

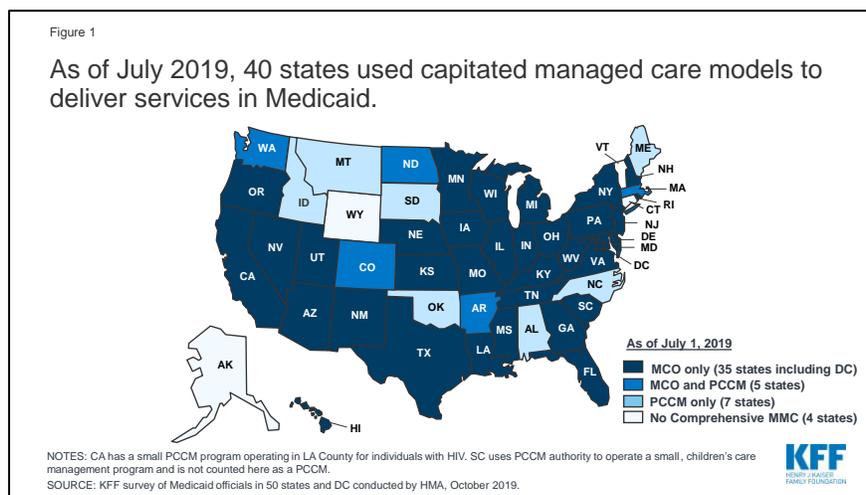
10 Things to Know about Medicaid Managed Care

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Managed care plays a key role in the delivery of health care to Medicaid enrollees. This brief describes key themes related to the use of comprehensive, risk-based managed care in the Medicaid program and highlights data and trends related to MCO enrollment, service carve-ins, spending, MCO parent firms, and state and plan activity related to quality, value-based payments, and the social determinants of health.

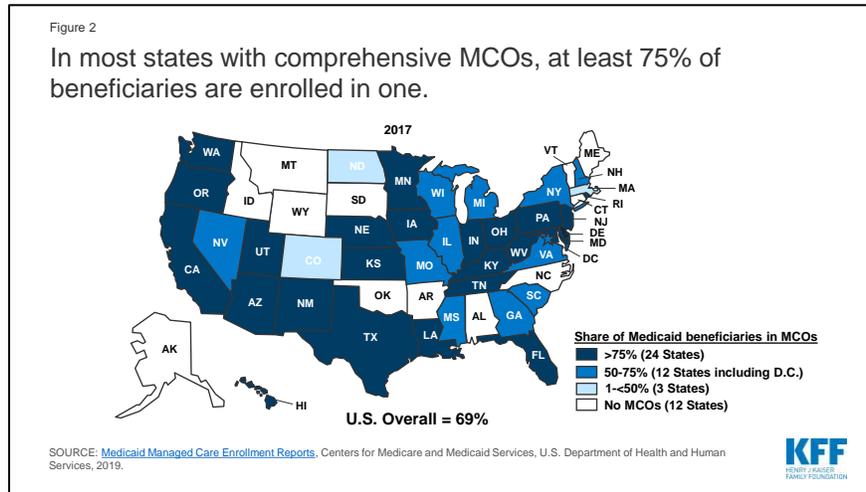
1. Today, capitated managed care is the dominant way in which states deliver services to Medicaid enrollees.

States design and administer their own Medicaid programs within federal rules. States determine how they will deliver and pay for care for Medicaid beneficiaries. Nearly all states have some form of managed care in place – comprehensive risk-based managed care and/or primary care case management (PCCM) programs.^{1,2} As of July 2019, 40 states, including DC, contract with comprehensive, risk-based managed care plans to provide care to at least some of their Medicaid beneficiaries (Figure 1). Medicaid managed care organizations (MCOs) provide comprehensive acute care and in some cases long-term services and supports to Medicaid beneficiaries. MCOs accept a set per member per month payment for these services and are at financial risk for the Medicaid services specified in their contracts. States have pursued risk-based contracting with managed care plans for different purposes, seeking to increase budget predictability, constrain Medicaid spending, improve access to care and value, and meet other objectives. While the shift to MCOs has increased budget predictability for states, the evidence about the impact of managed care on access to care and costs is both limited and mixed.³



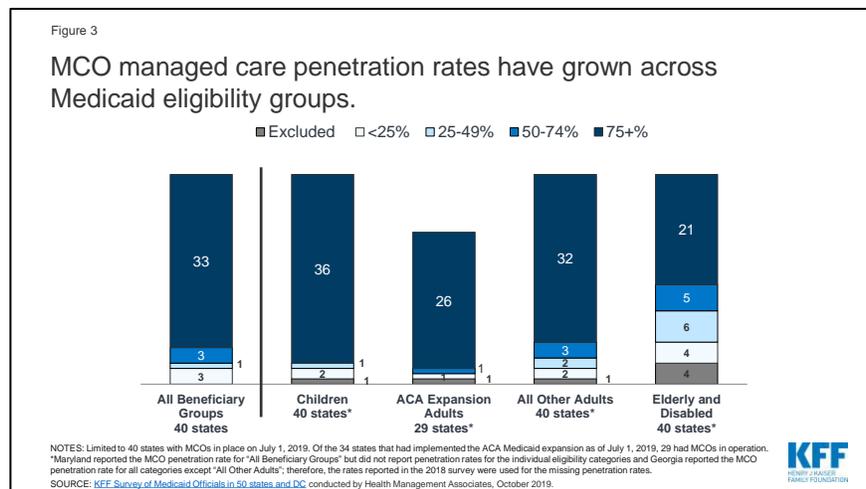
2. As of July 2017, over two-thirds (69%) of all Medicaid beneficiaries received their care through comprehensive risk-based MCOs.

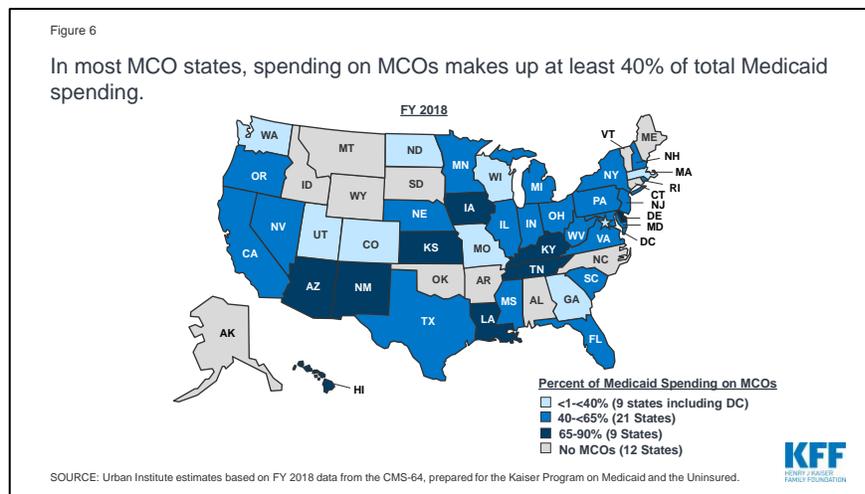
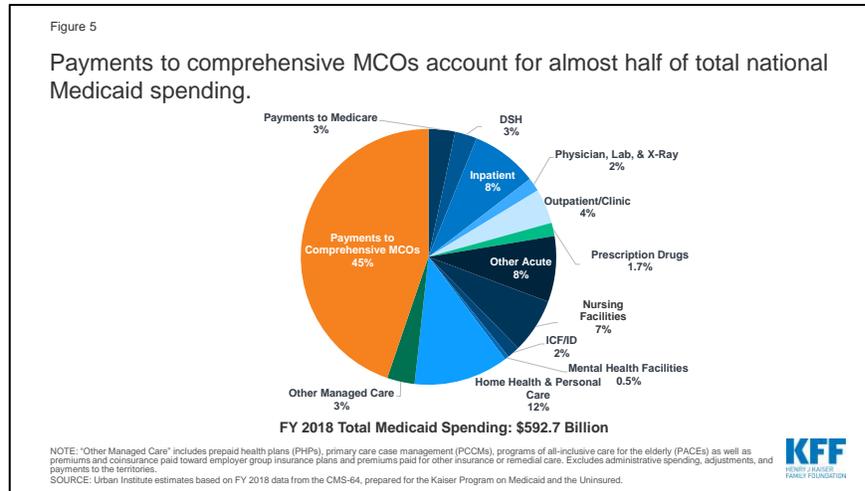
As of July 2017, 54.1 million Medicaid enrollees received their care through risk-based MCOs. Twenty-four MCO states covered more than 75% of Medicaid beneficiaries in MCOs (Figure 2).



3. Children and adults are more likely to be enrolled in MCOs than seniors or persons with disabilities; however, states are increasingly including beneficiaries with complex needs in MCOs.

As of July 2019, 36 MCO states reported covering 75% or more of all children through MCOs (Figure 3). Of the 34 states that had implemented the ACA Medicaid expansion as of July 2019, 29 were using MCOs to cover newly eligible adults and the large majority of these states covered more than 75% of beneficiaries in this group through MCOs. Thirty-two MCO states reported covering 75% or more of low-income adults in pre-ACA expansion groups (e.g., parents, pregnant women) through MCOs. In contrast, only 21 MCO states reported coverage of 75% or more of seniors and people with disabilities. Although this group is still less likely to be enrolled in MCOs than children and adults, over time, states have been moving to include seniors and people with disabilities in MCOs.



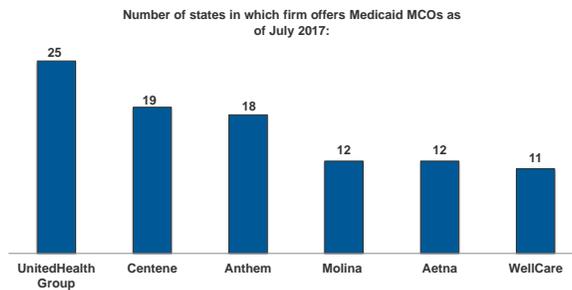


6. A number of large health insurance companies have a significant stake in the Medicaid managed care market.

States contracted with a total of 282 Medicaid MCOs as of July 2017.⁶ MCOs represent a mix of private for-profit, private non-profit, and government plans. As of July 2017, a total of 19 firms operated Medicaid MCOs in two or more states (called "parent" firms⁷), and these firms accounted for about 57% of enrollment in 2017 (Figure 8). Of the 19 parent firms, nine are publicly traded, for-profit firms while the remaining 10 are non-profit companies.⁸ Six firms – UnitedHealth Group, Centene, Anthem, Molina, Aetna, and WellCare – have MCOs in 10 or more states (Figure 7) and accounted for about 44% of all Medicaid MCO enrollment (Figure 8). All six are publicly traded companies ranked in the Fortune 500.

Figure 7

Six firms have a wide geographic reach in Medicaid, each with MCOs in 10 or more of the 39 MCO states.

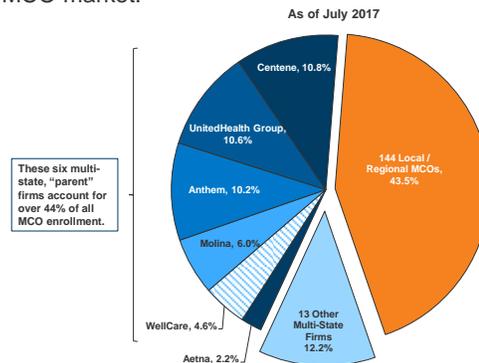


SOURCE: [Medicaid Managed Care Enrollment Reports](#), Centers for Medicare and Medicaid Services, 2019.



Figure 8

In the 39 MCO states, six Fortune 500 firms have almost half of the Medicaid MCO market.



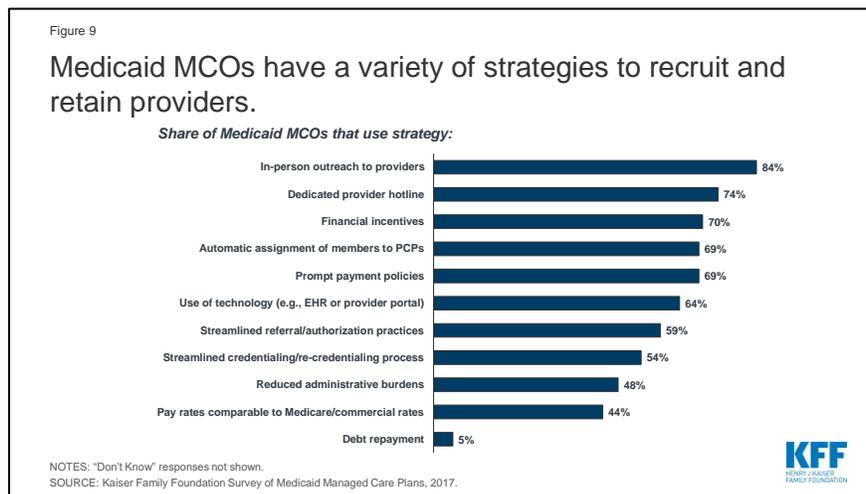
SOURCE: [Medicaid Managed Care Enrollment Reports](#), Centers for Medicare and Medicaid Services, 2019.



7. Although MCOs report challenges recruiting specialty providers, which may be linked to broader market trends, plans report a variety of strategies to recruit providers.

Plan efforts to recruit and maintain their provider networks can play a crucial role in determining enrollees' access to care through factors such as travel times, wait times, or choice of provider. Federal rules require that states establish network adequacy standards. States have a great deal of flexibility to define those standards. The [2016 CMS Medicaid managed care final rule](#) included specific parameters for states in setting network adequacy standards, although regulations [proposed by the Trump administration in 2018](#) would loosen these requirements. Medicaid fee-for-service rates tend to be lower than Medicare rates. MCOs have some flexibility to set rates for providers, but many states require minimum provider rates in their contracts with MCOs. In a 2019 KFF survey of Medicaid directors, about one-half of MCO states indicated that they mandate minimum provider reimbursement rates in their MCO contracts for inpatient hospital, outpatient hospital, or primary care

physicians.⁹ KFF conducted a survey of Medicaid managed care plans in 2017¹⁰ and found that responding plans reported more challenges in recruiting specialty providers than primary care providers to their networks. Plans were more likely to cite provider supply shortages than low provider participation in Medicaid as a top challenge in ensuring access to care. In the same survey, responding plans reported a variety of strategies to address provider network issues including direct outreach to providers, financial incentives, automatic assignment of members to PCPs, and prompt payment policies (Figure 9).

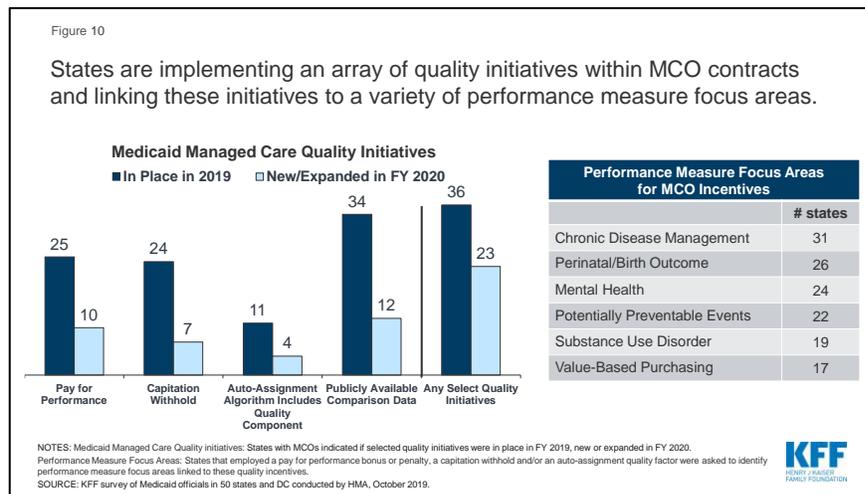


8. Over time, the expansion of risk-based managed care in Medicaid has been accompanied by greater attention to measuring quality and outcomes.

Nearly all MCO states reported using at least one select Medicaid managed care quality initiative in FY 2019 (Figure 10). More than three quarters of MCO states (34 of 40) reported having initiatives in place in FY 2019 that make MCO comparison data publicly available (up from 23 states in 2014¹¹). More than half of MCO states reported capitation withhold arrangements (24 of 40) and/or pay for performance incentives (25 of 40) in FY 2019 (up from 18 and 19 states, respectively, in 2014¹²). Fewer states reported use of an auto-assignment algorithm that includes quality performance measures (11 of 40) in FY 2019. The predominance of states reporting new or expanded activity in managed care quality in FY 2020 reported activity related to enhancing/expanding existing initiatives, versus establishing new ones.

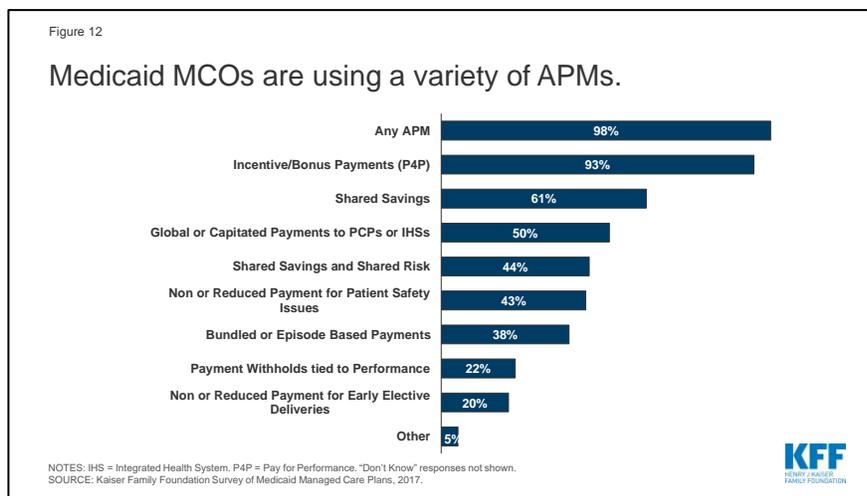
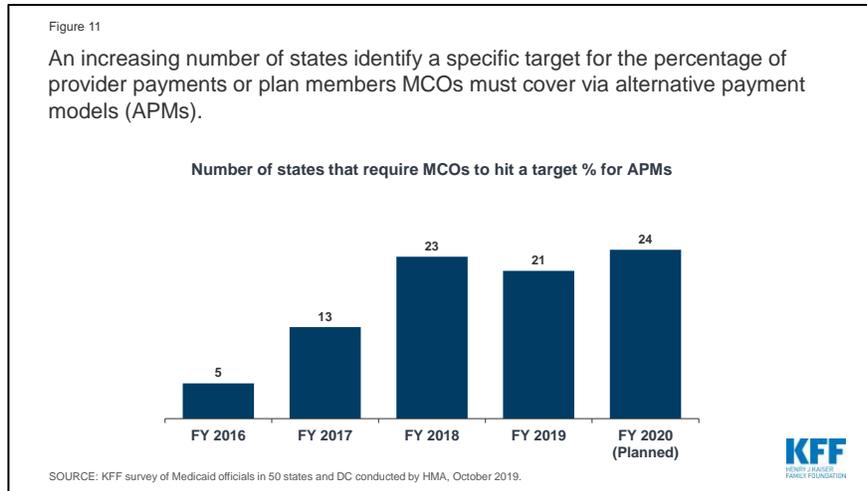
States that use a pay for performance bonus or penalty, a capitation withhold, and/or an auto-assignment quality factor report linking these quality initiatives to a variety of performance measure focus areas. Over three quarters of MCO states (31 states) reported using chronic disease management metrics when rewarding or penalizing plan performance (Figure 10).¹³ More than half of MCO states reported linking quality initiatives to perinatal/birth outcome measures (26 states) or mental health measures (24 states). These focus areas are not surprising given the chronic physical

health and behavioral health needs of the Medicaid population, as well as the significant share of the nation's births funded by Medicaid.



9. An increasing number of states set a target percentage of MCO provider payments that must be in alternative payment models (APMs).

Alternative payment models (APMs) replace FFS/volume-driven provider payments with payment models that incentivize quality, coordination, and value (e.g., shared savings/shared risk arrangements and episode-based payments). More than half of MCO states (21 of 40) set a target percentage in their MCO contracts for the percentage of provider payments, network providers, or plan members that MCOs must cover via alternative payment models in FY 2019 (Figure 11). Several states reported that their APM targets were linked to the Health Care Payment Learning & Action Network's (LAN's) APM Framework that categorizes APMs in tiers.¹⁴ KFF's 2017 survey of Medicaid managed care plans found nearly all responding plans reported using at least one alternative payment model for at least some providers (Figure 12). The vast majority of plans use incentives and/or bonus payments tied to performance measures. Fewer plans reported using bundled or episode-based payments or shared savings and risk arrangements.

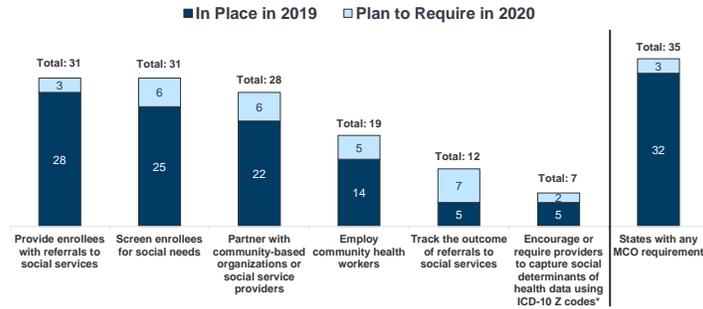


10. With increased attention to social determinants of health at the federal and state levels, states are looking to Medicaid MCOs to develop strategies to identify and address social determinants of health.

With Medicaid managed care delivery systems operating in 41 states as of FY 2020, many states are leveraging MCO contracts to promote strategies to address social determinants of health. Over three-quarters of the 41 MCO states as of FY 2020 (35 states) are leveraging Medicaid MCO contracts to promote at least one strategy to address social determinants of health (Figure 13). As of FY 2020, about three-quarters of MCO states require MCOs to screen enrollees for social needs (31 states); provide enrollees with referrals to social services (31 states); or partner with community-based organizations (28 states). Almost half of MCO states require MCOs to employ community health workers (CHWs) or other non-traditional health workers (19 states). KFF's 2017 survey of Medicaid managed care plans found that a majority of plans were actively working to help beneficiaries connect with social services related to housing, nutrition, education, or employment (Figure 14).

Figure 13

State MCO Contract Requirements Related to Social Determinants of Health, FYs 2019-2020



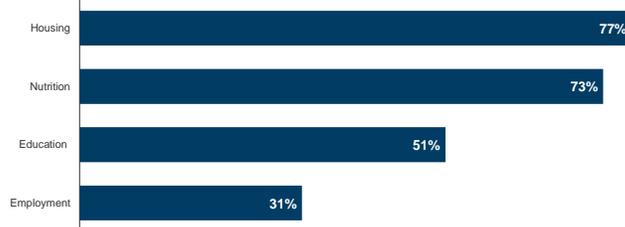
NOTES: States with MCOs (40 in FY 2019 and 41 in FY 2020) indicated if selected policies are part of MCO requirements in place in FY 2019 or new in FY 2020. *ICD-10 Z codes are a subset of the ICD-10 diagnosis codes that reflect patient social characteristics. SOURCE: KFF survey of Medicaid officials in 50 states and DC conducted by HMA, October 2019.



Figure 14

The majority of plans reported housing and nutrition activities to address social determinants of health.

Share of Plans Responding that Reported Undertaking Activities to Address Social Determinants of Health in the Past 12 Months:



NOTES: Plans were asked: "In the Past 12 months, has your Medicaid MCO used any of the following strategies to connect members with social services?" "Other" responses (4% of plans) not shown. SOURCE: Kaiser Family Foundation Survey of Medicaid Managed Care Plans, 2017.



Endnotes

¹ PCCM is a managed fee-for-service (FFS) based system in which beneficiaries are enrolled with a primary care provider who is paid a small monthly fee to provide case management services in addition to primary care.

² While MCOs are the predominant form of Medicaid managed care, millions of other beneficiaries receive at least some Medicaid services, such as behavioral health or dental care, through limited-benefit risk-based plans, known as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs).

³ <https://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html>

⁴ [Total Medicaid MCO Spending](#), FY 2018, State Health Facts, KFF.

⁵ [Total Medicaid MCO Spending](#), FY 2018, State Health Facts, KFF.

⁶ [Total Medicaid MCOs](#), 2017, State Health Facts, KFF.

⁷ [Medicaid MCO Enrollment by Plan and Parent Firm, 2017](#), State Health Facts, KFF.

⁸ [Medicaid MCO Parent Firm Financial Information](#), 2016-2017, State Health Facts, KFF.

⁹ [KFF survey of Medicaid officials in 50 states and DC](#) conducted by HMA, October 2019.

¹⁰ [Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans](#), 2018, KFF.

¹¹ Table 8 [Medicaid Reforms to October 2015 Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016](#)

¹² Table 8 [Medicaid Reforms to October 2015 Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016](#)

¹³ [KFF survey of Medicaid officials in 50 states and DC](#) conducted by HMA, October 2019.

¹⁴ Health Care Payment Learning & Action Network, Alternative Payment Model (APM) Framework, Fact Sheet; accessed at <http://hcp-lan.org/workproducts/apm-factsheet.pdf>. CMS launched the LAN in 2015 to encourage alignment across public and private sector payers by providing a forum for sharing best practices and developing common approaches to designing and monitoring of APMs, as well as by developing evidence on the impact of APMs.