



FACT SHEET
MACPAC's June 2011 Report to the Congress:
The Evolution of Managed Care in Medicaid
June 15, 2011

Medicaid is a source of health care coverage for 67 million low-income people, over a fifth of the U.S. population. Medicaid finances health care and related services for more than 30 million low-income children, more than 10 million persons with disabilities, and 6 million low-income seniors with Medicare.

The Commission's June 2011 Report to the Congress is comprised of two major sections. The first section describes what is known about the use of managed care in Medicaid today and includes information on the populations enrolled; Medicaid managed care plan arrangements; payment policy; access and quality; and program accountability, integrity, and data. The second section, MACStats—the Medicaid and CHIP program statistics supplement in the gray-banded portion of the Report—features national and state-level information on Medicaid enrollees, spending, and the use of managed care.

Key Facts about Medicaid Managed Care	
Enrollees	Medicaid managed care enrollees by eligibility status, who are in any form of Medicaid managed care (including comprehensive risk-based, primary care case management (PCCM), or limited-benefit managed care arrangements): <ul style="list-style-type: none"> • Non-disabled children: 60% • Non-disabled adults under age 65: 22% • Persons with disabilities: 14% • Individuals age 65 and older: 4%
Enrollment	<ul style="list-style-type: none"> • Number of Medicaid enrollees in any form of managed care: 49 million (71%) • Number of Medicaid enrollees in comprehensive risk-based managed care: 23 million (47%) • States with highest percentage of Medicaid enrollees in comprehensive risk-based managed care: Hawaii (97%), Tennessee (94%), and Arizona (90%)
Spending	<ul style="list-style-type: none"> • Share of Medicaid benefit spending for all forms of managed care: 21% • Share of Medicaid benefit spending for comprehensive risk-based managed care: 18%
States	Number of state Medicaid programs with: <ul style="list-style-type: none"> • Comprehensive risk-based managed care plans: 34 states and DC • PCCM programs: 30 states • Limited-benefit plans: 34 states and DC • No managed care: 2 states (Alaska and Wyoming)

Context and Overview of Managed Care in Medicaid

- Many states have pursued managed care as a tool to better coordinate care for enrollees, provide greater control and predictability over Medicaid spending, and establish provider networks for low-income enrollees.
- Managed care arrangements in Medicaid differ from those in the private sector and in Medicare due to differences in populations served and program design, including care management approaches and cost-sharing policies.
- States use multiple types of arrangements that differ in design, operation, and covered benefits to deliver services to enrollees including: comprehensive risk-based managed care, PCCM, and limited-benefit plans.
- Most Medicaid enrollees in managed care arrangements still receive at least some services through fee for service (FFS).

Populations and Enrollment in Medicaid Managed Care

- Comprehensive risk-based managed care enrollment in Medicaid is growing nationwide, and the population covered in comprehensive risk-based managed care is expanding to enrollees with disabilities. In FY 2008:
 - Low-income children and non-disabled adults under age 65 were more likely to be enrolled in comprehensive risk-based managed care (60 percent and 44 percent respectively) than other groups.
 - Twenty-eight percent of all Medicaid enrollees with disabilities and 11 percent of all Medicaid enrollees aged 65 and older, mostly with primary coverage through Medicare, were enrolled in comprehensive risk-based managed care.

Payment Policy

- States with comprehensive risk-based managed care typically make per member per month capitation payments to plans. Rates are required to be actuarially sound.
- States use different risk sharing methodologies and approaches for risk adjusting payments to reflect health and demographic characteristics of enrollees.

Access, Quality, and Program Accountability

- The federal and state governments share oversight responsibilities that include collecting data, monitoring appropriate payment and access to quality care, and preventing fraud, waste, and abuse.
- The consistency, availability, and timeliness of the data submitted by managed care plans to states and from states to CMS vary considerably, creating challenges for analyzing and monitoring managed care programs and policies at the national level.

MACStats: presents trends in Medicaid enrollment and spending and provides data on current health status and service use among Medicaid and CHIP populations. MACStats is divided into four sections:

- Trends in Medicaid Spending and Enrollment. Highlights growth in enrollment and spending across eligibility groups; for example, individuals with disabilities account for a disproportionate share of Medicaid benefit spending growth.
- Medicaid and CHIP Populations. Describes differences in health status between subgroups of Medicaid/CHIP enrollees and those with other types of coverage, as well as differences in benefit spending among Medicaid eligibility groups and users of long-term services and supports (LTSS).
- Medicaid Managed Care. Presents state-level data on managed care enrollment and spending.
- Technical Guide to the June 2011 MACStats. Provides supplemental information to accompany the tables and figures in MACStats.

The June 2011 *Report to the Congress: Evolution of Managed Care in Medicaid* can be downloaded from MACPAC's website: www.macpac.gov. For more information, contact Michelle Herman at 202-273-2460.

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MACPAC is the first nonpartisan congressional support agency that is solely focused on issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). MACPAC was established by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. The Commission's statutory charge requires that the Commission review and advise the Congress on federal and state Medicaid and CHIP policies on issues involving payment; access; eligibility; enrollment and retention; coverage; quality; and interactions of Medicaid and CHIP with Medicare and other components of the U.S. health care delivery system.