The Medicaid Program and Health Plans’ Role in Improving Care for Beneficiaries: What You Need to Know

KEY TAKEAWAYS

Today, Medicaid is the largest federal health program in the country. Over 72 million individuals are now enrolled in the Medicaid and Children’s Health Insurance Programs (CHIP).

Medicaid health plans are fundamental to the operation of the Medicaid program. Now Medicaid health plans are the predominant approach used in state Medicaid programs, enrolling approximately 73 percent of all Medicaid beneficiaries.

It is crucial for Medicaid health plans to continue to play a crucial role in the Medicaid program. Medicaid health plan innovations are demonstrating improved outcomes for beneficiaries and have served as the engine for delivery system reform throughout the Medicaid program.
The Medicaid Program and Health Plans’ Role in Improving Care for Beneficiaries

Summary

Congress established the Medicaid program in 1965 to serve as a health care safety net for low-income Americans. Today, Medicaid is the largest federal health program in the country. Over 72 million individuals are now enrolled in the Medicaid and Children’s Health Insurance Programs (CHIP). The program has become a crucial component in our health care system. Medicaid beneficiaries are more likely to be in poor health, with many suffering from chronic conditions, as well as managing other related health issues that can adversely affect overall health and well-being, such as inadequate housing and low English proficiency. Medicaid provides coverage meeting the unique needs of low-income individuals including low copayments for preventive benefits, coverage of screening and diagnostic services for children, and home- and community-based services and supports for individuals with disabilities.

Medicaid health plans are fundamental to the operation of the Medicaid program. During its first decades, the program was based on a fee-for-service payment system that resulted in fragmented care, inconsistent access to services, a lack of accountability, and little emphasis on improving quality and controlling costs. Now Medicaid health plans are the predominant approach used in state Medicaid programs, enrolling approximately 73 percent of all Medicaid beneficiaries. As a result of more than 20 years of participating in the Medicaid program, Medicaid health plans understand what Medicaid beneficiaries need to take advantage of the health care coverage available to them:

• By offering integrated health care delivery systems, Medicaid health plans promote access to coordinated, quality care and prevent overutilization of services that are both unnecessarily costly and potentially harmful for their enrollees, including dual eligibles.

• By conducting outreach and health education efforts that encourage Medicaid beneficiaries to receive necessary preventive care, Medicaid health plans can reduce unnecessary and costly hospital stays.

• By helping to manage chronic conditions through patient-centric disease management programs, Medicaid health plans are improving care while also reducing the costs of providing health care to beneficiaries with complex health care needs.

• By facilitating access to non-medical services, Medicaid health plans enhance the effectiveness of health care service delivery and enables beneficiaries to live in the community while at the same time reducing costs for states, for example by promoting access to social services or to services that help reduce or avoid nursing home stays for beneficiaries with long-term health care needs.

• By being held accountable through extensive state and federal regulations and detailed contractual agreements for ensuring access to services, and reporting on beneficiary satisfaction and quality measures, Medicaid health plans are improving the access to and quality of care provided to the vulnerable beneficiaries they serve.

Numerous studies demonstrate the success of these programs. The following issue brief first provides background information on the Medicaid program and then further discusses how Medicaid health plans are moving the program forward by improving outcomes for beneficiaries and states.
Medicaid Program Basics

Federal-State Partnership

Medicaid programs are administered by states. While federal law does not require states to operate a Medicaid program, all states currently do so. States have significant latitude in administering the Medicaid program within federal guidelines. For example, as described below, federal law includes mandatory and optional eligibility categories and benefit coverage options. States choose whom to cover and the scope of benefits so long as these decisions are consistent with federal rules.

The Medicaid program is funded jointly by the federal and state governments. Federal payment to the state is conditioned upon the state adhering to the federal statutory and regulatory requirements. The federal share of total Medicaid spending in a state is determined according to a formula specified in the Social Security Act. For every dollar of Medicaid expenditures, the federal government reimburses states a specified percentage – the Federal Medical Assistance Percentage (also called the FMAP or the matching rate) – which falls between 50 and 74 percent for most Medicaid populations and services unless otherwise directed by federal law (for example, see the discussion of the Affordable Care Act Expansion Population below). States with lower average incomes receive higher federal contributions (see map below). FMAPs are recalculated on an annual basis.

If a state would like to include program features not specifically permitted in federal law, it may...
apply for a waiver from the Centers for Medicare & Medicaid Services (CMS). Common types of waivers are listed below. All state Medicaid programs operate under at least one waiver.

- **1115 demonstration waivers** are used for significant changes in eligibility, benefit, and delivery structure.
- **1915 (b) waivers** mandate additional populations into managed care.
- **1915 (c) waivers** provide home and community-based services (HCBS) in lieu of facility-based long term care.

State flexibility is a fundamental component of the Medicaid program. Consequently, key elements of Medicaid programs – including covered populations, the scope of benefits, and use of Medicaid health plans – vary from state to state. This flexible structure has been an engine for innovations, with states serving as laboratories for reforms (e.g., wellness programs, coverage of non-medical benefits such as long-term services and supports) that improve outcomes for Medicaid beneficiaries. However, Medicaid health plans operating in multiple states face a range of different oversight requirements. A recent AHIP letter to the Senate Finance Committee documented these challenges. States require Medicaid health plans to report compliance in a number of areas (see text box below), and these requirements (e.g., network adequacy, quality metrics) often vary from state to state. Medicaid health plan accountability standards are discussed in more detail in the next section of this issue brief.

### Who Is Covered

The Medicaid program provides coverage to individuals based on numerous categories of eligibility defined by law - some mandatory populations and others at the option of the state. For example, federal law directs state programs to cover individuals defined by specified characteristics including children under 19, pregnant women, and individuals with disabilities or those who are over age 65. The maximum income threshold for eligibility often differs by category, and in some cases, such as those needing extended nursing home care, there are asset limits. The result is a complex system where there are approximately 50 pathways to Medicaid eligibility. The chart below lists examples.

### Examples of State Medicaid Health Plan Reporting Requirements:

- Encounter data
- Performance and quality measures (e.g., HEDIS and CAHPs)
- Provider network
- Program integrity
- Third party liability
- Financial audits
- Prescription drug data
- Special reports

### Populations all States Participating in Medicaid Must Cover (Mandatory Coverage Groups)

- Pregnant women and children up to age 18 with family incomes below 133% FPL
- Adults with children with incomes below the income threshold that was in place in the state in 1996
- Individuals with disabilities and incomes qualifying them for SSI (approximately 70% FPL)

### Populations States Have the Option to Cover (Optional Coverage Groups)

- Pregnant women and infants in families with incomes 133 - 185% FPL
- Individuals in mandatory coverage groups with higher incomes pursuant to federal approval
- Medically Needy
- Nonelderly adults not otherwise eligible and who have incomes below 133% FPL (ACA Medicaid Expansion Population)
Prior to the enactment of the ACA, only a small number of states covered childless adults in Medicaid programs under the authority of a waiver. The ACA created a new Medicaid eligibility category for childless adults up to 133 percent FPL to expand coverage to this population. In recognition of the additional costs this provision would impose on states, the ACA established a federal match rate for this population of 100 percent from 2014 – 2016, phasing down to 90 percent thereafter. States not participating in theACA expansion risked losing federal matching funds for their entire Medicaid programs. However, the Supreme Court subsequently ruled that the ACA’s mandatory expansion was unconstitutional, and instead made such expansions optional.

Since 2014, 31 states and the District of Columbia have moved forward with Medicaid expansion (see map below). States that have implemented the ACA Expansion have primarily done so through their pre-existing Medicaid structure, generally enrolling beneficiaries in Medicaid health plans. However, other states have pursued “alternative” models through waivers. Most prominently, Arkansas has received a federal waiver to enroll Medicaid expansion populations in Qualified Health Plans (QHPs) operating in Exchanges established by the ACA. Other states have proposed to increase beneficiary cost-sharing above currently allowable amounts (see discussion below), implement premiums, or require participation in other special programs such as wellness or job training as a condition of enrollment.
The Medicaid Program and Health Plans’ Role in Improving Care for Beneficiaries

What is Covered

The Medicaid program is designed to provide comprehensive benefits to populations with complex health needs. In general, the program provides a comprehensive scope of benefits with minimal cost-sharing. States are permitted to place some restrictions on a benefit such as limiting the number of hospital inpatient days covered in a year. States also have the option to cover additional benefits (see chart below). Coverage of these optional benefits varies significantly. For example, while all states provide coverage of prescription drugs for Medicaid beneficiaries, some do not cover adult dental benefits or place major restrictions on the amount. In addition, some populations receive a different set of benefits. For example, the childless adults under the ACA expansion receive an alternative benefit package modeled on the Essential Health Benefits Packages provide in Exchanges while children can receive greater benefit coverage under the Early Periodic Screening Detection and Treatment (EPSDT) program.

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<th>Traditional Medicaid Benefits* — Examples</th>
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<td><strong>Mandatory Benefits</strong></td>
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<td>Acute Care</td>
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<td>• Inpatient hospital</td>
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<td>• Lab and X-ray</td>
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<td>• Outpatient hospital</td>
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<td>• Certain screening and testing services for</td>
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<td>children (“EPSDT”)</td>
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<td>• Family planning services and supplies</td>
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<td>• Services in Federally Qualified Health</td>
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<td>Centers and Rural Health Clinics</td>
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<td>• Nurse midwife</td>
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<td>• Certified nurse practitioner</td>
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<td>• Pregnancy-related benefits</td>
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<td>Long-Term Care</td>
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*Some populations receive more limited benefits such as alternative benefits
Federal law limits the amount of cost-sharing state Medicaid programs (and Medicaid health plans) may charge beneficiaries, and providers may not deny services to Medicaid beneficiaries for failure to pay. In general, the following rules apply:

- States may charge premiums, but only to individuals with incomes above 150 percent FPL.
- States may charge deductibles, co-payments, and coinsurance under the following conditions:
  - Cost-sharing must be nominal, as defined by CMS.
  - Cost-sharing may not be charged for specified populations (e.g., children < 18; hospice) or specified services.
  - Managed care co-payment limits may not exceed co-payments charged by the state to individuals in the non-managed/fee-for-service (FFS) program, or the specific CMS limit, if no FFS system.
  - Higher cost-sharing is allowed for certain groups based on income, subject to a cap of 5 percent of income.

Medicaid expenditure patterns differ among populations. According to the most recently available data (Federal Fiscal Year 2013), Aged and Disabled populations constitute 26 percent of Medicaid beneficiaries but almost two-thirds of Medicaid expenditures (see chart above). In contrast, adults and children – 73 percent of all beneficiaries – are responsible for only 36 percent of program costs. In order to provide more care coordination and reduce Medicaid expenditures, state Medicaid programs are increasingly turning to Medicaid health plans to enroll beneficiaries that have complex needs and fall in high-cost eligibility categories (described below).
Role of Health Plans in the Medicaid Program

CMS defines the term “managed care” broadly. States may contract with a single health plan or vendor to manage specific benefits. Common examples are behavioral health and dental care. States may also establish primary care case management programs (PCCMs) in which a primary care physician or other provider is paid a flat monthly fee to authorize specialty care and non-emergency hospital admissions. All services provided under a PCCM are paid on a fee-for-service basis. Both of these types of arrangements fall within CMS’s definition of managed care. In this document the term “Medicaid health plans” is used to mean health plans that contract with states to provide comprehensive benefits on an at-risk basis.

Medicaid Health Plan Value

Medicaid is a program with numerous challenges, both for its beneficiaries and the state and federal governments. It is crucial for Medicaid health plans to continue to be the predominant mode of providing health care coverage to low-income populations and individuals with complex needs. Innovative plan activities have served as the engine for delivery system reform throughout the Medicaid program. Health plans have pioneered capitated provider arrangements and value-based incentives that are the model for national proposals to expand the use of bundled payments and other strategies to improve quality of care. Research is demonstrating the success of these programs.

Quality of Care: One study examined the results of 23 HEDIS® measures and found that Massachusetts Medicaid health plans exceeded the national benchmark 83 percent of the time compared to only 43 percent for a program that paid providers on a fee-for-service basis. Another report found Medicaid health plans in Minnesota outperformed fee-for-service on 19 HEDIS measures, concluding “it would appear that managed care is able to deliver stronger health outcomes, and therefore stronger potential value, than what can be expected from the FFS system.”

Beneficiary Outreach: Medicaid health plans are increasingly using wireless technology such as texting to promote adherence to treatment and medication regimens, encouraging healthy activities such as smoking cessation and improved nutrition, and increasing attendance at medical appointments. Studies published in national journals are documenting the success of these Medicaid health plan programs. For example, a 2014 environmental scan of studies on the effectiveness and acceptance of health text messaging interventions concludes that research shows the value of health text messaging programs in a variety of areas including disease management, medication adherence, immunization rates, and clinical outcomes. Specific examples find these texting programs significantly increased influenza immunization rates among pregnant women using the service, reduced rates of alcohol consumption and smoking among pregnant women, improved levels of glycemic control among pregnant women with diabetes using this technology, and reduced costs by improving compliance with diabetes management programs.

Access to Care: One study found children enrolled in Medicaid health plans in Georgia are more than twice as likely to experience six or more well child visits during the first 15 months of life than beneficiaries in the FFS program, and Medicaid health plan enrolled children age 12 - 19 were more likely to visit primary care providers.

Chronic Disease Management: Medicaid health plans develop disease management programs to address many different conditions, including diabetes, pre-natal/post-natal health, asthma, congestive heart failure, children with special needs, and people with multiple chronic conditions. Studies have found these programs lead to better care for beneficiaries, such as children with asthma enrolled in Medicaid health plans.
Cost Effectiveness: Research commissioned by AHIP synthesized 24 studies on savings achieved when states implemented programs using Medicaid health plans and found states saved up to 20 percent compared to fee-for-service.\(^\text{14}\) Another AHIP-supported study highlighted the cost-effectiveness achieved when Medicaid health plans manage both acute care and pharmacy benefits, finding prescription drug costs in such “carve in” states were 14.6 percent lower than in states that maintained fee-for-service coverage for medications by “carving them out” of Medicaid health plan benefits.\(^\text{15}\) These studies provide compelling evidence that Medicaid health plans can reduce state Medicaid expenditures by providing high-quality health care.

**Enrollment Trends**

As noted above, partnering with Medicaid health plans is now the predominant approach used by state Medicaid programs. Medicaid health plan enrollment has grown to over 51 million, or 70 percent of all individuals in the program.\(^\text{16}\) There are several reasons for this growth, including additional states implementing new Medicaid health plan programs, states with existing health plan programs expanding to new regions; and states enrolling more Medicaid populations into health plans, such as individuals with disabilities and older adults. Many states electing to participate in the ACA’s Medicaid expansion are enrolling these beneficiaries in health plans. Also, an increasing number of states are relying on Medicaid health plans to serve beneficiaries with complex needs, including individuals with disabilities and those requiring an institutional level of care in managed long-term services and supports (MLTSS) programs.

As of July 2014, 39 states, Puerto Rico, and the...
America’s Health Insurance Plans

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District of Columbia enrolled some portion of their Medicaid populations in health plans. Several states have established or expanded existing Medicaid health plan programs since these data were compiled. For example, Alabama, North Carolina, and Oklahoma have initiated a process to contract with health plans to serve Medicaid beneficiaries, and Iowa recently implemented a significant expansion of its Medicaid health plan program. These developments are indicative of states’ increasing reliance on health plans to meet the needs of Medicaid beneficiaries.

Key Issues Facing Medicaid Health Plans

Actuarial Soundness: State Medicaid programs reimburse Medicaid health plans on a capitated basis, which may be risk adjusted to reflect the health status of the enrollees they serve. Federal law requires these rates to be developed in an actuarially sound manner. Federal regulations issued in May 2016 further define actuarial soundness. Medicaid health plans have raised concerns in the past that CMS is not consistently enforcing the actuarial soundness requirements resulting in inadequate payment rates. Medicaid plans have also raised concerns that many state rate-setting processes are not sufficiently transparent to permit the sharing of information on cost trends and other factors that would lead to the development of actuarially sound rates.

Accountability: A key distinction between Medicaid health plans and FFS Medicaid programs is the degree of accountability to which health plans are held. Medicaid health plans are highly regulated by CMS and state agencies, operating pursuant to detailed contracts signed with states and reviewed by CMS.

In addition (and in contrast to FFS programs), Medicaid health plans must undergo a rigorous review process and meet extensive regulatory and contractual requirements for beneficiary access to quality services. States hold plans accountable through the public reporting of performance outcome measures, requirements for quality improvement programs, and network adequacy standards.

Medicaid health plan contracts are dictated in large part by the federal regulatory structure. In 2015, CMS proposed significant changes to the rules and regulations governing state Medicaid managed care programs. CMS received volumes of comments on the proposed rule, including a comment letter from AHIP on behalf of its member plans.

On May 6, 2016, CMS published the Medicaid Managed Care Final Rule. The Final Rule includes comprehensive updates that will impact many aspects of state and Medicaid health plan operations, such as new requirements for minimum medical loss ratio (MLR), provider network access standards, and actuarially-sound payment rates, as well as development of a new Medicaid Quality Rating system. Some aspects of Medicaid operations are brought into closer alignment with similar rules for Medicare. Other aspects will challenge Medicaid plans and states alike, such as a requirement that health plan prescription medication management controls used by health plans cannot be more stringent than controls used in a state’s FFS operations. AHIP has developed a detailed summary of the Final Rule and is working with Medicaid health plans and other stakeholders to ensure implementation continues to promote the availability of Medicaid health plan options to beneficiaries.

Managed Long-Term Services and Supports and Non-Medical Benefits: As noted above, more states are now relying on Medicaid health plans to serve beneficiaries with long-term care needs. Long-term services and supports (LTSS) are a vital but complex set of benefits that support independence through a wide range of services (medical and non-medical, nursing, social, environmental modification, and community supports) for individuals with physical disabilities, serious mental illness (SMI), people with degenerative conditions, and aging adults. Working with their state partners, Medicaid health plans have developed successful managed long-term services and supports.
(MLTSS) models that encourage and provide opportunities for beneficiary self-direction of services and supports, provide services and supports using a holistic approach focused on the needs of the individual to address the key determinants of a beneficiary’s health, well-being, and quality of life. Health plan staff ensures that beneficiary needs and preferences are addressed through tools such as personalized care planning, in-home assessments, service coordination, and care management that engages the consumer, supports families, and monitors service delivery. Care managers and service coordinators manage physical and behavioral health services and functional and social supports, working actively with an enrollee’s caregivers and providers to address the enrollee’s identified needs.

In developing MLTSS programs, states often partner with Medicaid health plans to engage with provider groups, advocacy organizations, community agencies and other stakeholders to obtain input and feedback on program design and communicate details on processes for working together. These kinds of activities help engage the community in the program and can help facilitate a smooth transition from FFS to managed care. In addition, many healthy plans operate advisory councils that provide enrollees, providers, advocates and other stakeholders with a forum to provide the health plan with direct input and feedback on program operations.

Medicaid health plans devote considerable resources to training their staffs on LTSS benefits, principles of care coordination and the needs of the beneficiaries they serve. In designing their care management programs and service delivery networks, Medicaid health plans recognize that a beneficiary’s health is influenced by factors in addition to the medical care they receive. Stable housing arrangements, interaction within the community, employment, and adequate nutrition can have a major impact on a person’s health status. To address these circumstances, health plans engage with community organizations to provide assistance to their enrollees through housing agencies, and food programs such as community pantries and Meals on Wheels programs. Medicaid health plans recognize the important role community-based organizations can play in a beneficiary’s health and well-being, including volunteer service groups and faith-based organizations.

**High Cost Drugs:** The introduction of new high-cost prescription drugs is significantly threatening the ongoing viability of state Medicaid programs. For example, the Senate Finance Committee recently reported $1.3 billion was spent on Sovaldi (a drug used to treat hepatitis C) alone during CY2014, prior to any statutory or supplemental rebates. Another report estimated the introduction of just ten breakthrough drugs would likely increase Medicaid expenditures by almost $16 billion over the next ten years.

AHIP greatly appreciates the impact many breakthrough products may have to improve the lives of beneficiaries. Our member plans are working to ensure beneficiaries have access to the prescription drugs they need. However, there are concerns about the financial impact of these drugs on public programs, and with proposals that would limit clinically-based health plan management techniques that demonstrate promise in addressing the needs of beneficiaries and states. Greater transparency is needed in pharmaceutical manufacturer pricing practices to ensure that Medicaid enrollees continue to benefit from the full range of services and supports they rely on from Medicaid programs over the long term.
Conclusion

Medicaid health plans have demonstrated a track record of improving health care for Medicaid beneficiaries while ensuring that the federal government and state Medicaid programs and American taxpayers receive the highest value for the dollars they spend on health care. Recognizing the challenges associated with the growing Medicaid population and the long-term care needs of people with disabilities, functional limitations and the elderly, Medicaid health plans are uniquely positioned to assist in strengthening the Medicaid program for all of the populations it serves. AHIP will be working with state and federal leaders to promote policies supporting and expanding Medicaid health plan efforts to maintain and improve the health of the low-income individuals served by the program.

Related Topic

How Medicaid Managed Care Addresses Barriers to Care

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3 States that had already covered Expansion populations in their Medicaid programs prior to 2010 would be provided expanded federal matching funds on a different schedule.

4 It is important to note these proportions are likely to change once data is available after implementation of the ACA Expansion, though we expect the majority of Medicaid expenditures will be limited to populations with the most complex needs.

5 Jeremy D. Palmer, FSA, MAA and Sheamus K. Parkes, FSA, MAAA, Comparison of HEDIS® Results: MassHealth PCC Program and Managed Care, Milliman, February 11, 2013.

6 Public Consulting Group, Report on the Value of Minnesota Health Care Programs (MHCP) Managed Care as Compared to Fee-for-Service, September 24, 2013.


12 Janice Carson, MD, Georgia Department of Community Health, PQO Update: Performance Measurement, Presentation to the Georgia Department of Community Health Board, October 11, 2012.