
REAL SOLUTIONS: Policy Briefs

AMERIGROUP PUBLIC POLICY INSTITUTE

Savings in Medicaid Series

Debunk Myths about Medicaid Quality

Issue Defined

Approximately two in three Medicaid beneficiaries now receive care through a private insurer. States that contract with managed care organizations (MCOs) for Medicaid often calculate what they would spend on Medicaid patients directly and pay the MCOs a per-patient premium below that amount, giving MCOs an incentive to keep their costs under the premium because they keep the difference as profit. Under a managed care delivery model, questions naturally arise around the quality of care provided to Medicaid beneficiaries. Those that question the quality provided by MCOs are often unaware of program oversight conducted by the State and the existence of contract requirements that drive organizations to achieve specific quality standards.

Background

Over the course of Medicaid's 40-year history, the program has gradually transformed from a welfare-based health program to a program that provides health coverage to people with disabilities, long-term care coverage and financing, support to safety-net providers and assistance to low-income Medicare beneficiaries. Medicaid is jointly funded by the federal and state governments, and coverage varies across states. With the emergence of MCOs that administer benefits for Medicaid recipients on behalf of their state government partners, questions have arisen regarding the quality of care, due particularly to the administrators' for-profit status. The value that MCOs bring to Medicaid programs too often goes unnoticed by the policymaking community and the broader population; therefore, negative myths have emerged that are not supported by facts.

Myth

Medicaid is a poor-quality program that has little impact on access to care or health.

Reality

A considerable body of evidence demonstrates Medicaid's role in improving beneficiaries' access to care and improving clinical outcomes. This is proven through the Medicaid delivery system arrangement in New York, where managed care and fee-for-service co-exist. In New York City, there are three delivery system options that New York City Medicaid beneficiaries with HIV may choose: (1) the fee-for-service system, (2) managed care plans or (3) HIV "Special Needs Plans." A recent study illustrates the effectiveness of managed care over the other delivery systems; beneficiaries in managed care were less likely than beneficiaries in other delivery systems to experience inpatient admissions and emergency room visits but more likely to participate in preventive procedures such as breast cancer and cholesterol screenings.

The focal point of the managed care model is the medical home, from which the member receives necessary services and seamless coordination of care. The establishment of Medicaid managed care programs in 48 states has provided approximately 28.5 million

beneficiaries, or 64% of all Medicaid beneficiaries, with a medical home. MCOs serving the Medicaid population have created organized systems of care that have dramatically improved health care quality and access for the Medicaid population. MCOs consistently provide services promoting quality such as member outreach, access facilitation, innovation, cost-effective care and enhanced quality initiatives; these services are not available through other service models, such as the traditional fee-for-service model.

There are numerous examples of MCOs devoting resources and creating special programs to improve quality. In Maryland, asthma is a key area of concern for the Medicaid population. In partnership with a group of seven federally-qualified health centers, one Maryland MCO operates “Healthy Hoops,” a program seeking to educate asthmatic children and their parents about asthma, and how to manage the disease through appropriate medication usage, proper nutrition, monitored exercise and recreational activities. As a result of the program, emergency room visits decreased by 78 percent, and nocturnal awakenings sleep disturbances decreased by 70 percent.

Myth

Medicaid managed care organizations provide the least amount of care possible to make a larger profit.

Reality

States and federal agencies closely monitor the performance of Medicaid managed care programs and the MCOs that administer them; therefore, MCOs are contractually obligated to provide high quality services to members. The Social Security Act requires states that operate Medicaid managed care programs to provide for an external, independent review of their MCOs. States may contract with an independent entity called an External Quality Review Organization (EQRO) to conduct the review.

Additionally, MCOs ultimately make less profit when providing members with the least amount of care possible, since inadequately treated members would result in increased medical costs; sicker, unmanaged beneficiaries result in unnecessary emergency room visits and higher cost procedures. In New York, a state in which there has been an overwhelming shift in Medicaid beneficiary enrollment from fee-for-service to managed care, Medicaid managed care plans have not only made notable improvements in health outcomes over Medicaid fee-for-service, but have surpassed all national quality benchmarks in women’s health care, children’s health care, chronic care of adults and treatment of mental illness. In addition to New York Medicaid managed care’s positively-trending beneficiary outcomes, Medicaid managed care has reduced the rate of Medicaid cost growth. From 2000 to 2002, Medicaid managed care per-enrollee costs have grown 2.3 percent, while comparable Medicaid fee-for-service per-enrollee costs have grown more than twice as fast – 4.9 percent.

Savings Outlook

Savings resulting from a Medicaid managed care delivery system fluctuate from state to state, but most states share the same positive outcomes: healthier beneficiaries and lower Medicaid costs per enrollee. Several factors attribute to such outcomes, including state and federal agencies’ monitoring of MCOs and mandating strict quality guidelines, the inherent quality of managed care emphasizing the use of a medical home, quality-promoting activities conducted by MCOs, and a system in which MCOs make less profit when providing members less care.