



Medicaid Managed Care and Asthma: A Primer

Introduction

Medicaid is a joint federal-state public health insurance program for low-income children and adults. Nationally, the majority of Medicaid beneficiaries are served through managed care organizations. This primer describes how Medicaid managed care works, using examples related to asthma to illustrate features of the system and inform efforts to improve guidelines-based asthma coverage and care.

Medicaid Managed Care Landscape

Traditionally, the Medicaid program operated on a fee-for-service basis: state Medicaid agencies reimbursed providers directly for each eligible service they performed for a Medicaid beneficiary. Over time, states began to shift toward models that help control costs, the most prominent being Medicaid managed care.

In the Medicaid context, the term managed care encompasses a range of arrangements in which states contract with entities that take on responsibility for financing some or all of Medicaid beneficiaries' care in return for a set payment. The term can include limited benefit plans (e.g. plans that cover only behavioral health care), as well as primary care case management or PCCM models in which primary care providers are given a monthly fee to coordinate care for enrollees.¹

The most common Medicaid managed care arrangement is comprehensive "risk-based" managed care. In this model, Medicaid managed care organizations, or MCOs, are responsible for financing most or all of the care for their assigned enrollees.² In return, the MCOs receive a fixed monthly payment per enrollee, regardless of how much care the enrollee receives that month.

Overall, as of 2016, over two-thirds of all Medicaid beneficiaries were enrolled in comprehensive MCOs.³ However, enrollment varies significantly by state. In some states, nearly all Medicaid beneficiaries are enrolled in comprehensive MCOs; in others, only a small percentage are in MCOs, with the majority remaining in fee-for-service Medicaid.^{4,5} Most states make managed care enrollment mandatory for some categories of Medicaid enrollees, with some states exempting people with disabilities, the medically needy, children with special health care needs and foster children from mandatory managed care.⁶

How States Pay Medicaid MCOs

The monthly rate paid by state Medicaid agencies to an MCO is called the capitated rate. This rate is generally calculated by the state in consultation with MCOs, based on historical cost data, expected changes and a range of other factors.

Once enrollees select or are assigned to MCOs, states use a process called risk adjustment to ensure that MCOs whose enrollees have higher than average needs are being adequately reimbursed. Risk adjustment relies on individual enrollee factors including age, gender, and health status; MCOs with enrollee populations likely to incur higher costs receive an upward adjustment to the monthly premiums they receive from the state.

Medicaid MCO Enrollees: Access to Services

States' contracts with MCOs lay out the requirements of coverage. Generally, federal regulations require that managed care enrollees have access to all of the benefits in a state's Medicaid program and in any applicable Medicaid waivers.⁷ However, within this requirement, MCOs have certain flexibilities in how they cover care, with several key differences particularly relevant to asthma care and treatment.

MCO Networks

For physician and other healthcare services, Medicaid MCOs contract with a set of providers, called a network. Generally, enrollees must see in-network providers for services. Federal regulations require states to develop standards for assessing MCO network adequacy to make sure that beneficiaries can access needed primary and specialty care.⁸ For children and adults with asthma, this should mean that MCO enrollees have access to in-network primary care providers as well as pulmonologists or other specialists as needed.

Pharmacy Benefits

MCO coverage of prescription drugs may differ from a state's fee for service program. Generally, state Medicaid programs must cover all drugs from manufacturers that participate in the Medicaid National Drug Rebate Agreement, which offers large discounts in exchange for formulary inclusion. However, state fee-for-service programs can apply a range of methods to manage the use of pharmacy benefits. These "utilization management" techniques can include prior authorization requirements, quantity limits or step therapy.

In most states, pharmacy is included in MCO contracts and MCOs must cover all drugs that the state FFS program covers. However, MCOs generally have the flexibility to use different utilization management tools than the state's fee for service program. For example, a state Medicaid FFS program may cover Montelukast only with prior authorization requirements, but an MCO within the state may instead apply quantity limits. The exception is in states with standardized or common formularies, generally meaning that all MCOs in the state must apply utilization management approaches identical to those in the FFS program.⁹

A handful of states carve out the pharmacy benefit from their MCO contracts, meaning that all drugs for managed care enrollees are paid for directly by the state Medicaid agency rather than by the MCO.¹⁰ In these states, any utilization management techniques applied to asthma drugs would apply to all MCO enrollees as well as FFS beneficiaries.

Some Medicaid MCOs include asthma-related devices such as spacers in the pharmacy benefit, but others treat them as durable medical equipment, a different benefit category. This treatment may depend on contract requirements set by the state Medicaid agency. When asthma devices are categorized as DME, MCO enrollees may need to access them from DME suppliers that are part of the MCO's network, rather than in a pharmacy. In addition, MCOs can generally apply prior authorization requirements to DME.

MCO Coverage of Additional Services

Medicaid MCOs may cover additional services beyond those included in the state's fee-for-service plan. These services can be either "in lieu of" covered Medicaid benefits or "value-added" benefits beyond the state Medicaid package. For example, in Indiana, Medicaid MCOs are required to provide chronic disease management programs; some MCOs in the state offer a variety of asthma education services, including telehealth and education services, beyond what the state fee-for-service program covers.¹¹

When MCOs cover services to address asthma that go beyond a state's Medicaid plan, they must draw from a limited pool of administrative funds to cover value-added benefits. However, using funding for "quality improvement" activities such as asthma education programs could help plans meet a new regulatory requirement that plans attain an 85 percent medical loss ratio or MLR.¹² The MLR is calculated as the cost of benefits covered plus quality improvement costs and fraud prevention costs, divided by total premium revenue.¹³ Because MCOs must achieve an MLR of 85 percent or remit funds to the state, they may see a benefit in funding quality improvement activities for asthma and other conditions.

State Levers to Influence MCO Performance

State Medicaid agencies can influence Medicaid MCOs in a number of ways.

Contractual Requirements

First, states lay out standards for coverage and other expectations in their contracts with MCOs. Most states have a model contract available, but specific terms can be negotiated differently with each MCO.

States can use their contracts to require MCOs to take certain actions related to beneficiary health. For example, Michigan requires Medicaid MCOs, to the extent applicable, to "support the design and implementation of Community Health Worker (CHW) interventions delivered by community-based organizations which address Social Determinants of Health and promote prevention and health education, and are tailored to the needs of community members in terms of cultural and linguistic competency and shared community residency and life experience."¹⁴ This type of requirement can be used to address asthma, as well as other beneficiary health needs.

Requiring and Incentivizing Performance Improvement

States can require MCOs to engage in Performance Improvement Projects, or PIPs. For example, the District of Columbia is requiring its three Medicaid MCOs to engage in a collaborative PIP to measure and address outcomes for pediatric asthma (patients aged 2-20). Reported measures include the number of children with one or more emergency department visits with a principle diagnosis of asthma during the measurement year; the number of children who had one or more acute hospital inpatient admission with a principle diagnosis of asthma; and the number of children who were dispensed appropriate asthma controller medications that they remained on during the treatment period.¹⁵ PIPs can help MCOs, collaboratively or individually, closely assess the quality of care their enrollees receive and develop approaches for improvement.

States can also use financial incentives to reward MCOs for specific outcomes. In a national survey, the majority of states reported using at least one quality improvement system in their Medicaid managed care programs: 22 offered MCOs "pay for performance" bonuses for reaching certain thresholds; 29 applied "capitation withholds" or penalties for MCOs

that did not meet performance thresholds; and 36 required data collection and reporting for quality improvement.¹⁶ These incentive systems are often based on a set of performance measures called HEDIS, or the Healthcare Effectiveness Data and Information Set, though states can also develop and apply their own measures.¹⁷ The HEDIS measure set includes a compound measure related to appropriate management of asthma with medication: Medication Management for People with Asthma, and Asthma Medication Ratio (MMA, AMR).¹⁸

For example, New York State has an incentive system for Medicaid MCOs that offers both financial incentives and preference in auto-assignment of beneficiaries who do not select an MCO.¹⁹ MCO scores are based on a range of factors, including a set of HEDIS and state-specific measures; one of the measures is Medication Management for People with Asthma (Ages 5-64).²⁰

Conclusion

As the dominant financing method for care of Medicaid enrollees, comprehensive managed care is a crucial system for children and adults with asthma. Understanding how Medicaid managed care works is the first step in ensuring that states, managed care organizations and providers are working together to optimize guidelines-based asthma care and treatment.

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¹As of 2017, 15 states had PCCM models, with enrollment ranging from 2 to 95 percent of the state's Medicaid population. Kaiser Family Foundation, "Share of Medicaid Population Covered under Different Delivery Systems" (Jul. 2017). www.kff.org/medicaid/state-indicator/share-of-medicare-population-covered-under-different-delivery-systems/

²MACPAC, "Types of Managed Care Arrangements." www.macpac.gov/subtopic/types-of-managed-care-arrangements/

³CMS, "Medicaid Managed Care Enrollment and Program Characteristics, 2016" (Spring 2018). www.medicare.gov/medicaid/managed-care/downloads/enrollment/2016-medicare-managed-care-enrollment-report.pdf

⁴Kaiser Family Foundation, "Medicaid Managed Care Penetration Rates by Eligibility Group" (Jul. 2017). www.kff.org/medicaid/state-indicator/managed-care-penetration-rates-by-eligibility-group/?activeTab=map

⁵Kaiser Family Foundation, "Share of Medicaid Population Covered under Different Delivery Systems" (Jul. 2017). www.kff.org/medicaid/state-indicator/share-of-medicare-population-covered-under-different-delivery-systems/

⁶MACPAC, "Populations and Enrollment in Medicaid Managed Care," in Report to Congress: *The Evolution of Managed Care in Medicaid* (2015). https://www.macpac.gov/wp-content/uploads/2015/01/Populations_and_Enrollment_in_Medicaid_Managed_Care.pdf

⁷42 CFR 438.206 - Availability of services.

⁸Kaiser Family Foundation, "CMS's Final Rule on Medicaid Managed Care: A Summary of Major Provisions" (June 2016). www.kff.org/report-section/cms-final-rule-on-medicare-managed-care-issue-brief/

⁹Kaiser Family Foundation and NAM, "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>

¹⁰Id. Several states carve out only certain classes of drugs, such as behavioral health drugs, HIV drugs, or HCV treatment.

¹¹Horton et al., "Medicaid Coverage of Asthma Self-Management Education: A Ten-State Analysis of Services, Providers and Settings" (June 2017). www.lung.org/assets/documents/asthma/medicaid-coverage-of-asthma-self-management-education.pdf

¹²45 CFR 158.150 - Activities that improve health care quality.

¹³42 CFR 438.8 - Medical loss ratio (MLR) standards.

¹⁴STATE OF MICHIGAN Contract No.[] Comprehensive Health Care Program for the Michigan Department of Health and Human Services. www.michigan.gov/documents/contract_7696_7.pdf

¹⁵District of Columbia Department of Health Care Finance, "Medicaid Managed Care 2017 Annual Technical Report" (April 2018). https://dhcf.dc.gov/sites/default/files/dc/sites/dhcf/publication/attachments/FY%202017%20Annual%20Technical%20Report_FINAL.pdf

¹⁶Kaiser Family Foundation and NAMD, "Medicaid Moving Ahead in Uncertain Times: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2017 and 2018" (Oct. 2017). <http://files.kff.org/attachment/Report-Results-from-a-50-State-Medicaid-Budget-Survey-for-State-Fiscal-Years-2017-and-2018>

¹⁷NCQA, "HEDIS and Performance Measurement." www.ncqa.org/hedis/

¹⁸MMA is the proportion of children and adults aged 5-85 identified with persistent asthma who "were dispensed appropriate asthma-controlled medications that they remained on for at least 75% of their treatment period"; AMR is the proportion of children and adults aged 5-85 identified with persistent asthma who "had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year." NCQA, "HEDIS Measures and Technical Resources: Medication Management for People with Asthma and Asthma Medication Ratio (MMA, AMR)." www.ncqa.org/hedis/measures/medication-management-for-people-with-asthma-and-asthma-medication-ratio/

¹⁹New York State Department of Health, "2017 Quality Incentive for Medicaid Managed Care Plans: A Report on Quality Incentive Program in New York State." www.health.ny.gov/health_care/managed_care/reports/docs/quality_incentive/quality_incentive_2017.pdf

²⁰Id.

