Bulletin of
Health Policy and Law

Managed Care and Medicaid: Ensuring Quality and Access to Care

Luis G. Bautista, MD

Abstract: *For-profit Managed Care Organizations (MCOs) have become the overwhelmingly dominant insurer for Medicaid beneficiaries. As healthcare reform sets in motion, MCOs will play a vital role in providing medical coverage to millions of newly insured Medicaid patients. MCOs will likely save our nation millions of dollars. However, for-profit MCOs may result in lower quality of care. By mid 2013, quality-reporting requirements for insurers will be implemented by the federal government. Access to care for Medicaid patients is already a problem, which may become exacerbated by the MCO-Medicaid expansion.*

Keywords: healthcare reform; managed care organizations; quality of care

Introduction

Like the baby-boomer generation, traditional fee-for-service Medicaid has reached retirement age, and is no longer the dominant model for Medicaid. MCOs have taken over health care delivery for Medicaid beneficiaries. Managed care is currently the most common Medicaid contract used nationwide. By 2008, about 70 percent of all Medicaid enrollees were in MCO-Medicaid plans.[1] This is a jump from 40 percent in 1996 and 60 percent 2004.[2] Initially, these plans included a mix of Medicaid and privately insured patients.[3] Today, most MCO-Medicaid plans either primarily, or exclusively, serve Medicaid enrollees.[4] Thus, Medicaid has been deeply penetrated by private insurance companies, who contract with individual counties or states to administer the Medicaid system.

The Affordable Care Act (ACA) is expected to generate over 32 million newly insured people.[5] Health reform aims to reduce our uninsured by a dramatic expansion of the Medicaid system. This expansion is expected to absorb half of our currently uninsured population.[6] Additionally, Medicaid provides affordable care to millions of low-income Medicare beneficiaries, known as "dual eligibles," assisting them with long-term care and entitlements that Medicare does not fund.[7] Thus, MCOs are expected to become the primary delivery system for the Medicaid expansion under the ACA and along with the aging baby-boomer generation.[8]

In our current economic environment, state officials are looking for ways to save money. Contracting with private managed care firms will likely save millions of state government dollars.[9] The potential financial savings from managed care are substantial, and perhaps the primary motive for a move to the MCO model. However, the effect of low-cost MCO plans on the quality and access to healthcare is not clear.[10]

Issue: Managed Care Medicaid and Ensuring Quality Accessible Care

Quality of Care

Managed Care Organizations contract with Medicaid in the following two ways: publicly traded for-profit MCOs, and nonprofit MCOs that are not publicly traded. The Commonwealth Fund has recently reported publicly traded MCOs paid out the lowest percentage of Medicaid premium revenues, compared to non-traded MCOs.[11] This might indicate that for-profit plans are more driven to be economically viable. However, for-profit plans also received lower scores for quality of care metrics related to preventive care, treatment of chronic conditions, access to care, and customer service.[12] Additionally, for-profit MCOs were found to report larger administrative costs than nonprofit MCOs.[13] For-profit MCOs have consistently outbid nonprofit groups for Medicaid contracts.[14] Policymakers have questioned the long-term commitment of these for-profit companies, as they inherently receive shareholder pressure to increase enrollment and earnings at the expense of providing high-quality care.[15] Under the ACA, it is expected that for-profit MCOs will enroll the majority of new Medicaid beneficiaries.[16]

Clinical quality measures of preventive care and chronic illness care are much better for patients enrolled in nonprofit MCOs.[17] Similarly, customer care was reported to be significantly better in nonprofit MCOs. Plans with higher administrative costs, and lower medical costs have the lowest performance measures of clinical quality and patient experience.[18]

The ACA will require quality of care reporting by health insurers. The Secretary of Health and Human Services (HHS) is expected to

release guidelines and requirements for quality reporting.[19] Thus, soon we may assess more definitely on how different MCOs compare. Depending on the results, we may need to consider revitalizing the nonprofit MCO sector.

Access to Care

Physician participation and access to care may be affected by the Medicaid transition to MCOs.[20] Statutory federal law mandates adequate access. The equal access clause of the Medicaid Act provides that Medicaid rates should be "consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers so that such care and services are available...at least to the extent that such care and services are available to the general population in the geographic area."[21] Federal enforcement of this clause has been minimal. The federal government has never issued nor enforced any detailed compliance standards. However, this may change with implementation of the expected HHS quality reporting requirements.

Access to care is a major problem for Medicaid patients in most states.[22] Shortages and inadequacies in the distribution of certain specialties, and the overall low presence of physicians located in poor communities, create time, distance, and cost barriers for access.[23] To meet the demands of newly MCO-Medicaid insured patients, we will need an ample supply of Medicaid accepting doctors. Unfortunately, physician participation in Medicaid has consistently declined over the last several decades.[24] Low reimbursement rates and administrative burdens are the primary reasons why physicians reject Medicaid.[25] These burdens include; payment delays, rejection of claims, eligibility verification, preauthorization for services, and complex regulations.[26]

The MCO-Medicaid model pays its providers by capitated rates. So, low traditional fee-for-service reimbursement rates may not apply under the MCO model. Logically, reducing other types of administrative burdens may help boost physician participation. Over the last decade physicians who participate in Medicaid have become concentrated in large medical groups, hospitals, academic medical centers, and community health centers.[27] As these providers optimistically grow to absorb our nations newly insured, problems with access to care will likely exacerbate.

Conclusion

Managed Care Organizations and Medicaid will become consequential actors in expanding our nations health insured population. Controlling costs is a major problem that we must accomplish. However, low-priced healthcare may affect the quality and access to care for our Medicaid beneficiaries. Therefore, we need to ensure for-profit MCOs adhere to quality metrics as mandated by HHS. Further, we must promote policies that reduce administrative burdens to participating providers as a means to ensure adequate access to care.

Competing Interests: None reported

Author(s)

Luis G. Bautista, MD, is a third year law student at California Western School of Law and member of the Health Law Society. Dr. Bautista received his undergraduate degree in Biology with a minor in Chemistry from the University of San Diego, and his MD degree from New York Medical College. He serves as a primary care physician for the United States Navy and Marine Corps.

References (Bluebook)

[1] *Medicaid and the Uninsured: A Primer*, The Henry J. Kaiser Fam. Found. (June 2010), *available at* http://www.kff.org/medicaid/upload/7334-04.pdf (last visited Nov. 8, 2012).

[2] Cunningham, Peter, and May, Jessica, *Medicaid Patients Increasingly Concentrated Among Physicians*, CTR. FOR STUDYING HEALTH SYS. CHANGE, 4 (Aug. 2006), *available at* http://www.hschange.com/CONTENT/866/866.pdf (last visited Nov. 6, 2012), at 4.

[3] *Id*.

[4] *Id*.

[5] *Advancing Primary Care,* COUNCIL ON GRADUATE Med. Educ., 3 (2010), *available at* http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf.(last visited Nov. 6, 2012).

[6] *Medicaid and the Uninsured: A Primer*, *supra* note 1, at 31.

[7] *Id*. at 8.

[8] *See* Iglehart, John K., *Desparately Seeking Savings: States Shift More Medicaid Enrollees To Managed Care,* HEALTH AFFAIRS, 30, 1627 (2011), *available at* http://content.healthaffairs.org/content/30/9/1627.full.html (last visited Nov. 6, 2012).

[9] *Id*.

[10] *See* Minott, J, *Does Medicaid Managed Care Market Penetration Impact Provider Participation, Costs, Utilization, and Access?* HCFO FINDINGS BRIEF VOL. 13

NO. 5 (September 2010), *available at* http://www.academyhealth.org/files/HCFO/HCFOSeptemberFindingsBrief2010.pdf (last visited Nov. 7, 2012).
[11] McCue, Michael J., and Bailit, Michael H., *Assessing the Financial Health of Medicaid Managed Care Plans and the Quality of Patient Care They Provide,* THE COMMONWEALTH FUND, 9, 11 (2011), *available at* http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/Jun/Financial-Health-Medicaid-Managed-Care.aspx.
[12] *Id*. at 10.
[13] *Id*. at 9.
[14] *Id*. at 2.
[15] *Id*.
[16] *Id*. at 9.
[17] Id. at 10.
[18] *Id*.
[19] Patient Protection and Affordable Care Act, 42 U.S.C. § 2717 (2010).
[20] Minott, *supra* note 10.
[21] Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A) (2010).
[22] *Medicaid and the Uninsured: A Primer, supra* note 1, at 20.
[23] *Id*.
[24] *See* Jessie L. Tucker III, *Factors Influencing Physician Participation in Medicaid in the USA*, INT'L JOURNAL OF SOC. ECON. 29, 753 (2002).
[25] *See* Cunningham, Peter, and O'Malley, Ann S., *Do Reimbursement Delays Discourage Medicaid Participation By Physicians?,* HEALTH AFFAIRS 28, 1 (2009).
[26] *Id*. at 18.
[27] *See* Cunningham, Peter, and May, Jessica, *Medicaid Patients Increasingly Concentrated Among Physicians*, CTR. FOR STUDYING HEALTH SYS. CHANGE (Aug. 2006), *available at* http://www.hschange.com/CONTENT/866/866.pdf (last visited Nov. 6, 2012).

e-ISSN: 2168-6513