Medicaid Managed Care: An Overview and Key Issues for Congress

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Summary

In terms of federal spending, Medicaid is one of the largest major domestic entitlement programs in the U.S. today. During the 1980s and 1990s, steadily rising Medicaid costs were attributed to the economic incentive to provide more care under the traditional, widespread fee-for-service (FFS) delivery system in which provider payments are made for each unit of service delivered. During that time, following the lead in the employer health insurance market, many states began to turn to managed care for their Medicaid programs. The goal, then and today, is both to rein in Medicaid costs by making payments on a predetermined, per-person-per-month (PMPM) basis rather than for each unit of service rendered, and to provide a better, coordinated system of care for beneficiaries, with an emphasis on preventive and primary care services.

The reality of service delivery under Medicaid is gradually moving along this path. In terms of beneficiary participation, managed care is the dominant delivery system in Medicaid. Based on data from FY2003 (the latest available for all states), Medicaid managed care is widely used by children and adults, but less so among the elderly and those with disabilities. However, there is still significant penetration of managed care in these latter populations with special health care needs.

In terms of expenditures, the FFS delivery system still dominates Medicaid spending, largely because more expensive long-term care services available under Medicaid are seldom offered through managed care arrangements. Also, many users of long-term care services, the elderly and those with disabilities, are not enrolled in managed care programs. One of the next big challenges for Medicaid managed care is to develop and evaluate managed long-term care and holistic integration of primary, acute, and long-term care for special needs populations.

This report provides an overview of Medicaid managed care. It includes a discussion of the major features of both the managed care and the traditional fee-for-service delivery systems in Medicaid. The report also provides a series of tables that illustrate the distribution of people, services, and dollars across both systems of care. It concludes with a summary of some of the current policy issues facing Medicaid managed care, and a list of additional CRS resources. This report will be updated as legislative activity warrants.

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Introduction

In existence since 1965, Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services, as well as long-term care, to nearly 60 million people at an estimated cost to the federal and state governments of roughly $333 billion in FY2006,[1] making it as large as Medicare, the federal health care program for the elderly and certain individuals with disabilities. Among major domestic entitlement programs, only Social Security costs more.

Each state designs and administers its own Medicaid program under broad federal guidelines. For states, it is the second largest spending item after education. Medicaid is expected to represent 2.5% of GDP in FY2006.[2] The expenditure growth is even more striking. Program spending increased by more than 49% between 2000 and 2005, exceeding growth in general and medical inflation, and the rates of growth in spending for both Medicare and Social Security over the same period.[3] Medicaid spending has grown partly because medical care keeps getting more expensive, and because over time, federal law has been expanded significantly to cover more people and more benefits. Certain state financing mechanisms have also played a role in increased spending under Medicaid.

As Medicaid entered the 1980s and 1990s, more attention—and blame—for steadily rising Medicaid costs was attributed to the economic incentive to provide more care under the fee-for-service (FFS) delivery system, in which payments are made for each unit of service delivered. Under this system, Medicaid budgets were somewhat unpredictable, and outlays were significantly affected by the quantity and types of care provided. It was also unclear whether state Medicaid programs were getting good value for their ever increasing Medicaid dollars. Following the lead in the private sector among large employers, many states began to turn to managed care for their Medicaid programs. The goal, then and today, is both to rein in Medicaid costs by making payments on a predetermined, per-person-per-month basis, rather than for each unit of service delivered, and to provide a better, coordinated system of care for beneficiaries, with an emphasis on preventive and primary care services.

But Medicaid managed care has not fully achieved either goal yet. Data from FY2003 (most recent available) indicate that while about two-thirds of Medicaid beneficiaries nationwide participate in some form of managed care, the majority of expenditures still occur in the FFS setting, mainly because expensive long-term care services are rarely offered through managed care. In addition, while there are some data suggesting improvements in the quality of care delivered in Medicaid managed care, commercial (employer-based) and Medicare managed care plans continue to do better on some measures of effectiveness.

[1] Total expenditure estimate by CRS based on the *Fact Sheet for CBO's March 2006 Baseline*.

[2] Medicaid's percentage of the GDP estimated by CRS based on CBO data presented in http://www.cbo.gov/ftpdocs/70xx/doc7027/01-26-BudgetOutlook.pdf.

[3] Congressional Budget Office Analysis, *Monthly Budget Review*, Nov. 4, 2004, at http://www.cbo.gov/showdoc.cfm?index=6002&sequence=0.

Medicaid Eligibility and Covered Benefits

Before getting into the specifics of how care is delivered under Medicaid, it is important to understand who is eligible for the program and the range of benefits that may be covered.[4]

Eligibility

The Medicaid statute (Title XIX of the Social Security Act) defines more than 50 distinct population groups as being potentially eligible. Some eligibility groups are mandatory, meaning that all states must cover them; others are optional. To qualify for Medicaid coverage, applicants' income (e.g., wages, Social Security benefits) and often their resources or assets (e.g., value of a car, savings accounts) must meet program *financial requirements*. These requirements vary considerably among states, and different rules apply to different population groups within a state.

Medicaid eligibility is also subject to *categorical restrictions*—generally, it is available only to specific categories of people, including the elderly, persons with significant disabilities, members of families with dependent children, and certain other pregnant women and children. Other individuals (e.g., childless adults with no disability) are not eligible for Medicaid no matter how poor they are, unless they are covered under a special waiver. In recent years, Medicaid has been extended to additional groups with specific characteristics, including certain women with breast or cervical cancer and uninsured individuals with tuberculosis.

Standard Benefits

Medicaid benefits are identified in the federal statute and regulations as either mandatory or optional, and include a wide range of medical care, items and services. Examples of benefits that are *mandatory* for most Medicaid groups include (1) inpatient hospital services (excluding services for mental disease), (2) laboratory and x-ray services, (3) physician services, and (4) nursing facility services for persons age 21 and over. In addition to prescribed drugs that are offered by all states, other *optional* benefits covered by many states include for example: (1) routine dental care, (2) physician-directed clinic services (frequently for mental health care), (3) therapies (e.g., physical, occupational and speech), and (4) transportation (in order to receive medical care). In general, most Medicaid beneficiaries, whether covered via a mandatory or an optional eligibility group, are entitled to *all* the standard mandatory and optional benefits offered by a state Medicaid program.[5]

New Benefit Option

Under the recently enacted Deficit Reduction Act of 2005[6] (DRA; P.L. 109-171), as of March, 31, 2006, states may offer new packages of benefits to certain groups of Medicaid beneficiaries. This

[4] For more information on eligibility and benefits under Medicaid, see CRS Report RL33202, *Medicaid: A Primer*.

[5] Services provided through special program waivers are typically restricted to specific eligibility groups. Also, special benefit rules apply to groups classified as medically needy.

[6] For more information on the Medicaid provisions in DRA, see CRS Report RL33251, *Side-by-Side Comparison of Medicare, Medicaid, and SCHIP Provisions in the Deficit Reduction Act of 2005*.

new benefit option includes benchmark and benchmark-equivalent coverage that is nearly identical to the plans offered through the State Children's Health Insurance Program (SCHIP), with some additions. Nearly all states operate their SCHIP programs under managed care arrangements.

Under DRA, benchmark coverage includes the care and services available through: (1) the standard Blue Cross/Blue Shield preferred provider plan under the Federal Employees Health Benefits Plan (FEHBP), (2) health coverage for state employees, (3) health coverage offered by the largest commercial HMO in the state, and (4) Secretary-approved coverage, which may include any other package of benefits that the Secretary of Health and Human Services (HHS) determines will provide appropriate coverage for the targeted population. Benchmark-equivalent coverage must include certain services, and must have the same actuarial value as one of the benchmark plans, with at least 75% of the actuarial value for selected services.

A number of groups are explicitly exempted from mandatory enrollment in this new benefit option, including most individuals with special needs living in both the community and long-term care settings. Other groups can be required to enroll in the new benefit option, including most generally healthy children and certain adults (e.g., some parents and childless adults with no disability).

Key Concepts in Understanding How Care Is Delivered Under Medicaid

There are two major types of service delivery systems under Medicaid—fee-for-service and managed care. These two approaches to delivering services to Medicaid beneficiaries differ in important ways across several key dimensions, including:

- choice of providers for beneficiaries,
- how much professional management and coordination of medical care is provided,
- which entity has direct oversight responsibilities for service delivery,
- how states pay providers for services rendered, and
- assuring access to and quality of care.

In many cases, these two delivery systems are not entirely independent approaches to providing medical care under Medicaid. In a number of states, there are hybrid models that combine various features of fee-for-service and managed care for a given population or set of interrelated services. At a given point in time, beneficiaries may obtain all their services under a single system of care, or different sets of services under each system simultaneously (e.g., primary and acute care under managed care arrangements, and long-term care such as home health services or on-going rehabilitative services under the fee-for-service delivery system). Each of these features of delivery systems is described in more detail below.

Major Features of the Traditional Fee-for-Service Model

The fee-for-service (FFS) delivery system was the predominant system of care both within and outside of Medicaid until about the mid-1990s. Under FFS, beneficiaries have unrestricted provider choice; that is, they can seek services from any Medicaid participating provider. Hence, beneficiaries are largely responsible for their own medical care management and coordination.

The term "fee-for-service" evolved as a short-hand way to describe the method used to reimburse providers for services rendered. For Medicaid, payment rates for each type of service are set by the state within broad federal guidelines. The state directly (or through a fiscal intermediary) pays each participating provider for each covered service received by a Medicaid beneficiary. That is, each individual service rendered is paid a specified amount or rate. In essence, there is a one-to-one correspondence or "match" between payments and the quantity and types of care actually delivered.

Major Features of Medicaid Managed Care Models

Until the late 1990s, states had to obtain waivers of certain Medicaid rules to require that Medicaid beneficiaries get their services through managed care. For example, authority provided by Section 1915(b) of the Social Security Act was used by many states to waive the requirements that services be available statewide (so that managed care could be implemented in specific sub-state regions), and that beneficiaries have freedom of choice among all Medicaid providers (so that managed care enrollees could be required to receive certain services from a specified subset of managed care providers). Section 1115 of the Social Security Act provides additional flexibility to test benefit package and service delivery innovations. This authority has also been used to implement managed care demonstrations. In FY1998, nearly all states had at least one such waiver for some population subgroups or regions.[7]

The Balanced Budget Act of 1997 (BBA-97; P.L. 105-33) eliminated the need for waivers that many states complained were unnecessarily complex and time-consuming. BBA-97 also included managed care provisions that established standards for quality and solvency, and provided additional protections for beneficiaries (described below).

Plan Types and Benefits

Under Medicaid managed care, beneficiaries choose (or are assigned to) a primary plan as a "medical home." In turn, these plans provide care coordination and management. State Medicaid agencies must contract with at least two plans, or may offer one plan with a choice of at least two plan providers.

Comprehensive, traditional plans like health maintenance organizations (HMOs) make available to enrolled beneficiaries a broad range of preventive, primary and acute care services. Under primary care case management (PCCM) plans, primary care physicians provide basic medical care, and serve as case managers or gate-keepers (via referrals) to specialty care (e.g., mental health services, dental care). Such specialty care may be provided by another managed care entity

[7] Department of Health and Human Services, Health Care Financing Administration, *A Profile of Medicaid: Chartbook 2000*, Figures 3.5 and 3.6.

that offers only specialty care, called prepaid health plans (PHPs), or by providers in the FFS delivery system. PHPs may be limited to certain ambulatory services (prepaid ambulatory health plans or PAHPs) or specific types of inpatient care (prepaid inpatient health plans or PIHPs). A beneficiary's choice of provider under managed care is restricted; that is, beneficiaries must seek care for specified services from a specified list of plan providers.

Between 1990 and 2002, states increased their use of comprehensive managed care contractors with primarily public enrollment (i.e., more than one-half of the plan's enrollment was made up of Medicaid, Medicare and SCHIP enrollees) and decreased the use of such plans serving a primarily commercial population (i.e., one-half or less of the plan's enrollment was comprised of Medicaid, Medicare and SCHIP beneficiaries).[8] As of June of 2004, data from CMS show that despite these trends, nationwide, commercial MCOs outnumbered Medicaid-only MCOs (156 versus 131), and more Medicaid beneficiaries were enrolled in commercial plans than Medicaid-only plans (9.7 million versus 7.8 million).[9]

Payment Methods

Paying for services under most Medicaid managed care arrangements is significantly different from methods used under the FFS delivery system.

Traditional managed care plans, such as HMOs, agree to make available a specified set of services for which the State Medicaid Agency pays a fee on a "per member per month" (PMPM) basis, called a premium or capitation rate. These rates typically reflect the average FFS cost of providing care to specified groups (or subgroups) of beneficiaries expected to enroll in the plan. Such premiums are paid each month, *regardless* of the quantity or types of contracted care actually rendered to enrolled beneficiaries. Because the PMPM rates and the number and type of beneficiaries to be enrolled are generally known in advance, managed care expenditures, for both the plans and the State Medicaid Agency, are more predictable than FFS payments and budgets can be set accordingly. PHPs also involve capitated payments, but for limited benefit packages (e.g., inpatient substance abuse treatment, dental care, transportation).

Traditional managed care plans and PHPs must actively "manage" care for plan beneficiaries to control their financial risk. Such plans face a financial loss if more care is rendered than the agreed upon capitation rate accommodates. Conversely, if less care is rendered than is assumed in the premium, the plan will experience a financial gain. Overall, the economic incentive is to deliver less care or less costly care, so long as beneficiary health is not compromised as a result. That incentive may be passed on to contracted medical providers, such as physicians and hospitals, via what is sometimes called sub-capitation (i.e., when plans pay their contracted

[8] N. Kaye, *Medicaid Managed Care: Looking Forward, Looking Back*, National Academy for State Health Policy, June 2005, pages 39 - 40. Hereafter referred to as N. Kaye, 2005.

[9] Centers for Medicare and Medicaid Services, *2004 Medicaid Managed Care Enrollment Report*, table entitled "National Breakout of Managed Care Entities and Enrollment as of June 30, 2004." A commercial MCO is defined as any managed care entity meeting the managed care requirements in Medicaid statute that provides comprehensive services to both Medicaid and commercial and/or Medicare beneficiaries. A Medicaid-only MCO provides comprehensive services to only Medicaid beneficiaries, not to commercial or Medicare enrollees. Beneficiary counts are duplicated, meaning some individuals may be counted more than once if they were enrolled in more than one managed care plan. Because a different reporting system is used here, these data may also differ from analyses based on the Medicaid Person Summary File used elsewhere in this report.

providers a capitation rate for all or a selected subset of services) or via other kinds of financial rewards/penalties for performance.

In contrast, the payment methods under the PCCM model are a blend of both FFS and traditional managed care. The majority of expenditures associated with PCCM programs are FFS payments.[10] The case manager (i.e., an internist or pediatrician) is paid a small, pre-set monthly fee (e.g., $2 to $3) per enrolled beneficiary to handle coordination of, and referral for, other services, particularly specialty care. In addition, the case manager is typically paid on a FFS basis for direct delivery of basic primary care to his/her enrolled beneficiaries, as are the medical specialists to whom a referral is made.

The PCCM model of managed care has sometimes served as a first step toward more traditional models of managed care such as HMOs. In addition, PCCM programs have been implemented in rural areas where no traditional managed care plans operate, given few potential beneficiaries. PCCM programs may also be used for populations that frequently need a broad range of specialty care services (e.g., individuals with disabilities).

Oversight Responsibilities Under the Medicaid Managed Care and Fee-for-Service Delivery Systems

Under managed care, oversight responsibilities are shared among the State Medicaid Agency, the managed care plans, and the plan providers. The State Medicaid Agency has direct oversight of its contracted managed care plans, and establishes payment rates for these entities, as well as the parameters governing the amount, duration and scope of benefits covered in these contracts, in accordance with federal and state requirements. Similarly, the managed care plans have direct oversight of the plan providers. These plans set medical care and referral policies, in accordance with the contractual agreement negotiated with the State Medicaid Agency. The plans also determine payment methods and rates for plan providers. The providers deliver or prescribe medically necessary care to plan beneficiaries within the guidelines specified by the managed care plan. The specific details of a given state/plan/provider arrangement may vary from this generic scenario. Also, State Medicaid Agencies typically directly oversee PCCM programs as well, although some states contract with administrative service organizations (ASOs) to help administer these programs.[11]

Under the FFS delivery system, there is no plan "middle man." Generally, the State Medicaid Agency deals directly with all Medicaid participating providers statewide, in terms of both medical care policies (e.g., amount, duration and scope of covered benefits) and setting payment methods and rates specific to different types of providers (e.g., hospitals versus physicians versus physical therapists).

[10] See N. Kaye, 2005, pages 60 - 61.

[11] See N. Kaye, 2005, pages 88 - 89.

Access to and Quality of Care Under Medicaid Managed Care and the Fee-for-Service Delivery Systems

There are several requirements in federal statute to assure access to and quality of care under both the Medicaid FFS and managed care delivery systems. Some of these requirements are very general and broad, while others, particularly for nursing facilities, are detailed and specific. Examples of such assurances include the following:

- Services must be provided in a manner consistent with simplicity of administration and in the best interest of the recipients (Section 1902(a)(19));
- States must assure that payments are consistent with efficiency, economy, and quality of care, and are sufficient to enlist enough providers so that care is available at least to the same extent that such services are available to the general population in the geographic area (Section 1902(a)(30)(A));
- A medical evaluation and a written plan of care is required for certain people and services (Section 1902(a)(26)); and
- States must regularly survey and certify nursing facilities to ensure that such care meets certain standards for staffing and service delivery, as well as to assure that resident rights are protected (Section 1919).

When BBA-97 was passed, there was a lot of concern that beneficiaries may be harmed under managed care without additional significant safeguards. Thus, there are many additional requirements for assuring access to and quality of managed care under Medicaid. For example, the federal statute includes provisions requiring plans to

- assure coverage of emergency services under managed care (Section 1932(b)(2));
- have a system in place to address grievances (Section 1932(b)(4));
- demonstrate adequate capacity and services (Section 1932(b)(5)); and
- meet a series of quality assurance standards (Section 1932(c)).

Who Receives What Services at What Costs by Delivery System

Enrollment Patterns[12]

Nationwide, enrollment in Medicaid managed care has increased considerably over time. In June of 1996, 40.1% of 33.2 million Medicaid enrollees, at that point in time, participated in some

[12] With respect to total Medicaid enrollment and enrollment in Medicaid managed care, this report cites different figures for different purposes. These differences are due to the year of analysis, the source or database used, and/or the methodology applied to count beneficiaries (e.g., ever enrolled during the year versus point-in-time estimates).

form of managed care. Eight years later, that proportion had increased to 60.7% among 44.4 million Medicaid eligibles enrolled in June of 2004.[13]

Counting the number of Medicaid beneficiaries enrolled in various forms of managed care is difficult for several reasons. Beneficiaries may receive managed care services under multiple arrangements within one year. For example, some individuals may be enrolled in a PCCM program for part of the year, then switch to an HMO for the remainder of the year. Other individuals may be enrolled in an HMO or PCCM program for their primary care and simultaneously receive specialty services from one or more PHPs (e.g., for mental health care and/or dental services). A variety of other scenarios are also possible. To obtain unduplicated counts of beneficiaries by type of managed care experience, we examined person-level patterns of payments using a special FY2003 Medicaid claims database provided to CRS by the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicaid program.

In descending order of frequency, among the roughly 52 million Medicaid beneficiaries nationwide that had any payments made on their behalf in FY2003:

- 64% (33.3 million individuals) had managed care expenditures,
- 22% (11.5 million beneficiaries) had managed care payments made for HMOs only,
- 18% (9.5 million people) had managed care expenditures for both HMOs and PHPs,
- 11% (5.9 million) had managed care payments for PCCMs only,
- 10% (5.0 million) had managed care expenditures for PHPs only, and
- 3% (1.6 million) had managed care payments for other combinations of the three types of managed care.

Table 1 provides national data on the unduplicated number and percentage of Medicaid beneficiaries by type of managed care payments and basis of eligibility for FY2003. Among the elderly, a little less than one-third had any managed care experience, and the predominant form of that care was PHPs only (about 19%). Slightly more than one-half of individuals with disabilities had managed care experience, mostly through PHPs only (17%) or both HMOs and PHPs (15%). Among children, nearly 80% had managed care experience, most with HMOs only (31%) or both HMOs and PHPs (22%). Finally, 61% of adults had managed care experience, and like children, most adults were enrolled in HMOs only (25%) or both HMOs and PHPs (21%).

Table 2 displays state-by-state data on the percentage of Medicaid beneficiaries by type of managed care experience. In eleven states,[14] roughly 85% or more of beneficiaries had managed care experience, and in eight of these eleven states (excluding South Dakota, Kentucky and Iowa), beneficiaries were primarily enrolled in HMOs and PHPs, or PHPs alone. With some

[13] Centers for Medicare and Medicaid Services, *2004 Medicaid Managed Care Enrollment Report*, table entitled "Managed Care Trends."

[14] These states include Arizona, Colorado, Delaware, Iowa, Kentucky, Michigan, Oregon, Pennsylvania, South Dakota, Tennessee, and Utah.

exceptions, among all remaining states with lower concentrations of beneficiaries with managed care experience, there was substantial enrollment in HMOs only or PCCMs only.

In order to provide more information on the types of Medicaid PHPs, a different data source was analyzed. **Tables 3 and 4** show additional detail on the types of PHPs available by state as of June, 2004. Prepaid Inpatient Health Plans (PIHPs; see **Table 3**) provide less than comprehensive services and deliver or arrange for inpatient hospital or institutional services. In June of 2004, there were 119 PIHPs in 18 states. The majority of such plans provided either mental health services only (63 plans with 3.2 million beneficiaries), or a combination of mental health and substance abuse services in an institutional setting (34 plans with 3.4 million beneficiaries). Prepaid Ambulatory Health Plans (PAHPs; see **Table 4**) provide less than comprehensive services and deliver or arrange for services outside of an institutional setting. In June of 2004, there were 34 PAHPs in 13 states. While half of these plans (17) were for dental services, most PAHP beneficiaries (2.4 million individuals) were enrolled in a PAHP providing transportation services.

Expenditure Patterns

Data limitations related to the PCCM experience hinder a fully accurate accounting of managed care versus fee-for-service spending patterns under Medicaid. The monthly fees paid to case managers for care management and coordination under PCCM programs are counted as managed care expenditures. However, the medical services delivered by case managers are paid on a FFS basis, as are the payments made for related specialty care received as a result of referrals by case managers. The available data do not provide a means to treat payments for PCCM-related primary and specialty care services as managed care expenditures. With these data caveats in mind, Medicaid expenditure patterns are summarized below.

Despite the fact that nearly two-thirds of Medicaid beneficiaries have experience with some form of managed care, expenditures for managed care services are dwarfed by benefit expenditures under the FFS delivery system. As shown in the bottom row of **Table 5**, in FY2003, total federal and state spending on Medicaid services reached $233.2 billion. The vast majority of service spending—nearly 84%—was for care provided under the FFS delivery system. A little over one-third of total benefit expenditures was for long-term care, including both institutional and non-institutional services. Prescription drugs, one of the fastest growing categories of expenditures, accounted for nearly 15% of total service spending. All other FFS care, mostly acute and primary care services (e.g., inpatient and outpatient hospital, physician services, clinic care), accounted for nearly one-third of total benefit expenditures.

Managed care accounted for just 16% of total Medicaid service expenditures in FY2003. As shown in **Table 5**, in Arizona, nearly 85% of all Medicaid benefit spending was for managed care. Unlike other states, Arizona has had a statewide managed care waiver in place since the beginning of its Medicaid program in 1982. In all remaining states, less than one-half of total service expenditures was made for managed care, and there was considerable variation across these states in the proportion of total service spending on managed care.

Table 6 provides additional detail on Medicaid benefit expenditures by type of managed care and state. HMO plans account for the bulk of Medicaid managed care expenditures in most states.

Expenditures for PHPs exceeded 20% of total managed care spending in twelve states.[15] Finally, in seven states,[16] all Medicaid managed care spending was for PCCM programs.

Table 7 provides details on national Medicaid benefit expenditures by delivery system and type of beneficiary. Expenditures under the FFS delivery system dominate service spending by basis of eligibility in FY2003. For the elderly and individuals with disabilities, 90 to 95% of all Medicaid benefit spending involved care in the FFS delivery system, and most of the expenditures for these two groups was for long-term care services. In addition, nearly 30% of benefit spending for persons with disabilities was for other FFS care, mostly acute and primary care services. (For the elderly, Medicare, not Medicaid, is the principal payor for primary and acute care services.) For adults and children, about two-thirds of total benefit expenditures occurred under the FFS delivery system, and much of that spending was for acute and primary care services (as shown in the all other FFS column of **Table 7**).

Total benefit expenditures by type of managed care and beneficiary for FY2003 are shown in **Table 8**. For each type of beneficiary, the majority of Medicaid managed care expenditures was for HMO plans. In addition, nearly 30% of managed care expenditures made on behalf of individuals with disabilities was for services delivered by PHPs.

Policy Issues for Medicaid Managed Care: Where do We Go From Here?

Nationally, most Medicaid beneficiaries participate in some form of managed care. However, benefit expenditures under Medicaid, especially for long-term care services, still largely occur in the FFS delivery system. State variation in the proportion of beneficiaries and expenditures associated with managed care is the rule rather than the exception. Such variation is likely due at least in part to political, geographic, and market considerations unique to each state.

States continue to redesign their Medicaid programs and experiment with managed care via waiver authority. In addition, states may rely on managed care delivery systems for the new Medicaid benefit package option now available through DRA (described above). Recent examples include new programs in Florida using Section 1115 waiver authority, and Idaho, Kentucky and West Virginia, all using the DRA benefit option. Whether via waiver or the DRA option, these new programs provide access to a different set of tailored benefits for different groups of beneficiaries, based on their anticipated health care needs, rather than giving all beneficiaries access to the full range of Medicaid services covered in each state.

Groups participating in these new programs include not only healthy children and adults, but in some cases, also the elderly and individuals with disabilities living in the community and those needing institutional care. Most programs will start off in a subset of counties. Some programs will allow beneficiaries to "opt out" of the new Medicaid benefit plans and enroll in employer-sponsored or private health insurance subject to capped payments (e.g., Florida, Kentucky) or remain in traditional Medicaid (e.g., Idaho). Incentives such as access to additional benefits or

[15] These 12 states include Alabama, Colorado, Iowa, Massachusetts, Michigan, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, and Wisconsin.

[16] These 7 states include Arkansas, Georgia, Idaho, Louisiana, Maine, Montana, and Vermont.

credits for purchasing other goods and services may be offered to encourage healthy behaviors (all four states). Access to enhanced benefits may be subject to certain conditions such as signing a member agreement to fully comply with recommended medical treatment and wellness behaviors (e.g., West Virginia). All four states expect to use managed care delivery systems in these new programs.

Although managed care under Medicaid holds the potential for providing coordination and management of a variety of medical and related health services for beneficiaries, that potential has been largely limited to sub-populations of generally healthy adults and children. Significant challenges still remain for serving the elderly and individuals with disabilities under traditional models of managed care, most likely because of the wide range and intensity of services they require to meet their on-going special health care needs. Relative to other services, long-term care is expensive and an individual's need for such care may change repeatedly over time. For states that want to save money on long-term care under Medicaid, these factors make setting adequate per-person-per-month payment rates difficult, in turn leading to an inability to attract managed care plans to this market. In addition, many mainstream managed care plans lack experience with both these special needs populations and with delivering long-term care services.

How successful has Medicaid managed care been in reducing program costs and providing beneficiaries with better, coordinated care? This report is not intended to provide a detailed review of this literature. However, there is some evidence that savings can be achieved through Medicaid managed care. For example, in one analysis synthesizing results from 14 studies, the Lewin Group[17] concluded that (1) comprehensive, prepaid managed care plan models typically yield cost-savings compared to program costs under a FFS model, (2) savings can be gained in programs that serve individuals with disabilities, and (3) although cost savings is largely attributable to decreases in inpatient utilization, some savings is also associated with moving prescribed drugs from the FFS setting into managed care.

There is also some evidence that Medicaid managed care plans are not as effective as employer-based or Medicare plans, but some improvements have been observed in recent years. For example, the National Committee for Quality Assurance (NCQA) regularly publishes reports for commercial (i.e., employer-based), Medicare and Medicaid managed care plans. **Table 9** shows a few examples of the 40+ measures voluntarily reported to NCQA by more than 500 health plans for 2005.[18] In general, higher percentages represent greater effectiveness of care and member satisfaction.

On the selected effectiveness of care measures for preventive services, acute medical care and mental health services, the ratings for commercial and Medicare plans exceed those for Medicaid plans. Nonetheless, very similar (high) ratings were observed for both Medicaid and commercial plans on two acute care measures—appropriate treatment for children with upper respiratory infection and persistence of beta-blocker treatment after a heart attack. All three types of plans struggled with antidepressant medication management, probably reflecting the challenges of helping persons with severe mental illness regardless of the public or private sector health care system involved. Member satisfaction measures were consistently high for Medicaid plans.

[17] The Lewin Group, *Medicaid Managed Care Cost Savings—A Synthesis of Fourteen Studies*, prepared for America's Health Insurance Plans, Final Report, July 2004.

[18] National Committee for Quality Assurance, *The State Of Health Care Quality, 2006, Industry Trends and Analysis*, Washington, DC, 2006 at http://www.ncqa.org/Communications/SOHC2006/SOHC_2006.pdf. The breakdown of the number of plans by type (i.e., Medicaid, commercial, Medicare) was not provided in this report.

NCQA noted that regional differences in plan performance are large as are variations within each plan type (e.g., among Medicaid plans). Thus, attaining high quality in managed care is an on-going, continuous process for Medicaid, commercial and Medicare plans.

Building on the reforms introduced in BBA-97, what additional role can Congress play with respect to managed care under Medicaid? For example, Congress could elect to expand the use of Medicaid managed care to address some of the issues identified in this report, in particular with respect to managed long-term care, and with holistic integration of primary, acute and long-term care for special needs populations. Congress could also choose to monitor and evaluate access to and quality of Medicaid managed care programs, as well as assess the short- and long-term costs and savings attributable to various forms of managed care for different sub-populations of Medicaid beneficiaries.

Other Related CRS Resources

CRS Report RL33495, *Integrating Medicare and Medicaid Services Through Managed Care*.

CRS Report RL33357, *Long-Term Care: Trends in Public and Private Spending*.

CRS Report RL32219, *Long-Term Care: Consumer-Directed Services Under Medicaid*.

CRS Report RL32977, *Dual Eligibles: A Review of Medicaid's Role in Providing Services and Assistance*.

Table 1. Number and Percentage of Medicaid Beneficiaries by Type of Managed Care Payments and Basis of Eligibility, FY2003

Basis of Eligibility	Total Beneficiaries	Any managed care	HMO only	HMO and PHP	PCCM only	PHP only	PCCM and HMO and/or PHP
Aged	4,041,004	31.9%	3.6%	7.3%	1.7%	18.8%	0.4%
Blind/Disabled	7,668,598	52.5%	8.1%	15.1%	9.2%	17.0%	3.2%
Children	24,831,407	79.3%	30.9%	22.1%	15.6%	6.3%	4.4%
Adults	11,691,859	61.4%	24.8%	20.6%	8.2%	5.8%	2.0%
Unknown	3,742,813	35.8%	4.5%	4.4%	8.9%	17.9%	0.2%
National Total	51,975,681	64.5%	22.1%	18.3%	11.4%	9.6%	3.1%

Source: CRS analysis of FY2003 Medicaid Person Summary File (provided by CMS).

Note: All percentages are based on unduplicated counts of beneficiaries in each row. Managed care includes health maintenance organizations (HMOs), prepaid health plans (PHPs), and primary care case management (PCCM) programs. Excludes the territories. Includes Medicaid-expansion State Children's Health Insurance Program (M-SCHIP) beneficiaries. A beneficiary is a Medicaid enrollee for whom at least one payment was made during the year.

Table 2. Number and Percentage of Medicaid Beneficiaries by Type of Managed Care Payments and State, FY2003

State	Number of Beneficiaries	Any managed care	HMO only	HMO and PHP	PCCM only	PHP only	PCCM and HMO and/or PHP
Alabama	780,616	70.0%	0.0%	0.0%	3.6%	13.3%	53.1%
Alaska	116,211	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Arizona	1,014,813	96.8%	7.4%	77.9%	0.0%	11.6%	0.0%
Arkansas	704,322	66.8%	0.0%	0.0%	66.8%	0.0%	0.0%
California	9,319,147	69.4%	5.3%	38.0%	0.0%	26.2%	0.0%
Colorado	459,209	92.0%	0.0%	31.4%	0.0%	41.6%	18.9%
Connecticut	496,679	72.4%	72.4%	0.0%	0.0%	0.0%	0.0%
Delaware	149,863	93.4%	0.2%	76.3%	0.0%	16.9%	0.0%
District of Columbia	158,179	67.3%	67.3%	0.0%	0.0%	0.0%	0.0%
Florida	2,743,368	74.5%	33.4%	0.0%	33.2%	0.0%	7.9%
Georgia	1,732,205	69.6%	0.0%	0.0%	69.6%	0.0%	0.0%
Hawaii	208,985	80.2%	73.5%	6.7%	0.0%	0.0%	0.0%
Idaho	193,301	68.8%	0.0%	0.0%	68.8%	0.0%	0.0%
Illinois	1,830,238	11.0%	9.4%	0.2%	0.0%	1.4%	0.0%
Indiana	895,972	76.7%	37.4%	0.0%	37.8%	0.0%	1.5%
Iowa	361,759	84.0%	0.0%	24.0%	0.6%	31.1%	28.3%
Kansas	316,410	70.1%	29.7%	0.0%	36.9%	0.0%	3.4%
Kentucky	847,942	93.3%	0.6%	17.7%	1.6%	20.6%	52.9%
Louisiana	995,362	58.8%	0.0%	0.0%	58.8%	0.0%	0.0%
Maine	307,278	53.0%	0.0%	0.0%	53.0%	0.0%	0.0%
Maryland	727,576	82.2%	82.2%	0.0%	0.0%	0.0%	0.0%
Massachusetts	1,042,122	63.9%	13.5%	2.5%	0.0%	47.9%	0.0%
Michigan	1,589,500	96.0%	0.2%	69.0%	0.0%	26.7%	0.0%
Minnesota	667,499	74.7%	74.7%	0.0%	0.0%	0.0%	0.0%
Mississippi	717,435	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Missouri	1,081,495	47.7%	47.7%	0.0%	0.0%	0.0%	0.0%
Montana	110,402	66.9%	0.0%	0.0%	66.9%	0.0%	0.0%
Nebraska	253,728	37.5%	16.5%	0.0%	20.1%	0.0%	1.0%
Nevada	220,416	56.4%	56.4%	0.0%	0.0%	0.0%	0.0%
New Hampshire	112,043	13.9%	13.9%	0.0%	0.0%	0.0%	0.0%
New Jersey	949,745	75.9%	71.5%	0.0%	0.0%	4.3%	0.0%
New Mexico	452,119	74.0%	74.0%	0.0%	0.0%	0.0%	0.0%
New York	4,449,951	54.5%	49.6%	0.6%	0.0%	4.3%	0.0%

State	Number of Beneficiaries	Any managed care	HMO only	HMO and PHP	PCCM only	PHP only	PCCM and HMO and/or PHP
North Carolina	1,416,932	72.6%	1.1%	0.0%	70.2%	0.0%	1.3%
North Dakota	76,753	58.8%	5.6%	0.0%	52.8%	0.0%	0.4%
Ohio	1,778,324	33.8%	33.8%	0.0%	0.0%	0.0%	0.0%
Oklahoma	625,875	80.0%	42.8%	1.4%	0.4%	34.9%	0.5%
Oregon	598,109	92.2%	4.1%	66.9%	0.1%	18.6%	2.5%
Pennsylvania	1,721,706	84.0%	5.4%	65.3%	10.2%	2.1%	1.1%
Rhode Island	201,874	71.2%	71.2%	0.0%	0.0%	0.0%	0.0%
South Carolina	861,216	11.6%	8.9%	0.1%	0.0%	2.7%	0.0%
South Dakota	123,589	96.7%	0.0%	0.0%	0.0%	49.5%	47.3%
Tennessee	1,729,588	94.5%	0.5%	93.5%	0.0%	0.5%	0.0%
Texas	3,339,796	48.3%	25.2%	6.6%	11.2%	2.0%	3.3%
Utah	285,369	84.6%	4.4%	47.6%	0.0%	32.6%	0.0%
Vermont	154,663	67.8%	0.0%	0.0%	67.8%	0.0%	0.0%
Virginia	709,488	69.1%	55.3%	0.0%	4.1%	0.0%	9.6%
Washington	1,077,069	59.7%	59.1%	0.0%	0.5%	0.0%	0.0%
West Virginia	373,153	53.5%	18.5%	0.0%	33.6%	0.0%	1.4%
Wisconsin	829,287	55.8%	54.3%	0.0%	0.0%	1.4%	0.0%
Wyoming	67,000	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
National Total	51,975,681	64.5%	22.1%	18.3%	11.4%	9.6%	3.1%

Source: CRS analysis of FY2003 Medicaid Person Summary File (provided by CMS).

Note: All percentages are based on unduplicated counts of beneficiaries in each row. Managed care includes health maintenance organizations (HMOs), prepaid health plans (PHPs), and primary care case management (PCCM) programs. Excludes the territories. Includes Medicaid-expansion State Children's Health Insurance Program (M-SCHIP) beneficiaries. A beneficiary is an Medicaid enrollee for whom at least one payment was made during the year.

Table 3. Number of and Enrollment in Prepaid Inpatient Health Plans (PIHPs) and Enrollment by Type and State, as of June 30, 2004

State	Medical Only		Mental Health Only		Mental Health and Substance Abuse Disorders		Long-Term Care	
	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees
Alabama	1	423,112						
Arizona					1	75,548		
Colorado	1	12,042	8	369,270				
District of Columbia	1	3,198						
Florida			2	95,287				
Georgia			1	2,235				
Hawaii			2	673				
Iowa					1	262,487		
Massachusetts					1	325,344		
Michigan			17	1,219,626	1	35,441		
New York							12	9,849
Oregon			10	291,480				
Pennsylvania	3	292			25	1,030,361		
Tennessee					2	1,345,131		
Texas					1	292,623		
Utah	3	63,850	9	174,302				
Washington			14	1,077,312				
Wisconsin					2	640	1	8,713
Totals	9	502,494	63	3,230,185	34	3,367,575	13	18,562

Source: Prepared by CRS, based on data from the *2004 Medicaid Managed Care Enrollment Report*, by the Centers for Medicare and Medicaid Services, available online at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/mmcer04.pdf. A PIHP provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services.

Table 4. Number of and Enrollment in Prepaid Ambulatory Health Plans (PAHPs) by Type and State, as of June 30, 2004

State	Medical - Only		Mental Health		Substance Use Disorders		Dental		Transportation		Disease Management	
	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees	Number of Plans	Number of Enrollees
Arkansas									1	386,395		
California	2	997					9	296,183				
Florida											4	88,698
Georgia									1	1,273,133		
Kentucky									1	625,807		
Mississippi											1	73,445
New York			1	6,725								
Oklahoma	1	348,538										
Oregon					1	8,084	7	295,411				
South Carolina	1	16,480										
South Dakota							1	95,577				
Utah									1	154,730		
Washington											2	129,110
Totals	4	366,015	1	6,725	1	8,084	17	687,171	4	2,440,065	7	291,253

Source: Prepared by CRS, based on data from the *2004 Medicaid Managed Care Enrollment Report* by the Centers for Medicare and Medicaid Services at http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/downloads/mmcer04.pdf. A PAHP provides less than comprehensive services on an at-risk or other than state plan reimbursement basis; and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services.

Table 5. Expenditures and Percentages by Delivery System and State, FY2003

States	Total Expenditures (In Millions)	Managed Care	Fee-For-Service				Unknown
			Total	Long-Term Care	Prescribed Drugs	All Other	
Alabama	3,471	18.8%	71.2%	31.2%	15.5%	24.5%	10.1%
Alaska	836	0.0%	100.0%	33.6%	11.9%	54.4%	0.0%
Arkansas	2,212	0.7%	99.3%	37.0%	14.7%	47.6%	0.1%
Arizona	3,285	84.6%	15.4%	0.8%	0.1%	14.5%	0.0%
California	25,812	21.1%	78.9%	34.7%	15.6%	28.7%	0.0%
Colorado	2,269	18.1%	80.4%	39.2%	11.1%	30.2%	1.5%
Connecticut	3,359	18.4%	81.6%	57.4%	12.0%	12.2%	0.0%
District of Columbia	1,200	21.5%	78.5%	26.1%	6.9%	45.5%	0.0%
Delaware	750	28.9%	70.8%	35.4%	14.8%	20.6%	0.4%
Florida	11,104	11.5%	88.5%	32.7%	18.6%	37.2%	0.0%
Georgia	5,358	0.5%	99.3%	23.8%	18.7%	56.8%	0.1%
Hawaii	753	35.7%	64.3%	33.7%	12.8%	17.8%	0.0%
Iowa	1,996	9.5%	90.3%	45.7%	16.3%	28.4%	0.1%
Idaho	867	0.5%	99.5%	40.4%	15.8%	43.2%	0.0%
Illinois	9,391	2.1%	97.9%	33.5%	13.4%	51.0%	0.0%
Indiana	3,951	10.3%	89.7%	44.1%	16.6%	29.0%	0.0%
Kansas	1,615	7.0%	93.0%	48.3%	14.6%	30.2%	0.0%
Kentucky	3,558	12.8%	87.2%	28.7%	19.5%	39.0%	0.0%
Louisiana	3,615	0.4%	99.6%	34.9%	21.7%	43.1%	0.0%
Massachusetts	6,392	10.1%	89.9%	46.5%	14.7%	28.7%	0.0%
Maryland	4,398	29.7%	69.8%	40.0%	8.6%	21.2%	0.4%
Maine	2,074	0.2%	99.8%	31.4%	13.4%	54.9%	0.0%
Michigan	6,479	44.8%	55.1%	20.9%	11.6%	22.6%	0.1%
Minnesota	4,702	24.7%	75.3%	53.5%	7.2%	14.7%	0.0%

States	Total Expenditures (In Millions)	Managed Care	Fee-For-Service				Unknown
			Total	Long-Term Care	Prescribed Drugs	All Other	
Missouri	4,407	15.5%	84.5%	32.4%	21.6%	30.4%	0.0%
Mississippi	2,570	0.0%	100.0%	28.7%	22.1%	49.2%	0.0%
Montana	536	0.3%	99.7%	38.4%	16.2%	45.1%	0.0%
North Carolina	6,521	0.8%	99.2%	31.8%	19.4%	48.0%	0.0%
North Dakota	445	1.2%	98.8%	60.4%	12.7%	25.8%	0.0%
Nebraska	1,283	4.9%	95.1%	45.0%	15.4%	34.7%	0.0%
New Hampshire	786	2.2%	97.8%	47.5%	14.9%	35.4%	0.0%
New Jersey	6,030	19.7%	80.3%	48.0%	12.6%	19.7%	0.0%
New Mexico	2,033	44.0%	55.4%	30.7%	5.3%	19.4%	0.6%
Nevada	881	15.4%	84.6%	32.8%	12.5%	39.3%	0.0%
New York	35,207	11.9%	88.1%	47.7%	11.4%	29.0%	0.0%
Ohio	10,235	7.6%	92.4%	48.6%	15.3%	28.5%	0.0%
Oklahoma	2,129	18.1%	81.9%	44.1%	13.6%	24.2%	0.0%
Oregon	2,116	39.3%	60.6%	31.9%	11.9%	16.8%	0.0%
Pennsylvania	9,450	45.9%	54.1%	35.4%	8.1%	10.6%	0.0%
Rhode Island	1,338	15.8%	84.2%	51.7%	10.5%	22.0%	0.0%
South Carolina	3,642	2.1%	97.9%	24.6%	15.3%	58.0%	0.0%
South Dakota	542	1.6%	98.3%	48.1%	13.4%	36.8%	0.1%
Tennessee	5,459	9.7%	90.3%	21.7%	32.5%	36.1%	0.0%
Texas	12,525	10.4%	89.5%	33.2%	15.3%	41.0%	0.0%
Utah	1,201	20.7%	78.9%	23.2%	12.2%	43.5%	0.3%
Virginia	3,181	22.2%	77.8%	31.2%	15.9%	30.7%	0.0%
Vermont	642	0.6%	99.2%	33.6%	20.1%	45.4%	0.2%
Washington	4,524	15.0%	74.0%	32.5%	13.2%	28.3%	10.9%
Wisconsin	3,921	21.6%	78.3%	41.1%	15.6%	21.7%	0.0%

States	Total Expenditures (In Millions)	Managed Care	Fee-For-Service				Unknown
			Total	Long-Term Care	Prescribed Drugs	All Other	
West Virginia	1,830	4.1%	95.9%	40.3%	18.6%	37.0%	0.0%
Wyoming	325	0.0%	100.1%	49.2%	13.1%	37.8%	-0.1%
National	233,206	16.1%	83.5%	37.3%	14.5%	31.7%	0.4%

Source: CRS analysis of FY2003 CMS MSIS State Summary DataMart (downloaded April, 2006).

Note: All percentages are based on grand total expenditures. Managed Care includes HMOs, Health Insuring Organizations (HIOs), prepaid health plans (PHPs) and primary care case management (PCCM) programs. Long-Term Care includes institutional services (inpatient mental health services for those over 64 and under 21, intermediate care facilities for the mentally retarded, and nursing facilities) and non-institutional services (home health, personal care, targeted case management, rehabilitation, and private duty nursing). Excludes the territories, disproportionate share hospital (DSH) payments, program administration, and Medicare premiums. Includes expenditures for Medicaid-expansion State Children's Health Insurance Program (M-SCHIP) beneficiaries.

Table 6. Expenditures and Percentages for Managed Care by Type and State, FY2003

States	Total Expenditures (in Millions)	% of Total Expenditures for Managed Care	Managed Care			
			Total Managed Care Expenditures (in Millions)	% HMO/HIO	% PHP	% PCCM
Alabama	3,471	18.8%	651	0.2%	96.3%	3.5%
Alaska	836	0.0%	0	0.0%	0.0%	0.0%
Arizona	3,285	84.6%	2,778	88.5%	11.5%	0.0%
Arkansas	2,212	0.7%	15	0.0%	0.0%	100.0%
California	25,812	21.1%	5,447	86.6%	13.4%	0.0%
Colorado	2,269	18.1%	411	62.3%	37.2%	0.5%
Connecticut	3,359	18.4%	619	100.0%	0.0%	0.0%
Delaware	750	28.9%	216	96.5%	3.5%	0.0%
District of Columbia	1,200	21.5%	257	93.6%	6.4%	0.0%
Florida	11,104	11.5%	1,274	95.9%	2.0%	2.1%
Georgia	5,358	0.5%	29	0.0%	0.0%	100.0%

States	Total Expenditures (in Millions)	% of Total Expenditures for Managed Care	Managed Care			
			Total Managed Care Expenditures (in Millions)	% HMO/HIO	% PHP	% PCCM
Hawaii	753	35.7%	269	96.8%	3.2%	0.0%
Idaho	867	0.5%	4	0.0%	0.0%	100.0%
Illinois	9,391	2.1%	196	86.0%	14.0%	0.0%
Indiana	3,951	10.3%	408	97.9%	0.0%	2.1%
Iowa	1,996	9.5%	190	51.7%	47.5%	0.8%
Kansas	1,615	7.0%	113	98.3%	0.0%	1.7%
Kentucky	3,558	12.8%	456	87.4%	9.1%	3.5%
Louisiana	3,615	0.4%	13	0.0%	0.0%	100.0%
Maine	2,074	0.2%	4	0.0%	0.0%	100.0%
Maryland	4,398	29.7%	1,308	100.0%	0.0%	0.0%
Massachusetts	6,392	10.1%	645	54.0%	46.0%	0.0%
Michigan	6,479	44.8%	2,904	53.9%	46.1%	0.0%
Minnesota	4,702	24.7%	1,161	100.0%	0.0%	0.0%
Mississippi	2,570	0.0%	0	0.0%	0.0%	0.0%
Missouri	4,407	15.5%	684	100.0%	0.0%	0.0%
Montana	536	0.3%	2	0.0%	0.0%	100.0%
Nebraska	1,283	4.9%	63	97.1%	0.0%	2.9%
Nevada	881	15.4%	135	100.0%	0.0%	0.0%
New Hampshire	786	2.2%	17	100.0%	0.0%	0.0%
New Jersey	6,030	19.7%	1,187	99.5%	0.5%	0.0%
New Mexico	2,033	44.0%	895	100.0%	0.0%	0.0%
New York	35,207	11.9%	4,177	87.8%	12.2%	0.0%
North Carolina	6,521	0.8%	52	39.4%	0.0%	60.6%
North Dakota	445	1.2%	5	87.7%	0.0%	12.3%

States	Total Expenditures (in Millions)	% of Total Expenditures for Managed Care	Managed Care			
			Total Managed Care Expenditures (in Millions)	% HMO/HIO	% PHP	% PCCM
Ohio	10,235	7.6%	774	100.0%	0.0%	0.0%
Oklahoma	2,129	18.1%	384	92.4%	7.6%	0.0%
Oregon	2,116	39.3%	832	73.8%	26.1%	0.1%
Pennsylvania	9,450	45.9%	4,339	73.5%	26.4%	0.1%
Rhode Island	1,338	15.8%	211	100.0%	0.0%	0.0%
South Carolina	3,642	2.1%	78	79.7%	20.3%	0.0%
South Dakota	542	1.6%	9	0.0%	82.8%	17.2%
Tennessee	5,459	9.7%	532	30.6%	69.4%	0.0%
Texas	12,525	10.4%	1,307	96.2%	3.0%	0.9%
Utah	1,201	20.7%	249	35.1%	64.9%	0.0%
Vermont	642	0.6%	4	0.0%	0.0%	100.0%
Virginia	3,181	22.2%	706	99.7%	0.0%	0.3%
Washington	4,524	15.0%	681	100.0%	0.0%	0.0%
West Virginia	1,830	4.1%	75	95.3%	0.3%	4.4%
Wisconsin	3,921	21.6%	849	74.7%	25.3%	0.0%
Wyoming	325	0.0%	0	0.0%	0.0%	0.0%
National Total	233,206	16.1%	37,614	82.4%	17.0%	0.6%

Source: CRS analysis of FY2003 CMS MSIS State Summary DataMart (downloaded April, 2006).

Note: Within state sums may not add to 100% due to rounding. Managed care includes HMOs, Health Insuring Organizations (HIOs), prepaid health plans (PHPs) and primary care case management (PCCM) programs. Excludes territories, disproportionate share hospital (DSH) payments, program administration, and Medicare premiums. Includes expenditures for Medicaid-expansion State Children's Health Insurance Program (M-SCHIP) beneficiaries.

Table 7. Expenditures and Percentages by Delivery System and Basis of Eligibility, FY2003

Basis of Eligibility	Total Expenditures (in Millions)	Managed Care	Fee-For-Service				Unknown
			Total	Long-Term Care	Prescribed Drugs	All Other	
Aged	55,271	4.6%	95.4%	69.6%	15.0%	10.8%	0.0%
Blind/Disabled	102,014	10.5%	89.5%	41.4%	18.6%	29.4%	0.0%
Children	39,871	36.5%	63.5%	10.7%	8.1%	44.6%	0.0%
Adults	26,800	33.1%	66.9%	1.6%	11.4%	53.9%	0.0%
Unknown	9,251	9.8%	80.4%	17.0%	2.1%	61.3%	9.9%
National Total	233,206	16.1%	83.5%	37.3%	14.5%	31.7%	0.4%

Source: CRS analysis of FY2003 CMS MSIS State Summary DataMart (downloaded May, 2006).

Note: All percentages are based on grand total expenditures. Managed Care includes HMOs, Health Insuring Organizations (HIOs), prepaid health plans (PHPs) and primary care case management (PCCM) programs. Long-term care includes institutional services (inpatient mental health services for those over 64 and under 21, intermediate care facilities for the mentally retarded, and nursing facilities) and non-institutional services (home health, personal care, targeted case management, rehabilitation, and private duty nursing). Excludes the territories, disproportionate share hospital (DSH) payments, program administration, and Medicare premiums. Includes expenditures for Medicaid-expansion State Children's Health Insurance Program (M-SCHIP) beneficiaries.

Table 8. Expenditures and Percentages for Managed Care by Type and Basis of Eligibility, FY2003

Basis of Eligibility	Total Expenditures (in Millions)	% of Total Expenditures for Managed Care	Managed Care			
			Total Managed Care Expenditures (in Millions)	% HMO/HIO	% PHP	% PCCM
Aged	55,271	4.6%	2,550	85.1%	14.7%	0.1%
Blind/Disabled	102,014	10.5%	10,720	70.9%	28.8%	0.3%
Children	39,871	36.5%	14,566	87.7%	11.4%	0.9%
Adults	26,800	33.1%	8,874	91.0%	8.7%	0.3%
Unknown	9,251	9.8%	904	41.8%	56.2%	2.0%
National Total	233,206	16.1%	37,614	82.4%	17.0%	0.6%

Source: CRS analysis of FY2003 CMS MSIS State Summary DataMart (downloaded April, 2006).

Note: Within basis of eligibility, sums may not add to 100% due to rounding. Managed Care includes HMOs, Health Insuring Organizations (HIOs), prepaid health plans (PHPs), and primary care case management (PCCM) programs. Excludes territories, disproportionate share hospital (DSH) payments, program administration, and Medicare premiums. Includes expenditures for Medicaid-expansion State Children's Health Insurance Program (M-SCHIP) beneficiaries.

Table 9. Summary of Selected Effectiveness of Care Measures from the Health Plan Employer Data and Information Set (HEDIS), 2005

HEDIS Measure	Medicaid	Commercial	Medicare
Examples of Preventive Care			
Childhood Immunization Status (combination 2)	70.4%	77.7%	NA
Timeliness of Prenatal Care	79.1%	91.8%	NA
Breast cancer screening	53.9%	72.0%	71.6%
Examples of Acute Medical Care			
Appropriate Treatment for Children with Upper Respiratory Infection (URI)	82.5%	82.9%	NA
Persistence of Beta-Blocker Treatment After a Heart Attack	69.8%	70.3%	65.4%
Controlling High Blood Pressure	61.4%	68.8%	66.4%
Examples of Mental Health Services			
Antidepressant Medication Management—Effective Continuation Phase Treatment	30.3%	45.0%	41.0%
Follow-Up After Hospitalization for Mental Illness within 30 days	56.8%	75.9%	59.3%
Examples of Member Satisfaction Measures			
Rating of Health Plan	72.0%	65.2%	79.9%
Getting Needed Care	73.9%	80.2%	87.1%
Rating of Personal Doctor or Nurse	77.0%	77.2%	85.5%

Source: National Committee for Quality Assurance (NCQA), *The State of Health Care Quality: 2006*, NCQA, Washington, DC, 2006.

Notes: The definitions of each effectiveness of care measure are provided below.

Childhood immunization status—percentage of children who turned 2 years old during the measurement year and received a specified number of doses of vaccines to prevent diphtheria-tetanus, polio, measles-mumps-rubella, Haemophilus influenzae type b, hepatitis B, and chicken pox.

Timeliness of prenatal care—percentage of women beginning prenatal care during their first trimester or with 42 days of enrollment if already pregnant at the time of enrollment.

Breast cancer screening—percentage of women aged 52 - 69 enrolled in a health plan who had at least one mammogram in the past two years.

Appropriate treatment for children with upper respiratory infection (URI)—percentage of children 3 months to 18 years of age who were diagnosed with an URI and did not receive an antibiotic prescription for that episode of care within three days of the visit. Higher rates indicate more appropriate use of antibiotics.

Persistence of beta-blocker treatment after a heart attack—percentage of members 35 years of age and older who are hospitalized and discharged from the hospital after surviving a heart attack and who received one or more prescriptions for a beta-blocker covering a period of at least six months after discharge.

Controlling high blood pressure—estimates whether blood pressure was controlled in adults aged 46 - 85 years of age who have diagnosed hypertension. Adequate control was defined as a blood pressure of 140/90 mmHg or lower. Both the systolic and diastolic pressure must be at or under these thresholds for blood pressure to be considered controlled.

Antidepressant medication management/effective continuation phase treatment—percentage of eligible members who were treated with antidepressant medication and remained on anti-depressant medication for six months after diagnosis of a new episode of depression.

Follow-up after hospitalization for mental illness within 30 days—percentage of health plan members 6 years of age and older who received inpatient treatment for a mental health disorder and had an ambulatory or other specified types of follow-up within 30 days after hospital discharge.

Each *member satisfaction measure* shows the percentage of members who gave a rating of 8, 9 or 10 (highest) or who indicated "always" or "usually" depending on the measure.

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