MACPAC

Medicaid and CHIP Payment and Access Commission

Characteristics of Medicaid Managed Care Programs

April Grady and Moira Forbes

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Overview

Role of managed care in Medicaid

Key data points to inform MACPAC's current managed care agenda

- Encounter data analysis
- Capitation rate setting
- Oversight activities

Other models for service delivery and payment

Role of Managed Care in Medicaid

For a given set of benefits, plans generally take responsibility for provider networks, care coordination, utilization management, and provider payments.

States may turn to managed care plans for a variety of reasons, for example:

- potential cost savings and predictability;
- contractual guarantees of beneficiary access;
- expertise not readily available otherwise.

MACPAC's Managed Care Agenda

Past MACPAC work includes June 2011 report focused entirely on managed care, March 2013 chapter on rate setting for integrated plans, and annual enrollment and spending updates in June MACStats.

Today's session provides key data points to inform current projects on encounter data, rate setting, and oversight that were discussed at December 2013 meeting.

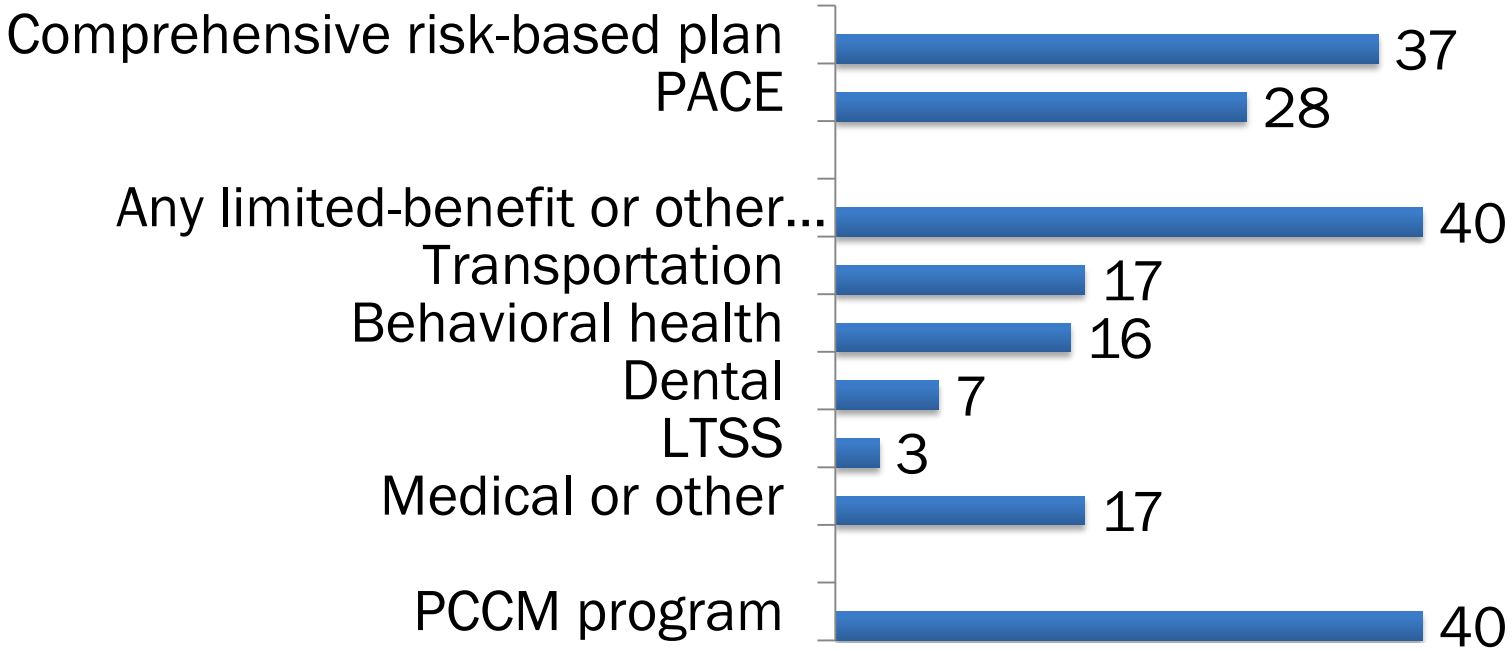
Encounter Data Analysis

All states with managed care programs obtain encounter data in some form.

Recent analyses show improvements in federal Medicaid Statistical Information System (MSIS) encounter data.

Using 2010 MSIS, MACPAC is assessing the completeness and quality of encounter data for enrollees in comprehensive and behavioral plans.

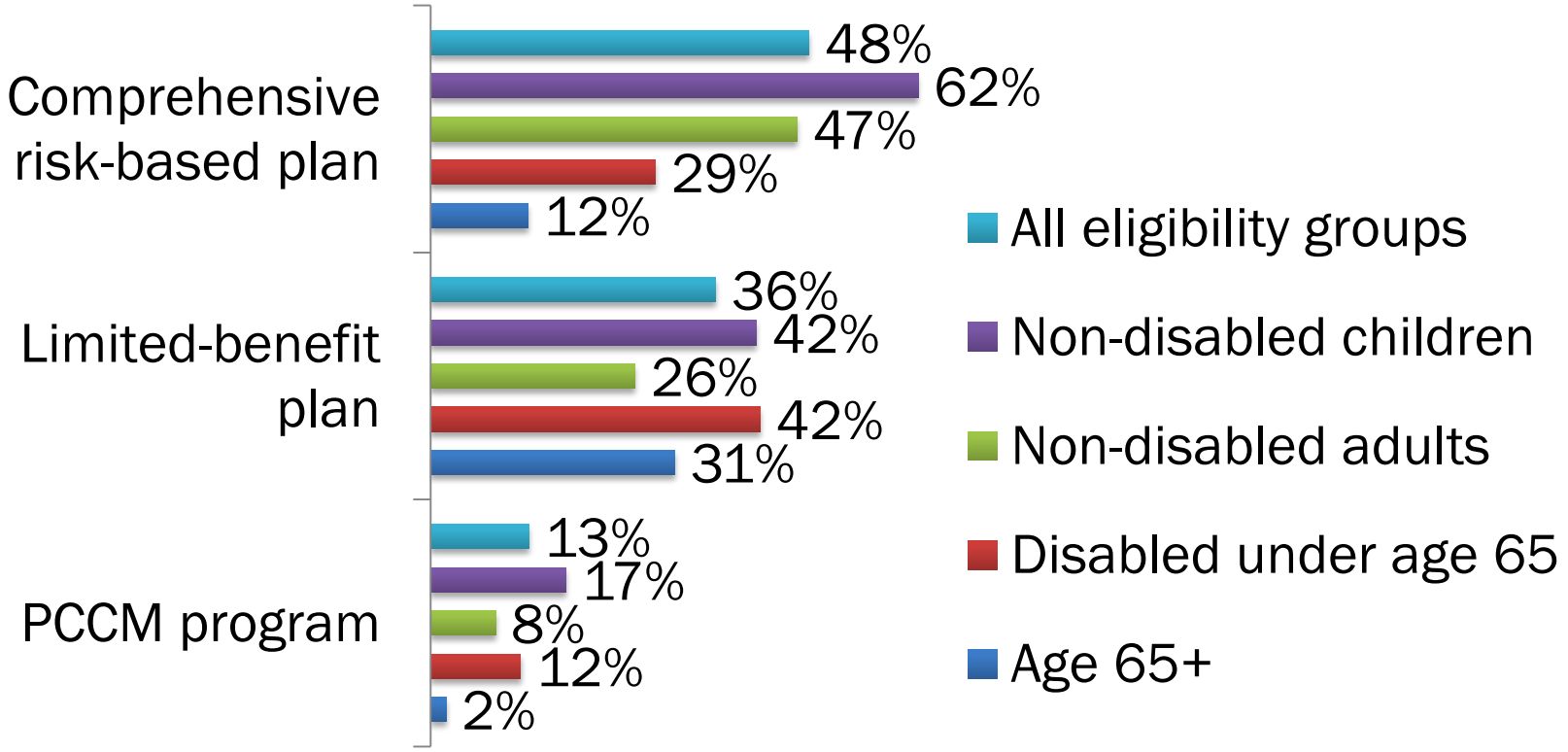
Number of States with Medicaid Managed Care, 2011



Notes: PACE is Program of All-inclusive Care for the Elderly. PCCM is primary care case management. LTSS is long-term services and supports.

Source: MACPAC analysis of Medicaid Managed Care Enrollment Report data from CMS.

Percent of Medicaid Enrollees in Managed Care, FY 2010



Notes: PCCM is primary care case management.

Source: MACPAC analysis of Medicaid Statistical Information System data from CMS.

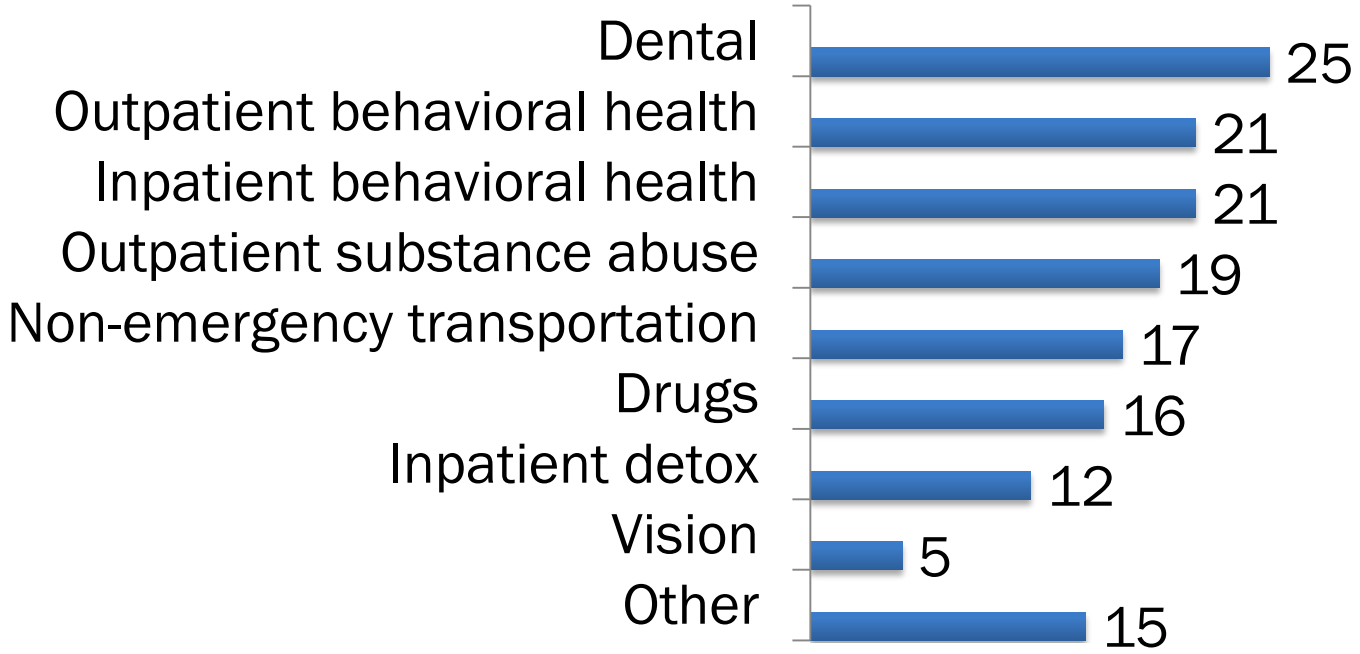
Trends in Medicaid Managed Care Enrollment and Spending

Between 2000 and 2011, the share of enrollees in comprehensive risk-based plans increased from 38 to 50 percent.

Between FY 2008 and FY 2011, the share of benefit spending on managed care plans and PCCM programs increased from 21 to 25 percent.

Most individuals gaining eligibility in 2014 are expected to enroll in managed care.

Number of States with Acute Care Benefit Carve-Outs from Comprehensive Managed Care, 2010



Notes: Out of 36 states with comprehensive managed care plans in 2010. May include partial carve-outs.

Source: Gifford et al., A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey, 2011.

Capitation Rate Setting

States use a variety of methods to set rates for risk-based managed care plans, but all must pay within an actuarially sound range.

- Many use an administrative process in which a specific rate is set by the state; others use a competitive bidding or negotiation process.
- At least 24 states use health status to risk adjust their rates, rather than relying on demographic factors alone.

MACPAC is currently planning a roundtable on capitation rate setting.

Review of Oversight Activities

Managed care program design affects both federal and state oversight responsibilities.

Specific activities (for example, with regard to provider networks and quality monitoring) vary across states.

MACPAC recently engaged a contractor to review a variety of issues related to managed care oversight.

Other Models for Service Delivery and Payment

Managed care plan contracting is just one approach on a continuum with varying levels of risk and state responsibility.

Additional models include PCCM, patient-centered medical homes, and accountable care organizations, among others.

These may involve a variety of contracting and payment arrangements between states, vendors, and providers.