Medicaid Managed Care and Children: An Overview

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Abstract

In recent years, states have increasingly turned to managed care arrangements for financing and delivering health services to Medicaid beneficiaries. In 1996, approximately 40% of all Medicaid recipients were enrolled in some form of managed care. The rapid escalation of managed care in this population has been fueled by states’ desire to slow the growth of Medicaid expenditures and by the trend toward managed care enrollment in the private health insurance industry. The effect of managed care on cost containment in the Medicaid program may be limited, however, because 85% to 90% of Medicaid managed care enrollees are women of childbearing age and children, who together account for 69% of Medicaid recipients, but only 26% of program costs. Nonetheless, the increase in managed care enrollment in this population may have a profound impact on health service delivery and health outcomes for U.S. children, approximately 20% of whom received health benefits through the Medicaid program in 1995.

In the future, the proportion of Medicaid-eligible children enrolled in managed care will likely increase as a result of recent legislation that relaxed the requirement that states seek federal approval prior to mandating managed care enrollment for Medicaid beneficiaries. More states are relying on fully capitated arrangements as the preferred type of managed care for Medicaid recipients, despite the relative lack of experience many of these plans have in serving this low-income population. Moreover, managed care organizations have few incentives to enroll chronically ill or disabled children with higher-than-average expected costs. Without mechanisms in place that adequately adjust capitated rates to account for these higher-cost enrollees, managed care organizations may lose money, and children with the greatest health care needs may be underserved. As mandatory managed care enrollment for Medicaid recipients increases nationwide, states should carefully monitor changes in program costs and quality as well as implications for the delivery of pediatric health services and health outcomes.

The use of managed care arrangements to deliver health services to Medicaid beneficiaries has increased in recent years as states and the federal government have sought new ways to control escalating health care expenditures associated with the Medicaid program. Low-income women and children, who represent the great majority of Medicaid beneficiaries but account for only a fraction of total program expenditures, have been the primary groups enrolled in Medicaid managed care.
Overview of the Medicaid Program

Eligibility Criteria
Created as Title XIX of the Social Security Act in 1965, Medicaid is the joint-funded federal-state program for financing health services for low-income groups, primarily women of childbearing age and children. Medicaid is also the major funding source for long-term care for the elderly and for health services provided to the blind and disabled. Historically, eligibility for health insurance coverage through Medicaid has been directly linked to enrollment in federal income-maintenance programs such as Aid to Families with Dependent Children (AFDC), also known as welfare, and Supplemental Security Income (SSI). During the 1980s, federal legislation extended mandatory Medicaid eligibility to additional groups of infants, children, and pregnant women who met specific income and resource requirements, but who did not meet other AFDC eligibility criteria. This change was made in response to concerns about disparities in health care utilization patterns among insured and uninsured children and pregnant women, the excessive costs to the health care system associated with adverse birth outcomes among low-income women, poor immunization rates among U.S. children, and the growth in the number of uninsured women of childbearing age and children who otherwise might not have access to health insurance.

At states’ discretion, other groups of categorically needy or medically needy persons—who do not meet the income requirements for mandatory eligibility, but who are still considered low income—also may receive benefits under Medicaid. The Balanced Budget Act of 1997 (Public Law 105-33) created additional eligibility options for states, two of which are specific to children. One option guarantees continuous Medicaid coverage to children for one year following the determination of eligibility, whether they do or do not continue to meet income and eligibility requirements during that time. Implementation of this option reduces the substantial discontinuity in children’s Medicaid coverage caused by frequent income fluctuations, which are common in low-income families. Another option allows states to extend Medicaid coverage to children temporarily, based on certain requirements, until the state Medicaid agency can formally determine eligibility status. This option to grant “presumptive eligibility” was previously available only to pregnant women.

The Balanced Budget Act of 1997 also created the State Children’s Health Insurance Program (CHIP), designed to provide health insurance for low-income, uninsured children who do not qualify for Medicaid or have a source of private insurance coverage. States may use the child health grants allocated under CHIP to expand Medicaid eligibility or to create new health insurance programs for this population. The expanded eligibility options created during the past two decades, along with the new CHIP program, can extend Medicaid coverage to many women of childbearing age and children who otherwise might not have access to health insurance.

The link between receipt of cash assistance through AFDC and Medicaid eligibility was severed by the welfare reform bill signed by President Clinton on August 22, 1996. This bill, known as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), replaced the traditional AFDC program with block grants to the states. With a few exceptions, Medicaid eligibility is still granted to individuals who would have met the AFDC eligibility criteria that were being used prior to the enactment of the welfare reform legislation. The 1996 welfare reform legislation did, however, tighten the definition of “disabled” under the SSI program, thus eliminating Medicaid coverage for functionally disabled and some mentally ill children. Medicaid coverage for these children was restored in the Balanced Budget Act of 1997.

Medicaid Benefits
The health services covered under Medicaid are more comprehensive than the services
offered by most employment-based commercial insurance plans. Federal legislation mandates that Medicaid programs provide reimbursement for a broad range of preventive, acute, and chronic care services; optional services also may be offered at each state’s discretion. The general list of services that must be covered under federal Medicaid regulations includes inpatient and outpatient hospital services; physician services; laboratory and x-ray services; nursing homes and home health care; the early and periodic screening, diagnosis, and treatment (EPSDT) program for children; family planning; and services provided by rural health clinics and federally qualified health centers.

For the pediatric population, one of the most critical health benefits under Medicaid is EPSDT, which was designed to ensure preventive health care services and treatment for low-income children under age 21. The basic preventive services under EPSDT include screening, vision, dental, and hearing services. Screening services encompass comprehensive physical and mental health screenings, a developmental history, a comprehensive physical exam, immunizations, laboratory tests, and health education and anticipatory guidance. Under EPSDT, all medically necessary services that are federally allowable must be covered, including optional Medicaid services that are not covered under the state’s Medicaid plan. Because of the expansiveness of this requirement, EPSDT has become a major funding source for children with special needs, who often require more extensive services, such as hearing aids; eyeglasses; extended therapies, including physical and occupational therapy; personal care; intensive mental health care; respiratory care; private-duty nursing; case management; and transportation.

**Trends in Enrollment and Expenditures**

In 1995, the Medicaid program spent $152 billion on health care services for more than 36 million beneficiaries: approximately 5.9 million blind and disabled adults and children; 4.4 million elderly people; 18.7 million other children; and 7.6 million other adults (mostly women of childbearing age). Among the children served by the Medicaid program, more than 1 million were disabled children covered under SSI. Of the total population of children in the United States, the proportion who receive Medicaid is quite astounding. The Medicaid program covered one of five children and one-third of all births in the United States during 1995.

The dramatic explosion of Medicaid expenditures in the past decade, from roughly $40 billion in 1985 to $152 billion in 1995, can be attributed primarily to two factors: the substantial increase in the number of beneficiaries, and the substantial increase in the per-enrollee costs of delivering health care services. More than half of the increase in the number of beneficiaries is attributable to the many low-income children and pregnant women added to the Medicaid rolls as a result of congressional expansions during
the 1980s. The relative proportion of children enrolled in Medicaid is likely to increase even more as a result of the recent implementation of CHIP. In contrast, the dramatic rise in the per-enrollee cost of delivering Medicaid health services has been influenced mainly by the substantial increases in the costs of caring for elderly, blind, and disabled recipients, who are primarily adults.

Although women of childbearing age and children represent the majority of Medicaid recipients, other groups consume a far greater proportion of program expenditures. As shown in Figure 1, children represented nearly half (48%) of all Medicaid beneficiaries in 1995, but accounted for only 15% of expenditures for health services. In contrast, while only 27% of enrollees were elderly, blind, or disabled, this group consumed nearly 75% of program resources.

Medicaid Managed Care

Trends in Managed Care Arrangements

Medicaid providers historically were reimbursed on a fee-for-service basis, usually with administratively set fees. While this approach could contain the per-unit cost of service, it offered little control over the volume of services provided. Consequently, the substantial increase in program costs during recent years has led a number of states to experiment with managed care arrangements for financing the delivery of health care services to Medicaid recipients. Enrollment in managed care plans also has the potential to increase access to care and improve continuity of care for Medicaid beneficiaries. The rapid proliferation of Medicaid managed care has been influenced by the expansion of these models in the commercial sector—to the extent that managed care arrangements currently represent the prevailing mode for delivering private health care benefits—and by the cumulative experience with Medicaid managed care initiatives among the states.

Between 1991 and 1996, the percentage of Medicaid recipients enrolled in managed care plans increased more than fourfold, from 9.5% in 1991 to 40.1% in 1996 (see Figure 2). By mid-1996, more than 13 million beneficiaries, mostly women of childbearing age and children, had their health care services covered by some type of managed care plan; roughly 8.5 million of these individuals were enrolled in fully capitated health plans. Among the states that had implemented Medicaid managed care, the percentage of individuals enrolled in these plans ranged from a low of fewer than 1% in Maine and Wyoming to a high of 100% in Tennessee. Only two states, Vermont and Alaska, did not have any Medicaid recipients enrolled in managed care as of 1996 (see Figure 3). In absolute numbers, California had the most Medicaid beneficiaries (1.2 million) enrolled in managed care plans.

The implementation of Medicaid managed care has grown considerably in recent years, and is expected to increase even more in the near future as a result of programmatic changes included in the Balanced Budget Act of 1997. Prior to the enactment of this legislation, states could enroll Medicaid beneficiaries in managed care plans on a voluntary basis, but were required to apply for federal waivers to implement mandatory Medicaid managed care programs. The two types of waivers granted—section 1115 “research and demonstration” waivers and section 1915(b) “freedom of choice” waivers—pertained to different federal regulations, though both offered states the flexibility to test innovative arrangements for financing and delivering health care services to Medicaid recipients. The Balanced Budget Act of 1997, however, altered prior law, permitting states to mandate managed care enrollment for Medicaid recipients without seeking federal waivers. Children with special needs, individuals who also receive Medicare benefits, and Native Americans are exempt from mandatory enrollment in Medicaid managed care plans, but the option remains for states to seek waivers to enroll these populations.
The 1997 federal budget legislation also gave states the flexibility to enroll Medicaid beneficiaries in a broader range of managed care plans, including plans that exclusively serve Medicaid recipients. This new flexibility is in contrast to the prior “75/25” rule, whereby state Medicaid programs could contract with capitated managed care plans only if at least 25% of total plan enrollees were privately insured individuals. In addition, the balanced budget legislation allows states to limit Medicaid beneficiaries’ selections to only two managed care arrangements. These arrangements may consist of two managed care organizations, two primary care case management programs to coordinate the delivery of health care services, or one of each. In rural areas, beneficiaries may be required to enroll in a single plan, as long as they are given a choice between at least two primary care providers. Without evidence of a legitimate cause for disenrollment,
Medicaid recipients can be locked into a given managed care plan for up to one year. In addition to these regulations, which give states greater authority to control managed care enrollment and plan choice, the legislation includes new consumer protection and quality-assurance standards to protect Medicaid beneficiaries. However, these protections may not achieve their desired effectiveness unless states and the federal government have the capacity and willingness to carefully monitor and enforce them.17

The growth of managed care enrollment in the Medicaid population has important implications for the delivery of pediatric health services, because enrollment has been restricted largely to AFDC-related eligibility categories and other groups of low-income children and pregnant women enrolled under state Medicaid expansions. According to estimates by the Congressional Budget Office, 85% to 90% of all Medicaid managed care enrollees are women of child-bearing age and children.5 A recent study based on interviews with state Medicaid administrators found that all states except Wyoming were planning to enroll at least one category of Medicaid-eligible children in some type of managed care plan in the future. In addition to enrolling the AFDC-eligible population, the majority of these states also planned to enroll some high-risk groups, including children who receive SSI benefits or children in foster care. Nearly all states anticipated mandatory managed care enrollment for one or more Medicaid eligibility groups.18

**Types of Medicaid Managed Care Arrangements**

States use three primary types of managed care arrangements to provide health care services for Medicaid recipients, and these vary substantially with regard to risk-sharing methods, service coverage, and potential cost savings (see Box 1). Two of the organizational approaches—fully capitated and
prepaid health plans—rely to some degree on capitation, a reimbursement mechanism whereby plans or providers are paid a fixed fee per enrollee for delivering a defined set of health services. The third managed care approach—primary care case management (PCCM)—preserves traditional fee-for-service reimbursement under Medicaid, and does not place health care providers at financial risk for services rendered.

The implementation of managed care programs for Medicaid recipients indicates a general trend toward states contracting with fully capitated plans. During 1995–96, enrollment of Medicaid beneficiaries in fully capitated health maintenance organizations (HMOs) grew by more than 60%, while enrollment in prepaid health plans and PCCMs increased only slightly. In 1996, more than 55% of Medicaid beneficiaries in managed care were enrolled in fully capitated plans; 26% were enrolled in PCCMs and 18% were in prepaid health plans. Seventy percent of all managed care plans that contracted with state Medicaid programs sought to provide services on a full-risk basis.

Despite the increased use of fully capitated health plans by state Medicaid programs, PCCM arrangements remain an important managed care alternative in some geographic areas. In 1996, PCCM programs were the only managed care arrangement available to Medicaid enrollees in 13 states. PCCM arrangements may be preferred in states that have a low penetration of fully capitated health plans or strong political pressure opposing a capitated reimbursement system for Medicaid managed care. In addition, some states may prefer PCCM programs for specific high-risk populations.
The use of capitated health plans or of PCCMs with fee-for-service payment has important implications for the delivery of health care services to the Medicaid population. The aim of PCCM programs is to increase access to primary care providers by offering them case management fees in addition to fee-for-service reimbursement, and to encourage primary care providers to assume a more active role in managing their patients’ care. PCCM programs, however, do little to alter the existing structure of the health care delivery system for Medicaid recipients. In contrast, Medicaid programs that adopt capitated payment systems contract with select managed care plans, which control the network of providers available to enrollees. Traditional Medicaid providers—including public health clinics and community health centers—may be excluded from these provider networks, unless states specify otherwise in their managed care contracts. The exclusion of traditional Medicaid providers from newly created networks may result in disruptions in continuity of care for many Medicaid recipients. In addition, traditional Medicaid providers often offer uncompensated care to the uninsured, and have relied on Medicaid reimbursements to cross-subsidize this care. Thus, the lack of Medicaid funding available to these providers may limit access to primary care services for the uninsured as well.20

Service Coverage Under Medicaid Managed Care

State Medicaid programs that contract with fully capitated managed care plans typically...
include basic pediatric medical services in their capitated contracts, although most states exclude one or more services that are important for children. For several reasons, state Medicaid programs may elect to “carve out” specific services from capitated managed care contracts and pay for them on a fee-for-service or separate capitated basis. A study of state Medicaid managed care policies in 1996 found that some states wanted to make capitated benefit packages for Medicaid closely resemble those offered to commercial enrollees. Other states wanted to ensure that plans were not given responsibility for services they lacked the capacity to offer, or wanted to protect federal Medicaid funds paid to providers in public programs by carving out services offered by these providers and paying for them separately. Services typically carved out of capitated contracts include mental health, health-related special education, dental care, early intervention, and personal care.

Carving out specific Medicaid services may increase access for poor children in situations in which these services otherwise would have been denied because the managed care plan was unable to deliver them or did not view them as medically necessary. Nonetheless, this approach is not without problems. Managed care plans have an obligation to provide services that are covered under contractual arrangements. If a set of services is not explicitly included and defined in a managed care contract, fully capitated plans have an incentive to interpret their service provision obligations narrowly and to reduce costs by shifting the responsibility for these services to fee-for-service providers. When this shift occurs, states run the risk of overpaying managed care plans for delivering health services to Medicaid recipients. Coordination of care across providers also may be problematic in this situation.

Contracting and Reimbursement Under Medicaid Managed Care

States with capitated contracts for the delivery of Medicaid-covered health services typically use one of two methods—rate setting or competitive bidding—to select managed care plans and establish payment levels. Although the majority of states with fully capitated contracts in 1996 used rate setting to determine pediatric reimbursement levels, most states planned to move to a competitive-bidding process in the future. With rate setting, most states pay a set amount—usually 95% or less of the average cost per recipient in fee-for-service plans—to all plans for particular subgroups of enrollees. The amounts paid vary based on individuals' categorical eligibility status and other factors. Other states pay a blended rate to individual plans, weighted to account for differences in the types of individuals enrolled. Rate setting has the advantage of allowing states to determine in advance their target levels of savings, and it guarantees some uniformity
across plans with regard to reimbursement levels. This type of contracting also makes it possible for states to structure contracts that include a broader range of providers, such as safety net providers that otherwise might not participate in managed care networks.\textsuperscript{21}

The alternative to rate setting, known as competitive bidding, requires that managed care organizations submit bids to state Medicaid programs specifying the capitation rate they would require to deliver a predetermined package of health care benefits. Participating plans are then selected based on their relative ratings on administrative, technical capacity, quality, and cost criteria.\textsuperscript{18,21}

Regardless of the method used for selecting health plans and setting reimbursement levels, managed care plans have few incentives to enroll vulnerable children with higher-than-average expected costs. As a result, it is important to vary capitated rates based on the expected costs of caring for enrollees with different risk characteristics. The cost savings to states resulting from Medicaid managed care depends, in large part, on the availability of adequate risk adjusters, factors that help determine subsequent health care utilization. If the risk adjusters used to set capitated payments are poor predictors of the future use of health care services, health plans may end up being either substantially overpaid or underpaid for the services rendered. Overpayment results in large profits for health plans and may make managed care a more costly, rather than more cost-effective, means for delivery of health care services. Conversely, underpayment may encourage the underutilization of preventive, diagnostic, and therapeutic services, and may result in health plan insolvency.

Despite the importance of risk adjustment for determining capitated rates under Medicaid managed care, the development of pediatric risk adjusters is quite unsophisticated. All states, however, vary capitation amounts for pediatric services based on one or more demographic characteristics. Age is the most common characteristic used to adjust pediatric capitation rates, and the majority of states vary reimbursement amounts based on three or four age categories to reflect different costs of care among infants, children, and adolescents. Adjustments based on gender and geographic residence also are quite common. In addition to these demographic factors, pediatric capitated payments typically are varied based on a child's categorical eligibility status, and a few states increase capitation rates for children with an AIDS diagnosis. In the future, numerous states plan to use a more comprehensive approach, based on diagnostic categories, to adjust capitation payments for children with chronic or disabling conditions.\textsuperscript{18}

**Conclusion**

Efforts to control the growth of Medicaid expenditures and the recent expansion of managed care in the private sector have resulted in the rapid proliferation of Medicaid managed care arrangements across the United States. To date, low-income women and children have been the primary eligibility groups enrolled in Medicaid managed care, and mandatory enrollment for these populations is expected to grow substantially in the future. Although capitated managed care arrangements have the potential to control the growth of health care expenditures, while at the same time encouraging more coordinated health care delivery and better access to primary care, potential drawbacks of these arrangements for mothers and their children must be considered as well (see the article by Szilagyi in this journal issue). In particular, capitated reimbursement systems may encourage physicians to underprovide health care services, especially if Medicaid payments are set too low. Interrupted patient-provider relationships are also a concern as states move Medicaid recipients into managed care plans, because many individuals enrolled in Medicaid may have previously established relationships with traditional safety net providers who may not have contracts with

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2. The categorically needy include infants and pregnant women whose family incomes are up to 185% of federal poverty guidelines; children under age 21 who meet certain income and resource requirements but are not eligible for AFDC; specific groups of elderly, blind, or disabled adults; certain institutionalized groups; individuals who meet income and medical requirements for institutionalization; individuals who receive state supplementary payments; and low-income persons infected with tuberculosis. See note no. 1, King and Christian, p. 1-5.

3. The medically needy include individuals who meet certain categorical requirements such as being pregnant, having children, or having disabilities, but who do not qualify for cash assistance. The medically needy might also include individuals with very large medical expenses who are forced to use their resources to “spend down” to a level at which they would qualify for Medicaid. See note no. 1, King and Christian, p. 1-5.


8. See note no. 1, King and Christian, p. 2-5.

9. See note no. 1, King and Christian, pp. 3-23-3-25.


16. This includes children who meet the definition of “disabled” under the Supplemental Security Income (SSI) program, children with special health care needs under Title V of the Maternal and Child Health Services Block Grant (MCH block grant), and children in foster care or other out-of-home placements.


