

Medicaid Managed Care: Increasing Expectations and Accountability

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The Issue

Over the past two decades, state Medicaid programs have been on a steady march away from fee-for-service toward payment and delivery systems designed to bring greater budget predictability, quality, and accountability. For most states, this has meant increasing reliance on Medicaid managed care. Today, managed care is the primary delivery system for Medicaid nationally, with more than 8 in 10 beneficiaries enrolled in some type of managed care across 48 states plus the District of Columbia.¹ With this growth has come similar growth in expectations. States are covering a broader array of services for more high-need enrollees, bringing more rigor to their contracting, oversight, and payment processes, and holding managed care plans accountable for achieving targeted goals. For new state officials, this begs a critical question: **Is my state getting enough value from our Medicaid managed care program?**

Why It's Important

A well-managed Medicaid managed care program has the potential to help states bring more predictability to program costs while enhancing efficiency and outcomes. But managed care is no panacea. [Evaluations](#) over time have documented mixed results, ranging from measurable improvements in access, quality, and efficiency, to headline-grabbing horror stories of care disruption and cost overruns.² With this in mind, states with managed care are increasingly focused on getting more value from plans and explicitly building [state priorities](#) into contractual requirements. New state policymakers should consider assessing their current managed care programs and exploring strategies for advancing cost, quality, and accountability goals.

Considerations for State Policymakers

Consider Integrating the Full Service Array Into Managed Care. Early on, Medicaid managed care was mostly reserved for relatively healthy populations and a core subset of mostly physical health services. As managed care has taken root, states have begun to include a broader range of services—including behavioral health, prescription drugs, and even long-term care—into integrated risk arrangements. These efforts generally have been met with success, aligning financial incentives and enabling better coordination of care across the care continuum.³ Yet most states have a long way to go to realize the full value of integration. For example, while mounting [evidence](#) indicates that integration of physical and behavioral health is a best practice, only a minority of states currently do so.⁴

Exercise Caution With High-Need Populations. States have increasingly enrolled more vulnerable populations in managed care. For example, one-fourth of managed care states enroll individuals with intellectual/developmental disabilities (I/DD) into managed care.⁵ Twenty-four states operate some form of managed care to provide long-term services and supports (LTSS) to older adults and those with physical disabilities. States design managed

care products for high-need individuals differently—sometimes adding subpopulations and new services into comprehensive plans that serve the majority of Medicaid enrollees, and sometimes developing “specialty” plans for targeted higher-need members. High-need individuals are far more likely to have complex care relationships with multiple providers and informal caregivers; manage more chronic conditions and medications; and be highly vulnerable to care disruptions. Enrolling these populations requires time and thoughtful planning, including consultation and partnership with beneficiaries, their families, their providers, and communities, and is best attempted in mature managed care environments.

Create Accountability for State Priorities. While wide variation exists among states’ managed care programs, states are increasingly including contractual mandates designed to hold plans accountable for specific policy, operational, and financial priorities. Many states include operational provisions tied to withholds and incentives designed to, for example, minimize administrative burden on providers, create rate floors for essential providers, or mandate a certain medical loss ratio. A smaller but growing number of states are going further—using their contracts to drive innovation and test new ways to achieve state health care priorities.

- **Targeting vulnerable populations.** Many states have begun requiring plans to identify and address needs for targeted subpopulations, including [children](#) with neonatal abstinence syndrome and individuals transitioning out of incarceration.⁶
- **Addressing social determinants of health (SDOH).** States are [beginning](#) to include SDOH-related provisions in their managed care contracts that, for example, require screenings for social needs and ensure enrollees are connected to community-based resources. (See Medicaid Policy Brief #5 for details.)
- **Shaping care management.** States are [demanding](#) more, in terms of how and where care management is delivered, including mandating coordination with health homes⁷ and requiring locally based care management.⁸
- **Accelerating value-based payment.** States are [increasingly](#) looking to enhance accountability through upside and downside risk arrangements between plans and providers, including requiring plans to expand their deployment of meaningful value-based payment with provider networks and setting targets for the proportion of plan payments that are value-based.⁹

For additional information on how states can get the most out of their Medicaid managed care programs, please refer to the resources below.

Additional Resources

Resources on Managed Care and Payment Reform

- Bindman, A. Redesigning Medicaid Managed Care. *JAMA*, 319(15):1537-1538; 2018. <https://jamanetwork.com/journals/jama/fullarticle/2678602>
- Boozang, P., Davis, H. Leveraging Medicaid Managed Care to Advance Value-Based Purchasing [webinar]. Manatt Health. November 2018. www.manatt.com/Insights/Webinars/Leveraging-Medicaid-Managed-Care-to-Advance-Value
- Chu, B., Dutton, M., et al. How Are States and MCOs Redefining Care Management? [webinar]. Manatt Health. May 2018. www.manatt.com/Insights/Webinars/How-Are-States-and-MCOs-Redefining-Care-Management
- Rosenbaum, S., Schmucker, S., et al. Medicaid Payment and Delivery System Reform: Early Insights from 10 Medicaid Expansion States. The Commonwealth Fund. October 2017. www.commonwealthfund.org/publications/issue-briefs/2017/oct/medicaid-payment-and-delivery-system-reform-early-insights-10

Resources on Medicaid and Behavioral Health

- Bachrach, D., Anthony, S., et al. State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment. The Commonwealth Fund. August 2014. www.commonwealthfund.org/publications/fund-reports/2014/aug/state-strategies-integrating-physical-and-behavioral-health
- Grady, A., Boozang, P., et al. Medicaid: The Linchpin in State Strategies to Prevent and Address Opioid Use Disorders. Manatt Health. March 2018. www.shvs.org/resource/medicaid-the-linchpin-in-state-strategies-to-prevent-and-address-opioid-use-disorder/

Resources on Medicaid and Social Determinants of Health

- Bachrach, D., Guyer, J., et al. Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools. The Commonwealth Fund. January 2018. www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review
- Dutton, M., Mann, C., et al. Addressing Social Determinants of Health in Medicaid Managed Care [webinar]. Manatt Health. October 2018. www.manatt.com/Insights/Webinars/Addressing-Social-Determinants-of-Health-in-Medicaid
- Kartika, T. How States Address Social Determinants of Health in Their Medicaid Contracts and Contract Guidance Documents. National Academy for State Health Policy (NASHP). August 2018. <https://nashp.org/how-states-address-social-determinants-of-health-in-their-medicaid-contracts-and-contract-guidance-documents/>

Endnotes

1. Total Medicaid Managed Care Enrollment. Henry J. Kaiser Family Foundation website. 2016. www.kff.org/medicaid/state-indicator/total-medicicaid-mc-enrollment/
2. Herring, B., Adams, EK. Using HMOs to serve the Medicaid population: What are the effects on utilization and does the type of HMO matter? *Health Economics*, 20(4), 446-460; 2011. <https://doi.org/10.1002/hec.1602>; Duggan, M., Hayford, T. Has the shift to managed care reduced Medicaid expenditures? Evidence from state and local-level mandates. *Journal of Policy Analysis and Management*, 32(3), 505-535; 2011. www.nber.org/papers/w17236.pdf; Caswell, KJ, Long, SK. The expanding role of managed care in the Medicaid program: Implications for health care access, use, and expenditures for nonelderly adults. *The Journal of Health Care Organization, Provision, and Financing*, 52; 2015. www.ncbi.nlm.nih.gov/pubmed/25882616; United States Government Accountability Office (GAO). Medicaid Managed Care: Improvements Needed to Better Oversee Payment Risks. DC: GAO; 2018. www.gao.gov/assets/700/693418.pdf
3. For more information see: Anthony, S., Traub, A., Lewis, S., et al. Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment: A Toolkit for States. Center for Healthcare Strategies. December 2017. www.chcs.org/resource/strengthening-medicicaid-long-term-services-supports-evolving-policy-environment-toolkit-states/
4. Herman Soper, M. Integrating Behavioral Health into Medicaid Managed Care: Design and Implementation Lessons from State Innovators. Centers for Health Care Strategies. April 2016. www.chcs.org/media/BH-Integration-Brief_041316.pdf
5. Manatt Health analysis. States covering I/DD populations include: Arizona, Arkansas, Iowa, Kansas, Michigan, New York, Pennsylvania, Virginia and Wisconsin; North Carolina plans to cover the I/DD population in its Medicaid managed care program in 2019.
6. For example, Arizona requires its managed care plans to implement a "justice system reach-in care coordination" program for incarcerated members that have an anticipated release date; Arizona Health Care Cost Containment System Administration (AHCCCS). Notice of Request for Proposal: Complete Care Program Contract for Contractors. Phoenix: AHCCS; 2017. www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/ACC_RFP_11022017.pdf
7. Example states include: Minnesota, Missouri and New York.
8. Example states include: Ohio and Pennsylvania.
9. Manatt on Medicaid: 10 Trends to Watch in 2018. Manatt Health. February 2018. www.manatt.com/Insights/White-Papers/2018/Manatt-on-Medicaid-10-Trends-to-Watch-in-2018