



NIHCM

**MEDICAID: THE MOVE
TO MANAGED CARE**

Prepared For:

**The National Institute For
Health Care Management,
The National Governors' Association, and
The Federation of American Health Systems**

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Contents

	<u>Page</u>
INTRODUCTION	1
MEDICAID MANAGED CARE	2
Current status	2
Background, Medicaid managed care requirements	6
POLICY AND IMPLEMENTATION ISSUES	7
Federal/State design re: managed care	8
Monitoring quality, service	9
Infrastructure/capacity development	11
CONCLUSION	12

MEDICAID: THE MOVE TO MANAGED CARE

INTRODUCTION

Medicaid is a federal-state matching program that finances health care services for 36 million low income individuals. States administer Medicaid within federal guidelines, and states and the federal government share in program costs.

The Congressional Budget Office (CBO) estimates that total federal and state Medicaid spending in FY 1995 will reach about \$158 billion: of that, about \$90 billion is federal, and \$68 billion is state and local funding.¹ Medicaid has been one of the fastest growing items in federal and state budgets.

- o Over the last five years (1990-1995), federal Medicaid spending more than doubled -- growing from \$41 billion to \$90 billion. In just five years, Medicaid grew from three percent to nearly six percent of total federal spending.²
- o The state share of Medicaid spending also more than doubled in this same time period -- growing from \$31 billion in 1990 to \$67 billion in FY 1995.³ Medicaid accounted for about 18 percent of State spending in 1993.

States have turned toward the use of managed care arrangements in attempting to control the costs of their Medicaid programs. Certain managed care options are available under federal statute, but subject to constraints. States have increasingly sought waivers of these federal statutory constraints in order to implement managed care programs more aggressively.

This issue brief reviews the development and growth of Medicaid managed care and

¹Congressional Budget Office (CBO), Preliminary Baseline, January, 1995.

²CBO, January, 1995; CBO, The Economic and Budget Outlook, January, 1994.

³FFIS Federal Funds Information for States. Issue Brief. Recent Trends in Medicaid Spending, December 16, 1994.

identifies policy and implementation issues to consider as state Medicaid programs increase their use of managed care arrangements.

MEDICAID MANAGED CARE

Current status

The growth in Medicaid managed care was recently documented in "States as Payers: Managed Care for Medicaid Populations" prepared by Lewin-VHI and published by the National Institute for Health Care Management (NIHCM). Unless otherwise noted, the information that follows is derived from that report, which is referred to in this paper as the NIHCM/Lewin-VHI report.⁴

Through the use of the current statutory authority for managed care, and especially with increasing use of two types of waiver (see section that follows on the Medicaid managed care requirements), states have dramatically increased their use of Medicaid managed care. The NIHCM/Lewin-VHI report estimates that by June 30, 1994, total enrollment in all types of managed care arrangement reached 7.6 million -- a 57 percent increase in Medicaid managed care enrollment in just one year. As a result, nearly one-fourth of Medicaid enrollees are in some form of managed care. Table 1 presents that enrollment in three categories:

- o Primary Care Case Management (PCCM) systems: under the PCCM approach (available through waivers), states contract with primary care physicians, who manage the care of Medicaid beneficiaries. Beneficiaries must choose a primary care provider, who provides primary care services and authorizes the use of other services and coordinates that care -- in other words, the physician provides primary care access and serves in a "gatekeeper" function. In most programs,

⁴National Institute for Health Care Management. States as Payers: Managed Care for Medicaid Populations. Prepared by Lewin-VHI, February, 1995.

Medicaid continues to pay for services on a fee-for-service basis, and the primary care provider is also paid a monthly case management fee.

- o Partially capitated plans: partially capitated programs pay providers for a limited package of services on a capitation basis (a fixed amount of payment per month), and pay for other services on a fee-for-service basis. In some cases, outpatient services are capitated, and inpatient services paid on a fee-for-service basis. In other cases, specialty services (such as mental health, substance abuse, and/or dental services) are paid on a capitation basis, with the remainder of the program operating on a fee-for-service basis.
- o Fully capitated plans: these are contracts with health maintenance organizations (HMOs) or prepaid health plans (PHPs) to provide a comprehensive range of services on a capitated basis (a fixed amount per member per month).

Most enrollees (4.8 million) are in fully capitated plans -- and this was the fastest growing category, increasing 91 percent in just one year.

Table 1
Medicaid Managed Care Enrollment, June 30, 1994
and percentage increase over June 30, 1993

	Enrollment (In millions)(1)	Percent increase over 1993(2)
Total Enrollment (Unduplicated)	7.6	57 %
PCCM	2.4	59 %
Partially Capitated	.8	9 %
Fully Capitated	4.8	91 %

Source: NIHCM/Lewin-VHI, February, 1995.

Notes:

(1) The individual enrollment figures add to more than the unduplicated total because about 400,000 individuals are in two types of plan (for example, a PCCM for some services and a partially capitated plan for others).

(2) The percentage changes from 1993 are rough estimates: the base year 1993 data could not be assessed as rigorously by the contractor as the 1994 data.

The NIHCM/Lewin-VHI report also went beyond the traditional measure of managed care penetration -- recipient counts -- and assessed the percentage of Medicaid dollars paid out in capitation. This was intended as a measure of the magnitude of the states' efforts to move to more comprehensive, fully capitated programs -- a measure that generally excludes from consideration the PCCM models, which are typically paid on a fee for service basis. Nationwide, about seven percent of total Medicaid spending is paid in the form of capitation payments. The variation among states is dramatic. Two states operating with Section 1115 waivers (see next section on waivers) are at the high end of the scale: 100 percent of program dollars are capitated in Arizona, and 75 percent in Tennessee. Six states are between 10 and 22 percent: Oregon, Minnesota, Florida, Maryland, Washington, and Pennsylvania. The rest of the states are under 10 percent, with the percent of payments made on a capitation basis below 1 percent in some states.

The percent of Medicaid dollars paid in capitation (seven percent) is substantially lower than the percent of enrollees in Medicaid managed care (24 percent) for reasons that relate to the evolution of Medicaid managed care programs and the underlying Medicaid program. First, as noted earlier, the definition of a managed care Medicaid enrollee includes individuals in PCCMs (2.4 million individuals, or about 32 percent of total managed care enrollees). Since these PCCMs are generally not subject to capitation payments, the capitation base is smaller.

Second, for the most part, Medicaid capitation payments and managed care enrollment has focused on acute care services, and the eligibility groups related to children and adults in families with children. While some states have moved to include the aged and disabled, and/or long-term care, the movement is not yet substantial. This is important because of the spending patterns in the Medicaid program. While the beneficiary base is heavily weighted to children and families

with children, total Medicaid spending is heavily weighted to the aged, blind and disabled (because spending is substantially higher per person in this category):

- o The aged, blind, and disabled constitute only 27 percent of program recipients, but they constitute nearly 70 percent of program spending. Thus, until they are brought into Medicaid managed care, the percent of program spending subject to capitation will remain low.
- o Long-term care services constitute more than one third of total program spending (this is, of course, an especially important service for the aged and disabled).⁵

A number of studies have examined the impact of the move to Medicaid managed care, and the NIHCM/Lewin-VHI report reviewed and reported on the results of studies to date.

- o Emergency room use is reduced.
- o Inpatient use is lower.⁶
- o Managed care increases satisfaction, largely because it allows beneficiaries to gain access to private physicians.
- o Because incentives for physicians to treat Medicaid patients do work, whether in the form of increased FFS payments or the use of PCCM programs, access is slightly better than in traditional programs.
- o Studies report quality similar to that in traditional FFS Medicaid programs; outcome measures require further study.
- o Costs to states are lower: some report that costs to states are lower by 5 to 15 percent; it is not clear if this is due to lower utilization, discounts, or cost shifting. Others report that cost analyses are conflicting.

⁵Note: a separate set of waiver programs is available for states to provide home and community-based services under Medicaid. States have aggressively pursued these waivers. While there is substantial state activity in these programs, they were not included in the NIHCM/Lewin-VHI report.

⁶Inpatient use is declining for the population as a whole; some of the Medicaid decline may be attributed to market trends.

Background on Medicaid managed care requirements

The federal Medicaid statute (title XIX of the Social Security Act) has for many years allowed states to include as part of their state Medicaid plan provisions for contracting with comprehensive health maintenance organizations (HMOs) or HMO-like entities often referred to as "Prepaid Health Plans." Certain standards are set for these plans, and enrollment must be offered on a voluntary basis: while beneficiaries may be offered the option to enroll in the HMO, they must also have the option to remain in the state's traditional Medicaid fee-for-service (FFS) system. This is based on the underlying "freedom of choice" requirement in Medicaid law.⁷

While some states pursued voluntary enrollment in such plans, and continue to do so today, many sought increased authority to move more aggressively to implement Medicaid managed care through the use of waivers in order to take advantage of the cost savings, access, and care coordination that can be made available under such plans. There are two general types of waiver that are available.

First are "programmatic" waivers. The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) included a new Sec. 1915(b) in title XIX that provided for waivers of certain provisions of Medicaid, including "freedom of choice" and some of the requirements for contracting with prepaid health plans. Under Sec. 1915(b), states can seek waivers to limit freedom of choice in their Medicaid programs through certain types of managed care. Most notably, they can implement "Primary Care Case Management" (PCCM) programs -- and require enrollees to sign

⁷For complete description of Medicaid and its managed care options, see: House Committee on Energy and Commerce, Subcommittee on Health and the Environment, Medicaid Source Book: Background Data and Analysis, January, 1993. Chapter VI and Appendix G provide detailed information on Medicaid managed care options.

up with a primary care provider, who provides access to primary care and serves as a manager or “gatekeeper” for other services.. The NIHCM/Lewin-VHI report estimates that 38 states and the District of Columbia have Sec. 1915(b) waiver programs in effect, with an additional six state requests pending.

The second type of waiver is a “demonstration” waiver. Section 1115 of the Social Security Act provides broad waiver authority to the Secretary of Health and Human Services (HHS) under the Social Security Act: the Secretary can waive provisions of the statute to conduct demonstrations. Medicaid waivers are but one use of this broad authority. The Sec. 1115 demonstration authority had typically been used to authorize small demonstrations, but is increasingly being used by states and HHS to allow states to implement more comprehensive managed care and health reform programs under Medicaid.

In general, these Sec. 1115 waivers are used to allow states to extend Medicaid coverage to individuals who would not otherwise qualify for the program because they do not meet the federal categorical requirements for eligibility. In addition, states have sought waivers to require mandatory Medicaid enrollment by some or all Medicaid beneficiaries in managed care plans -- i.e., the “freedom of choice” provision is waived -- so long as beneficiaries have a choice of plans. Nine states have been granted comprehensive Sec. 1115 waivers as of January, 1995.

POLICY AND IMPLEMENTATION ISSUES

As policy makers in the states and federal government consider options to expand the use of managed care in the Medicaid program, a number of policy and implementation issues merit review.

Federal/state design re: managed care: One issue is the longest-standing issue in Medicaid, and every other federal-state program: what are the appropriate types of federal vs. state policy decisions. As noted above, the Medicaid statute has allowed states to implement voluntary enrollment in HMOs and similar entities for years, subject to certain constraints. However, states must seek “programmatic” waivers to implement PCCMs, and “demonstration” waivers to implement more comprehensive reforms allowing broader coverage and/or mandatory enrollment in managed care.

The issue is whether and how to change the federal requirements to alter some of those federal rules related to state use of managed care programs -- with those changes moving along a spectrum toward increasing state control in deciding whether and how to incorporate managed care into their state Medicaid program..

The basic options relate to whether changes should be made through expanded use of waivers or through changes in the basic Medicaid statute.

- o Ease waiver requirements: one option is to maintain the basic statutory provisions related to managed care in Medicaid, but substantially ease the requirements that states must meet to gain and renew waivers.
- o Change underlying statute: Instead of requiring waivers, a second option is to change the underlying statute in a manner that no longer precludes states from moving toward managed care in Medicaid if they so choose. Such an approach would allow states to incorporate a managed care design feature in their state plan without the need for federal waivers.

In moving along this spectrum toward increased state flexibility in implementing managed care, the difficult question is how to redefine the appropriate federal policies as regards Medicaid managed care. If the statute is revised, should the federal statute impose any constraints on state use of managed care, and if so, what standards are appropriate? One example is whether fiscal

requirements would be linked to state Medicaid managed care. States already are required, as part of the waiver process, to meet a cost neutrality requirement -- the federal government will not approve the waiver unless the projected costs are no greater than the state would have incurred if the waiver had not been approved.

One additional issue may be linked to the general movement toward increased state flexibility in design of their Medicaid program -- including implementation of managed care. Such increased policy flexibility could, under some scenarios, be coupled with a cap on federal funding. For example, one option that has been suggested is to cap the federal Medicaid growth rate at five percent per year. Such a plan would reduce the rate of increase in federal funds available to the states by a cumulative total of \$196 billion below CBO baseline levels from 1996 - 2002. In the year 2002 alone, this proposal would reduce federal funding below the existing CBO baseline estimate for that year by \$52 billion, or 29 percent. Policy makers at the federal and state level would need to consider what steps they would have to take -- in managed care or otherwise -- to operate Medicaid within such federal funding targets, and the programmatic impact of such actions.

Monitoring quality, service: a second question relates to the appropriate mechanisms and roles in monitoring the evolving managed care system. Two basic policy and implementation questions arise.

Appropriate monitoring mechanisms: the first is to define the appropriate policy mechanisms to monitor and deal with the incentives of a market that is based on managed care arrangements as opposed to the fee-for-service (FFS) market. This is an issue for the health system generally, and must be dealt with in the context of Medicaid managed care as well.

Federal and state governments and private organizations have worked for years to develop mechanisms to deal with the nation's fee-for-service system and its incentives to increase service volume (measures such as utilization controls; "fraud and abuse" rules targeted at incentives for over provision of services).

As more and more individuals move into managed care, how should such mechanisms be revised? One potential answer is that market pressures will suffice. Large employers and organizations such as the National Committee for Quality Assurance (NCQA) have identified standards for health plans as another approach. Government and the private sector will need to continue to redefine these activities if the health care market and programs like Medicaid continue to change into fully capitated, managed care arrangements, so that policy makers have some level of comfort about assuring access to services, appropriate use, and quality of care.

Federal and/or state role in monitoring: second is the degree of responsibility -- federal vs. state -- for whatever monitoring processes are required. One option is to make these federal standards -- but that raises the issues noted above about the political desire for increased flexibility for states in managing their Medicaid program. Alternatively, responsibility could fall within the purview of the states under a redefined federal-state relationship -- subject to some broad federal requirement that states have some system -- or no federal requirement at all.

This issue of federal vs. state accountability can never be settled completely because of the dynamic tensions involved between the two branches of government in a joint federal-state program. Whatever change is made in the near future -- toward more state control or more federal control -- those tensions will remain, and the political process will have to continuously manage the difficult balancing act inherent in this relationship.

Infrastructure/capacity development: one final issue state policy makers interested in increasing their use of managed care in Medicaid relates to the health plan and service infrastructure. Two basic issues arise.

Managed care infrastructure: is there an existing capacity to implement substantial increases in managed care in Medicaid -- and if not, how can the states work to develop such an infrastructure? A number of elements are important, including primary care physicians willing to assume responsibility for seeing Medicaid patients, other providers accessible to this population, and health plans able and willing to accept risk, provide care, and assure access and quality for Medicaid beneficiaries.

One obvious factor is the availability of HMOs. The NIHCM/Lewin-VHI study documented a relationship between the availability of HMOs for the private sector and Medicaid HMO enrollment: about 30 percent of the variation among states in Medicaid enrollment is "explained" by variation among states in private sector enrollment. Further, states with more competing HMOs have higher Medicaid managed care penetration.

Role/future of existing Medicaid providers: a related issue is how the existing structure of providers serving the Medicaid population and other low-income individuals (such as public hospitals and community clinics) adapts to the new models. Such entities can work to become networks -- or part of networks -- to meet the needs of individuals under the new arrangements and keep their market share of Medicaid. Alternatively, if states and beneficiaries turn to other providers to provide services under managed care arrangements, such entities would be at risk, forcing states and local governments to consider how to meet needs of the un- and under-insured who also often depend on this network of providers.

CONCLUSION

Many states are well on their way to implementing Medicaid managed care. With one-fourth of the Medicaid population already enrolled in some type of managed care, and annual growth of more than 50 percent this past year, policymakers at the federal and state level will confront Medicaid managed care design and implementation issues as they continue to change this important program.