CAN IT SUCCEED?

States to Roll Out More Medicaid Managed Care

BY DEANNA OKRENT, M.P.A., M.A.

Medicaid managed care, increasingly adopted by states as a way of delivering care to Medicaid recipients, has grown since the 1990s until today it pervades the American landscape. In 2010, some 27 million people, or half of Medicaid's 54 million beneficiaries, were enrolled in a managed-care plan, compared to just over one-third of beneficiaries who were in Medicaid fee-for-service.[1] According to a survey of states, in 2010, 47 states — all but Alaska, New Hampshire and Wyoming — had Medicaid managed-care programs.[2]

Though these programs are operating in nearly all states, they are far from identical in their approach and scope. Many are run by private, for-profit corporations, such as Centene or Molina, that specialize in providing care for Medicaid beneficiaries and bid for managed-care contracts with states.

There is also great variation in the numbers of people enrolled in these programs and in the range of services provided. Some provide only home and institutional long-term services and supports (LTSS), while others cover a broader range of services including acute care, primary care, behavioral health and long-term services and supports.

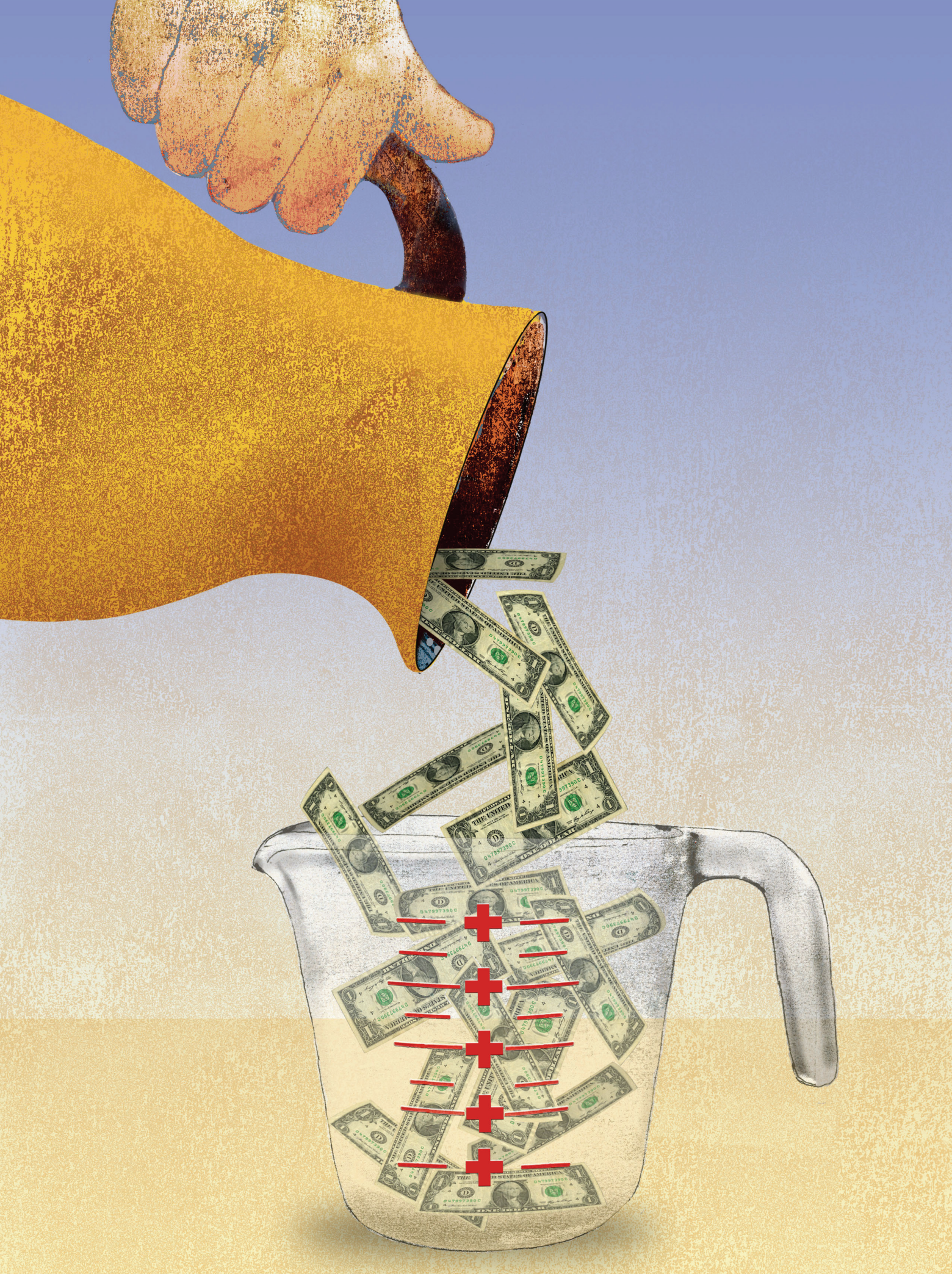
The share of state budgets devoted to the Medicaid program can be greater than 25 percent, taking both federal and state funds into consideration, or as high as 16 percent, counting state funds alone. So to states, one of the big attractions of the Medicaid managed care program is that it promises to save money without compromising access and quality — clearly very important in tough economic times. However, that very attraction should signal caution. In general, the Medicaid enrollment cycle runs counter to the traditional economic cycle, so that, at the very time when state revenues are down, the number of Medicaid enrollees goes up. And today, when so many are enrolled in managed-care programs for some or all of their care, a question of concern to all who care about poor and vulnerable persons is whether, as the trend grows, states can adequately monitor these programs.

WHAT IS IT?

Like managed-care programs under private insurers or Medicare HMOs, Medicaid managed-care organizations receive a fixed payment per member enrolled in the plan, often known as a capitated payment. The program's aim is to deliver less-fragmented, better coordinated care and to meet consumer preferences for where they want to live and get care. Medicaid managed care also may be able to add services not typically covered by traditional fee-for-service Medicaid, especially in the quality-of-life arena.

In the case of Medicaid managed care, the state is the payer. For the set amount of money it receives from its capitated, or fixed per-person payments, the managed-care organization provides various services and supports to its members through a network of providers. Because these organizations must deliver needed medical services to all their members within the money allotted, rather than be paid for each service delivered, they have a financial incentive to keep members healthy. They typically emphasize coordinated care which helps to reduce duplication of services, increase patient compliance with treatment protocols and reduce hospital admissions and readmissions.

Nearly half of Medicaid spending overall goes for long-term needs, which include institutional long-term care and home and community-based services for elderly or disabled persons. Examples of the latter include adult day care and home care services that provide assistance with activities of daily living. The people receiving these services represent only 6 percent of the Medicaid population. The



high cost of institutional care and the imbalance in use of institutions versus community-based services account for the disproportion.

In recent years, efforts have been made to rebalance the locus of services, putting a greater emphasis on community-based services. This is due primarily to these four factors: a 1999 U.S. Supreme Court decision which said disabled persons have a right to receive care in the least restrictive setting, meaning home and community-based care where appropriate; the "Money Follows the Person" initiative of the Centers for Medicare and Medicaid Services (CMS), which has enabled thousands of people to transition from institutional to community-based care; provisions in the Older Americans Act, which provides home and community-based social and nutritional services to seniors, such as adult day care and Meals on Wheels; and various incentives in the Affordable Care Act, including grants to states to develop programs that improve the quality of care at lower cost.

Only seven states spend more than 50 percent of their Medicaid LTSS dollars on community-based services. (A leader in this regard is New Mexico, which spends over 90 percent of its Medicaid LTSS dollars on home and community-based services.) Nationally, however, home and community-based services represent about 45 percent of total spending for Medicaid LTSS. Various CMS initiatives encourage the rebalancing trend by moving away from the current institutional bias. Among them are demonstrations affecting the so-called dually eligible, those people, including members of the elderly or disabled populations, who are eligible for both Medicare and Medicaid dollars. In addition to saving money, these demonstrations aim to enhance quality of care and improve outcomes.

The speed with which Medicaid managed-care programs are taking hold reflects the crisis in state budgets, not to mention the aging of the population and consequent increased numbers of people needing assistance with activities of daily living and other long-term services and supports. It therefore is important to look at states' capacity for monitoring these programs.

A 2012 study by Mathematica Policy Research and the AARP Public Policy Institute looked at eight states that have varying years of experience with managed LTSS.[3] The authors noted several guiding principles and promising practices from which to draw lessons for policymakers. Among them, they pointed to the need to have adequate capacity for oversight, including monitoring, before enrolling beneficiaries in the program.

Although oversight is critical to consumer protection and maintaining quality and safety, providing it can present a hurdle when states are reducing staff in response to budgetary challenges. Some states are enlisting partners to help. These partners might include consumer groups, external quality review organizations (also known as EQROs), health, aging and disability agencies and others.

The study's authors also noted the need to recognize the differences between managed care programs for younger people and programs that serve older people with multiple chronic conditions and people with disabilities. Programs in the latter two categories require different services and a different staff skill set. Programs serving these populations might require partnerships with several different "specialty" managed-care organizations, such as those that serve a population with behavioral health needs and others that serve acute care needs and provide other long-term services and supports.

Important monitoring functions for states that contract with managed-care organizations include overall contract monitoring that assures accountability, network adequacy and sound payment rates to providers. One of the oft-heard cries about lack

BY THE NUMBERS

- **36** states had contracts with private Medicaid managed-care plans in 2010.
- States might have contracts with more than **1** private plan: for example, New Mexico contracts with **2** managed care plans, and New York contracts with **14** different plans.
- Some states limit their programs to those under age **65**.
- Others enroll people age **65** and older in both Medicare and Medicaid.
- As of May 2012, **16** states have extended their Medicaid managed care programs to include long-term services and supports for seniors and people with disabilities.
- The longest any state program has been operating is **20** years, in Arizona. **1** of the newer programs, in Tennessee, has been operating just **2** years, and there are others that are still on the drawing boards, awaiting legislative approval, a governor's signature or state program implementing regulations.

of access to care in Medicaid is that providers aren't paid enough to participate; hence they don't. This creates a shortage of providers for vulnerable populations, including minorities, older people at risk for multiple chronic conditions and people living in rural and other medically underserved areas.

In the case of a managed-care organization, adequate payment also prevents the organization from looking to cost-cutting measures that could compromise care, such as reducing benefits, staff and network adequacy in order to make the capitated payment sufficient to cover their operations.

In the range of oversight practices, there are some states that go further than the minimum required by federal rules and regulations. These are seen as "promising practices."[4] They seem to improve plan performance and quality outcomes. They typically exercise more frequent review, and they may need greater resources — staff, technology and funds — than are typically available in most states. Some states in this category provide incentives beyond the norm for managed-care organizations to meet or exceed quality standards. Some employ a dedicated ombudsman (member advocate) to investigate member problems and monitor critical incidents, even daily.

POLICY LESSONS, CHALLENGES AND CAUTIONS

With regard to Medicaid managed care and Medicaid managed long-term services and supports, states differ in design, experience and readiness. Some Medicaid managed care and Medicaid managed long-term services and support programs are providing evidence of higher quality and more efficient health care delivery. State oversight is an important part of the equation. We see evidence of this in Arizona, where care for diabetics is improving and rebalancing long-term services and supports in general is progressing.

But not all states have the capacity to do more than the minimum. Oversight or enforcement may be sporadic and insufficient to address poor practices. Monitoring of plan performance may be so loose that beneficiaries are at risk of poor care. States may not use incentives or penalties to help bring plan performance up to speed. This may be because there is insufficient capacity to monitor rapidly growing programs and to enforce rules and regulations. It may also be due to quick decisions made by states to contract with one or more managed-care organizations before the capacity to monitor was in place.

States therefore need to exercise caution in interpreting the results of their model. If it does not produce the results they hope for, failure could be due to failed implementation, not a flawed model. Other contributing factors include availability and quality of care delivered by providers, beneficiary health status and health behaviors, federal and state funding, and marketplace incentives.

The consumer also is an important part of this equation. Providers and consumers need to participate jointly to develop new models of care that achieve the best outcomes possible. Education of consumers with culturally appropriate materials, allowing consumer-directed care and family caregiver participation in choosing a health plan and a care plan is necessary for satisfactory outcomes.

In a health care system where health information technology is developing at great speed, where quality performance measures are being developed to determine improved outcomes and where innovations are being implemented on a regular basis, many eyes need to be watching — consumers, providers, legislators, advocates and stakeholders. In this milieu, Medicaid managed long term services and supports are evolving.

Stay tuned.

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NOTES

1. Another 16 percent of Medicaid recipients are in primary care case management, a fee-for-service arrangement with the state in which a primary care provider serves as a gatekeeper for services. There is no intermediary managed-care organization.
2. Kathleen Gifford et al., "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey," Kaiser Family Foundation, September 2011.
3. Debra Lipson et al., "Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports" (Washington, D.C.: AARP Public Policy Institute, 2012).
4. Lipson et al. The term "promising practices" is used in this report to categorize those programs that go above the minimum in their oversight and monitoring activities, that deserve further review and that may serve as models for others to follow. The report was released at an Alliance for Health Reform congressional briefing on Aug. 3, 2012. It can be found at http://allhealth.org/briefing_detail.asp?bi=256 along with speaker presentations and other materials from the briefing.

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