
Medicaid Reform in the 1990s

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The 1990s saw considerable change in the Medicaid program. At the beginning of the decade, Medicaid was still primarily a program that provided health care coverage to persons receiving cash assistance under the Aid to Families with Disabled Children (AFDC) or Supplemental Security Income (SSI) programs, although expansions of eligibility for low income pregnant women and children had already begun shifting the focus of coverage away from cash recipients. Health care providers were reimbursed directly for services rendered, and little was offered in the way of care management. While fee-for-service (FFS) reimbursement remains important, by the end of the decade State Medicaid programs had taken on a new role as purchasers of managed health care and case management services. At the same time, many States relaxed eligibility standards for Medicaid, extending coverage to higher income pregnant women and children or, in some cases, to the general low income uninsured population. In these States, Medicaid reform was a component of a broader effort to increase access to health insurance generally, and to encourage the development of managed care.

The States were not the only actors in the Medicaid reform arena. Congress enacted a number of reforms at the national level, including changes in the laws governing Medicaid payments to disproportionate share hospitals (DSH), welfare reform, repeal of the Boren Amendment and enactment of the State Children's Health Insurance Program (SCHIP).

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As we enter the first decade of the 21st Century, these various reform movements continue to develop, and their full implications are not yet clear. One thing that is certain, however, is that Medicaid reform has thrown into relief the program's broad reach and its relationships to multiple constituencies. It has also highlighted the administrative, logistical, and political challenges inherent in any attempt to reform a large public program such as Medicaid. This special issue of the *Health Care Financing Review* features eight articles that examine various aspects of Medicaid reform, their impact and possible future directions for the reform movement. Together they provide an overall view of the impact, successes, and challenges of Medicaid reform, and the prospects for the future.

BACKGROUND FOR REFORM

States had many motivations for pursuing Medicaid reform in the early 1990s (Ku, et al., 2000). Among the most important of these was a desire to control costs. Between 1990 and 1992, Medicaid expenditures nationwide grew at an average annual rate of 27 percent. While much of the increase was fueled by congressionally mandated eligibility expansion¹ and large increases in DSH spending, other factors, such as general health care inflation and

¹ Between 1986 and 1990, Congress passed a series of laws to extend Medicaid coverage to additional pregnant women and children, based on participants' family income relative to the Federal poverty level (FPL), rather than participation in the AFDC program. Ultimately, States were required to cover pregnant women and children up to age 6 with incomes up to 133 percent of FPL, and children born after September 30, 1983, with incomes up to 100 percent of FPL (Hakim, Boben, and Bonney, 2000).

increased enrollment of persons with high levels of health care need, also contributed to the increase (Bruen and Holahan, 2001). Managed care seemed to offer a means of controlling the cost of Medicaid. By paying private managed care plans a fixed fee per covered life, State Medicaid agencies achieved cost predictability, while passing the risk for increased expenditures on to the private managed care plans. Medicaid managed care was also seen as an opportunity to improve the quality of care for Medicaid beneficiaries, and to accomplish some longstanding public health goals. Contracted managed care plans could be held accountable for improvements in immunization rates and use of primary and preventive care, and would have an incentive to minimize unnecessary emergency room use. Finally, enrolling Medicaid eligibles into managed care plans that also catered to private sector employers offered the hope of increased access to “mainstream” health care providers, even while restricting their choice to those providers contracting with specific health plans.

For most of this period, Federal waivers were required for States to implement mandatory Medicaid managed care.² States had two routes to pursue the needed waivers. States could seek waivers under section 1915(b) of the Social Security Act,³ which permitted mandatory enrollment of Medicaid beneficiaries with capitated managed care plans or primary care case managers. States could limit managed care to selected populations, regions or services, and use projected savings to provide additional services not included in the State plan. Section 1115 offered even broader waiver authority. Under

²The Balanced Budget Act of 1997 created a "State plan option" in which States could implement mandatory Medicaid managed care without obtaining waivers. As of January 2001, eight States had established Medicaid managed care programs under the 1932(a) State plan option. A number of these States had begun their programs under 1915(b).

³Henceforth, all "section" references will be to sections of the Social Security Act.

1115, States could receive waivers of essentially any provision of section 1902, including those that could be waived under 1915(b), as well as receive Federal matching funds for additional expenditures not normally included under Title XIX. The latter provision is used to allow States to offer Medicaid coverage to persons not normally entitled to participate, such as childless adults and others not eligible under cash assistance criteria.

In 1990, only a handful of States had waivers under 1915(b), and only two (Arizona and Minnesota) had 1115 waivers to implement Medicaid managed care. As of June 1999, 34 States had at least one 1915(b) program, and 16 States were operating research and demonstration programs under 1115 that involved managed care in some way.⁴ The percentage of Medicaid eligibles in managed care increased from approximately 10 percent in 1990 to 55 percent in 1999, of which 42 percent were enrolled in capitated managed care, and 13 percent were assigned to a primary care case manager.⁵

CHALLENGES IN TRANSITION TO REFORM

The transformation of Medicaid from FFS to managed health care services has been a difficult process, and has left few of Medicaid's many constituencies untouched. The following is a brief review of some of the issues faced by Medicaid managed care programs as they have developed, with emphasis on the experience of 1115 waiver demonstrations.

Administrative Issues—All of the 1115 waiver demonstrations experienced significant administrative problems in their early

⁴For a review of recent innovations in section 1115 Research and Demonstration waiver programs, refer to Jordan, Adamo, and Ehrmann, 2000.

⁵Percentages were computed from HCFA internal data, and figures obtained from HCFA's Medicaid managed care website, <http://www.hcfa.gov/medicaid/omchmpg.htm>.

stages (Ku, et al., 2000; Gold and Mittler 2000b). Erecting and maintaining systems that could enroll and track Medicaid eligibles participating in managed care plans, monitor plan performance, and address quality issues proved to be a considerable challenge. States that took a slower, more deliberate approach to implementation tended to encounter fewer problems than those that implemented their programs rapidly (Ku, et al., 2000). Over time, many of the problems encountered in the initial phases were addressed and resolved. Contrary to the expectations of some, Medicaid managed care programs appear to require more administrative resources than FFS Medicaid, because of the need for additional monitoring (Wooldridge and Hoag, 2000).

Plan Participation—In order for mandatory Medicaid managed care to work, States typically must recruit and retain more than one managed care plan to serve Medicaid beneficiaries in each service area. This is needed to provide Medicaid beneficiaries with a choice of managed care plans.⁶ Also, States need to attract and retain commercial health maintenance organizations if they are to attain their goal of “mainstreaming” Medicaid beneficiaries. Most States implementing Medicaid managed care programs have experienced some difficulty in attracting or retaining a sufficient number of plans. As programs have matured, some of the plans that participated initially, particularly commercial HMOs, have dropped out, although others have entered (Ku, et al., 2000). Plans cited low capitation rates, the administrative burden of compliance with Medicaid requirements, and (for commercial plans) differ-

ences between Medicaid and commercial health insurance as barriers to participation (Gold and Mitler, 2000b).

Traditional Providers—Medicaid managed care was an unwelcome change for many of the public and voluntary hospitals and community health clinics that have traditionally served the low-income population. Prior to Medicaid reform, many States had developed systems of “safety net” providers dedicated to addressing the health care needs of the poor. These systems were supported by a combination of State and Federal grants, charitable donations, Medicaid claims, and DSH payments and whatever funds their clients could pay out of pocket. Medicaid managed care disrupted these financial arrangements and placed administrative demands on traditional providers that many were not prepared to face. This was especially true of federally qualified health centers (FQHCs) and other community health clinics, many of which were heavily dependent on Medicaid funding (Gold and Mittler, 2000b). Clinics were faced with the loss of full-cost reimbursement, and need to develop additional administrative capacity to contract with managed care plans, and competition for patients from mainstream providers (Hoag, Norton, and Rajan, 2000; Ku, et al., 2000). FQHCs have been able to meet these challenges, but with some difficulty and with additional financial help from their States (Hoag, Norton, and Rajan, 2000). Traditional providers of mental health and substance abuse services were similarly affected by the switch to Medicaid managed care. Their operations were also affected by the various “carve-in” and “carve-out” arrangements used by States to provide mental health and substance abuse service coverage (Gold and Mittler, 2000a; Ku, et al., 2000).

⁶The Balanced Budget Act of 1997 relaxed the requirement that States implementing mandatory capitated Medicaid managed care provide a choice of plans. Prior to that, 1115 demonstrations in Kentucky and Alabama experimented with sole-source Medicaid managed care arrangements.

ELIGIBILITY EXPANSION

Cost containment has not been the only emphasis of Medicaid reform. In many States, expansion of eligibility was a key reform component. Of the 16 States with current section 1115 managed care demonstrations, 11 feature some kind of eligibility expansion.⁷ The experience of Tennessee shows that eligibility expansion through Medicaid can significantly reduce the number of people who lack health insurance (Ku, et al., 2000). The impact of eligibility expansions in Hawaii, Oregon, and Rhode Island, however, has been less pronounced (Ku, et al., 2000). In Oregon, the expansion population was in poorer health and had greater need for health care services than expected, compared with the State's initial projections for this population and the experience of traditional Medicaid eligibles (Haber, Khatutsky, and Mitchell, 2000). This phenomenon has been observed in other States with eligibility expansions (Sirica, 2001).

FINANCING MEDICAID

Much of the increase in Medicaid spending in the early 1990s can be attributed to the increased use by States of novel financing arrangements in conjunction with their supplemental funding programs for DSHs. These practices were part of a strategy by the States to maximize their receipt of Federal Medicaid dollars. Between 1990 and 1992, national DSH expenditures rose from \$1.4 billion to \$17.5 billion annually. In 1991, 1993, and 1997 Congress acted to curtail these practices and limit the aggregate amount of DSH spending. By 1997, DSH spending had fallen to \$15.9 billion. States relied less on provider taxes and donations, and more on intergovernmental

⁷ For the status of current comprehensive State health reform demonstrations, refer to website <http://www.hcfa.gov/medicaid/1115/default.htm>.

transfers, to fund their DSH programs. Hospitals also retained a greater percentage of DSH spending, with States retaining less (Coughlin, Ku, and Kim, 2000).

FUTURE OF REFORM

When Medicaid managed care programs first began, States focused their efforts on the AFDC and related populations. Consisting mainly of children and their working-age adult caretakers, these populations were considered to be most similar to those typically served by commercial health maintenance organizations. Because a large percentage of non-disabled adults and children have now been enrolled in managed care, States are now extending Medicaid managed care to their elderly and disabled beneficiaries. These individuals typically have special health care needs, and often qualify for Medicare in addition to Medicaid, making their incorporation into Medicaid managed care especially difficult (Gold and Mittler, 2000b). As States implement Medicaid managed care for their disabled and elderly populations, care must be taken to ensure that their access to quality health care is not diminished.

More research is needed on the impact of Medicaid managed care on access to care, quality of care, and satisfaction of beneficiaries. To date, few studies have examined these issues directly. Those that have tend to show patterns of care similar to those found under FFS Medicaid (Coughlin and Long 1999a, 1999b).

The reforms of the 1990s have provided partial solutions to the longstanding problems of Medicaid (Gold and Mittler 2000b). More work is needed to address old issues, such as provider participation and program financing, as well as new ones, such as ensuring quality care for beneficiaries enrolled in managed care plans. Medicaid

reform, especially eligibility expansion, has highlighted the potential role that Medicaid could play in a broader health care reform effort. The coming decade is likely to be another reform decade, as State and Federal governments grapple to meet these challenges.

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