement policies that capitalize effectively on the potential managed care offers, while also ensuring that the incentives and risks associated with capitation do not undermine access to care, are likely to require Medicaid agency sophistication and leadership.

The managed care contract is a critical policy tool for states. The requirements of a contract provide the legal basis for their enforcement. They also establish expectations. Panelists thought that contract requirements should be outcomes-oriented. For example, they could set goals for reduced emergency room use or for “touching” each new patient, and hold plans accountable for these outcomes. Requirements also need to be “smart” and support efficient care delivery without adding process burdens that yield little value. Incentives should be designed not just to keep costs down, but also to promote good outcomes achieved efficiently. Officials from states with many years’ experience serving complex populations pointed to the importance of appropriate network access standards that include specialists; contract provisions that require plans to notify enrollees of provider terminations or departures and any denials of services; provisions that require or encourage MCOs to meet National Committee for Quality Assurance (NCQA) accreditation standards; and payment incentives that promote value by rewarding access, chronic disease management, effective pregnancy care, and other best practices. MCOs are concerned that some newly emerging state requirements, such as mandated use of personal health records, could be expensive to implement and not necessarily as valuable as other

features a plan could develop. MCOs with recent experience contracting for new populations said that states also need to structure the procurement process carefully and be prepared for litigation as firms jockey for position in the expanding Medicaid market.

Adequate and appropriate data are important in managing and overseeing care. The current interest in global or bundled payment systems, which move away from paying for units of care and instead provide incentives for more efficient and effective care, is a positive development. But the value of such systems has to be balanced against the loss of transaction-level data (e.g., claims, encounter data) to support measuring, monitoring, and holding plans and providers accountable for performance. Both the lack of integration between clinical settings and community-based organizations, and data and financing siloes, can serve as barriers to effective integration and oversight of care. Finally, new metrics to capture the quality of care delivered to high-need populations need to be developed.

Looking forward to the 2014 expansion of coverage under the ACA

The broad expansion of coverage under health reform presents an opportunity to streamline and integrate coverage through a single entry point. The challenge is to design and implement eligibility and enrollment systems and benefit packages that foster smooth transitions and continuity between Medicaid and exchange coverage and care and minimize disruptions. Several states are developing “bridge” products to that end. Expanded coverage will increase demands on the health care system; the new enrollee market may increase plan and provider interest in participating in Medicaid, but payment rates will also influence their behavior. States have considerable experience implementing reforms in Medicaid, but implementing the ACA at a time when economic and political conditions have limited the financial and human resources available to them poses some challenges. States need as much support as possible to develop and operate managed care programs that advance the goals of the ACA.

The coverage expansion under the ACA is an important opportunity to integrate coverage. The panelists cited the potential, under health reform, to streamline and integrate access to coverage through a single point of entry. They emphasized that the challenge is to determine how to maximize this potential by building systems that facilitate smooth transitions that maintain continuity between Medicaid and exchange coverage, thereby reducing gaps and instability in coverage and care.

As of the time of the roundtable, states had been more focused on the outcome of the Supreme Court case and eligibility issues than on smoothing transitions between coverage in Medicaid and the exchanges. (The panel met before the Supreme Court decision on the ACA was announced.) While important issues emerging from the Supreme Court decision could not be foreseen, the concerns and challenges highlighted by the roundtable participants remain central as implementation of the ACA proceeds.

States are weighing whether they should require health plans to participate in both Medicaid and the exchanges to make it easier for enrollees to move smoothly between the two systems. However, this approach poses some practical challenges. Many Medicaid MCOs are interested in participating in exchanges, but many plans built around safety-net providers would find it difficult to meet the reserve requirements for exchange products. These MCOs are also concerned about whether risk-adjustment in the exchanges would be adequate for those choosing to enroll in their plans, and about how serving a higher-income population might affect their mission. Expansion to a wider population may also require expertise that these plans currently lack and may have difficulty acquiring due to their limited capital and other resource constraints.

Some models may help to limit the disruptive impacts of coverage transitions on care and provider access. For example, Tennessee is developing a “bridge product,” and Washington State is developing a Basic Health Plan product for new eligibles with income close to Medicaid eligibility levels, who are likely to migrate between Medicaid and exchange coverage. Medicaid MCOs might find it more feasible to participate in a Basic Health Plan that covers individuals up to 200% of the poverty level than in an exchange. Designs that provide for 12 months of continuous eligibility could lessen the adverse impacts of coverage transitions and “churning,” for both plans and enrollees. Rhode Island is seeking to establish consistent language across Medicaid and exchange products to reduce disruptions associated with coverage transitions. (Panelists noted, however, that Rhode Island’s size and small number of plans may make some policy actions less challenging to undertake there than they might be in a larger, more complex state.) The history of the federal Children’s Health Insurance Program (CHIP) illustrates similar challenges involved in developing a system of seamless coverage and care for low-income children, as children in states that chose to operate a separate, non-Medicaid CHIP program could face a change in health plans if they moved from Medicaid to CHIP or vice versa. Lessons from that experience can provide valuable guidance to states.

The expansion of coverage will bring new demands on the health care delivery system. The anticipated large increase in demand when coverage expands will pose significant challenges system-wide. Inadequate access to specialty care has long been an issue, and the coverage expansion introduces new pressures on primary care capacity. Provider willingness to participate in MCO networks could be influenced both positively and negatively by the large expansion in enrollment anticipated in 2014. While the increased demand may be attractive to providers, concerns about payment rates could deter their participation. Analyses suggest that the population newly eligible for Medicaid under the ACA is likely to be less expensive than the current Medicaid population, but actual experience is limited and state-to-state variation is likely. In addition, it is not clear whether current risk-adjustment will deal adequately with dynamic changes in the profile of the enrolled population. One panelist described ambitious efforts now underway by the National Association of Insurance Commission to develop standards for exchange products in such areas as network adequacy, rate review, accreditation and quality, and marketing and consumer outreach.

Effective health information technology (HIT) infrastructure will be critical for smooth transitions. The federal government has been supporting state efforts to establish HIT infrastructure that can bridge Medicaid and the insurance exchanges, as well as provide real-time access to federal data needed to determine eligibility. However, some states still have legacy eligibility systems and, because the process for determining Medicaid eligibility for the SSI population will not change under the ACA, in these states, many individuals with disabilities will still have to interact with the old systems. Such systems need to be modernized, streamlined, and simplified.

Inconsistent benefits remain an issue of concern. Many states are now making or will soon make decisions about the essential health benefits packages that will be offered through the exchanges, as well as the Medicaid benchmark benefits that will be in effect for most individuals newly eligible for Medicaid, beginning in 2014. Based on states’ decisions in these two matters, there are likely to be “cliffs” in many states – where benefits and cost-sharing change markedly when people move from one subsidized coverage program to another. Individuals may experience these changes not only in transitions between Medicaid and exchange products, but also, potentially, in transitions within Medicaid if a state’s Medicaid benchmark benefits are different from its traditional Medicaid benefit package.

States face many demands but few resources. Given the ongoing growth of Medicaid managed care, initiatives to better integrate benefits and care for the dually eligible, the expansion of Medicaid in 2014, and the anticipated new demands for care that the new coverage will generate, states have a great deal on their plates. Both political and economic conditions have limited the financial and human resources available to states to meet these challenges. States need as much support as they can get to operate managed care programs that advance the coverage, access, outcomes, and efficiency goals that are expressed by the ACA and reflect priorities in many states.

Conclusion

State Medicaid programs have considerable experience with comprehensive risk-based managed care systems, which must now be expanded to handle the anticipated large influx of new enrollees in 2014, and adapted to address the needs of these newly eligible people, including many with chronic diseases and disabilities. Identifying the right policies and incentives to encourage systems of care that can serve these vulnerable Americans well will be critical to achieving the policy goals discussed by the panel. Moving forward to improve health care organization and delivery at a time of severe budget and resource strains will inevitably be challenging. A sharp focus on the outcomes of interest, the structuring and implementation of incentives that promote these outcomes, and adequate support for states and other stakeholders pursuing these goals will be essential to ensuring meaningful progress.

This brief was prepared by Marsha Gold of Mathematica Policy Research and Julia Paradise of the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

ENDNOTES

¹ *Medicaid Managed Care: Key Data, Trends, and Issues*, Kaiser Commission on Medicaid and the Uninsured, February 2012, #8046-02, <http://www.kff.org/medicaid/8046.cfm>.

² *An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees*, Kaiser Commission on Medicaid and the Uninsured, April 2012, #8290, <http://www.kff.org/medicaid/8290.cfm>.

³ Gifford K et al. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, Kaiser Commission on Medicaid and the Uninsured, September 2011, #8220, <http://www.kff.org/medicaid/8220.cfm>.

⁴ The broad outline and diversity of arrangements is, in many ways, similar to that observed in a 2000 survey of Medicaid MCOs in 11 states with extensive managed care enrollment. See Gold M et al., "Participation of Plans and Providers in Medicaid and SCHIP Managed Care," *Health Affairs* 22(1), January/February 2003.

⁵ States are required to pay FQHCs prospective cost-based rates for Medicaid and CHIP services and to make up any difference between these rates and what the managed care contract covers. See February 4, 2010 letter from CMS to Medicaid directors at <http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html#Search> (use "Federally Qualified Health Centers" as search term). For Medicare policy, see <http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html?redirect=/center/fqhc.asp>

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