

Medicaid Managed Care Delivers Value and Efficiency to States

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Contents

Overview	2
Factors that Influence State Medicaid Costs	2
More Medicaid Beneficiaries Are Now Enrolled in MCOs than in Fee-for-Service	2
Medicaid MCOs Improve Quality, Enhance Member Experience and Better Manage Costs	4
Conclusion	7

OVERVIEW

Managed care and other delivery system reform efforts have improved quality of care and health outcomes in state Medicaid programs across the country while also achieving cost savings. As policymakers at the state and federal levels consider reforms and modernization efforts for the Medicaid program, it will be important to understand how states' efforts to date have already achieved value-driven and cost-efficient programs.

This paper discusses findings from an array of studies examining the impact of Medicaid managed care on quality, costs, and the overall experience of Medicaid beneficiaries.

FACTORS THAT INFLUENCE STATE MEDICAID COSTS

There are a variety of factors that influence states' Medicaid program spending. Some of these cost drivers may be managed by the state while others lie outside of the state's sphere of influence. For example, states have some flexibility, within federal parameters, to determine the breadth of program benefits, income eligibility levels, and provider reimbursement rates.¹ But states have less, if any, influence over factors such as the underlying cost of services (e.g., provider wages) or population demographics (e.g., prevalence of chronic conditions).²

There is a large body of literature demonstrating that variation in health care spending is attributable to a number of inter-related factors such as local market conditions and local and regional practice patterns. An analysis conducted by the Government Accountability Office (GAO) found substantial variation in Medicaid spending across states. In 2008, overall Medicaid spending per beneficiary ranged from a low of \$3,800 in California to a high of \$11,700 in Rhode Island. Spending also varied within eligibility groups, with per beneficiary spending for individuals with disabilities ranging from \$9,000 (Alabama) to \$32,000 (New York).³

This variation results from factors such as the distribution of enrollees among eligibility groups, health service needs of Medicaid enrollees in a state, cost of delivering care, and scope of benefits offered by the state program.⁴ Much of the variation in total Medicaid spending, per GAO, can be attributed to differences in enrollment driven by eligibility rules, age distribution, and prevalence of disability.⁵

These are just some of the factors that can drive spending in state Medicaid programs. Another is the extent to which states have turned to managed care to create a more stable delivery system and better control cost drivers.

MORE MEDICAID BENEFICIARIES ARE NOW ENROLLED IN MCOs THAN IN FEE-FOR-SERVICE

States have increasingly relied on managed care to serve individuals enrolled in Medicaid. Recent data on enrollment and spending illustrate the extent to which states have transitioned their Medicaid programs away from fee-for-service (FFS) and into more comprehensive, cost effective approaches to service delivery.

State Medicaid programs have made a significant investment in managed care and continue to do so as a way to develop a value-based delivery system, improve care for beneficiaries, and better manage costs. Managed care programs deliver on this promise—improving outcomes and the beneficiary experience while also creating program efficiencies.

Enrollment

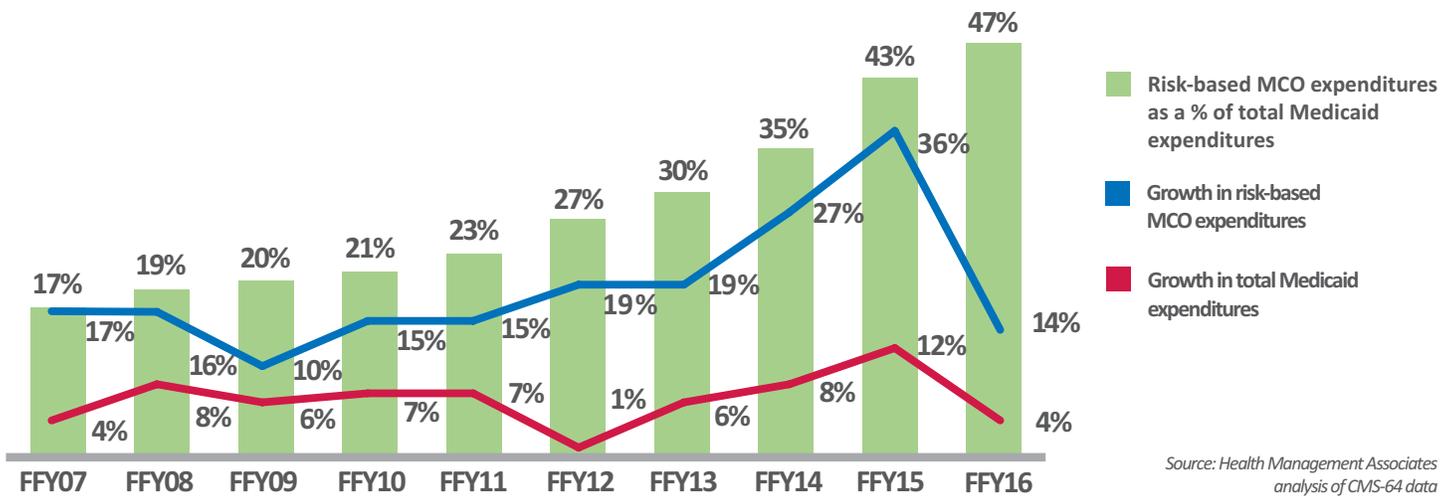
Historically, states relied on comprehensive risk-based managed care organizations (MCOs) to serve pregnant women and children while all other Medicaid beneficiaries received care through FFS.⁶ Over time, states have gradually moved more eligibility groups into MCOs. Between 2010 and 2013, enrollment in MCOs grew by 10 percent annually, on average. And from 2013 to 2014, with the expansion of Medicaid under the ACA, enrollment in MCOs grew by 24 percent.⁷ Managed care has become so prevalent among states that, as of the most recent complete year of enrollment data, a higher percentage of Medicaid beneficiaries receive services through risk-based managed care (61 percent) than FFS.⁸

States are continuing to expand the number and eligibility groups of Medicaid beneficiaries who can enroll in risk-based managed care plans. Between 2013 and 2014, eight states expanded comprehensive managed care to cover older adults as well as children and adults with disabilities and seven states enrolled children without disabilities into managed care.⁹ Additionally, states increasingly are using managed care as a solution for high-cost, high-need populations—managed long-term services and supports (LTSS) grew by 175 percent from 2013 to 2014.¹⁰

Spending

Over the last three federal fiscal years (FFYs), the share of spending on risk-based managed care as a percent of total Medicaid spending grew from 35 percent (2014) to 43 percent (2015) to 47 percent (2016).¹¹ (See Figure 1.) Over the past decade, Medicaid spending on managed care has grown, on average, 19 percent annually while total Medicaid spend has grown at an average rate of about 7 percent.

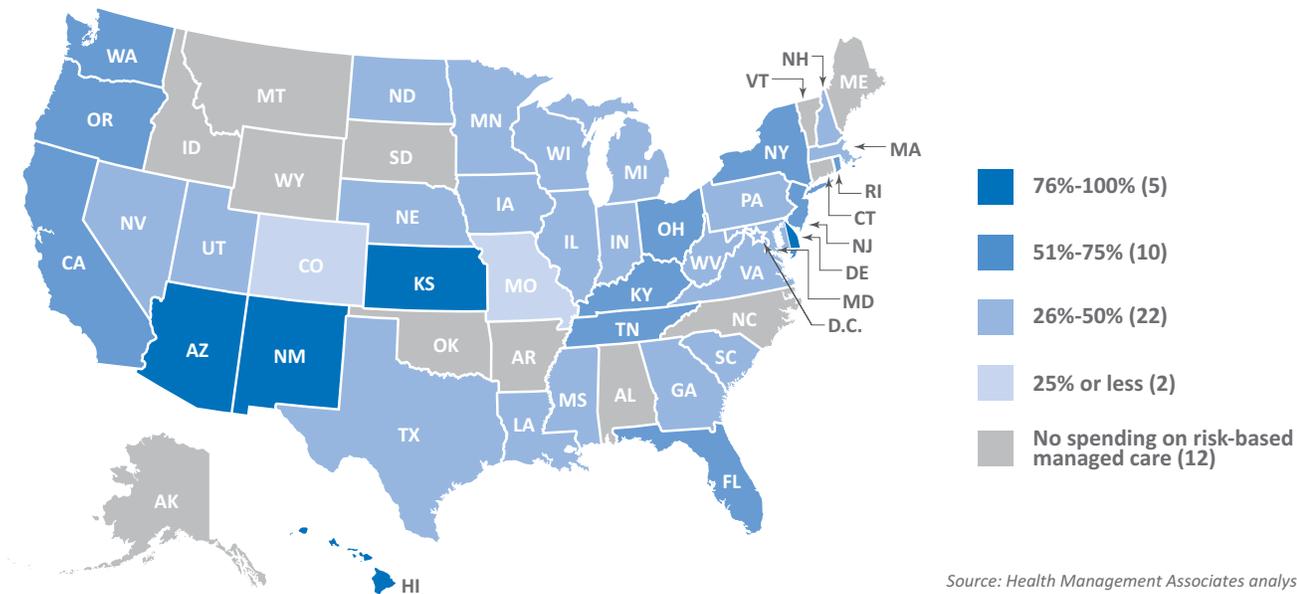
Figure 1. Growth in Risk-Based Medicaid MCO Expenditures (FFY 2007-2016)



Between 2015 and 2016, a dozen states experienced growth in managed care above the national average. Nine of these states saw sizable spending growth of 10 percent or more; among these states, increases ranged from 10 percent (Delaware) to 20 percent (West Virginia) to 36 percent (Iowa).¹²

Overall, among the 38 states and the District of Columbia that enroll any beneficiaries in managed care, 15 states direct more than 50 percent of their total Medicaid funding to managed care.¹³ (See Figure 2 for additional detail.) State Medicaid programs have made a significant investment in managed care and continue to do so as a way to develop a value-based delivery system, improve care for beneficiaries, and better manage costs.

Figure 2. Spending on Risk-Based Managed Care as a Percent of Total Medicaid Spending (FFY 2016)



Source: Health Management Associates analysis of CMS-64 data

MEDICAID MCOs IMPROVE QUALITY, ENHANCE MEMBER EXPERIENCE AND BETTER MANAGE COSTS

As states increasingly adopt or expand managed care programs, an important question is whether these efforts deliver the expected innovations, improvements in outcomes, and program efficiencies. Findings from an array of studies help demonstrate the value that MCOs can deliver.

Improving Quality and Beneficiary Satisfaction

Numerous studies illustrate the ways in which managed care improves quality of care and the health and well-being of beneficiaries. For example, a 20-state survey of managed care programs found that use of preventive care, including more timely receipt of prenatal care, improved among Medicaid MCO and CHIP enrollees over a 10-year period.¹⁴ Additionally, the survey found high satisfaction with care; in 15 of the reporting states, adults enrolled in Medicaid rated their health plans higher than did adults with commercial insurance.¹⁵

Additional examples include:

- MCOs in Texas have had notable success providing quality care for the state’s Medicaid members, especially children. For instance, the rate of follow-up care for children prescribed medication for attention deficit hyperactivity disorder (ADHD) increased by three percent from 2009-2011.¹⁶ In addition, MCOs have helped to reduce hospitalization rates among children for chronic conditions such as asthma (22 percent reduction).¹⁷ Similarly, Texas’ statewide managed care plan for children in foster care reduced admissions due to complications from diabetes by 45 percent.¹⁸
- Following Kentucky’s managed care implementation, the state observed: a 93 percent increase in smoking cessation consultations, a 33 percent increase in flu vaccines for children, a 14 percent increase in HPV vaccines, and a 17 percent decrease in amputations (often caused by untreated diabetes).^{19,20} The state also found increases in mammograms and screenings for heart problems.²¹

- In Missouri, managed care out-performed FFS on eight key quality measures—typically measures related to well care visits and preventive care such as cancer screenings.²² Although FFS performed better than managed care on 10 measures, most were related to behavioral health and prescription drugs—benefits that were carved out of the MCO contracts.
- In 2015, New York’s managed care plans outperformed national benchmarks published by the National Committee for Quality Assurance (NCQA) on 94 percent of measures, including several key measures related to behavioral health.²³ The managed LTSS component of New York’s program has also achieved high marks from members; an overwhelming majority (87 percent) rated their plan as good or excellent. Managed LTSS plans’ members’ perceptions of quality (81 percent) and timeliness (82 percent) of care were also high.²⁴
- Member satisfaction with Tennessee’s TennCare program—the state-wide Medicaid managed care program—has exceeded 90 percent annually, since 2009.²⁵ TennCare integrates physical health, behavioral health, and LTSS for all of its Medicaid beneficiaries through MCOs.
- A review of beneficiaries’ perspectives of managed care found seniors and people with disabilities enrolled in managed care are more likely to be “very satisfied” with their benefits than those in FFS (roughly 40 percent versus 27 percent).²⁶ Nearly half of beneficiaries (49 percent) said quality of care was better in managed care than in FFS while 38 percent said quality of care was about the same and only 13 percent said it was worse.²⁷
- A review of 2010 data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey show that enrollees in Medicaid managed care plans gave their health plan a higher overall rating than did individuals who were commercially insured or enrolled in Medicare.²⁸
- According to a survey of Florida Medicaid beneficiaries enrolled in managed LTSS plans, 76 percent indicated that their quality of life had improved since enrollment.²⁹
- In Indiana, early findings from one plan participating in the state’s HIP 2.0 program indicated that nearly 90 percent of members were satisfied with their overall healthcare, according to results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.³⁰

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Enhancing Access and the Overall Member Experience

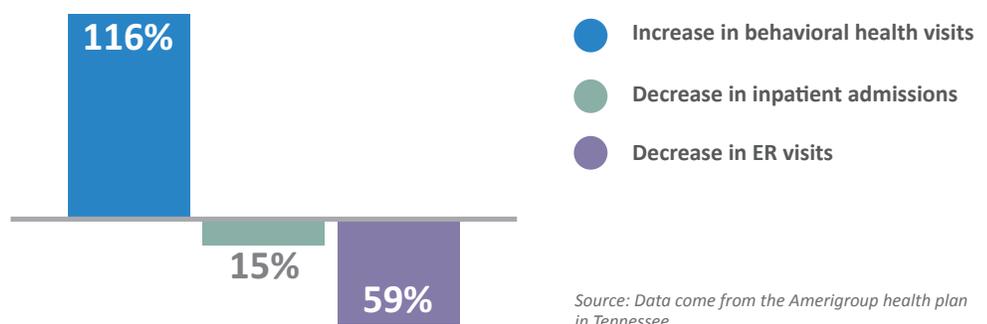
Managed care can improve access to services for Medicaid beneficiaries and enhance their experience engaging with the delivery system. For instance, an evaluation of Rhode Island’s Global Waiver demonstrated the state’s success enrolling children with special health care needs and adults with disabilities into managed care plans. Compared to individuals in FFS, beneficiaries who joined managed care plans had lower use of higher cost settings such as the emergency room (35 percent reduction for both groups) while experiencing improved access to physician visits (38 percent increase for adults while visits for children more than doubled).³¹

Other examples show the potential that managed care holds to improve beneficiaries’ experience:

- Kentucky’s early experience with managed care reduced disparities among Medicaid beneficiaries—one study found improved care coordination under managed care led to more regular use of primary care among minorities.³² A separate study found that managed care was associated with a 33 percent reduction in hospital utilization compared to FFS; the difference in hospitalization rates between managed care and FFS was significantly larger for minority populations compared to whites.³³
- Most seniors and people with disabilities in managed care in California said their current benefits were the same as or better than FFS with respect to access to care (e.g., prescription drugs, primary care, specialty care, disability access). For example, roughly 41 percent of beneficiaries said access to specialists was better in managed care than in FFS while 44 percent said it was about the same.³⁴

- In Indiana, approximately 91 percent of enrollees in one HIP 2.0 plan accessed care in their doctor’s office and other out-patient settings, according to ambulatory care data from the Healthcare Effectiveness Data and Information Set (HEDIS).³⁵
- In Florida, Medicaid managed care was associated with shorter lengths of stay in inpatient settings when compared to FFS from 2006 to 2012.³⁶ The study also found that the more highly concentrated the managed care market is, the larger the impact is on shorter length of stay.
- In the first two years of the TennCare Choices program—Tennessee’s managed LTSS program—the state saw a 37-day reduction in average length of stay at nursing facilities, relative to baseline, and an increase in the number of transitions from nursing facilities to the community (129 in the baseline year to 567 in year one and 740 in year two).³⁷ Additionally, the number of HCBS participants more than doubled while the number of nursing facility residents decreased by about 9 percent.³⁸
- Among children and adolescents in Medicaid managed care in Texas, 93 percent reported having a primary care physician and 90 percent said they visited their PCP during the year.³⁹
- An evaluation of one health plan’s experience implementing managed LTSS in New Mexico revealed that after one year of managed care enrollment, participants were 17 percent less likely to use a nursing facility, 19 percent less likely to visit an inpatient hospital, and 8 percent less likely to use the emergency department.⁴⁰
- In Texas, the percent of individuals who use self-direction under managed care (4.5 percent) is nearly double the percent who utilize the option under FFS (2.4 percent). Managed care service coordinators are credited with providing members with better and more comprehensive information regarding self-direction.⁴¹ Self-direction (also known as consumer-direction) and the associated support tools help individuals to select and secure LTSS that allows them to remain in their homes and communities.
- In Tennessee, after integrating physical and behavioral health benefits in the MCOs, one plan’s care coordination program for members who had both Serious Mental Illness (SMI) and diabetes drove marked improvements in outcomes for members who transitioned from the prior “carve-out” model. These improvements included an increase in the number of behavioral health visits (116 percent) and a reduction in inpatient admissions (15 percent) and emergency room visits (59 percent).⁴²
- Individuals with behavioral health conditions enrolled in managed care in Texas had more follow-up care after hospitalization. Between 2009 and 2011, follow-up within 7 and 30 days increased by approximately 7 percent.⁴³
- Also in Texas, a high-touch, person-centered outpatient program implemented by one of the MCOs achieved as much as a 90 percent reduction in inpatient admissions among individuals with significant behavioral health conditions (e.g., schizophrenia, bipolar disorder, and substance use disorder).⁴⁴
- In Ohio, enhanced care coordination efforts by one Medicaid managed care plan enhanced follow-up counseling for members after an inpatient stay for behavioral health services. Direct outreach to behavioral health facilities and increased engagement with members led to a 53 percent increase in 7-day follow-up visits and a 47 percent increase in 30-day follow-up visits.⁴⁵

Figure 3. Outcomes for Members who Transitioned from a Carve-out to Carve-In Model in Tennessee



Managing Costs

Recent studies have demonstrated the role of managed care in reducing Medicaid spending. Most recently, an analysis of Ohio’s experience with Medicaid managed care found sizeable savings compared to FFS, translating to roughly \$2.5 to \$3.2 billion in savings from 2013 to 2015.⁴⁶ In Texas, another study found that over a six year period, managed care resulted in \$3.8 billion in Medicaid savings.^{47,48}

There are numerous other studies that illustrate the ability of managed care to better manage costs in Medicaid. They include:

- An analysis of Pennsylvania’s HealthChoices program found cost savings from managed care of \$5.0 to \$5.9 billion over 11 years (2000 to 2010) when compared to FFS.⁴⁹ The researchers also projected up to \$16.8 billion in additional total savings from 2011 to 2020. Managed care reduced administrative costs over time and achieved cost savings from inpatient hospitalizations and prescription drug utilization. These savings were driven by care coordination, utilization management, beneficiary outreach and education.⁵⁰ Many of the most effective cost-containment strategies were not present in FFS, such as providing personalized disease management services, directing beneficiaries to lower-cost settings, and using cost-effective high quality providers.
- An analysis of federal Medicaid data estimated that risk-based managed care delivered \$2.4 billion in total Medicaid savings in 2011.⁵¹ Further analysis projected additional savings in 2016, due to managed care expansions.
- Almost two years after implementing managed care in 2011, Kentucky reported it was on target to achieve \$1.3 billion in total savings over the 2011-2013 period and realize costs per beneficiary below forecasted amounts.^{52,53}
- An assessment of the value of managed care showed that early evaluations of Medicaid expansions resulted in savings in Arkansas, Kentucky, Michigan, New Mexico, Washington, and West Virginia.⁵⁴
- A review of the literature on the impact of managed care found savings ranging from 0.5 percent to 20 percent.⁵⁵ Consistent with the findings in Pennsylvania, the studies reviewed indicated that savings were largely attributable to decreases in inpatient utilization as well as pharmacy savings.
- Managed care approaches have also shown positive results when it comes to controlling prescription drug costs. One study found higher generic dispensing rates in managed care compared to FFS (83 percent versus 78 percent).⁵⁶
- The same study also found that including prescription drugs in the managed care contract (“carve-in”) yielded greater savings than carving-out the drug benefit. In FFY 2014, 28 states that carved-in drugs saved an estimated \$2.1 billion more, in total, than states that carved-out drugs.⁵⁷ Carve-in states also realized a 15 percent lower cost per prescription and had a smaller increase in the net cost per prescription over a three-year period than the carve-out states.⁵⁸
- Another study projected large savings for 14 states if they converted from a carve-out to a carve-in approach for prescription drugs. Savings were estimated to be about 17 percent in the first year (\$750 million) and 21 percent (\$11.7 billion) over a 10-year period.⁵⁹

States’ efforts to innovate and drive value in the Medicaid program have helped produce lower annual spending growth compared to other programs. From 2000 to 2015, average annual growth in Medicaid spending per enrollee was lower than per enrollee spending growth in commercial health insurance and Medicare.⁶⁰

CONCLUSION

With 61 percent of Medicaid enrollees and 47 percent of Medicaid spending flowing through comprehensive risk-based managed care, states have made significant progress establishing innovative, value-driven, and cost-effective approaches to serving Medicaid beneficiaries. And state investments in managed care continue to grow.

As the aforementioned examples and studies illustrate, Medicaid managed care offers a successful base on which to build future Medicaid reform efforts.

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