

Medicaid Managed Care: Further Reform Needed to Deliver on Promise

Courtney R. Zott, BA; and Andrew M. Ryan, PhD

Since beginning in the 1960s, Medicaid managed care has now been adopted in various forms by 48 US states, with private insurers (both nonprofit and for-profit) covering an increasing number of beneficiaries. Despite its widespread adoption, there is limited evidence on the relationships between Medicaid managed care and access, spending, and quality. Value-based payment reform with stronger quality monitoring and alignment among states, plans, and providers will be necessary for Medicaid managed care to enhance value.

States' Adoption of Medicaid Managed Care Is Widespread

Medicaid managed care is widespread, covering 66.1 million enrollees in 2018. Every state except Alaska and Connecticut uses some type of managed care (Table 1^{1,2}).¹ Private managed care organizations (MCOs) have become increasingly dominant since the 1990s, when federal Medicaid policy became more favorable to their operation. They now cover more than two-thirds of all US managed Medicaid enrollees, up from 6.0% in 1991.^{3,4} Six for-profit insurers—UnitedHealth Group, Centene, Anthem, Molina, Aetna, and WellCare—accounted for approximately 47% of all private MCO enrollment in 2018.³ Reports indicate that these companies profit significantly off their Medicaid business lines: For instance, Health Net (part of Centene) made \$1.1 billion in net income and Anthem made \$549 million from California's Medicaid program alone from 2014 to 2016.⁵

How Managed Care Can Affect Quality, Value, and Access

Proponents argue that such profits are earned because of the variety of strategies that private MCOs invest in to reduce costs and provide high-value care to enrollees. Examples include establishing provider networks, implementing tools to manage chronic disease or address social determinants of health, incorporating value-based payment models into provider contracts, and monitoring fraud. However, opponents argue that such strategies can come with various downsides, such as more restricted access to physicians, increased steps to obtain certain drugs or services, and higher

TAKEAWAY POINTS

Evidence indicates a need for further reform in Medicaid managed care to ensure that private managed care organizations are improving spending, access, and quality outcomes for beneficiaries.

- ▶ Private managed care organizations are increasingly responsible for administering Medicaid benefits across the United States, yet there is little research on how they affect access, spending, and care quality.
- ▶ The limited research suggests that private managed care organizations may have slowed state spending growth but have not improved beneficiary care and may have reduced access for certain populations.
- ▶ Further reforms are needed to enhance value in managed Medicaid as states increasingly contract with private managed care organizations.

administrative costs. They claim that capitation may also give plans an incentive to exaggerate the risk of their enrollee base to secure higher payments from states, as is seen in the Medicare Advantage program.⁶

Limited Research Has Evaluated the Effects of Medicaid Managed Care

Surprisingly little research has evaluated the effects of private Medicaid MCOs.⁷ Much of what has been published stems from the 1990s and early 2000s, when MCOs were relatively new and still being challenged from an ethical standpoint. Waning interest has also likely been compounded by the difficulty of obtaining Medicaid claims data for private insurers.

Two separate literature reviews reveal that managed Medicaid has produced mixed results on access, spending, and quality since the early 1990s.^{8,9} The reviews indicate that although MCO programs may have matured enough to effectively slow state spending growth, they have not coincided with wholesale improvements in access and quality expected by policy makers (Table 2⁹⁻¹⁹). Several studies even find that access and care quality worsened in managed care vs fee-for-service models in some states. The scant evidence that exists on for-profit MCOs shows worse performance than nonprofit and public counterparts.

TABLE 1. Types of Medicaid Plans and Potential Impact^{1,2}

Type of plan	Percentage of Medicaid beneficiaries in 2017	Dominant insurers	Defining characteristics	Pros	Cons
Comprehensive risk-based managed care	69.2%	UnitedHealth Group, Centene, Anthem, Molina, Aetna, and WellCare accounted for 44% of all comprehensive Medicaid MCO enrollment.	States pay commercial insurers via capitation to cover a wide range of benefits. Insurers establish networks of physicians to deliver those benefits. Uniquely, Vermont operates its model publicly.	Plans are incentivized to use care management, coordination, and cost-saving measures.	Plans may exaggerate enrollee risk to inflate state payments and reduce utilization at the expense of quality.
PCCM	6.8%	Programs in Colorado, North Carolina, Oklahoma, Arkansas, and Alabama accounted for approximately 72% of all PCCM enrollment in 2017.	States pay primary care providers via capitation or an additional fee on top of fee-for-service payments to manage the care of Medicaid enrollees. Beneficiaries must receive referrals from primary care providers to see specialists.	PCCMs increase access to primary care providers, promote greater care coordination, and reduce low-value care.	Noncapitated versions may not provide strong enough incentive to manage enrollees' health.
Limited benefit	38.6%	States typically use local or regional plans, but some (eg, Florida, Georgia) contract with the commercial insurers that dominate the comprehensive MCO market.	States pay commercial insurers via capitation to administer specific benefits (eg, nonemergency transportation) or cover specific populations (eg, adults with autism). Insurers establish networks of physicians to deliver those benefits.	Resources and care management interventions can be tailored to meet the needs of unique populations.	The limited nature may inhibit care coordination and/or cause confusion for enrollees.

MCO, managed care organization; PCCM, primary care case management.

Policy Recommendations

The widespread adoption of Medicaid MCOs, limited research about their effectiveness, and their underwhelming record of success suggest room for improvement across several dimensions:

Align quality and value improvement efforts within Medicaid managed care. There may be disconnects among states, private MCOs, and providers regarding quality improvement initiatives. For example, since 2012, the Affordable Care Act has barred states from paying Medicaid claims for hospital-acquired conditions, but the Office of Inspector General as recently as 2019 has found inconsistency in states' ability to ensure that MCOs comply with this rule.²⁰ Additionally, a 2019 single-state study found that providers were unaware of MCO quality improvement efforts or felt that the measures they tracked were not conducive to improving care quality, causing unnecessary frustration and additional paperwork burdens.²¹

This evidence partially speaks to implementation issues, which rely on administrative structures and processes that policy largely cannot fix. However, it also speaks to the complexity of quality improvement requirements and quality measures in Medicaid that has resulted from piecemeal, largely decentralized development over time. Federal and state policy makers need to step in with simplification and standardization measures to ease compliance and promote alignment among all parties. This should involve minimizing differences in quality improvement goals across MCOs and reducing changes in requirements from year to year—while maintaining some important flexibility—as well as implementing reporting tools and other administrative supports for MCOs and

providers to facilitate participation. Importantly, such efforts should include input from providers, MCOs, and beneficiaries to gain buy-in.

Accelerate the shift toward alternative payment. Most MCOs continue to reimburse on a fee-for-service basis, thereby leaving providers without equal incentives to improve beneficiary care access and quality.²² Value-based insurance design and payment reform would strengthen alignment among MCOs and providers on spending, access, and quality goals. There is scant literature on the effectiveness of value-based payment models in Medicaid, likely because of their scarcity and need for approval from CMS, but anecdotal evidence from Minnesota and Ohio shows promises of cost savings without harming care quality or while improving it.²² Minnesota has implemented accountable care organizations and requires MCOs to share in savings with them, whereas Ohio requires MCOs to implement episodic payments for certain services and pay primary care providers an additional fee for coordinating beneficiary care.²²

State policy makers should again work with providers, MCOs, and beneficiaries to create a standardized value-based payment program; it should start by requiring MCOs to allocate a certain amount of reimbursement to the program, increasing the amount over time. To avoid the program becoming too complex, states should require MCOs to seek approval if they wish to pilot new value-based payment models. If provider buy-in is a concern, states may also want to consider incentives or penalties to encourage provider participation. For example, New York imposes penalties

on providers that reject discussions with MCOs despite having the ability to enter value-based contracts.²²

Experiment with coverage decisions and cost-effectiveness cutoffs.

Well-intentioned and in many cases necessary limitations on benefit flexibility in Medicaid make it difficult for managed care models to work as intended—that is, to control costs and reduce low-value care. For example, Medicaid programs are required to cover all prescription drugs, no matter how expensive upon market arrival, if they accept federal rebates (which all states do).²³ MCOs are therefore barred from denying coverage of drugs that do not appreciably alter life expectancy, quality-adjusted life-years, specific health outcomes, or another barometer of efficacy in relation to cost. Massachusetts requested permission in a Section 1115 waiver to create a restricted drug formulary for its Medicaid program in 2017, but CMS rejected the proposal and no state has submitted one since. Significant access and equity concerns would need to be addressed in incorporating cost-effectiveness analysis into drug, medical services, and medical technology coverage decisions in Medicaid, but the federal government should take lessons from other countries that have successfully done so, such as the United Kingdom, and open this avenue for managed Medicaid programs.

Enhance monitoring and evaluation. States that contract with MCOs of any tax and ownership status are required under Section 1932(c)(2) of the Social Security Act and 42 CFR § 438.350-370 to employ a third-party organization to perform an annual quality review. The reviews broadly assess each plan’s performance on select Healthcare Effectiveness Data and Information Set (HEDIS) measures and other compliance matters, but the methods and content of these reviews vary widely depending on the organization conducting them.²⁴ Putting variability aside, the reviews do not take the critical steps of making comparisons and trending over time to answer the larger question of what types of managed care plans, and what initiatives within them, are most effective in the state.²⁴ Finally, the reliance on HEDIS measures makes for a greater emphasis on care structure and processes vs outcomes.²⁵ States should work with researchers to produce more candid evaluations of the successes and failures of their managed Medicaid programs, particularly as they move forward with mandated quality strategies and value-based payment initiatives.

Additionally, the federal government should standardize quality metrics for state Medicaid programs to facilitate national comparison and evaluation. Although CMS produces the Adult and Child Core sets annually, reporting is voluntary and does not distinguish among types of managed care models. Medicaid officials also argue that some of the measures are difficult to report because the necessary information is not available in claims or electronic health records.²⁶ This has resulted in wide variation in what and how states report on the quality of their programs. For example, researchers found just 5 overlapping measures related to quality of care for children across California’s quality review, New York’s quality review, and the Child Core Set.²⁴

TABLE 2. Summary of MCO Evidence⁹⁻¹⁹

Domain	Evidence summary
Access	<ul style="list-style-type: none"> MCOs’ impact on access to care varies across states and populations, but they generally do not improve upon fee-for-service Medicaid or even result in worse outcomes, although they do provide better access than PCCM plans and have larger office-based physician networks than exchange plans.¹⁰ MCOs can reduce some types of potentially low-value care use (eg, emergency department visits) but also may inhibit access to other needed services (eg, preventive care).⁷ Only 1 national study compared nonprofit and for-profit MCOs; it found that beneficiaries enrolled in for-profits reported fewer doctor visits and more unmet health care needs.¹¹ Private MCOs may contribute to racial health disparities by avoiding high-risk enrollees. A 2018 Texas study found that HMOs may be strategically disenrolling high-risk, pregnant African American women.¹²
Quality	<ul style="list-style-type: none"> No definitive evidence exists that MCOs have improved care quality for Medicaid beneficiaries. Only 2 studies compared performance of private and public managed care plans, finding that nonprofit and public plans generally perform better on HEDIS measures.^{13,14} A 2020 study found that MCO implementation was associated with worse birth outcomes, worse prenatal care, and heightened risk of inappropriate gestational weight gain in Pennsylvania.¹⁵ A 2019 study found that dual-eligible patients—individuals covered by both Medicare and Medicaid—were more likely to have a preventable hospitalization if enrolled with a private Medicaid HMO vs fee-for-service Medicaid.¹⁶ Managed care plans may be dropping low-quality providers: A 2020 study found that providers who exited plans in Tennessee performed worse on a composite HEDIS measure in the year prior to leaving than those who remained with the plan.¹⁷ There does not appear to be research on quality of care for other specific Medicaid populations, such as children with complex health needs and people with serious mental illness.
Spending	<ul style="list-style-type: none"> National studies have produced conflicting results, whereas more granular analyses of specific states and Medicaid populations find both successes and failures. When savings are achieved, they are typically due to shifts in utilization (eg, from inpatient to outpatient services).⁹ The most recent study from 2017 found that capitated managed Medicaid programs have slowed state spending growth, indicating that states have improved rate-setting processes as they gain experience.¹⁸ A lens of efficiency is also important: A 2019 study of individuals with disabilities covered by Texas’ managed Medicaid programs found that although spending increased, shifting utilization patterns indicated that dollars were being used more efficiently (eg, from inpatient treatment to drug treatment for chronic conditions).¹⁹ No spending studies have looked at spending differences between for-profit and other types of MCOs.

HEDIS, Healthcare Effectiveness Data and Information Set; HMO, health maintenance organization; MCO, managed care organization; PCCM, primary care case management.

CONCLUSIONS

The Medicaid program has changed considerably over the past few decades, with private, for-profit insurance companies playing an increasing role in benefit administration. The scant available research indicates that this has not resulted in increases in access and quality, although it has potentially slowed spending growth. Reforms to Medicaid managed care have the potential to overcome these shortcomings to enhance value. ■

Author Affiliations: University of Michigan School of Public Health (CRZ, AMR), Ann Arbor, MI.

Source of Funding: None.

Author Disclosures: The authors report no relationship or financial interest with any entity that would pose a conflict of interest with the subject matter of this article.

Authorship Information: Concept and design (CRZ, AMR); analysis and interpretation of data (AMR); drafting of the manuscript (CRZ, AMR); critical revision of the manuscript for important intellectual content (CRZ, AMR); administrative, technical, or logistical support (CRZ, AMR).

Address Correspondence to: Andrew M. Ryan, PhD, University of Michigan School of Public Health, M3124 SPH II, 1415 Washington Heights, Ann Arbor, MI 48109. Email: amryan@umich.edu.

REFERENCES

1. Mathematica Policy Research. Medicaid managed care enrollment and program characteristics, 2018. CMS. 2020. Accessed February 2, 2021. <https://www.medicaid.gov/medicaid/managed-care/downloads/2018-medicaid-managed-care-enrollment-report.pdf>
2. Types of managed care arrangements. Medicaid and CHIP Payment and Access Commission. Accessed February 29, 2020. <https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/>
3. Hinton E, Diaz M, Rudowitz R, Singer N. 10 things to know about Medicaid managed care. Kaiser Family Foundation. December 16, 2019. Accessed February 2, 2021. <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>
4. Gold MR. HMOs and managed care. *Health Aff (Millwood)*. 1991;10(4):189-206. doi:10.1377/hlthaff.10.4.189
5. Terhune C, Gorman A. Insurers make billions off Medicaid in California during Obamacare expansion. *Los Angeles Times*. November 5, 2017. Accessed February 29, 2020. <https://www.latimes.com/business/la-fi-medicaid-insurance-profits-20171101-story.html>
6. Geruso M, Layton T. Upcoding: evidence from Medicare on squishy risk adjustment. National Bureau of Economic Research working paper 21222. May 2015. Accessed June 22, 2020. <https://www.nber.org/papers/w21222>

7. Landon BE, Huskamp HA, Tobias C, Epstein AM. The evolution of quality management in state Medicaid agencies: a national survey of states with comprehensive managed care programs. *Jt Comm J Qual Improv*. 2002;28(2):72-82. doi:10.1016/s1070-3241(02)28007-4
8. Franco Montoya D, Chehal PK, Adams EK. Medicaid managed care's effects on costs, access, and quality: an update. *Annu Rev Public Health*. 2020;41:537-549. doi:10.1146/annurev-publhealth-040119-094345
9. Sparer M. Medicaid managed care: costs, access, and quality of care. Semantic Scholar. 2012. Accessed June 11, 2020. <https://pdfs.semanticscholar.org/66dd/bde562413f7488d01fbd7cd27d9b9f4eb515.pdf>
10. Wallace J, Lollo A, Ndumele CD. Comparison of office-based physician participation in Medicaid managed care and health insurance exchange plans in the same US geographic markets. *JAMA Netw Open*. 2020;3(4):e202727. doi:10.1001/jamanetworkopen.2020.2727
11. Long SK. Do for-profit health plans restrict access to care under Medicaid managed care? *Med Care Res Rev*. 2008;65(5):638-648. doi:10.1177/1077558708316930
12. Kuziemko I, Meckel K, Rossin-Slater M. Does managed care widen infant health disparities? evidence from Texas Medicaid. *Am Econ J Econ Policy*. 2018;10(3):255-283. doi:10.1257/pol.20150262
13. Bindman A. Redesigning Medicaid managed care. *JAMA*. 2018;319(15):1537-1538. doi:10.1001/jama.2018.3411
14. McCue MJ, Bailit MH. Assessing the financial health of Medicaid managed care plans and the quality of patient care they provide. *Issue Brief (Commonw Fund)*. 2011;11:1-16.
15. Yan J. The impact of Medicaid managed care on obstetrical care and birth outcomes: a case study. *J Womens Health (Larchmt)*. 2020;29(2):167-176. doi:10.1089/jwh.2019.7792
16. Toseef MU, Jensen GA, Tarraf W. Is enrollment in a Medicaid health maintenance organization associated with less preventable hospitalizations? *Prev Med Rep*. 2019;16:100964. doi:10.1016/j.pmedr.2019.100964
17. Pivnic-Worms K, Wallace J, Lollo A, Ndumele CD. Association of provider performance with changes in insurance networks. *J Gen Intern Med*. 2020;35(7):1997-2002. doi:10.1007/s11606-020-05784-4
18. Perez V. Does capitated managed care affect budget predictability? evidence from Medicaid programs. *Int J Health Econ Manag*. 2018;18(2):123-152. doi:10.1007/s10754-017-9227-7
19. Layton TJ, Maestas N, Prinz D, Vabson B. Private vs. public provision of social insurance: evidence from Medicaid. Social Science Research Network. July 9, 2019. Accessed July 16, 2020. <http://papers.ssrn.com/abstract=3416345>
20. Jarmon GL. Rhode Island did not ensure its managed-care organizations complied with requirements prohibiting Medicaid payments for services related to provider-preventable conditions. Office of Inspector General. January 2019. Accessed May 20, 2020. <https://oig.hhs.gov/oas/reports/region1/11700004.pdf>
21. Gadbois EA, Gordon SH, Shield RR, Vivier PM, Trivedi AN. Quality management strategies in Medicaid managed care: perspectives from Medicaid, plans, and providers. *Med Care Res Rev*. Published online April 4, 2019. doi:10.1177/1077558719841157
22. Bailit Health. State strategies to promote value-based payment through Medicaid managed care final report. Medicare and CHIP Payment and Access Commission. March 13, 2020. Accessed June 11, 2020. <https://www.macpac.gov/wp-content/uploads/2020/03/Final-Report-on-State-Strategies-to-Promote-Value-Based-Payment-through-Medicaid-Managed-Care-Final-Report.pdf>
23. Medicaid's prescription drug benefit: key facts. Kaiser Family Foundation. May 1, 2019. Accessed February 10, 2020. <https://www.kff.org/medicaid/fact-sheet/medicaids-prescription-drug-benefit-key-facts/>
24. Schneider A. How can we tell whether Medicaid MCOs are doing a good job for kids? Georgetown University Health Policy Institute Center for Children and Families. February 26, 2018. Accessed February 29, 2020. <https://ccf.georgetown.edu/2018/02/26/how-can-we-tell-whether-medicaid-mcos-are-doing-a-good-job-for-kids/>
25. Normile B, VanLandeghem K, Agrawal A. State strategies for Medicaid quality improvement for children and youth with special health care needs. National Academy for State Health Policy. November 2017. Accessed May 20, 2020. <https://www.nashp.org/wp-content/uploads/2017/11/MQM.pdf>
26. Medicaid: state views on program administration changes. US Government Accountability Office. April 2020. Accessed June 11, 2020. <https://www.gao.gov/assets/710/706559.pdf>

Visit ajmc.com/link/88583 to download PDF