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Changes in
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findings brief

Access and Use of Health Care Vary by Type of Medicaid Managed Care Program

Currently, 49 states rely on some form of Medicaid managed care, and enrollment has increased from 10 percent of all enrollees in 1990 to about 57 percent in 2001.

Different types of Medicaid managed care (MMC) programs—mandatory HMOs, primary care case management (PCCM) programs, and combination HMO/PCCM programs—affect beneficiaries' access to and use of health care services in different ways, according to research at the Urban Institute by Stephen Zuckerman, Ph.D., Niall Brennan, and Alshadye Yemane. [1]"The study shows that state decisions about which type of Medicaid managed care program to implement and who to include in mandatory enrollment will significantly influence a program's effect," says Zuckerman.

In general, beneficiaries of programs that include HMOs have better access to care than those enrolled in non-HMO programs. The findings vary according to the types of access and use indicators being examined and the types of beneficiaries enrolled in a given program, the researchers found. For example, children seem to fare better overall than adults with respect to both access and utilization, regardless of program type.

Zuckerman's study uses nationally representative data to evaluate the effects of specific Medicaid managed care programs on beneficiaries. Unlike many investigations of MMC programs, Zuckerman's study was not limited to analyses of a small number of states.

"Although we recognize that Medicaid managed care is by no means the same in all states," says Zuckerman, "this research goes beyond many earlier studies to estimate average policy effects across states using nationally representative data."

Background

States started to use managed care in their Medicaid programs in the 1980s in response to concerns that beneficiaries did not have adequate access under fee-for-service (FFS) care. Several states adopted prepaid health plans and PCCM programs with voluntary enrollment to expand access and make future Medicaid costs more predictable. As Medicaid expenditures rose rapidly throughout the early 1990s, states increasingly turned to managed care as a cost-containment mechanism.

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Related Findings: Payment Rates for Medicaid Managed Care Affect Access

One factor affecting the "success" of Medicaid managed care programs is the level and type of payment. Payment rates influence plans' willingness to participate in Medicaid, which in turn affects access to care. In a January/February 2003 *Health Affairs* article, "Medicaid Managed Care Payment Methods and Capitation Rates in 2001," John Holahan, Ph.D., and Shinobu Suzuki report findings that underscore Zuckerman's conclusions about the impact of Medicaid managed care on beneficiaries' access to care. In 2001, the researchers updated an Urban Institute study conducted in 1998, which surveyed Medicaid managed care payment methods and rates, focusing on AFDC/TANF and poverty-related Medicaid populations.

The principal findings were:

- There is slightly more than a twofold variation in aggregate statewide Medicaid capitation rates. The states with the highest rates are the District of Columbia, Kentucky, Minnesota, New Mexico, North Carolina, and North Dakota. The states with the lowest rates are Florida, Kansas, Michigan, Oklahoma, and Texas.
- States that had low Medicaid rates relative to the national median for Medicaid, but Medicare rates that are above the median for Medicare, may face issues of rate adequacy. These states are Arizona, California, Florida, Illinois, Michigan, New Jersey, New York, Nevada, Pennsylvania, and Texas.
- The study found that the average increase between 1998 and 2001 in Medicaid rates was about 18 percent, slightly under 6 percent per year. But over the same period Medicare rate increases averaged about 10 percent, roughly half of the rate of increase in Medicaid rates. This low rate of growth is related to the controls in the Balanced Budget Act on fee-for-service spending, and somewhat to the change in payment structure for Medicare+Choice plans.
- While Medicaid rates grew faster than Medicare rates, they did not grow as fast as commercial premiums. Data from annual employer surveys showed a 26 percent increase in rates over the same period.

The authors caution that while the level of rates as well as the way states adjust for risk will affect managed care plans willingness to serve Medicaid patients, a number of other factors matter as well. These include the amount of excess provider capacity in the state that allow plans to negotiate lower provider payment rates, the degree of Medicaid managed care regulation, and the ability and willingness of plans to adapt to the product being purchased by the state. Ultimately, the key issue is whether the rates that states are paying result in satisfactory levels of plan participation, beneficiary access, and quality of care. If states with low rates have no issues of plan participation, access or quality, rates are probably adequate, and vice versa. Finally, the authors caution that states with low rates are probably not buying the same product as states with higher rates with likely implications for access, quality of care, and health.

care plans used within Medicaid vary considerably among states. For example, most states with established mandatory enrollment programs use fully capitated HMOs. In others, PCCM programs are still popular. Still other states combine HMOs and PCCMs by requiring enrollment into managed care but allowing beneficiaries to choose between programs.

Methods

Using data from the 1997 National Survey of America's Families (NSAF) and a 1998 Urban Institute survey of state Medicaid officials, the researchers assessed how various MMC programs affect access to care and service use. They evaluated access and use measures among nondisabled children and adults enrolled in MMC programs relative to similar beneficiaries[2] in fee-for-service Medicaid and low-income people covered by private insurance.

The researchers evaluated beneficiaries' access to a usual source of care, the location of that care (e.g., a doctor's office, clinic, or hospital emergency room), their reported unmet health care needs, and their confidence in getting care when it is needed. To measure utilization, they studied whether a beneficiary had had at least

one visit to a doctor, health professional, dentist, or emergency room (ER) in the year prior to the survey as well as whether the beneficiary had received certain types of preventive health care services.

Results

Access

Among children, those in mandatory HMOs were less likely to depend on an ER as a usual source of care relative to children in Medicaid FFS or private insurance plans for low-income individuals. Children in mandatory PCCMs also were less likely to use an ER as a usual source of care and more likely to rely on a physician's office for their usual source of care than children in FFS plans. Children in combination HMO/PCCM programs were more likely to have had a usual source of care and less likely to rely on an ER as a usual source of care than their counterparts in FFS. They were also more likely to have a usual source of care in comparison to low-income children in private insurance programs. Only combination HMO/PCCM programs influenced children's overall chances of having a usual source of care. This was not observed in either the HMO or PCCM models alone, according to Zuckerman.

Compared to adults in FFS plans, adults in mandatory HMOs were less dependent on an ER as their usual source of care. Similarly, adults in combination programs were more likely to have a usual source of care and less likely to rely on an ER as a usual source of care relative to adults in FFS or private plans. Compared to the privately insured, adults in combination programs with a usual source of care relied more on clinics for that care than a doctor's office. Adults in PCCMs were more likely to have had some usual source of care than adults in FFS plans.

Utilization

Compared with children in Medicaid FFS or low-income children in private insurance plans, children in HMOs were more likely to have visited a physician or dentist and received preventive care. Children in PCCMs were more likely to have visited a physician or other health care professional than children in FFS, and were more likely to have visited an ER than those in private insurance plans. Children in combination programs were more likely to have received preventive care than low-income children in private insurance plans.

Adults in mandatory HMO programs were more likely to have visited an ER compared to low-income adults with private insurance plans. Additionally, they were less likely to have visited a dentist than their FFS and privately insured counterparts. Adult enrollees in combination plans were more likely to have had unmet dental needs and more likely to have been confident in their ability to get needed care relative to enrollees of private insurance plans.

Utilization was not significantly different for adults in PCCMs relative to adults in FFS or private insurance plans, with one exception: adults in PCCMs were more likely to have made an ER visit than low-income adults with private health insurance.

Conclusions

It is difficult to draw overarching conclusions based on these data, in part because of the large degree of variation among states in areas such as program structure and reimbursement strategies. In the case of combination programs, these systems' mixed nature may also make interpretation of the results challenging, says Zuckerman.

"Our findings for children and adults enrolled in HMO/PCCM programs are not as clear as those for HMO or PCCM independently and are less consistent across adults and children," he says.

It seems certain, however, that Medicaid managed care programs affect children and adults differently, says Zuckerman, with greater access to and use of health care services observed among children. "HMOs, PCCMs, and combined programs produce different effects on beneficiaries' access and use," he says. "Policymakers need to understand that they cannot shift among types of managed care without expecting consequences."

About the Author

Lisa Fleisher is a research assistant working primarily on The Robert Wood Johnson Foundation's HCFO program, which supports investigator-initiated research and policy analysis, evaluation, and demonstration projects examining major changes in health care financing and their effects on cost, access, and quality. AcademyHealth (www.academyhealth.org) serves as the national program office for HCFO. Ms. Fleisher can be reached at 202.292.6700 or lisa.fleisher@academyhealth.org.

Endnotes

1 *Zuckerman, S. et al. "Has Medicaid Managed Care Affected Beneficiary Access and Use?"* Inquiry *(Fall 2002) Vol. 39, No. 3, pp. 221–242.*

2 *Medicaid beneficiaries receiving Supplemental Security Income and/or Medicare were excluded from the study group since most states do not make enrollment mandatory for these individuals. Beneficiaries living in counties with voluntary Medicaid managed care programs were excluded to eliminate potential selection bias.*

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