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Research Brief

TO: Senator Pete Kelly

FROM: Chuck Burnham, Legislative Analyst

DATE: March 2, 2015

RE: Medicaid: Status of State Expansion under the Affordable Care Act and Selected Information on the Use of Managed Care Organizations

LRS Report 15.284

You asked about the status of Medicaid expansion under the Affordable Care Act (ACA) among the states. You also wished to know about the use of managed care organizations (MCOs) in state Medicaid programs. Specifically, you wanted to know whether states that expanded Medicaid under the ACA implemented use of MCOs as part of the expansion, and if that administrative structure was delineated in legislation authorizing the expansion.

The federal Patient Protection and Affordable Care Act (P.L. 111-148), or ACA, includes a requirement that states expand Medicaid programs to cover individuals with incomes of up to 138 percent of the federal poverty level.[1] However, the June 2012 U.S. Supreme Court decision in *National Federation of Independent Business v. Sebelius*, made Medicaid expansion under the ACA optional for the states. According to the Kaiser Family Foundation (KFF), to date 28 states have expanded their Medicaid programs under the provisions of the ACA. Governors and/or legislative leadership in seven of the 22 states that have thus far rejected expansion, including Alaska, are currently considering expansion.[2]

Use of Private Managed Care Organizations in Medicaid[3]

"Managed care organization" (MCO) is a term covering an array of health insurance delivery models. Typically MCOs contract with health care providers and medical facilities to provide services at reduced costs for members covered by the organization. According to the federal Centers for Medicare and Medicaid Services (CMS), managed care is intended to provide a

> health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of health benefits and additional services through contracted arrangements between state agencies and managed care organizations that accept a set per member per month (capitation) payment for these services.
>
> By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce program costs and better manage utilization of health services.

[1] Text of the ACA can be accessed at *http://www.gpo.gov/fdsys/granule/PLAW-111publ148/PLAW-111publ148/content-detail.html*. Portions of the federal healthcare overhaul are also contained in the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), *http://www.gpo.gov/fdsys/pkg/PLAW-111publ152/pdf/PLAW-111publ152.pdf*.

[2] The KFF tracks state actions on expansion of Medicaid under the ACA at *http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#*. The Foundation is a not-for-profit research organization with the goal of being "a trusted source of information in a health care world dominated by vested interests." The KFF generally supports the ideal that all people have access to health insurance, but takes no position on the ACA or any other law.

[3] The efficacy of managed care as a means to reduce costs and improve quality is a question outside the scope of your request. It is important to note, however, that research on the topic has reached mixed conclusions. Nonetheless, recent studies have shown that well-designed and implemented managed care strategies can transfer risk away from government payers (see, for example, *http://www.columbia.edu/~jnv2106/jvanparys.jmp.pdf*).

> Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.[4]

According to the federal Centers for Medicaid and Medicare Services (CMS), pursuant to regulations at 42 CFR 438, four types of managed care entities are recognized for Medicaid programs as follows:

- Managed Care Organizations (MCOs)
  - Comprehensive benefit package
  - Payment is risk-based/capitation
- Primary Care Case Management (PCCM)
  - Primary care case managers contract with the state to furnish case management (location, coordination, and monitoring) services
  - Generally, paid fee for service for medical services rendered plus a monthly case management fee
- Prepaid Inpatient Health Plan (PIHP)
  - Limited benefit package that includes inpatient hospital or institutional services (example: mental health)
  - Payment may be risk or non-risk
- Prepaid Ambulatory Health Plan (PAHP)
  - Limited benefit package that does not include inpatient hospital or institutional services (examples: dental and transportation)
  - Payment may be risk or non-risk

States can implement managed care delivery systems for Medicaid recipients under three separate authorizations within the federal Social Security Act (P.L. 74-271): state plans (Section 1932[a]), plan waivers under Section 1915(a-b), and plan waivers under Section 1115.[5] The KFF provides a useful overview of states' use of waivers in expanding Medicaid under the ACA at *http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers*.

Recent Medicaid MCO Activity in the States

Research by the KFF and others has illustrated that Medicaid enrollment in MCOs has increased substantially in recent years. This growth has been driven, in part, by expansion of Medicaid under the ACA; however, the use of MCOs has also increased in non-expansion states as policymakers and others continue to seek ways to control the growth of costs. According to data compiled by the consultancy PricewaterhouseCoopers (PwC), enrollment in private MCOs by Medicaid recipients increased by roughly 9.3 million individuals in the year beginning third-quarter 2013. Over the same time period, total Medicaid enrollment increased by approximately 9 million enrollees. That is to say, net growth in the number of Medicaid enrollees covered by a private MCO has been somewhat greater than overall Medicaid expansion.

According to PwC, the share of Medicaid recipients nationwide receiving comprehensive medical coverage through a private MCO increased from about 59 percent to 66 percent over the year studied.[6] These recipients are spread among the 39 states with Medicaid MCOs in place, wherein enrollment ranges from 11 percent in Iowa to 100 percent in Tennessee—one of the states that has rejected expansion under the ACA. According to the KFF, 90 percent of all Medicaid recipients live within the 39 states with Medicaid MCOs.

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[4] *http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html*.

[5] Waivers exempt states from certain requirements of federal law in order to allow flexibility to design programs to most effectively deliver and fund services. Relevant sections of federal law and regulation, state managed care profiles, details on the parameters of waivers, and technical assistance for states regarding managed care are all available at *http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html*.

[6] Ari Gottlieb, "The Expanded State of Medicaid in the United States: Private Medicaid Health Plans Crossing the Tipping Point," PricewaterhouseCooper, January 2015, *http://www.mhpa.org/_upload/201501StateofMedicaid2014.pdf*.

As the increases in enrollment figures referenced above suggest, a great deal of activity has occurred with regard to Medicaid managed care in recent years.[7] Among the changes states have variously implemented over fiscal years 2014 and 2015 is the addition of geographic areas covered by MCOs (9 states), creation or expansion of eligibility groups (34 states), and enactment of policies making enrollment in managed care mandatory for some segment of Medicaid recipients (13 states).[8] The attached table shows for each state the status of Medicaid expansion under the ACA, level of enrollment in private MCOs for Medicaid recipients, and an account of the states where selected expansions to MCO coverage have been implemented.

Implementation of Medicaid MCOs in Legislation Expanding Medicaid under the ACA

We located no instance in which legislation to expand Medicaid under the ACA created an associated MCO program, or directed state agencies to do so, where no such program previously existed. There are likely a number of reasons this approach has not widely been undertaken. First, of course, is the fact that Medicaid MCOs were already operating in many states when ACA expansion was undertaken. Further, where those programs do not exist at the time of expansion, an amendment to the state plan or approval of a waiver as mentioned above is required prior to the implementation of a Medicaid managed care program.

In a number of states where expansion under the ACA has taken place, it was not accomplished through stand-alone legislation. For example, Delaware, New Jersey, Rhode Island, and Washington expanded Medicaid through line items in budget bills—a legislative vehicle that is not necessarily well suited for detailed programmatic directives. In other states—prominently Kentucky and Ohio—expansion under the ACA was directed by their respective governor absent enabling legislation.

Although we located no legislation directing creation of Medicaid MCOs, a number of states' enabling measures provided some degree of direction regarding managed care. For example, California's voluminous ACA legislation includes a requirement that Medicaid recipients enroll in Medi-Cal managed care in counties where such plans are or become available [Cal. Welfare and Institutions Code § 14005.60(c)(1-2)].[9] Enabling legislation in Michigan is more broadly prescriptive regarding the use of MCOs, directing an aggressive move toward the use of waivers to mandate Medicaid managed care as follows:

> By September 30, 2015, the department of community health shall develop and implement a plan to enroll all existing fee-for-service enrollees into contracted health plans if allowable by law, if the medical assistance program is the primary payer and if that enrollment is cost-effective. This includes all newly eligible enrollees [in Medicaid under the ACA]. The department of community health shall include contracted health plans as the mandatory delivery system in its waiver request. The department of community health also shall pursue any and all necessary waivers to enroll persons eligible for both Medicaid and Medicare into the 4 integrated care demonstration regions beginning July 1, 2014. By September 30, 2015, the department of community health shall identify all remaining populations eligible for managed care, develop plans for their integration into managed care, and provide recommendations for a performance bonus incentive plan mechanism for long-term care managed care providers that are consistent with other managed care performance bonus incentive plans.[10]

The legislation authorizing Medicaid expansion under the ACA in New Hampshire seeks to control costs, in part, by making premium assistance for certain adults newly eligible for Medicaid contingent upon those enrollees choosing either a qualified health plan from a federally-facilitated health exchange or one of the state-contracted MCOs.[11]

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[7] Legislative Research calculations based on data provided by Gottlieb, PwC, pp. 13-14.

[8] The KFF publishes a great deal of data and analysis through its Medicaid Managed Care Market Tracker at *http://kff.org/state-category/medicaid-chip/medicaid-managed-care-market-tracker/*.

[9] See § 9 of the enabling legislation in California is available at *http://www.leginfo.ca.gov/pub/13-14/bill/asm/ab_0001-0050/abx1_1_bill_20130614_amended_sen_v97.htm*.

[10] Act No. 107, 2013, Section 105d(i)((4), *http://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2013-PA-0107.pdf*.

[11] New Hampshire SB 413-FN-A, § XXIV(a), *http://www.gencourt.state.nh.us/legislation/2014/SB0413.html*.

These examples are by no means exhaustive of legislative directives regarding MCOs and ACA expansion, and as we indicated above, policymakers across the country are aggressively seeking changes to and increased use of managed care for Medicaid enrollees. Ultimately, should Alaska pursue such policies, their specific design and implementation would necessarily be driven by the state's unique geography, demographics, medical markets, and the needs of Medicaid recipients.

We hope this is helpful. If you have questions or need additional information, please let us know.

Medicaid: Status of State Expansion under the Affordable Care Act (ACA) and Selected Information on the use of Private Managed Care Organizations (MCO)						
Location	Status of Medicaid Expansion Under the Affordable Care Act[1]	Private MCO Enrollment[2] (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015[3]		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
United States	Adopted: 28 states Reconsidering: 7 states Rejected: 15 states	43,331	65%	9 States	34 States	13 States
Alabama	Rejected	0	0%			
Alaska	Reconsidering	0	0%			
Arizona	Adopted	1,316	83%		X	
Arkansas	Adopted	166	19%			
California	Adopted	7,931	77%	X	X	X
Colorado	Adopted	780	72%	X	X	
Connecticut	Adopted	0	0%			
Delaware	Adopted	181	78%		X	
Florida	Rejected	2,685	74%	X	X	X
Georgia	Rejected	1,177	68%		X	
Hawaii	Adopted	326	100%		X	
Idaho	Rejected	0	0%			
Illinois	Adopted	378	12%	X	X	X
Indiana	Adopted	760	68%		X	X
Iowa	Adopted	59	11%	X	X	
Kansas	Rejected	399	93%			
Kentucky	Adopted	1,050	90%		X	
Louisiana	Rejected	907	71%		X	X
Maine	Rejected	0	0%			
Maryland	Adopted	1,077	84%			
Massachusetts	Adopted	773	42%		X	X
Michigan	Adopted	1,459	76%		X	
Minnesota	Adopted	801	75%		X	
Mississippi	Rejected	160	21%		X	
Missouri	Reconsidering	389	47%			
Montana	Reconsidering	0	0%			
Nebraska	Rejected	188	81%		X	
Nevada	Adopted	403	67%		X	
New Hampshire	Adopted	127	86%	X	X	X
New Jersey	Adopted	1,476	92%		X	
New Mexico	Adopted	578	89%		X	X
New York	Adopted	4,389	76%	X	X	X

Medicaid: Status of State Expansion under the Affordable Care Act (ACA) and Selected Information on the use of Private Managed Care Organizations (MCO) (continued)

Location	Status of Medicaid Expansion Under the Affordable Care Act[1]	Private MCO Enrollment[2] (Thousands)	Private MCO as a Percent of Total Enrollment	Fiscal Years 2014-2015[3]		
				New Geographic Areas Added	New Eligibility Groups Added	New Mandatory Enrollment
North Carolina	Rejected	0	0%			
North Dakota	Adopted	13	Unavailable	X	X	X
Ohio	Adopted	2,133	84%		X	
Oklahoma	Rejected	0	0%			
Oregon	Adopted	850	86%		X	
Pennsylvania	Adopted	1,668	74%		X	
Rhode Island	Adopted	223	86%		X	
South Carolina	Rejected	737	64%		X	X
South Dakota	Rejected	0	0%			
Tennessee	Reconsidering	1,241	100%			
Texas	Rejected	3,539	89%		X	
Utah	Reconsidering	195	78%		X	X
Vermont	Adopted	0	0%			
Virginia	Reconsidering	707	78%		X	
Washington	Adopted	1,186	73%		X	X
West Virginia	Adopted	202	40%		X	
Wisconsin	Rejected	702	62%	X	X	
Wyoming	Reconsidering	0	0%			

Notes: 1) Expansion status as of January 27, 2015. "Reconsidering" indicates that following the state's initial rejection of expansion, the governor and/or legislature in the states listed have indicated that serious consideration is being given to pursuing Medicaid expansion under the ACA.

2) This column shows the number of Medicaid enrollees covered by a comprehensive Managed Care Organization plan for medical services offered by private-sector insurance providers or public organizations that are not state agencies. Figures include only medical coverage; behavioral, dental, and pharmaceutical managed care plans are not considered.

3) These three columns indicate whether states have expanded the geographical scope and eligibility of Medicaid MCO plans, and if mandatory enrollment in an MCO has been implemented, during fiscal years 2014 and 2015.

Sources: Status of Medicaid expansion and MCO geographic / eligibility expansion and mandatory enrollment: Kaiser Family Foundation, State Health Facts, Medicaid and CHIP, *http://kff.org/state-category/medicaid-chip/* . Private MCO enrollment by state data: Ari Gottlieb, "The Expanded State of Medicaid in the United States: Private Medicaid Health Plans Crossing the Tipping Point," PricewaterhouseCooper, January 2015, *http://www.mhpa.org/_upload/201501StateofMedicaid2014.pdf* .