

## A Look at Medicaid and Managed Care

By Fernando Trevino, PhD, MPH, Professor and Chairman,  
Department of Public Health and Preventive Medicine, University of North Texas Health Science Center  
Closing the Gap, The U.S. and U.K. Collaborate on Minority Health • March 1998

**M**edicaid is the publicly-funded health insurance program designed to care for the poor populations in the U.S. It is funded through state and federal funds and managed at the state level.

Each state designates a single agency that is responsible for Medicaid program operations. The states determine eligibility of Medicaid applicants, determine provider qualifications, payment methods and levels, as well as negotiate contracts with managed care plans and other providers. The state also processes and pays medical claims, communicates with beneficiaries and oversees quality of care in facilities funded by Medicaid.

For each state, the federal medical assistance percentage (FMAP) is calculated using a formula that relates state per capita income to national per capita income. Thus it is one measure of relative individual state poverty. The FMAP pays for medical services in Medicaid.

The state share is the difference between FMAP and the total costs for Medicaid. Medicaid programs, poverty lines, and FMAP's vary considerably from state to state. The percentage of Medicaid costs borne by the federal government varies from 50 percent in more affluent states to 79 percent in the poorest states, and averages 57 percent nationwide. A state's Medicaid plan must be in effect throughout the entire state. And the amount, duration, and scope of services must be equal among eligible groups.

The U.S. Department of Health and Human Services may grant a waiver of these requirements under two broad categories: research and demonstration (1115 waivers) and freedom of choice (1915 waivers).

Medicaid operates as a vendor payment program, with payments made directly to providers by states. Payment levels are subject to conditions that all state Medicaid plans and agencies must satisfy. Payments must be sufficient to enlist enough providers to participate in the plan and ensure comparable services statewide. Participating providers must accept the Medicaid reimbursement as payment in full, and payments to providers must be consistent with efficiency, economy, and quality of care standards.

### Medicaid Managed Care

Managed health care organizations integrate the delivery and financing of health care for their members. This integration changes the historical supply side (provider) incentives. The change in incentives forces the provider to bear part of the financial risk, and the organization has a strong incentive to cut costs, and reduce excessive care and efficiencies. At the same time, the goal is to improve quality.

There exists bipartisan support for the concept that states should have the flexibility to enroll Medicaid beneficiaries in managed care plans. This support stems from the belief that managed care is a way to stem the rapid growth of Medicaid expenditures and state funds, and as a way to expand coverage to more uninsured people with low incomes.

The health care system in the United States is thus moving from fee-for-service to capitation, where individual providers are merging into integrated delivery systems and managed care systems are vying for business in a newly-created price-sensitive market.

Historically, for-profit corporations shunned the Medicaid market, leaving the job to nonprofit HMOs organized by charity hospitals, community clinics, and physicians working in poor neighborhoods. Now, with state Medicaid programs leaping into managed care, offering huge and potentially lucrative contracts, commercial plans are actively seeking this market.

Medicaid is now attractive to managed care companies because it delivers a ready-made pool of enrollees that otherwise would take years of costly and uncertain marketing efforts to develop. With the instant market share that a Medicaid contract can provide, such companies enjoy important advantages in the scramble to build provider networks and compete for the more lucrative business of private purchasers.

While it is clear that Medicaid is increasingly moving toward managed care, it is less clear how racial and ethnic minorities are being impacted. The limited research that has been conducted has found a positive impact on cost reduction, along with better access to care and higher levels of satisfaction when compared with conventional Medicaid beneficiaries. But what has not been researched is the quality and acceptability of care for minorities. Though the U.K. may have fewer financial access barriers for minority populations, this very issue—acceptability of services—must be addressed in both countries. ❖

