

ACA Implementation—Monitoring and Tracking

Are State Medicaid Managed Care Programs Ready for 2014?

A Review of Eight States

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Teresa A. Coughlin, Brigette Courtot, and Rebecca Peters



Robert Wood Johnson Foundation



INTRODUCTION

With the Medicaid coverage expansion authorized by the Affordable Care Act (ACA), in 2014 Medicaid will experience the single largest surge in enrollment growth since the program was established nearly 50 years ago. The bulk of new program enrollees will receive their care through a managed care plan, the principal way states deliver services to current Medicaid enrollees: In 2010, all but 15 states had comprehensive risk-based Medicaid managed care programs (hereafter referred to simply as managed care), and nearly two-thirds of the nation's over 50 million Medicaid enrollees received their health care services through managed care.^{1,2}

In this brief we examine how eight states are altering their Medicaid managed care programs as they move into the home stretch of implementing the ACA. In particular, we draw on the experiences of eight states

(Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia) participating in the Robert Wood Johnson Foundation's State Health Reform Assistance Network and the related health reform implementation monitoring and tracking project. We describe how these states are revamping their Medicaid managed care programs and how they are preparing the programs to provide coverage to new enrollees under health reform, and look into health plan and health care stakeholders' perceptions of the changes and preparations.

The information in this brief is based on interviews conducted with health care stakeholders—including state Medicaid officials, health plan representatives, health care providers, and advocates—in each of the eight states between January 2013 and March 2013, as well as a review of state documents and the published and gray literatures.

SUMMARY OF RECENT MEDICAID MANAGED CARE PROGRAM CHANGES

Managed care is an integral part of Medicaid in the eight study states; each has decades of experience with Medicaid managed care and uses it to serve the majority of program beneficiaries. Building off this infrastructure, the states continue to increase their reliance on Medicaid managed care by expanding it to include new populations, geographic areas, and services. The role of Medicaid managed care is growing but is also evolving. Even states with mature programs such as those in the eight study states continue to make modifications, often major ones, as they adapt to changes in the health care marketplace and the shifting coverage landscape; as one informant explained, “[our managed care program] is not your grandmother's Medicaid managed care program.” Table 1 shows some of the most common types of Medicaid managed care program changes reported by the study states.

Most of the eight study states have begun using managed care to serve new eligibility groups, including many high-cost, high-need populations that were previously exempt (Table 1). For instance, Oregon extended managed care to Medicaid breast and cervical cancer treatment program beneficiaries, and New York began using managed care to serve homeless beneficiaries and intends to move non-dual-eligible nursing home patients into managed care in October 2013. Most of the study

states (including Michigan, Minnesota, New York, Rhode Island, and Virginia) are also planning to participate in the ACA-authorized State Demonstrations to Integrate Care for Dual Eligible Individuals—an initiative which, among other things, relies on managed care to serve beneficiaries who are dually eligible for Medicaid and Medicare (the so-called dual eligibles).

A number of states—for example, New Mexico, New York, and Oregon—modified their managed care enrollment rules so that more beneficiaries are required to enroll on a mandatory (as opposed to voluntary) basis. In practice, this type of change increases managed care enrollment. New York, for example, has operated a voluntary managed long-term care program that it is now converting to a mandatory program. Similarly, Minnesota replaced its “opt-in” managed care enrollment policy for adults with disabilities with a more passive “opt-out” approach; though enrollment is technically still voluntary for this population, the change resulted in a considerable influx of new enrollees.

In addition to enrolling greater numbers of beneficiaries in a managed care arrangement, the states are expanding the scope of Medicaid managed care by increasing the number and types of services that are part of their managed care benefit package. For instance, New Mexico extended its managed care package by including

TABLE 1: Medicaid Managed Care Program Changes in Eight Study States, 2011–13

| | Expanded Managed Care to New Eligibility Groups | Shifted Groups from Voluntary to Mandatory Managed Care Enrollment | Covered More Services Under Managed Care | Reorganized Managed Care Delivery System | Modified Payment Methods or Approach |
|---------------------|---|--|--|--|--------------------------------------|
| Maryland | | | | | Yes |
| Michigan | Yes | | | | |
| Minnesota | Yes | Yes** | | Yes | Yes |
| New Mexico | Yes | Yes | Yes | Yes* | Yes |
| New York | Yes | Yes | Yes | | Yes |
| Oregon | Yes | Yes | Yes | Yes | Yes |
| Rhode Island | Yes | | Yes | | |
| Virginia | Yes | | | | |
| TOTAL | 7 | 4 | 4 | 3 | 5 |

* Change is planned for 2014.

** Minnesota implemented an opt-out policy (previously opt-in) for its managed care program for adults with disabilities.

SOURCE: Interviews with state Medicaid officials, conducted by the Urban Institute in January–March 2013.

community health worker services and methadone treatment. Oregon began using managed care for the delivery of nonemergency transportation and residential mental health services. And in late 2013, Rhode Island plans to integrate long-term services and supports (LTSS) with behavioral and acute health services for delivery under a risk-based managed care plan or a Primary Care Case Management model.

The Medicaid managed care programs in a few study states are undergoing substantial reorganization. One such effort—Oregon’s establishment of Coordinated Care Organizations (CCOs) in 2012—involves 15 CCOs (local entities that are essentially networks of health care providers) that provide acute and behavioral health services and eventually dental care to the vast majority of Oregon beneficiaries statewide. Long-term care services remain outside the CCO initiative. Previously, acute and behavioral health had been delivered by separate health plans under separate contracts. Under the new structure, a CCO receives a monthly global payment to deliver acute and behavioral health care and, sometimes, dental care. The global payment includes a capitated and noncapitated component. The capitated part is a prospective per-member per-month payment

and includes services that had been previously covered by Oregon’s managed care program; the noncapitated portion is for programs and services that had been outside of managed care. While most counties have one operating CCO, more populous areas in the state have multiple CCOs that beneficiaries can choose from.

New Mexico is similarly consolidating its managed care programs under a single program, Centennial Care. In that state, LTSS, acute and behavioral health services are currently covered under managed care but through separate contracts. Beginning in 2014, four managed care organizations (reduced from the seven plans that currently serve beneficiaries) will provide the full range of services to Medicaid enrollees under a single contract.

In addition to Oregon’s adoption of a global payment method for acute and behavioral health services, other states made changes to the way they pay health plans. Maryland, for example, increased the proportion of plans’ premium payments that are “at risk,” or contingent upon plans’ ability to meet certain performance standards. Minnesota’s competitive bidding effort met and exceeded cost savings expectations, creating \$175 million in state budgetary savings. For 2013, the state used administrative rate setting, and held rates flat compared to 2012. As a

result of these changes, in 2013, Minnesota pays less in per member per month capitation than in 2010. The state is using competitive bidding to set rates for 2014 contracts for 27 counties outside the Twin Cities region.

State officials described a number of reasons for pursuing the aforementioned changes (and others) to their Medicaid managed care programs. Though the motives behind the changes—which include controlling program spending while improving quality and efficiency—are consistent with the ACA vision, the federal health reform law itself

was not generally the impetus. In fact, states pursuing large-scale managed care reorganization (e.g., Oregon and New Mexico) or expansion (e.g., New York) began planning these initiatives in advance of the passage of the ACA in 2010, though informants acknowledged that the federal reform provided additional momentum. Efforts targeting dual eligibles are a notable exception, however, as most state officials credited the ACA with providing the opportunity and motivation to pursue a managed care approach for this population or—as in Minnesota’s case—to expand an already successful model of managed care for dual eligibles.

HEALTH REFORM AND STATE MEDICAID MANAGED CARE PROGRAMS

As of this writing in May 2013, executive leaders in each of the eight study states have indicated support for expanding Medicaid to individuals with incomes up to 139 percent of the federal poverty level (FPL), as authorized by the ACA.³

As shown in Table 2, the potential Medicaid enrollment increase that the study states could experience when ACA coverage expansions are implemented varies considerably—over a ten-year period, projected increases in Medicaid enrollment range from less than 25 percent in New York to more than 100 percent in Oregon. These enrollment projections assume that a

state implements the ACA Medicaid expansion and also include enrollment related to what is known as the “woodwork effect,” where individuals who are currently eligible for Medicaid but not enrolled decide to enroll in the program in a post-reform world.

To a great extent, pre-ACA Medicaid eligibility standards drive a state’s level of increase in Medicaid enrollment. Additional factors that influence a state’s expected growth include the availability of other insurance options in the state, the share of the state’s current Medicaid eligibles enrolled in the program, and its underlying poverty rates.

TABLE 2: Medicaid Expansion Plans and Enrollment Projections in Eight Study States

| | Medicaid Expansion Decision – Executive Activity (a) | Projected Medicaid Enrollment, 2022 (b) | | |
|---------------------|--|--|---|----------------------------|
| | | Baseline Enrollment, with No ACA (Thousands) | New Enrollment with ACA Incl. Expansion (Thousands) | Increase in Enrollment (%) |
| Maryland | Supports | 761 | 209 | 27.5 |
| Michigan | Supports | 1,732 | 547 | 31.6 |
| Minnesota | Supports | 697 | 193 | 27.7 |
| New Mexico | Supports | 464 | 247 | 53.2 |
| New York | Supports | 4421 | 1026 | 23.2 |
| Oregon | Supports | 464 | 471 | 101.5 |
| Rhode Island | Supports | 174 | 48 | 27.6 |
| Virginia | Conditional (c) | 769 | 407 | 52.9 |

SOURCES:

(a) KFF State Health Facts, *State Decisions for Creating Health Insurance Exchanges and Expanding Medicaid*, as of March 5, 2013. See <http://www.statehealthfacts.org/comparetable.jsp?ind=1075&cat=17>.

(b) Holahan et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*. See <http://www.kff.org/medicaid/upload/8384.pdf>.

(c) On May 7, 2013, Virginia Governor McDonnell signed a budget bill into law that, among other things, authorized the ACA Medicaid expansion, conditional that certain reforms be made to the state’s Medicaid program.

STATES AND HEALTH PLANS FEEL PREPARED FOR ACA-RELATED MEDICAID ENROLLEES

On balance, officials in the seven states (Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, and Rhode Island) most likely to implement the Medicaid expansion felt that their managed care programs would be ready to provide coverage to new Medicaid enrollees come January 2014, including those that are expected to experience significant enrollment growth, such as New Mexico and Oregon. In large part, the states have such confidence because their managed care programs are stable and mature, with some dating back more than three decades. Moreover, many of the states described long-standing, collaborative relationships with the health plans participating in their programs, which informants cited as major factor in their readiness for the ACA Medicaid expansion. Capsulated summaries of the study states' health plans are provided in the text box.

Further bolstering state confidence, several states (including Maryland, Minnesota, New Mexico, New York, Oregon, and Rhode Island) already have experience caring for the population targeted by the ACA Medicaid expansion through earlier coverage initiatives, and thus have a "huge part of the capacity-building" in place now. For example, Rhode Island extends Medicaid to parents with incomes up to 175 percent FPL in its RiteCare program, and its Rhody Health Partners program covers adults with disabilities with incomes up to 100 percent FPL. Likewise, New Mexico has gained experience with providing coverage to low-income adults (with and without children) through its State Coverage Insurance program, and New York already provides Medicaid to adults (also with and without children) in the expansion eligibility range through Family Health Plus.

Considering this previous experience, state officials and health plans alike feel that they have a good sense of what to expect with the ACA expansion group. Central to this is an understanding of the risk profile of the population. Informants believe that the ACA expansion population will be diverse in terms of health risk: It will include some individuals with higher-than-average health care needs, particularly for mental health and substance abuse services, which, informants noted, might make them "harder to place" in a health plan that can fully meet their needs. At the same time, the expansion enrollees will include young, healthy adults (the so-called "young invincibles") who, according to informants, "will help balance" the expansion population's overall risk profile.

State officials and plan representatives also expect to experience some initial adverse-risk selection when Medicaid is expanded, with sicker individuals in the expansion group enrolling first to access needed health services. In addition, given that many in the expansion population will likely have been without health insurance for a long time, informants anticipate pent-up demand for services, likely contributing further to higher-than-average utilization at first. Indeed, officials in several states expressed "relief" that the federal government is fully financing the expansion population for the first three years.⁴ Over time, officials and plans expect that demand will stabilize and that ACA expansion adults will "look more like" other nondisabled adults in terms of risk, service use and cost.

While health plans feel ready to enroll the ACA Medicaid expansion population, they are concerned about some of the broader Medicaid managed care program changes that many of the states are undertaking simultaneously, such as the inclusion of new services (particularly long-term care) and populations (such as the dual eligibles) in managed care. To the extent that the risks associated with these and other endeavors cannot be adequately managed or that Medicaid's payments to health plans are insufficient to meet these new responsibilities, plans worry about possible spillover effects to other parts of their business, which could potentially compromise their ability to serve the ACA Medicaid population.

Plan Capacity Viewed as Sufficient for ACA Medicaid Expansion. As further indication of their readiness to serve the ACA Medicaid expansion population, most of the study states feel that they already have sufficient health plan capacity and infrastructure to absorb the new enrollees. (Importantly, plan capacity was widely perceived as adequate whereas there was more ambivalence about provider capacity, which will be discussed in the next section.) Overall, state officials did not expect to execute major contractual changes to accommodate the ACA expansion group, nor do they intend to contract with new health plans, even in states with large enrollment increases expected, such as in Oregon and New Mexico. In fact, as mentioned above, in 2013, New Mexico reduced the number of Medicaid managed care plans it contracts with from seven to four, and in Michigan (where 13 health plans participate in Medicaid) informants observed that there may be too many plans. As one official put it, Medicaid programs have not spent much "time and energy

worrying” about plan capacity. Officials in several states did, however, acknowledge that enrollees in some areas—particularly rural residents—may not have a wide choice of health plans.

Maryland was the exception in its plan contracting activity. In 2013, three new health plans (Kaiser Permanente, Molina Healthcare, and a local, provider-owned plan called Riverside Health) will begin participating in Maryland’s Medicaid managed program. According to informants in the state, these new plans will help accommodate general enrollment growth in Medicaid that has occurred independent of health reform, and were not added to the program solely because of the ACA. At the same time, informants suggested that the new contract with Kaiser Permanente was motivated in part by the desire to offer another plan to Medicaid enrollees that also has a commercial product (two other Medicaid managed care plans in the state already sell commercial insurance), to help provide continuity of care for individuals who “churn,” or cycle between Medicaid and private coverage.

New York officials noted that there could be some plan changes in their Medicaid managed care program, but that these would be due to the structural changes the state is making to its program rather than to the ACA Medicaid expansion. They anticipate some plan consolidation and new plans coming into the market. A few other states noted that it was still unclear whether new plans would enter the Medicaid managed care market in advance of or soon after the expansion takes effect. In Minnesota, for instance, informants commented that plans could enter the Medicaid market rather easily, given the state’s approach of contracting with “any willing provider”—that is, the state will contract with plans that agree to its contract terms. With a state law requiring that Medicaid-participating plans be nonprofit, however, informants were dubious that this would occur.

Among the states included in this study, Virginia is an exception in how it is preparing its managed care program for the ACA. This is not surprising given the tentative nature of the Medicaid expansion that was only recently approved by the state’s governor. In May 2013, Virginia’s Governor McDonnell signed into law a budget bill that could provide for Medicaid expansion under the ACA under certain conditions, effective as early as July 1, 2014. As a prerequisite to the expansion, however, the bill requires Virginia’s Department of Medical Assistance Services to continue implementation of existing Medicaid reforms and to pursue and implement additional reforms. If a newly created legislative Medicaid commission determines that the state has met the specified conditions for Medicaid

reform, the bill provides for Medicaid expansion without an additional vote by Virginia’s General Assembly.

In the meantime, Virginia officials are considering the approach they might take if the state goes forward with the expansion. For example, state officials envision using managed care to serve ACA expansion enrollees but are unsure how many plans would be sufficient for this effort. Consistent with other states, Virginia officials stated that they are not as concerned about plan capacity as with the need to give plans sufficient time to beef up their provider networks to cover adults, a population (other than pregnant women) that Virginia largely does not cover in its current Medicaid program. State officials estimated that it would take health plans at least 12 months to build provider networks. Virginia officials have also completed some basic calculations of a capitation rate and considered the risk profile of the Medicaid expansion group. Unlike the other study states, however, Virginia officials recognize that they are somewhat disadvantaged in this regard because they have very limited prior experience in caring for non-disabled adults without children.

Unsurprisingly, health plans are pleased that the study states are looking to managed care as the primary delivery system for the new Medicaid expansion population. As one official put it, “It means more business for them.” That said, officials and plans admit that there is a lot of activity in Medicaid managed care, some stemming from the ACA and some from general program changes as discussed above. It is an “exciting but challenging” time for health plans, according to one state official.

Medicaid Plans Participating in the Exchange. One ACA-related consideration that is causing consternation for some Medicaid managed care plans is the decision about whether to participate in the Health Insurance Exchange (Exchange). Many plans that participate in Medicaid managed care already have commercial products and state officials believe that most—if not all—of these plans will participate in the Exchange. Indeed, Maryland’s Exchange law states that commercial plans with a market share above a certain threshold must participate in the Exchange if they wish to continue selling coverage in the external (outside the Exchange) private market.⁵

Many, but not all, of the managed care health plans interviewed for this study suggested that they would participate in their state’s Exchange. Plans that are not planning to participate cited onerous state commercial insurance regulations as a deterrent, and some provider-based plans felt the Exchange was not consistent with

their organizational mission, since “health insurance isn’t their core business.” More commonly, however, plans reported interest in the Exchange, including some who observed that while they understand they must agree to serve the entire Exchange market, they hope to serve a “niche” market by focusing on enrollees with incomes up to 200 percent FPL. These plans recognize that they do not have the “branding” or the full provider network to compete in the traditional private insurance market and thus are not looking to compete with large commercial insurers through the Exchange.

Plans offered many reasons for wanting to participate in the Exchange. For some, Exchange participation represents a business opportunity. For others, it is more of a “defensive strategy”—that is, the plan wants to keep its Medicaid enrollees who cycle between the two programs (e.g., a Medicaid enrollee who becomes Exchange-eligible when family income increases) and fears that if it does not participate in the Exchange, it could lose these individuals to other plans that have both Medicaid and Exchange products. Providing continuous care for individuals who cycle between Medicaid and the Exchange could also help the plans better manage their costs, according to study informants. Finally, some plan representatives also stated that participating in the Exchange is consistent with their mission to serve low-income individuals.

Notably, pending provisions in Maryland may help to mitigate concerns about continuity of care for individuals cycling between Medicaid and the Exchange, and—according to key informants in the state—may somewhat lessen the need for Medicaid plans to participate in the

Exchange. Specifically, individuals who move between Medicaid and commercial coverage (including but not limited to Exchange coverage) are allowed to go out of network for a period of time to complete a treatment plan that was initiated before the change in insurance carriers. Also, when a person switches insurance, the new carrier has to honor authorizations (e.g., prior authorization for a surgery) that the relinquishing carrier has already approved.⁶

Related to Exchange participation, a predominant concern of both state officials and health plans regarding readiness for the 2014 coverage expansions involves the development of an information technology (IT) system that addresses “all the moving pieces in the eligibility and enrollment process” and that is coordinated between the Exchange and Medicaid, as well as the ability of health plans to “talk” to the state. As one informant noted, “If you mess that up, there are big consequences.”

Each study state is taking advantage of the enhanced federal Medicaid funding for IT system modernization that is temporarily available under the ACA, and state officials have devoted much of their time over the past two years to establishing a system that is ACA-compliant. Even so, state officials are acutely aware that they are undertaking a significant change for which a new IT system is still being developed, and doing all of this under tight deadlines. Overlaying this is the fact that for many of the study states, the ACA expansion (those enrolled in Medicaid and the Exchange) requires that different state agencies “have a shared vision that is being clearly communicated.” As one official noted, the IT system being developed for the ACA is forcing them to rethink how they do business.

Brief Description of Eight Study States' Medicaid Managed Care Programs

Maryland

Maryland's statewide Medicaid managed care program enrolls children and adults (with and without disabilities) on a mandatory basis. More than three-quarters of Maryland's Medicaid beneficiaries are enrolled in Health Choice, though dual eligibles and those who are institutionalized are excluded from the program, as well as some additional small populations like certain children with special health care needs. At the time of our interviews, seven health plans participated in Medicaid managed care (three additional plans will begin participating in 2013), including two plans that also participate in commercial health insurance markets, and five that serve public coverage programs only.

Michigan

The majority of Michigan's Medicaid beneficiaries are in managed care. Throughout the state, children and adults (with and without disabilities) are required to enroll in a health plan, though for dual eligibles, enrollment is voluntary and health plans are only responsible for Medicaid services. The state plans to launch a demonstration project to integrate care for dual eligibles (under which plans will deliver Medicaid and Medicare services) in 2014. A relatively large number of plans (13) participate in Michigan's managed care program—including several "homegrown" plans—and about half also serve the commercial market. Most beneficiaries have a choice of at least two (and in some cases, as many as eight) plans with the exception of those living in the rural Upper Peninsula region, who are served by a single plan.

Minnesota

Minnesota's Medicaid managed care program is statewide and enrolls nondisabled children and adults (including seniors) on a mandatory basis; blind and disabled beneficiaries (including dual eligibles) can enroll voluntarily. In 2013, the state plans to implement a demonstration project to integrate care for dual eligibles under a managed care approach. A total of eight plans currently participate in Minnesota's Medicaid managed care program, including three county-based purchasing plans which are owned and operated by the group of rural counties they serve. Most beneficiaries have a choice of between two and four health plans, though in a handful of rural counties just a single health plan is available. Half of the plans also serve (or are affiliated with insurers that serve) the commercial market.

New Mexico

About 80 percent of New Mexico's Medicaid beneficiaries are currently enrolled in managed care, including dual eligibles. While New Mexico is fundamentally reshaping its Medicaid managed care program with its Centennial Care initiative (see text), at present the state contracts with four plans for physical health care, one plan for behavioral health care, and two for long-term services and supports. Under Centennial Care, health plans will be responsible for providing all three services—physical, behavioral, and long-term services. New Mexico has negotiated contracts with four plans and full implementation of the new

initiative is slated for January 1, 2014. Among the plans that will participate in Centennial Care there are two regional plans, a commercial plan, and a national for-profit, Medicaid-only plan.

New York

More than 15 health plans participate in New York's Medicaid managed care program, which enrolls children and families on a (mostly) mandatory basis. In most counties, but not all, enrollees are given a choice of health plans. In addition, New York contracts with several health plans that provide long-term care or care to particular populations, such as HIV/AIDS enrollees. Health plans that participate in the program include for-profit commercial insurers, regional non-profit health plans, and prepaid health service plans or PHSPs. The latter are primarily provider-sponsored, Medicaid-only health plans that play a dominant role in New York City, covering some 70 percent of Medicaid lives in the metropolitan area.

Oregon

Roughly 90 percent of Oregon's Medicaid beneficiaries are enrolled in one of 15 coordinated care organizations (CCOs) that began operating in August 2012. Virtually all major Medicaid eligibility groups, including dual eligibles, are served by a CCO, which is a network of local health care providers including physical health, mental health, and eventually dental care providers. Each CCO is a unique entity that involves a wide array of health care providers coming together to form a partnership, such as hospitals, health plans, counties, and individual providers. Most counties in Oregon have a single CCO, but in more populous regions as many as four CCOs are in operation.

Rhode Island

Almost all Medicaid beneficiaries are mandatorily enrolled in RItE Care, Rhode Island's managed care program. Virtually all Medicaid services are covered under RItE Care, with the major exception of long-term services and supports. Statewide, Medicaid beneficiaries chose between two health plans: United Health Care and Neighborhood Health Plan, a "homegrown" health plan that currently serves only the Medicaid population.

Virginia

Six health plans currently participate in Virginia's Medicaid managed care program, which operates statewide and mandatorily enrolls children, pregnant women and other nondisabled adults, and the aged and disabled who are not receiving long-term services and supports. Dual eligibles are currently excluded from managed care, but will be enrolled (voluntarily) as part of the state's demonstration project to integrate care for dual eligibles which is slated to begin in 2014. Plan choice varies by region, but all beneficiaries have a choice of between two and four health plans. Of the six participating plans, four also serve (or are affiliated with insurers that serve) the commercial market, while two serve only public programs. At the time of our interviews, the state was pursuing the addition of a seventh plan, which also has a commercial side.

PROVIDER CAPACITY: MIXED VIEWS

Though the study states generally felt that their Medicaid managed care programs were prepared for the influx of enrollees expected in 2014, one common area of concern involved the capacity of health plans' provider networks to meet new demand. Most (though not all) informants expected provider capacity to be a challenge for their state, but often qualified their concerns—in Minnesota an informant noted that capacity issues “will not be insurmountable,” and in New York another suggested that there would be “some demand-driven challenges but it won't be a major problem.”

Study states' experiences with previous coverage initiatives involving the Medicaid expansion (or a similar population was also considered advantageous in terms of provider networks' preparedness to serve new enrollees, because many of the newly eligible individuals are already interacting with the health system in some way. For example, Maryland's Primary Adult Care (PAC) program provides limited outpatient care to adults, many of whom will be eligible for Medicaid coverage under the ACA expansion. Because of PAC, Maryland already contracts with many community-based behavioral health care providers, prompting one key informant to explain: “We're not anticipating having an [access] issue with specialties. I think we're well positioned. Because of the nature of Maryland's current design, I think we're in much better shape than Medicaid health plans in other states.” Key informants in other states echoed this sentiment, suggesting that much of the uninsured population already receives health care through either a Medicaid-based program or from safety-net providers that are already part of Medicaid managed care networks (e.g., Federally Qualified Health Centers).

Importantly, many viewed provider capacity as problematic for their state's health system more broadly—including for the privately insured population—though perhaps more pronounced in Medicaid given the program's often lower provider reimbursement rates. Worries about provider capacity also varied depending

on the type of provider. In some states, concern was mainly related to primary care; in others, informants were worried about access to specialists, especially those providing behavioral health and dental care since many speculated that the Medicaid expansion population would have pent-up demand for these services.⁷

With the vast majority of health plan contractual requirements already in place,⁸ a number of state officials noted their Medicaid managed care programs would—at least in theory—be prepared to meet the health care demands of new enrollees. In practice, however, some suggested that network providers may not currently accept new Medicaid patients, and expressed concern that the expansion will only exacerbate the problem. Moreover, as they absorb new enrollees, plans will need to expand their networks to remain compliant with network adequacy standards. This would involve contracting with additional providers who are not already participating in Medicaid managed care, but in some states such as Maryland, New Mexico, and Oregon, informants were concerned that general provider shortages in both the Medicaid and commercial markets, especially in rural areas, could make this challenging for health plans.

Several states also suggested that the extent of provider capacity issues will depend on how quickly newly eligible individuals enroll in Medicaid and the degree to which individuals currently eligible for Medicaid but not enrolled (the “woodwork effect” population) would enroll in the program. Informants agreed that there would be some level of pent-up demand (discussed above) that could put a strain on provider resources, at least initially, but this was not perceived as a threat uniformly across the states, or even across regions within a single state. For example, in New York City, a strong safety net has enabled many uninsured individuals to gain access to health care; while some New Yorkers in suburban and rural areas do not have such a social safety net and have gone many years without seeing a health care provider.

CONCLUSION

Overall, study state officials and plan representatives alike feel that, from a health care delivery perspective, they are ready to take on the ACA Medicaid expansion population. Each of the states has a long track record

in managed care and a strong infrastructure to build off. Further, through various earlier Medicaid initiatives, many of the states and plans have experience with serving populations similar to that of the ACA

expansion, and thus feel confident about what to expect in terms of their health risks and needs. With few exceptions, states intend to use their existing network of Medicaid managed care plans in the post-reform world, and, moreover, do not expect to make major modifications to plan contracts to accommodate the ACA Medicaid expansion population.

Even with this basic confidence that the infrastructure is ready, informants acknowledge there are many challenges facing Medicaid managed care programs as they move into the home stretch before January 1, 2014. Independent of the ACA, states are implementing several major changes in their Medicaid managed care programs, and health plans are “scrambling” to add new major benefits. As one informant put it, “there are a lot of changes now [in our state Medicaid managed care program] and ACA is just another big one.” Also, several of the health plans intend to participate in the Exchange; for plans that currently serve only the Medicaid market, this requires developing an entirely new insurance product and serving a wholly new market—that is, the commercial market. Provider access and capacity is another acknowledged challenge, though opinions about the gravity of this issue—which most agree is “not just a Medicaid problem”—varied considerably. Perhaps most urgent was the worry about whether the IT systems responsible for determining eligibility for Medicaid and Exchange-based subsidies, and then enrolling eligible beneficiaries into health plans, would be ready come fall 2013. Even with these acknowledged challenges, however, states and plans still believe they will be ready

to launch by “hook or crook,” but it may not be “perfect” and it may be “bumpy.”

Concerns expressed by Virginia informants echo those of other study states, but Virginia officials described an additional concern related to implementing any future authorized expansion within a very compressed time frame. Given that Virginia Medicaid has limited experience in serving nondisabled adults without children, plan preparations likely would be more extensive in this state than in some others. Virginia’s worries are likely emblematic of other states that currently have more restricted Medicaid eligibility rules and programs.

In conclusion, Medicaid managed care programs in the study states seem on balance well-positioned to handle the ACA Medicaid expansion. As implementation proceeds, however, it will be critical to monitor if and how other ACA provisions and general state Medicaid changes influence managed care programs. Also, it will be important to track the progress states and health plans make in implementing enrollment and eligibility IT systems, a key ingredient to a successful implementation. The study states include a number of Medicaid trailblazers, with several of the states being leaders in expanding Medicaid and using a managed care delivery system. More recently, many of the states have been front-runners in implementing the ACA’s Medicaid provisions. Accordingly, other states (and other state Medicaid managed care programs) may be less prepared for the Medicaid expansion.

NOTES

¹ Medicaid and CHIP Payment and Access Commission. 2012. Report to the Congress on Medicaid and CHIP: Washington, DC, June.

² In Medicaid there are several types of managed care arrangements such as primary care case management and comprehensive risk-based managed care. In this brief we focus on the latter—managed care programs involving health plans that receive a fixed payment per person per month to cover a comprehensive set of health care services, regardless of the services rendered.

³ Though executive support is critical, state legislatures also typically play a major role in implementing Medicaid expansions. For instance, in one study state—Michigan—officials expected a robust legislative debate over the expansion and indicated that expansion is “far from a done deal,” even with the governor’s support. In other states, informants were very confident that their state legislatures would take the steps necessary to ensure that the expansion goes into effect in January 2014. Also, on May 3, 2013, Virginia’s Governor McDonnell signed into law a budget bill that could provide for Medicaid expansion under the ACA under certain conditions, effective as early as July 1, 2014. As a prerequisite to the expansion, however, the bill requires Virginia’s Department of Medical Assistance Services to continue implementation of existing Medicaid reforms and to pursue and implement additional reforms. If a newly created legislative Medicaid commission determines that the state has met the specified conditions for Medicaid reform, the bill provides for Medicaid expansion without an additional vote by Virginia’s General Assembly.

⁴ Under the ACA, the federal government will fund 100 percent of the cost of coverage for expansion enrollees from 2014–16; the federal share will gradually decline to 90 percent in 2019 and beyond. Currently, the federal government funds an average of 50 percent of the cost of coverage for Medicaid enrollees.

⁵ This minimum threshold is \$20 million in annual premium revenues for the small group market and \$10 million in the individual market. See http://marylandhbe.com/wp-content/uploads/2012/10/Maryland_Health_Benefit_Exchange_Act_of_2012_Senate_Bill_238_House_Bill_443.pdf.

⁶ As of April 19, 2013, HB 228 had passed in both the Maryland Senate and the House; SB 274 remained under consideration in the house. See <http://mgaleg.maryland.gov/webmgafirmMain.aspx?id=sb0274&stab=01&pid=billpage&tab=subject3&sys=2013RS>.

⁷ Dental care is not part of the ACA-prescribed set of Essential Health Benefits that states must include in the benefit packages they offer to newly eligible (expansion-related) Medicaid beneficiaries, though states may decide to cover dental care as an optional benefit.

⁸ As a condition of participating in Medicaid managed care, health plans are required to comply with program requirements for network adequacy. An adequate provider network must contain not only a sufficient number of providers across a plan’s service area, but also an appropriate distribution of primary care providers and specialists. Network requirements are stipulated in managed care contracts and typically include provider to enrollee ratios (e.g., one primary care provider for every 500 enrollees) and standards for geographic proximity (e.g., the network must include a particular specialist within 60 miles of a rural enrollee’s home address).

About the Authors and Acknowledgements

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