
Health Reform, Year Seven: Observations About Medicaid Managed Care

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Over the last 7 years, State and Federal policymakers have reformed State medical assistance programs and, in the process, have grappled with goals of both containing program costs and expanding health insurance coverage to the uninsured. Currently, nearly one-quarter of all States have implemented health care reform demonstrations, and this article summarizes trends seen since health care reform began in the 1990s. As well as noting the accomplishments of health care reform through the use of Medicaid managed care, the article speculates, based on recent evidence, about new directions health care reform may take in the future.

INTRODUCTION

Shortly after taking office, President Clinton committed to the Nation's governors that his Administration would work closely with States to test innovative concepts and programs within existing health and welfare demonstration authorities. By August 1993, several policy principles were articulated and were later published in the *Federal Register* (1994). Among the Administration's commitments were: a streamlined process for demonstration waivers pursuant to Section 1115 of the Social Security Act (the act); a willingness to test a broad variety of policy alternatives; and a granting of waivers of provisions of the act for a sufficient duration to test the

success of new policy approaches (typically 5 years for statewide health care reform demonstrations). Where appropriate, the Department of Health and Human Services (DHHS) was also committed to seeking statutory changes in recognition of successful aspects of State programs.

Since that time, nearly one-quarter of all the States have sought authority under the auspices of section 1115 to implement reform efforts. While the overarching goals of these States have varied—including cost containment, Medicaid coverage expansions to previously ineligible individuals and, most often, a combination of both—it is important to note at the outset that State health care reform efforts have always, to some degree, been tied to managed care. In every large-scale health care reform demonstration approved by HCFA, managed care has been a mechanism to find savings to redirect in State health care systems.

The Balanced Budget Act (BBA) of 1997 provided a streamlined process for extending health care reform demonstrations for 3 additional years. Most States with approved health care reform demonstrations have opted to avail themselves of this process, which allowed them to keep current managed care contracting arrangements—and other significant changes to their health care delivery systems—in place. As of this writing, several States are in year two of this 3-year extension period, which provides a useful vantage point to summarize existing reform efforts, and make some suppositions regarding future trends in State

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demonstration programs. Managed care, as implemented through other authorities, will be considered as well.

MANAGED CARE AUTHORITIES

There are currently three options that States may use to implement mandatory managed care programs. These are the authorities found in sections 1915(b), 1115, and 1932(a) of the act. Both section 1915(b) program waivers and section 1115 research and demonstration waivers allow States exemption from certain statutory requirements. These waiver authorities, delegated by the Secretary of DHHS to HCFA, allow States to pursue programmatic options not available under the State plan amendment process. A significant recent development stemming from BBA is a State plan amendment (SPA) process under section 1932(a), which allows States to implement a significant programmatic feature—mandatory enrollment in managed care—without waiver or demonstration authority.

Waiver and Demonstration Authority

Section 1915(b) waivers—also known as Freedom of Choice waivers—allow States to pursue greater use of managed care delivery systems for Medicaid beneficiaries. Since these waivers are limited to section 1902 provisions of the act, they are more limited in scope and flexibility than 1115 waivers. Specifically, section 1915(b) waivers cannot be used to allow States to: cover nontraditional Medicaid populations; modify Medicaid benefits and cost sharing; restrict access to certain provider types; pay some provider types, such as federally-qualified health centers at rates other than those required by the act; or cover services provided by managed care organizations which do not comply with the requirements of section 1903(m).

Under section 1115, the Secretary of DHHS is granted much broader authority and may waive many of the requirements that are not waivable under section 1915(b). Section 1115 requires that any waiver given under its authority for research and demonstration purposes “...assist in promoting the objectives of the Medicaid statute,” as determined by the Secretary. States have used this authority to implement mandatory managed care, while simultaneously implementing the other types of reforms previously noted.

State Plan Amendment Authority

Before the BBA, States could not implement mandatory managed care without approval of a section 1915(b) waiver program or a section 1115 demonstration project. The BBA added a process (1932(a) of the act) through which States may implement mandatory managed care under the SPA process. There is no requirement that such programs demonstrate cost effectiveness or budget neutrality, requirements for 1915(b) waivers and 1115 demonstrations, respectively. While this aspect of section 1932(a) would appear advantageous to State policymakers, there are statutorily-defined restrictions regarding which populations may be included in mandatory managed care (for example, there are prohibitions on including children with special health care needs, dual eligibles, and Native Americans). To date, 10 SPAs have been approved to implement mandatory managed care. The restrictions on populations that may be included—in addition to the familiarity States have with waiver and demonstration programs—likely means that States will not, for the most part, be attempting to transition waiver and demonstration programs into ones authorized by a SPA.

OBSERVATIONS

As some of these demonstrations have now been operational for as long as 7 years in some cases, it is clear that two significant observations may be made about the evolution of Medicaid managed care and the use of section 1115 authority: the focus on large-scale coverage expansions has decreased; at the same time, the interest in tailoring State managed care programs to meet the needs of higher-cost, higher-use populations has increased.

Coverage Expansions

Despite the addition of the 1932(a) SPA process, it is clear that demonstration and waiver authorities continue to be central to State strategies for health care reform. However, it is clear that over time, the nature of State proposals under section 1115 has shifted away from large-scale expansions in coverage and has come to focus increasingly on using managed care while altering payment arrangements or limiting access to certain providers. Furthermore, the expansions that States do propose tend to be linked in some way to Title XXI of the Act, the State Children's Health Insurance Program (SCHIP).

Of the first six demonstrations awarded in the early 1990s, all included significant expansions to groups that previously had not been eligible for Medicaid. Oregon (1993), Hawaii (1993), Kentucky (1993), Rhode Island (1993), Tennessee (1993), and Florida (1994) proposed to expand Medicaid coverage to higher income levels, in some cases adding the uninsured up to 300 percent of the federal poverty level. However, while the Florida and Kentucky demonstrations were never implemented as approved, the uniformity of the States' approach is clear: managed care and new payment arrangements for certain

providers are used as a means to find savings to expand health care coverage. The number of additional individuals expected to be covered under these original health care reform efforts was roughly 1.7 million (Rotwein et al., 1995).

The mid- and late-1990s still saw some emphasis placed on expanding coverage. Yet, contrasted with the first 6 demonstrations approved, those that followed expanded coverage in 10 cases out of 15. Perhaps significantly, one of the non-expansion States was a revised proposal that eliminated a previously approved coverage expansion (Kentucky). Also, among those States that did expand coverage, one expansion (New Mexico) was financed entirely with funds from a separate title of the Act—Title XXI—not from savings within Title XIX; it used 1115 authority only to implement an alternative cost-sharing structure. Two other States (Missouri and Wisconsin) have implemented Medicaid expansions for adults, but only in concert with related expansions for children under Title XXI. Factoring out these 3 States, it is noted that only 7 out of the remaining 12 represented the type of coverage expansions seen with the earlier demonstrations.

Thus, it is reasonable to conclude from these data that States are no longer as focused on using section 1115 demonstration authority under Title XIX for significant coverage expansions. As we have seen, comparatively fewer new demonstrations seek to expand coverage; among those that do, they link adult expansions done with 1115 demonstration authority to children covered under Title XXI. These developments support the contention that since the inception of SCHIP in the 1997 BBA, the focus of health care expansions in States shifted to children. Aside from programmatic flexibility, Title XXI offers States an enhanced Federal matching rate for covering low-income children previously cov-

erable only under section 1115 authority. Thus, one can theorize that many future adult expansions using section 1115 demonstration authority will typically be linked to child expansions under SCHIP.

Special Populations, Capitated Programs, and Coverage Expansions

Over the course of the 1990s, States have also moved to incorporate higher-cost, higher-use populations into Medicaid managed care. Generally speaking, States first concentrated upon enrolling individuals eligible for Medicaid by virtue of being eligible for Aid to Families with Dependent Children—or later Temporary Assistance for Needy Families (TANF)—into managed care, whether this enrollment was through waiver or demonstration authority. In recent years, the enrollment into Medicaid managed care of higher-cost, higher-use populations comprised of individuals with more complex medical conditions has been another discernable trend. It is, however, important to remember that while either sections 1115 or 1915(b) authority may be used to enroll higher-cost populations into managed care, the broad scope of section 1115 authority also allows States to expand health insurance coverage to such individuals without reference to the type of delivery system to be used. In recent years, HCFA has observed that both types of State initiatives have become more commonplace.

SSI—Enrollment in Managed Care

One Medicaid-eligible population of significant size, made up of those individuals eligible for Supplemental Security Income (SSI), was traditionally carved out of Medicaid managed care under waiver and demonstration authorities. SSI-eligible adults have functional impairments that

prevent them from gainful employment; SSI-eligible children have an impairment or combination of impairments that are considered disabling if it causes marked and severe functional limitations (Social Security Administration, 1997). Given these factors, SSI eligibility is a reasonable indicator of higher—or perhaps less predictable—need for medical services than the TANF population.

Currently, many within the SSI population are included in State Medicaid managed care initiatives. By 1998, nearly 75percent of the States were using either section 1915(b) or section 1115 waiver authority to enroll at least some Medicaid/SSI beneficiaries into Medicaid managed care. The number of individuals served by these programs, 1.6 million, represents nearly one-fourth of Medicaid's non-elderly disabled beneficiaries (Regenstein and Schroer, 1998) and may be expected to climb.

Dually-Entitled—Services in the Community

States are also increasing focus on the frail elderly, many of whom are entitled to both Medicare and Medicaid. The Consolidated Omnibus Budget Reconciliation Act of 1985, authorized the original Program of All-Inclusive Care for the Elderly (PACE) section 1115 demonstration waiver for On Lok Senior Health Services, which served the elderly in San Francisco's Chinatown. Later, the Omnibus Budget Reconciliation Act of 1986 authorized HCFA to conduct a PACE demonstration project to determine whether the model of care developed by On Lok could be replicated across the country.

Most recently, the BBA authorized coverage of PACE under the Medicare program and as a State option under Medicaid. PACE is a prepaid, capitated plan that provides comprehensive health care services

to frail, older adults in the community, who are eligible for nursing home care according to State standards. Services are furnished through an adult day health center, which is staffed and equipped to provide multidisciplinary care, at participants' homes, and at inpatient facilities if warranted by the participant's medical condition. The movement of PACE from demonstration to program status and the widespread State interest that has been expressed in the State option, signals an increased focus on reforming the health care delivery systems that serve the frail elderly.

HIV/AIDS—Coverage Expansion

In addition to initiatives focused on the SSI population and the dually entitled, another trend in 1115 demonstrations has been to use this authority to cover individuals with complex conditions in a fee-for-service environment. For example, in February 2000, Maine received approval to implement a demonstration for individuals living with HIV and/or AIDS up to 300 percent of the FPL. The goal of this demonstration is to increase access to highly active retroviral therapy treatment that can delay the onset of disabling illnesses for this population. HCFA anticipates that other States may attempt to replicate such an approach for this population, whether through stand-alone proposals or through amendments to existing demonstrations.

MEDICAID REFORM AND THE FUTURE

Clearly, the Medicaid program continues to evolve as we move into the next century. The 1990s witnessed a significant attempt on the part of States and HCFA to reform this

large public insurance program: waiver and demonstration authority would permit the use of managed care and the restructuring of payments to certain providers, and in turn States could expand coverage to the previously uninsured. Currently, it is estimated that over 1 million people have health insurance through these reform efforts that they would otherwise not have.¹ As previously noted, however, over the course of the 1990s, expansions in coverage using demonstration authority decreased, due to the focus on children and enhanced Federal matching funds brought about by the SCHIP program. Accordingly, there is reason to conclude that the new directions taken in State health care reform, using section 1115 authority, will be parent expansions related to child expansions under SCHIP, or will be attempts to either extend fee-for-service or managed care health insurance coverage to additional special populations while addressing their unique health care needs.

What these new directions demonstrate is that State efforts will continue to have a critical role to play in determining the future course of health care policy. Past State efforts to expand health care coverage to additional low-income individuals have made a significant difference to over 1 million individuals previously lacking this coverage. At the same time, we can observe that, as States have adapted to changing conditions, they are sustaining the health care reform agenda by focusing on innovative programs that expand coverage for high-cost populations, integrate services for them more fully, or both; these efforts are in addition to those to expand health care coverage for children.

¹This number excludes the cases of Missouri, New Mexico, and Wisconsin for reasons discussed earlier. The disparity between this number and the 1.7 million that were anticipated to be covered under the first six demonstrations is in large part due to the fact that Florida Health Security (capped enrollment at 1.1 million) was never implemented.

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