



NIHCM

Medicaid Managed Care Facts

February 1995

Overview of Medicaid

Medicaid is a federal-state partnership program that finances health care services for 36 million low income individuals.

The Medicaid Program is authorized under title XIX of the Social Security Act. The program is financed by state and federal governments, and is administered by the states. Medicaid represented approximately 15% of total US health care expenditures while covering approximately 13% of the US population in 1993.

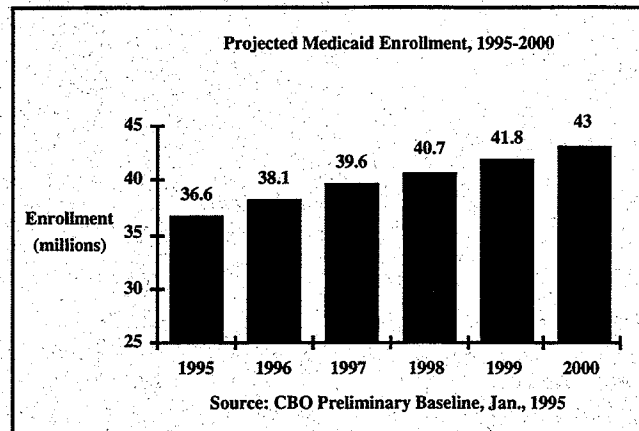
Federal oversight of the Medicaid program is the responsibility of the Medicaid Bureau in the Health Care Financing Administration (HCFA) within the Department of Health and Human Services.

Medicaid Coverage

Medicaid is a means tested entitlement. Medicaid defines over 50 distinct population groups as potentially eligible, including certain segments for which coverage is mandatory. However, states have flexibility in deciding other segments they wish to cover. There are generally two categories of Medicaid beneficiaries, "categorically needy" and "medically needy". "Categorically needy" beneficiaries are usually, but not always, eligible for cash assistance type programs, while "medically needy" beneficiaries are usually included due to their health status.

There are six basic groups of Medicaid beneficiaries:

- Current and some former recipients of cash assistance from Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI).
- Low income pregnant women and children who do not qualify for AFDC.
- Persons who do not meet the financial standards for cash assistance programs, but due to their medical condition qualify under limits set by the states.
- Persons requiring institutional care.
- Low-income Medicare beneficiaries.
- Low-income persons losing employer coverage and are entitled to continue coverage through COBRA.

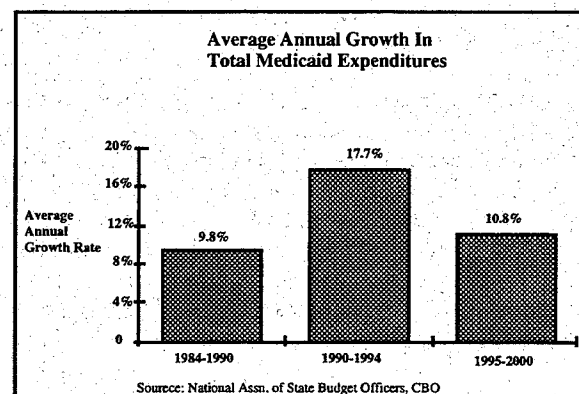


Medicaid enrollment grew at an average annual rate of 5% (from 1992 to 1994). Medicaid enrollment is expected to grow from 36.6 million recipients in 1995 to 43.0 million recipients in 2000. This represents a growth rate of 3.3% per year.

Medicaid Expenditures

Total Medicaid expenditures have grown from \$41 billion in 1984 to \$138 billion in 1994. The average annual growth rate from 1984-1990 was 9.8% while the average annual growth rate from 1990-1994 was 17.7%. The Congressional Budget Office projects that Medicaid expenditures will grow from \$157 billion in 1995 to \$262 billion in 2000. This represents a compound annual growth rate of 10.8% over the next 5 years.

Currently, Medicaid consumes approximately 18% of state spending and approximately 6% of federal spending.

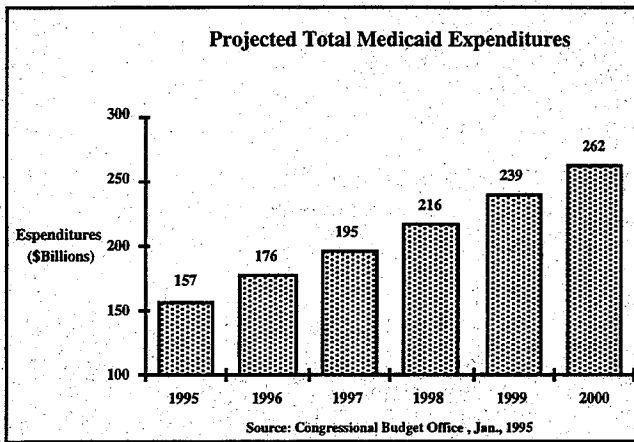


The National Institute for Health Care Management, established in 1993 by leading managed care companies, supports fact based research and dissemination of effective and innovative practices in health care, especially those involving management, financing, and delivery. The Institute is also a clearinghouse for studies on health management and provides a forum for learning and building upon existing managed care expertise.

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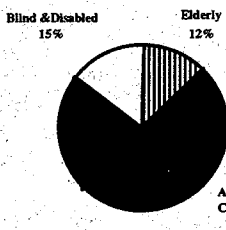
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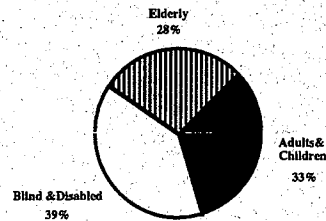
Overall, the federal government pays about 57% of Medicaid costs and states pay the other 43%, though the federal portion ranges from 50-80%. The Federal expenditures for Medicaid have grown from \$41 billion in 1990 to \$82 billion in 1994. The federal portion of Medicaid is expected to grow at an average of 10.6% per year from 1995 to 2000, reaching \$149 billion in 2000.

While welfare related adults and children make up over 70% of beneficiaries, they comprise only 33% of Medicaid expenditures. 67% of expenditures are associated with the elderly, blind and disabled populations that Medicaid serves.

Medicaid Beneficiaries, by Category 1993



Medicaid Expenditures, by Category 1993



Source: Urban Institute Analysis of HCFA Data

Medicaid Services

The federal government mandates that the Medicaid program include the following services:

- Inpatient and outpatient hospital costs
- Physician services
- Laboratory and X-Ray costs
- Family planning
- Nursing home and home health care costs
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children

States may opt to include additional services such as:

- Prescription drugs
- Clinic services
- Intermediate care facilities

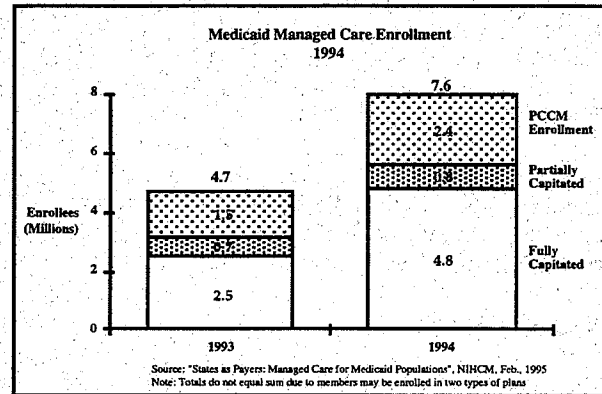
Medicaid and Managed Care

States have increasingly turned toward managed care arrangements in attempting to control the costs of their Medicaid programs. As of June 1994, 7.6 million Medicaid recipients, almost one-fourth of all Medicaid

recipients, were in some form of managed care. This is a 57% increase over 1993.

There are three categories of Medicaid managed care:

- Primary Care Case Management (PCCM), provides for a physician that serves in a "gatekeeper" function, but most services continue to be paid on a fee for service basis.
- Partially capitated plans pay for a limited package of services on a capitation basis, while other services are paid on a fee-for-service basis.
- Fully capitated plans are contracts with HMOs or prepaid health plans that provide comprehensive services on a capitated basis (fixed amount per member per month).



Source: "States as Payers: Managed Care for Medicaid Populations", NINCM, Feb., 1995
Note: Totals do not equal sum due to members may be enrolled in two types of plans

While 24% of recipients are enrolled in managed care, only about 7% of total Medicaid spending is paid in a capitated form. States with a large % paid in capitation are:

- Arizona 100%
- Tennessee 75%
- Oregon 22%
- Minnesota 12%
- Florida 11%

The federal Medicaid statute allows states to include managed care as part of their state's Medicaid plan on a voluntary basis. However, many states have sought increased authority to move more aggressively towards managed care through the use of waivers. This would allow states to take advantage of cost savings, increased access, and increased coordination of care. There are two classes of waivers presently available to states:

- "Programmatic" Waivers (1915(b)): States can require recipients to enroll in managed care programs.
- "Demonstration" Waivers (1115(a)): The Secretary of Health & Human Services has broad authority to grant waivers to states implementing innovative delivery systems including managed care programs.

Many studies have examined the impact of the move to Medicaid managed care, and some of the results to date:

- Emergency room use is reduced.
- Inpatient use is lower.
- Increased satisfaction due to increased access to private physicians.
- Costs to states appear to be lower.