

Medicaid Health Plans and Medicaid Managed Care



As federal policy expands Medicaid to help cover the uninsured and states struggle with limited budgets and cost containment, it is important to consider the prominent role that Medicaid health plans play in providing coverage to low income individuals, children and families.

While most Medicaid beneficiaries receive care through Medicaid health plans, health plans are often neglected in state and federal policymaking conversations. This primer aims to provide an introduction to the Medicaid health plans, their role in state Medicaid programs, and the improved health care services they provide.

What is Medicaid Managed Care?

Medicaid managed care is a delivery system model that improves access to care and care coordination by assuring that enrollees have access to their primary care physician and a network of providers.

What is the role of Medicaid Health Plans?

To implement a Medicaid managed care program, many states will enlist private health plans to provide Medicaid benefits. These “Medicaid health plans” enter into contracts with state Medicaid agencies to provide these benefits to enrollees. The state pays the health plan a per-member-per-month, or “capitated” fee transferring the financial risk away from the state to the health plan.

States rely on Medicaid health plans to contract with an adequate network of providers to ensure patients have access to physicians. Medicaid health plans also provide additional services such as disease management, case management, and managed behavioral health services.

How does it work for patients?

Depending upon the state rules, enrollees either choose a health plan or are automatically assigned to a health plan. Patients are assigned to a primary care physician who will be the patient’s primary point of contact for their health care services.

Medicaid managed care is an alternative to traditional fee-for-service where a Medicaid enrollee finds a physician that accepts Medicaid, obtains medical services, then the physician seeks reimbursement directly from the state Medicaid agency. Patients in fee-for-service Medicaid often have difficulty finding physicians that accept Medicaid patients due to low provider reimbursement rates for Medicaid services.

Medicaid Managed Care In Brief

- Medicaid managed care is an alternative to traditional fee-for-service
- States generally use Medicaid health plans for managed care
- Medicaid health plans provide predictable costs to states through capitation
- Medicaid managed care ensures that enrollees have access to a medical home and a network of qualified providers.

The Scope of Medicaid Managed Care

While many are familiar with Medicare Advantage, many people do not know that Medicaid health plans provide coverage to significantly more people than the number enrolled in comparable Medicare Advantage plans.

The scope of Medicaid health plans in the Medicaid program is significant and important to recognize as states begin to expand their Medicaid populations and enroll an estimated 24 million additional Americans.

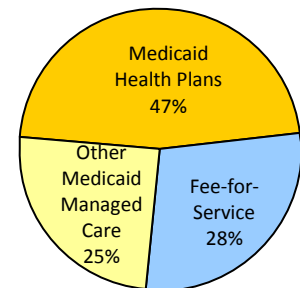


Nearly half of the nation's Medicaid beneficiaries are enrolled in Medicaid health plans

Since the early 1990s, states have had the authority to enroll Medicaid beneficiaries in health plans under the authority of a federal waiver. Today, over 23 million Medicaid beneficiaries are enrolled in Medicaid health plans representing nearly half of the Medicaid population. With an additional 12 million in other managed care systems such as primary care case management - that brings the total Medicaid managed care enrollment to 72%.

In addition, 72% of children enrolled in the Children's Health Insurance Program (CHIP) receive benefits through private health plans.

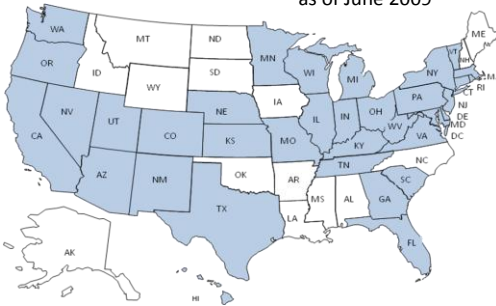
Total Medicaid Enrollment 2009



Most states use Medicaid health plans

Since the 1990s, state Medicaid programs have increasingly relied on managed care. As of June 2009, 35 states and the District of Columbia have some or all of their Medicaid beneficiaries enrolled in Medicaid health plans. Even more states are planning to implement Medicaid managed care in the near future. States operate Medicaid managed care programs either through federal waivers or through state plan amendments (authorized in the Balanced Budget Act of 1997).

States with Medicaid Health Plans
as of June 2009



States are also expanding the number of enrollees in Medicaid health plans. Until recently, mandatory managed care was largely limited to children and families; now states are offering Medicaid managed care for more complex populations such as adults with disabilities and chronic illnesses and dual-eligibles.

State Use of Medicaid Health Plans In Brief

- 35 States and DC contract with health plans to provide health care coverage for some or all of their Medicaid enrollees.
- 47% of Medicaid beneficiaries (23.5 million) are enrolled in Medicaid health plans
- 72% of kids covered by state Children's Health Insurance Programs (CHIP) receive their services through Medicaid health plans.

Benefits of Medicaid Managed Care



States and enrollees have enjoyed numerous benefits of Medicaid managed care over fee-for-service including...

- *Predictable costs*
- *Access and care coordination*
- *Delivery system innovation*
- *Fraud and abuse prevention*
- *Quality assurance and improvement*

Predictable Costs

One of the largest factors that drive states to Medicaid health plans is the potential cost savings. By transferring financial risk to health plans through capitation, state budgets are not subjected to as much variability experienced with fee-for-service. States have reported cost savings under Medicaid managed care models.

For example, according to a report by the Lewin Group, Medicaid health plans saved Pennsylvania \$2.7 billion over a 5-year period.ⁱ

Access and Care Coordination

Medicaid health plans negotiate payment rates with providers that are typically well above fee-for-service provider payments, therefore Medicaid health plan enrollees often enjoy better access to providers than those in traditional Medicaid.

Medicaid health plans coordinate care for Medicaid populations with special needs, including those with multiple chronic conditions and 8 million dual eligibles, through primary care coordination and disease management programs. The capitation arrangement provides different financial incentives to providers versus fee-for-service. Medicaid health plans work with their physician networks to support practice management systems that emphasize prevention, early diagnosis and treatment, and coordinated management of patient care. This “medical home” approach to providing care is not feasible under fee-for-service.

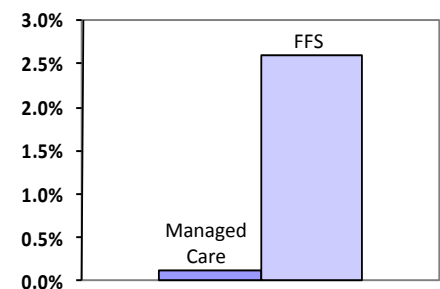
Innovation in delivery system reform

Collaborating with Medicaid programs and state stakeholders, Medicaid health plans have been able to implement innovative delivery system reforms like patient-centered medical homes, coordinating benefits for dual-eligibles, and state health care coverage expansions. In addition, Medicaid health plans and states partner on disease-specific quality improvement projects and implement best practices.

Preventing fraud and abuse

Medicaid managed care has also experienced significantly less fraud and abuse than traditional Medicaid fee-for-service. CMS reported that in FY 2008 payment error rates for Medicaid managed care were 0.1% compared to 2.6% for Medicaid fee-for-service.

FY 2008 Medicaid Payment Error Rates



Quality assurance and improvement

One of the most significant benefits of Medicaid health plans is quality measurement and improvement. Federal regulations require annual quality reviews of Medicaid health plans and specify state oversight expectations. Most states conduct additional reviews of Medicaid health plans to ensure that they meet state rules and regulations in areas such as utilization review and grievances and appeals. The state and federal rules provide additional consumer protections for Medicaid health plans, such as network adequacy and the provision of culturally and linguistically appropriate services, that are unique from commercial health insurance plans.

Medicaid health plans are required to report performance measures, such as HEDIS, to the state. Performance measures provide valuable data to health plans, states, researchers and policymakers for demonstrating the quality of care in Medicaid programs, identifying gaps in care, and creating quality improvement projects. Through performance measurement, the quality of care in Medicaid health plans has improved.

Many states also field the Consumer Assessment of Health Plans Survey (CAHPS) that assesses patient satisfaction with their experience of care. Studies have shown that Medicaid enrollees are more satisfied with the quality and experience of care received through managed care than in fee-for-service.ⁱⁱ

About 25% of Medicaid health plans have achieved accreditation by the National Committee for Quality Assurance, meeting a nationally recognized standard for demonstrating the delivery of high quality care. Additional Medicaid health plans are accredited by other organizations.

Medicaid Health Plans vs. Primary Care Case Management and Fee-for-Service

	Health Plan	PCCM	FFS
Benefits to Members			
Identification card proving coverage	✓	✓	✓
A designated primary care physician	✓	✓	
Case management of primary care services	✓	✓	
Disease management	✓	✓	
Comprehensive case management	✓		
Quality standards and continuous quality improvement programs	✓		
National accreditation	✓		
Cost Containment			
Claims analysis	✓		
Utilization review	✓		
Improved generic utilization	✓		
Using lower cost service where available	✓		
Cost predictability	✓		

ⁱ Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program. The Lewin Group. May 2005.

ⁱⁱ Evaluation of Medicaid Managed Care: Satisfaction, Access, and Use. Jane E. Sisk, PhD; Sheila A. Gorman, PhD; Anne Lenhard Reisinger, PhD; Sherry A. Glied, PhD; William H. DuMouchel, PhD; Margaret M. Hynes, PhD. JAMA. 1996;276(1):50-55.

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