Vol. VIII, No. 6
November 2005

Changes in
HEALTH CARE
FINANCING &
ORGANIZATION

findings brief

Managed Care for Children in Medicaid: Some Good News, but Not a Cure-All

By Susan Edwards

Impressed by the successes of managed care in the private sector, many states in the 1990s began to move their Medicaid populations from fee-for-service (FFS) into managed care. They hoped to not only control costs, but also improve access to care, utilization, and patient satisfaction. Between 1996 and 1998, the number of Medicaid recipients covered by managed care plans grew by nearly 3.5 million, from 40 percent of all recipients to nearly 54 percent. Despite this growth, little is known about the effects of Medicaid managed care on health care access and use.

New research by Stanford University's Laurence Baker, Ph.D., and colleagues finds mixed results when evaluating the impacts of Medicaid managed care on children. Increases in health maintenance organization (HMO) enrollment, for example, were associated with less emergency room use, more outpatient visits, and fewer hospitalizations than in FFS. However, managed care enrollment was also associated with higher rates of reporting having delayed, and lower satisfaction with, the most recent visit.

Enrollment in another managed care model, primary care case management (PCCM) plans, was associated with increases in outpatient visits for children, but also with higher rates of reporting unmet medical needs, and having no usual source of care, according to the study. Primary care case management plans differ from typical HMO plans because PCCMs use primary care physicians to coordinate care for Medicaid patients. Additionally, medical services provided by the primary care physician usually are reimbursed on a fee-for-service basis rather than capitation, as is the usual practice in HMOs .

"In some ways, the findings suggest relatively complex patterns of effects. There are some findings that seem to suggest that Medicaid managed care is associated with better care and other findings that suggest it is associated with worse care," says Baker. "We find things like more outpatient visits at the same time that we find more reports of putting off care in Medicaid HMOs, for example."

The reality of Medicaid managed care programs, according to Baker, is that they vary from place to place. For example, some states pay providers more than others, or use different payment mechanisms, such as varying rates of capitation. Additionally, some states use private sector HMOs under contract to Medicaid, while others build their own Medicaid specific HMOs. Therefore, getting a clear handle on the impact of managed care in a general way is challenging.

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Background and Data

The move toward Medicaid managed care emerged as many states searched for a remedy to the budgetary strains caused by rising health care expenditures and the ever-increasing proportion of states' budgets consumed by Medicaid. Medicaid managed care appealed to states because of its potential to improve quality of care and increase access to medical services. Opponents of managed care, however, believe that cost-saving strategies used by managed care could compromise the well-being of plan members by increasing the difficulties that an already challenged population has in navigating the health care system. For example, capitated reimbursements and utilization controls can make it difficult for an individual covered by Medicaid managed care to find a physician that will treat them.

Although there have been substantial expansions nationwide in enrollment in Medicaid managed care during the past decade, differences in the timing of legislative action mandating Medicaid beneficiaries to enroll in a managed care plan, along with differences in the population covered by the plans, caused differences in timing and enrollment rates across states. Such variation made it possible for the researchers to complete a before-after comparison of changes in states adopting Medicaid managed care and compare them to states that did not adopt Medicaid managed care.

The researchers used longitudinal data from the 1997 and 1999 National Survey of America's Families (NSAF) and the 1996/97 and 1998/99 Community Tracking (CTS) Household Surveys to track changes in health care access and use among children ages 0 to 18 covered by Medicaid between study year pairs. Survey questions were often answered by the parents of these children (e.g., the adult who accompanied the child to his or her last visit would be questioned about the patient's satisfaction). Though the project incorporated the NSAF data, in the end the publication that came from it focused only on the CTS data because the NSAF data produced few statistically significant results. They used these data to examine how changes related to the implementation or expansion of Medicaid managed care—particularly HMOs and PCCM models—at the state-level.

A goal of the Medicaid program is to ensure high quality care for children. Unfortunately, the effects of Medicaid managed care on children have not been as widely studied as the impacts on adults. "Because children comprise a large part of the Medicaid population, a key goal of the Medicaid program has been ensuring high quality care for children," says Baker. "We felt that examining this group would yield a clear picture of the effects of the shift to managed care." The researchers hope that their findings will be helpful to state decision makers as they evaluate and perhaps even continue to expand Medicaid managed care programs.

Findings

The researchers studied changes in health care access and utilization over time as well as the relationship between these changes and changes in the size of the Medicaid population covered by managed care. Using the CTS data, the researchers found that on a state level, increases in the share of the Medicaid population enrolled in managed care were associated with a number of changes in health care utilization and outcomes.

Increases in the share of Medicaid enrollees in HMOs were associated with:

- Less emergency room use;
- More inpatient visits to nurse practitioners and physician assistants, but not more outpatient visits to physicians;
- Fewer hospitalizations;
- Higher rates of having to put off care; and
- Lower satisfaction and perceptions of quality in the most recent visit.

Increases in the share of Medicaid enrollees in PCCM plans were associated with:

- Increases in outpatient visits to nurse practitioner/physician assistant/midwife and to physicians;
- Higher rates of reporting unmet medical needs;
- Higher rates of having no usual source of care.

Some of the results suggest better care in Medicaid managed care. For example, in a population that historically has difficulties with access, more nurse practitioner, physician assistant, and midwife visits may be viewed as an encouraging sign. Additionally, the decreased use of emergency departments may be construed as positive, since using emergency departments to obtain primary care is often inefficient and expensive.

However, other results suggest worse access to care and lower satisfaction under Medicaid managed care. These results may simply reflect the struggles in the shift to managed care, or they could represent serious issues with the basic ability of Medicaid managed care to delivery high-quality care.

Clearly, the effects of Medicaid managed care vary based on the type of managed care implemented. The variations in the findings may also reflect the variation across states in their programs, and the importance for those implementing and refining Medicaid managed care to monitor the impacts of the program on beneficiaries with an eye toward identifying successful models on a state-by-state basis.

"Focusing on specific examples and lessons learned from successful Medicaid managed care programs may be more useful than adopting the view that any kind of managed care will produce beneficial results," Baker concludes.

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End Notes

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