Medicaid Delivery Systems and Managed Care: A National Overview and State Experiences

Idaho Medicaid Managed Care Task Force

July 10, 2023

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NCSL provides trusted, nonpartisan policy research and analysis

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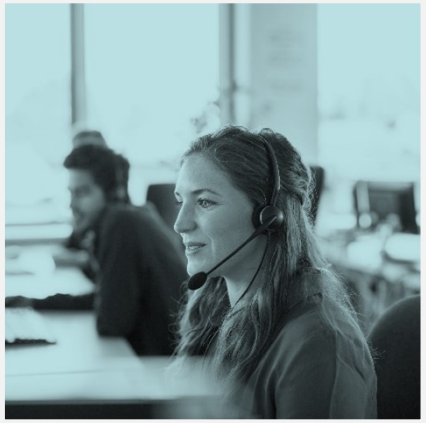

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NCSL delivers training tailored specifically for legislators and staff

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NCSL meetings facilitate information exchange and policy discussions

2023 Indy Legislative Summit

NCSL LEGISLATIVE SUMMIT INDY2023

Aug. 14-16, 2023

Agenda

- Medicaid 101
- Medicaid Delivery Systems, History and Current Trends
- Evidence and State Experiences with Managed Care
- Legislative Role and Considerations for Delivery System Transition

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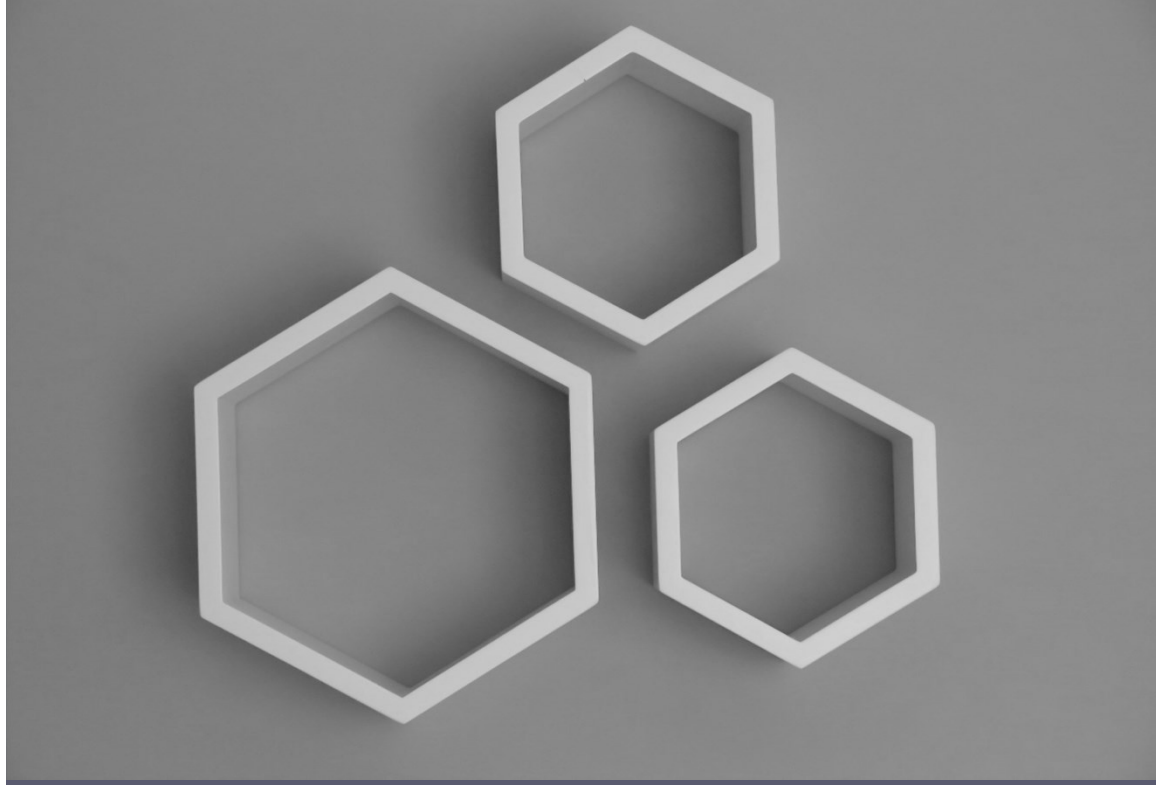

Medicaid 101

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Medicaid is:

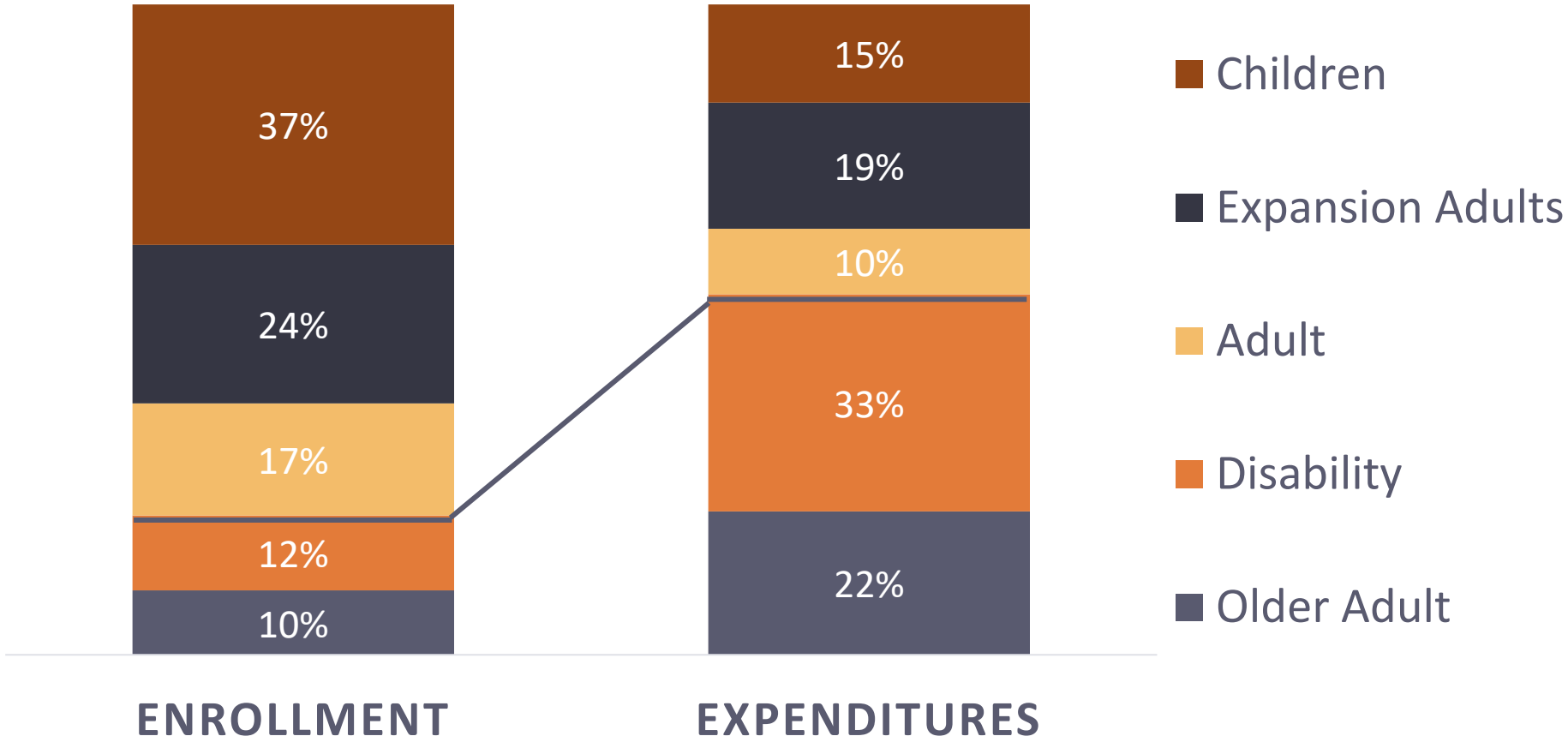
- ***health insurance*** for
- ***people with low incomes*** that is
- ***jointly funded and regulated*** by both the federal and state governments

Medicaid v. Other Payors

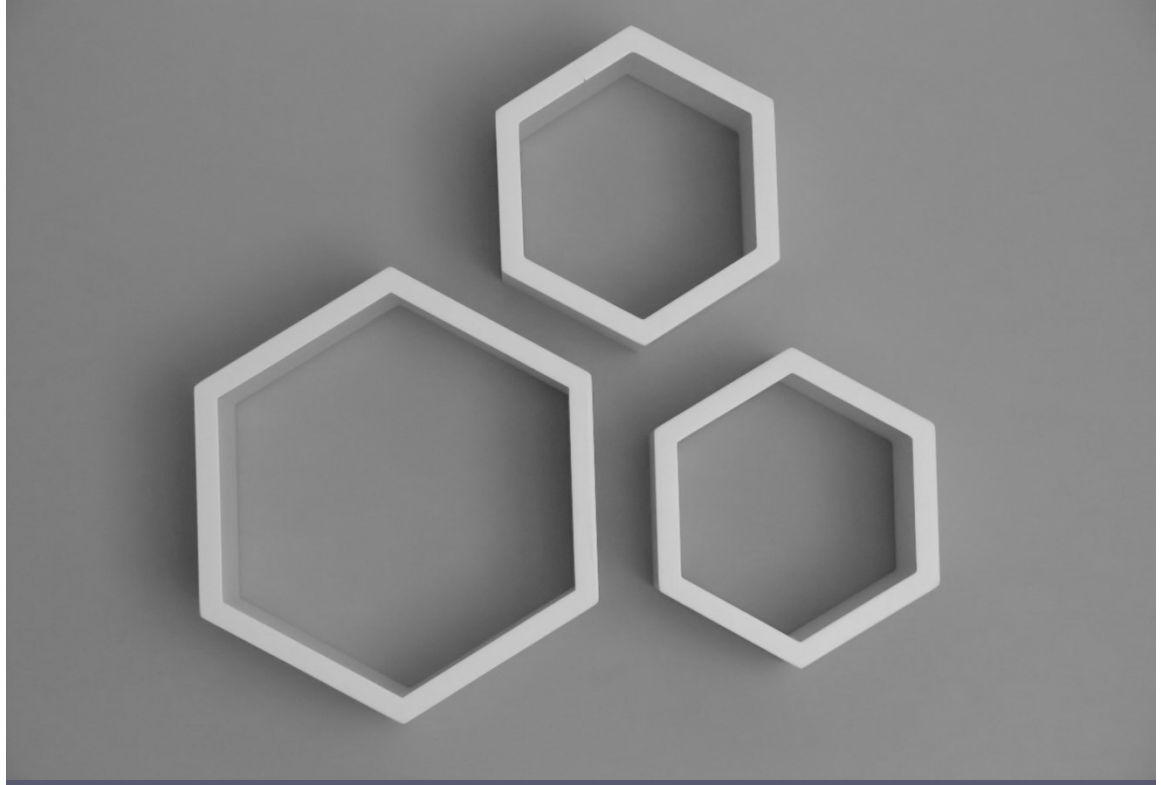
	Who is covered?	Who pays?	Who regulates?	Pays for long-term care?
Medicaid	Eligibility by **income** and **population**: Children, pregnant women, parents, older adults, people with disabilities, childless adults	State and federal governments	State and federal governments	**YES**
Children's Health Insurance Program (CHIP)	Eligibility by **income** and **population**: Uninsured children up to age 19 in families with incomes too high to qualify for Medicaid, some pregnant women.	State and federal governments	State and federal governments	NO
Medicare	Eligibility by **age** or **disability**: Adults ages 65 and older, people with certain permanent disabilities	Federal government **only**	Federal government **only**	NO

Medicaid Enrollment and Spending

MEDICAID ENROLLMENT AND SPENDING BY ELIGIBILITY GROUP (2020)



Source: Data from MACStats 2022, Exhibit 14 and Exhibit 21, analyzing FY 2020 enrollment and expenditure data.



Medicaid Delivery Systems, History and Current Trends

Legislative standards, financing and oversight

State Operated / Fee-for-Service

State agency ***controls***:

- Costs, Quality, and Access
- Program Operations
- Provider and Beneficiary Stakeholder Relationships
- Program Integrity

Managed Care

State agency ***delegates or shares responsibility*** for some or all of the following:

- Costs, Quality, and Access
- Program Operations
- Provider and Beneficiary Stakeholder Relationships
- Program Integrity

Medicaid Delivery Systems

State Operated / Fee-For-Service (FFS)

Structure: State administers the program and manages day-to-day operations.

Payment: Providers bill the state. State pays providers, usually per service.

Providers: State enrolls providers. State must accept any willing provider.

Beneficiaries: State determines beneficiary eligibility and enrolls beneficiaries.

Primary Care Case Management (PCCM)

Structure: Similar to FFS. Beneficiary is also assigned a primary care provider that is responsible for coordinating care.

Payment: Same as FFS. State also pays primary care provider an administrative fee plus regular payments for services.

Providers: Same as FFS

Beneficiaries: Same as FFS

Comprehensive Risk-Based Managed Care (MCO)

Structure: State contracts with a private commercial payer (MCO).

Payment: State pays the MCO a per member per month fee for each beneficiary. MCO is "at-risk" for cost of services.

Providers: Providers bill MCO. MCO pays providers. State *and* MCO enroll providers. MCO can limit providers.

Beneficiaries: State *and* MCO enroll beneficiaries.

Limited-Benefit Plan

Structure: MCO manages a subset of benefits:

- Behavioral health
- Non-emergency transportation
- Dental
- Managed long-term services and supports (MLTSS)

Payment: Can be "at risk" or not, depending on if coverage for inpatient services is included.

Providers: Same as MCO

Beneficiaries: Same as MCO

Federal

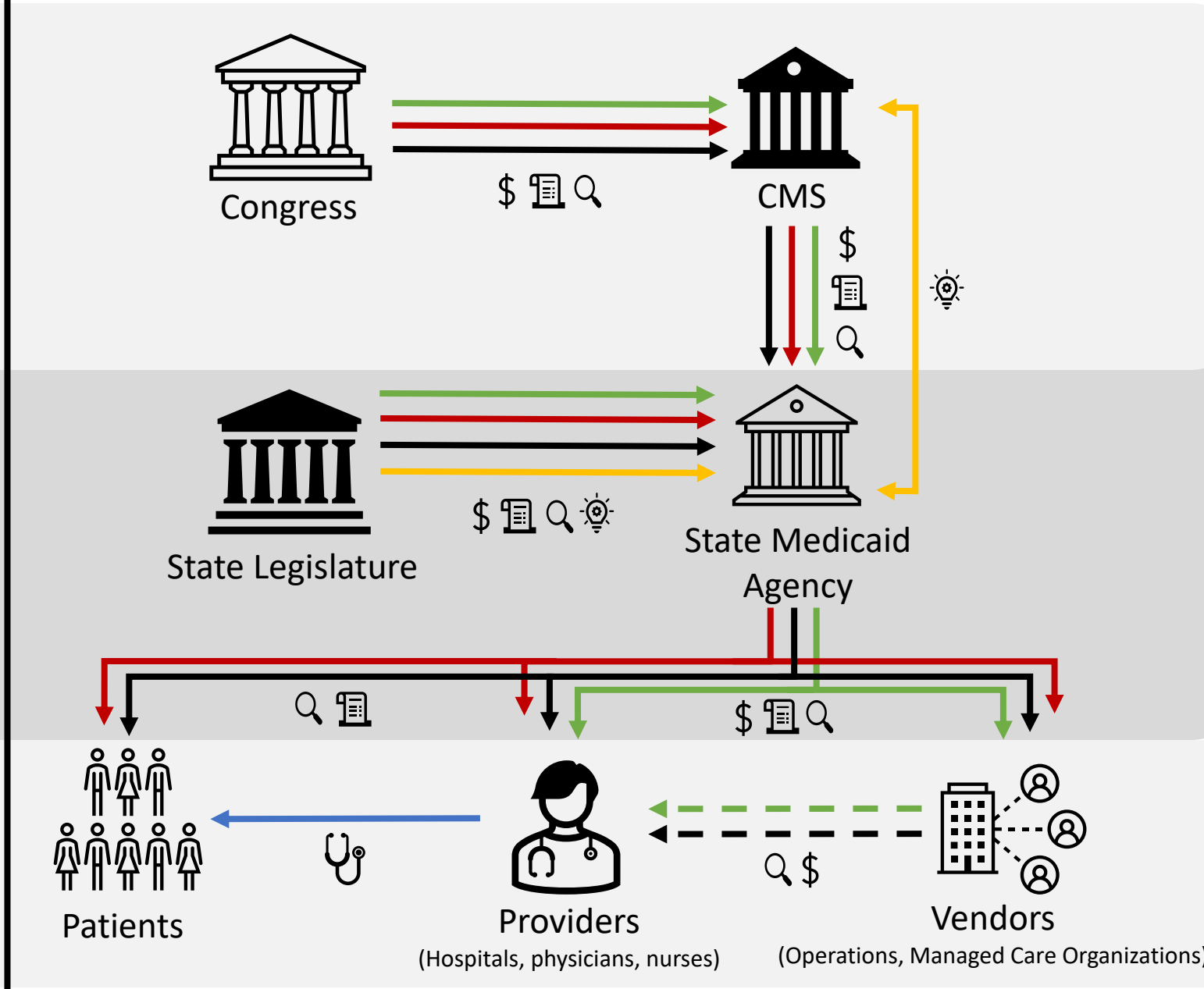
- Minimum requirements
- Funds

State

- **Funds**
- **Operates program**
- **Tests innovations**

Constituents

- Receive services
- Provide services
- Contract with the state
- Paid by state



Appropriations, Payments

Laws, Regulations, Guidance

Oversight, Data Collection

Innovations, waivers, pilots, flexibilities

Health Services

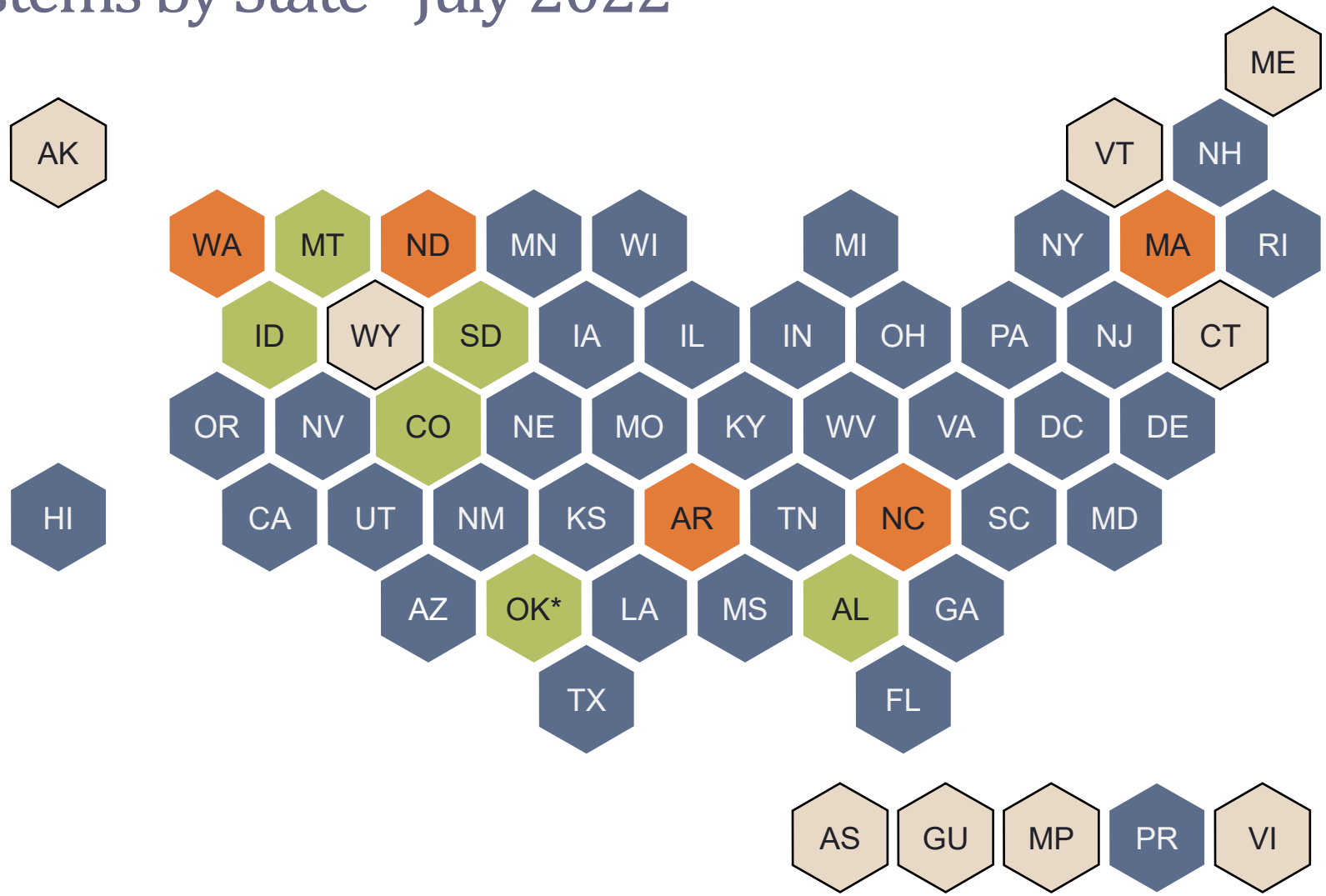
Medicaid Delivery Systems:
Types of Delivery Systems by State - July 2022

Comprehensive MCOs

PCCM

MCO and PCCM

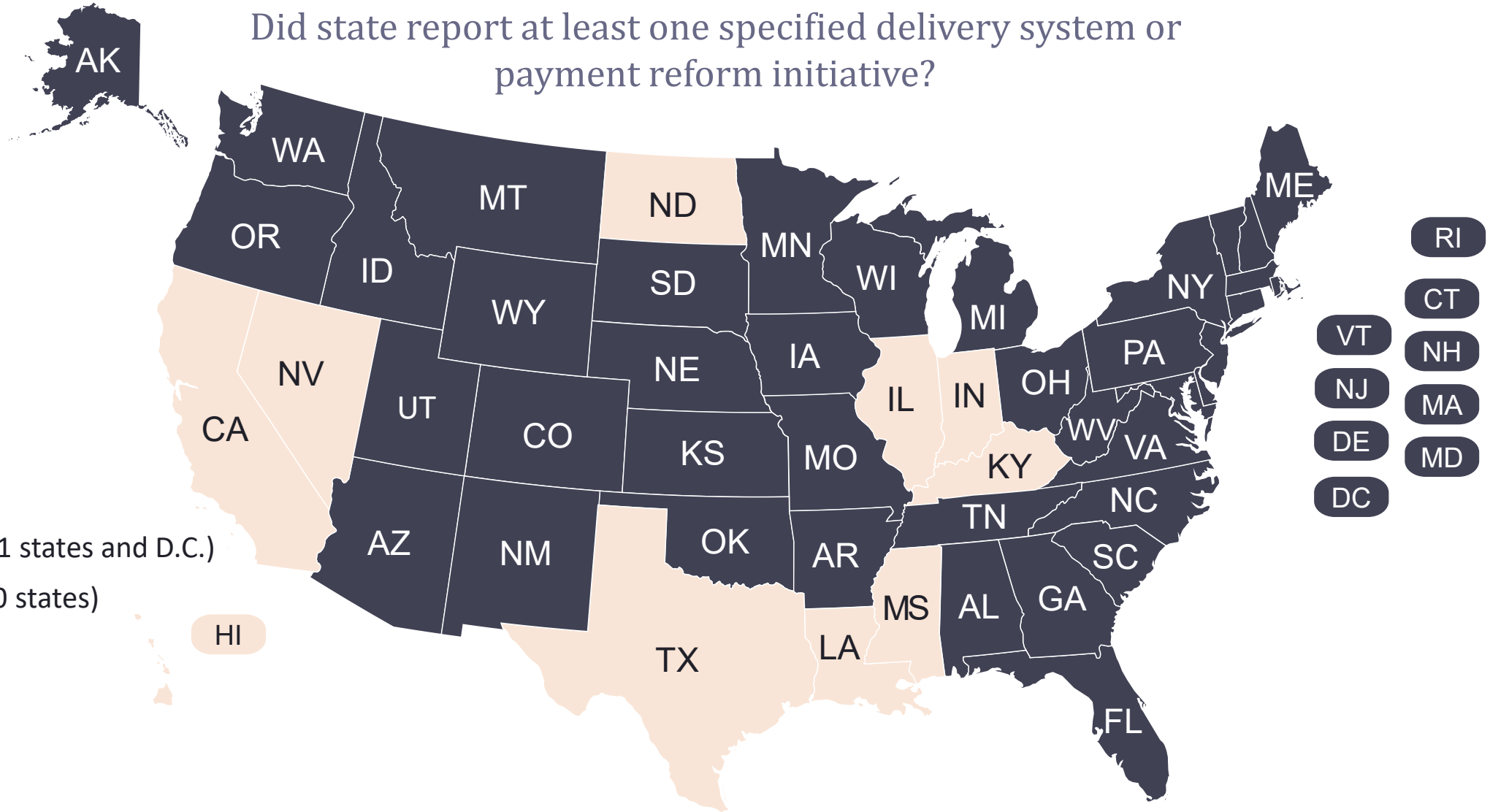
State Operated / FFS



Source: Results from an Annual Medicaid Budget Survey For State Fiscal Years 2022 and 2023, KFF (October 25, 2022).
* Oklahoma is currently transitioning from PCCM to MCO

Delivery System *Reforms*

Did state report at least one specified delivery system or payment reform initiative?



Source: Results from an Annual Medicaid Budget Survey For State Fiscal Years 2022 and 2023, KFF (October 25, 2022).

Idaho

Model(s) and Percent of Medicaid Population Covered by Model:

MCO = N/A

PCCM = 89.0%

FFS / Other = 11.0%

Limited Benefit Plans = Managed long-term services (for dual eligibles), Behavioral Health, Dental and Transportation

Delivery System Reforms:

Patient Centered Medical Homes

Accountable Care Organizations (value care organizations)

Oregon

Model(s) and Percent of Medicaid Population Covered by Model:

MCO = 91.5%

PCCM = N/A

FFS / Other = 8.5%

Limited Benefit Plans = None

Delivery System Reforms:

Accountable Care Organizations

Payment reforms, including primary care initiatives and global budgets

Arizona

Model(s) and Percent of Medicaid Population Covered by Model:

MCO = 87.3%

PCCM = 1.8% (Tribal nation)

FFS / Other = 10.9%

Limited Benefit Plans = Managed long-term services

Delivery System Reforms:

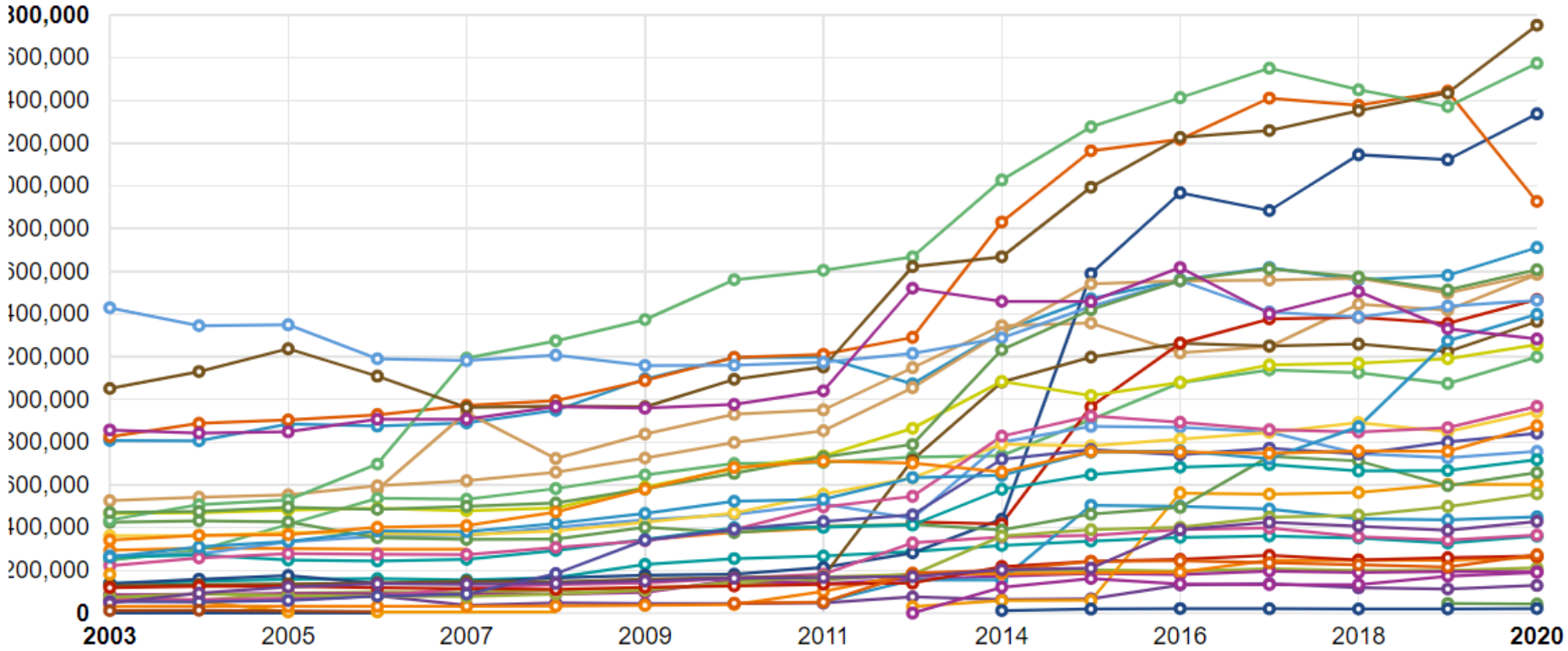
Accountable Care Organizations

Current Medicaid Managed Care Trends

1990s New Federal Flexibilities:

- Mandated Enrollment
- Statewide programs
- Contract with health plans serving only Medicaid

Total State Population Enrolled in Medicaid Comprehensive Managed Care from 2003 – 2020*



Source: State Indicator, Total Medicaid MCO Enrollment, Kaiser Family Foundation

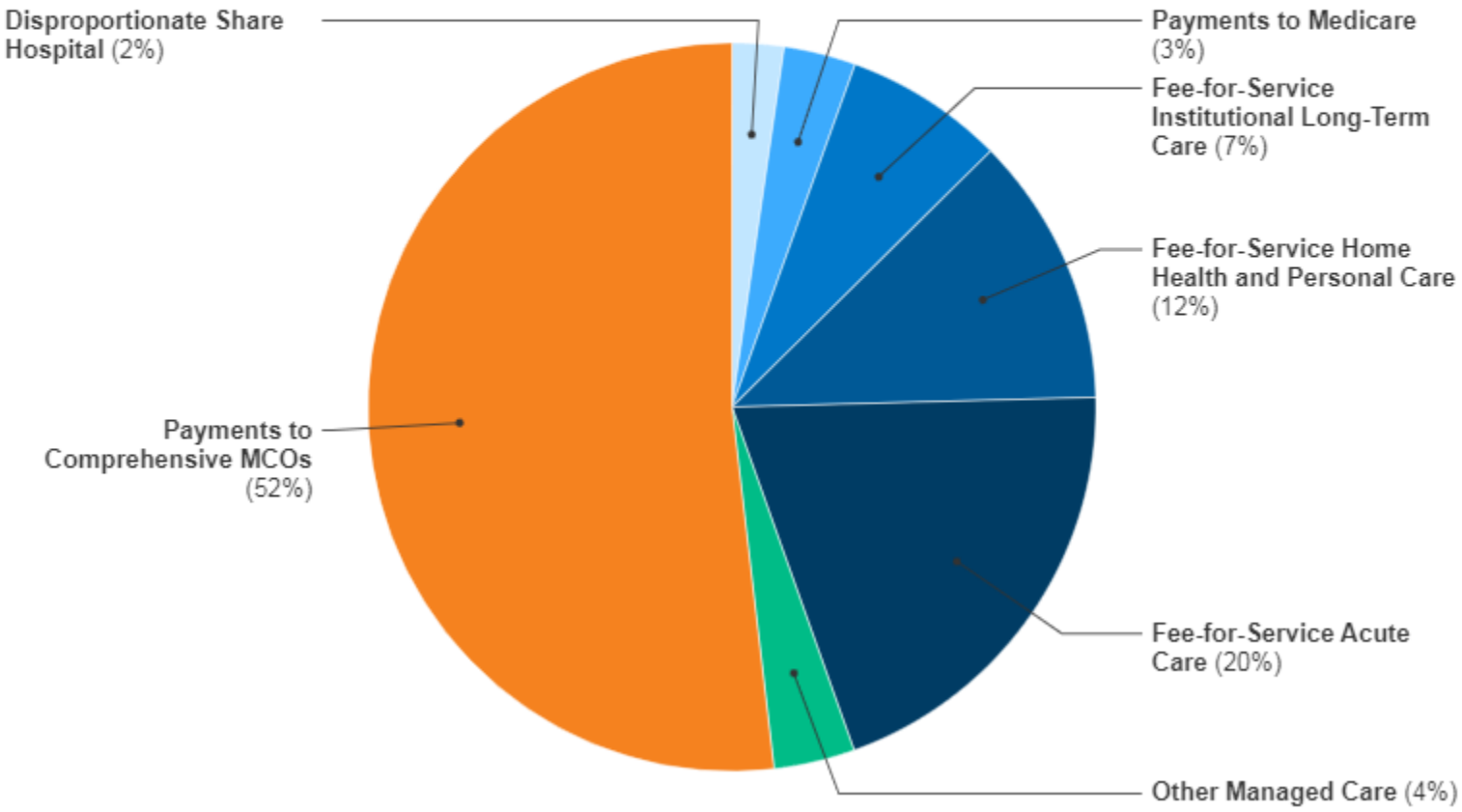
**Note that this visual excludes the 4 states with the highest total population enrolled in Medicaid managed care: California, Florida, New York, and Texas to better illustrate trends in other states. The Y-axis is cut off in the original source, but ranges from 0 – 2,800,000 in this data set.*

Current Medicaid Managed Care Trends

Figure 4

Payments to Comprehensive MCOs Account for More than Half of Total National Medicaid Spending.

FY 2021 Total Medicaid Spending: $728 Billion



Source: 10 Things to Know About Medicaid Managed Care, Kaiser Family Foundation (2022).

Current Medicaid Managed Care Trends: Other

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Adoption of Comprehensive MCOs	Integrating Behavioral Health [1]	Managed Care for Complex Populations [2]	Program Integrity / Oversight of Operations
North Carolina implemented integrated MCO model July 2021. **Oklahoma** plans to implement comprehensive MCO model in 2024.	Behavioral health benefits "carved-in" to MCO benefit package. **Arizona** reported plans to transition all behavioral health benefits to MCO. **25 states** use financial incentives with MCOs to improve behavioral health quality.	**21 states** use MCOs to cover Medicaid acute care and LTSS. **Arkansas** introduced a new capitated MLTSS model for people with disabilities and behavioral health needs. **Missouri and Ohio** introduced MCOs for children with complex needs.	As of February 2023, Centene has agreed to pay $805.6 million in settlements with 14 states so far related to prescription drug claims. A 2022 OIG report estimates that almost 50% of MCO reported data is not adequate to verify MCO spending.

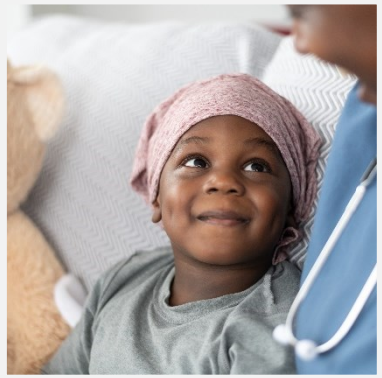
[1] Source: How do States Delivery Administer, and Integrate Behavioral Health Care? Findings from a Survey of State Medicaid Programs.
[2] Source: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020; Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023; Demonstrating the Value of Medicaid MLTSS Programs.

Current Medicaid Managed Care Trends: 2022 – 2023 Legislative Session

New Hampshire HB 103 (2022)

Requires agency to contract with a **limited benefit plan** for dental services.

New York AB 289 (2022)

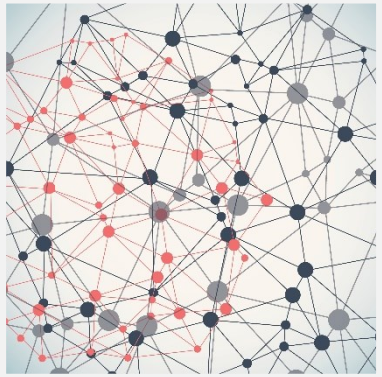


Clarifies the **standard** for medical necessity and review processes that **MCOs** must use for medically fragile children.

Virginia HB 2262 (2023)

Establishes deadlines and standards for **MCOs** enrolling new providers in the network.

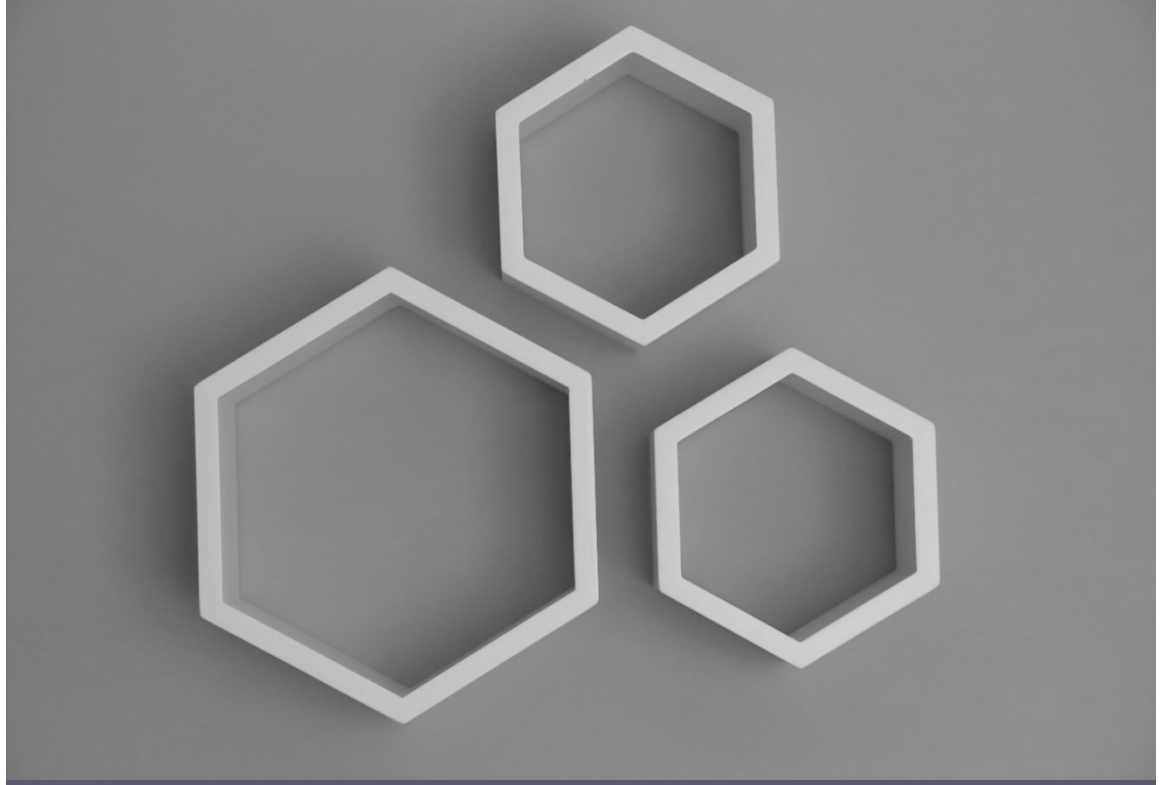
Oklahoma SB 1337 (2022)



Requires the state Medicaid agency to **transition to MCO delivery system**, requires legislative authorization for certain contracts.

North Dakota SB 2030 (2023)

Requires the state Medicaid agency to participate in **payment reforms for prescription drugs** like rebate programs and value-based purchasing.



Evidence and State Experiences with Medicaid Managed Care

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“When you’ve seen one Medicaid program . . .

. . . you’ve seen one Medicaid program.”

Evidence on Medicaid Managed Care

Cost and Budget Predictability

- Evidence is **mixed** on managed care impact to **cost**[1]
  - Potential savings in inpatient and outpatient spending and reduced hospitalizations with some offsets.
- Evidence on **budget predictability is limited**.
  - One national study evaluating MCOs from 1998 – 2008 found no impact on budget predictability.

Access and Quality

- Evidence is **mixed** on managed care impact to **access**[1]
  - Sometimes improved access to primary and preventive care with significant state variability
- Evidence is **mixed** on managed care impact on **quality**[1]
  - Significant variability in results and quality metrics.

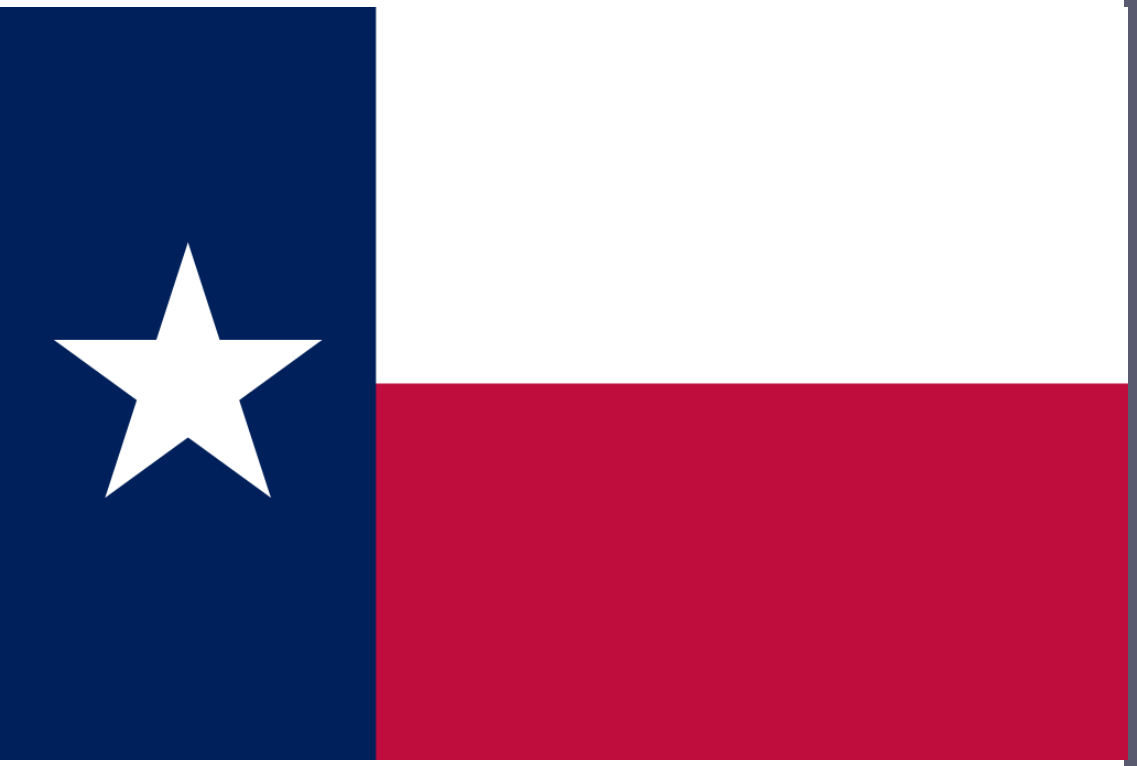
Comparisons of Delivery Systems

- One study suggested a PCCM model was more effective at coordinating care for children.
- Another study suggested MCOs outperform both PCCM and FFS models on key quality indicators for behavioral and women's health.
- A 2009 Missouri comparative analysis of quality of care and access found no significant difference between FFS or MCO.

[1] Source: Robert Wood Johnson Foundation, Medicaid Managed Care (September 4, 2012); Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update (April 2020); MACPAC, Managed care's effect on outcomes.

States that transitioned to comprehensive managed care

Texas

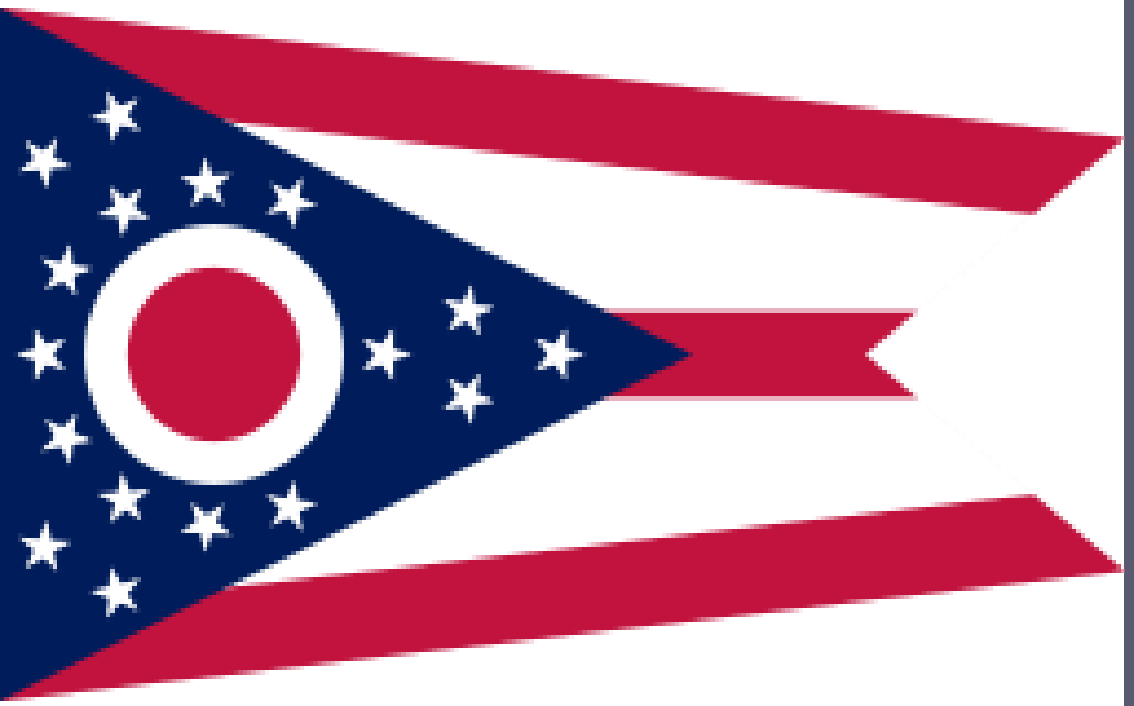


Texas adopted managed care in 1993 for women and children and has expanded over time to cover additional populations and services.

One peer reviewed study found mixed evidence on quality: infant mortality increased among births to black mothers and fell among births to Hispanic mothers.

An evaluation estimated cost savings between 4.7% - 11.5% resulting in an estimated **total** $5.3 to $13.9 billion saved between 2009 and 2017.

Ohio

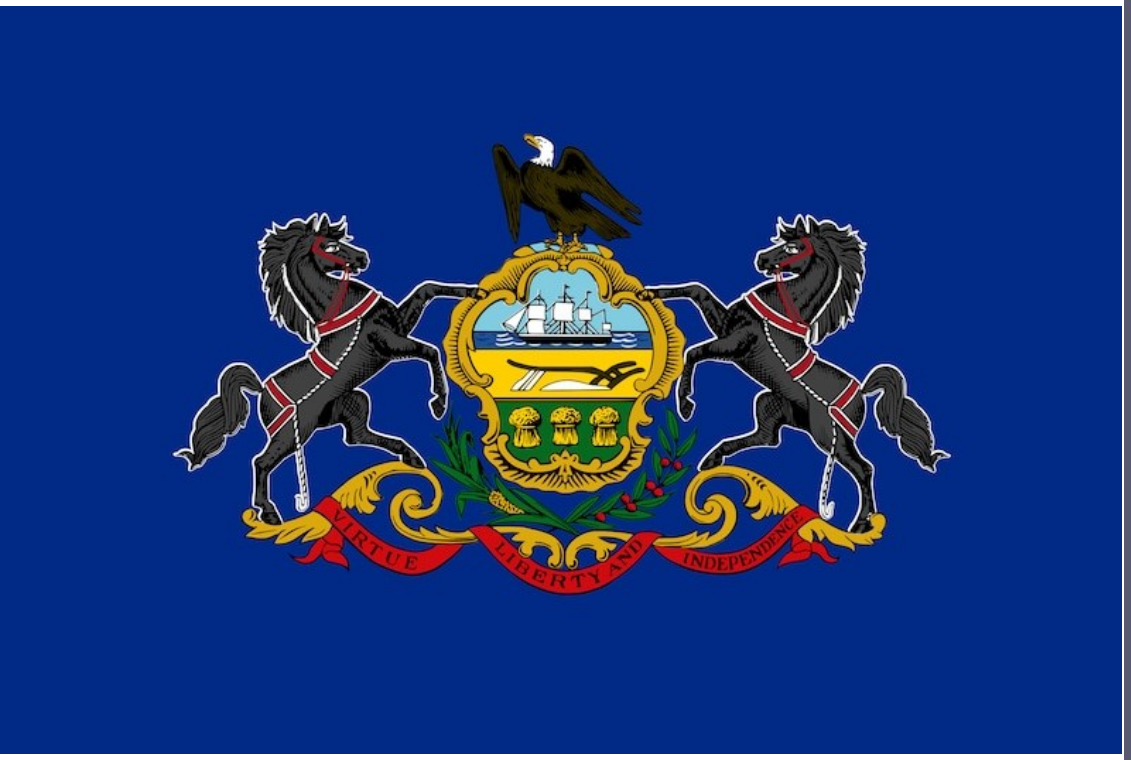


Transitioned from FFS to MCO in 2015.

An evaluation estimated that capitation rates paid to MCOs were 13.5% - 17.1% lower than they would have been in FFS, resulting in **total** $4.1 - $5.4 billion in savings.

One peer reviewed study found some cost savings for reductions in inpatient and outpatient spending but partial savings offset by prescription drug costs.

Pennsylvania



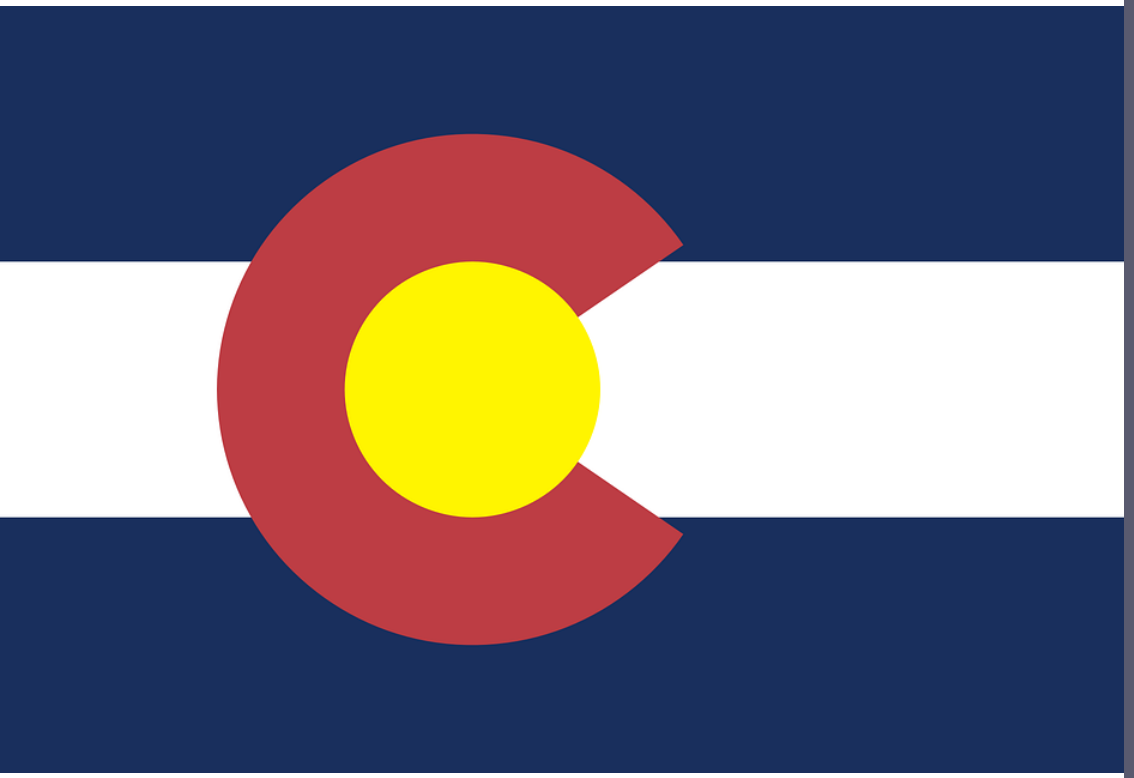
Pennsylvania adopted managed care in 1997 which was mandatory in 25 counties in 2011. The other 16 counties mandated to use PCCM in 2011.

An evaluation estimated cost savings of $2.9 billion to $3.3 billion in **state funds** compared to estimated FFS costs from 2000 – 2010.

Evaluators noted that savings gap between MCO and ongoing PCCM program narrowed when cost containment strategies incorporated into PCCM program.

States that transitioned away from comprehensive managed care to other models

Colorado



Ended comprehensive MCO model due to lawsuits and unanticipated costs

Moved to PCCM model in 2011 and integrated behavioral health in 2018

PCCM model saved $900 per enrollee after 4 years of operations while maintaining quality

Connecticut

Transitioned from MCO to “managed FFS” delivery system in 2012. Administrative functions performed through an administrative services organization (ASO).

Evaluations in 2019 and 2021 found that per member per month costs decreased from 2012 to 2018 resulting in estimated savings of $968 million.

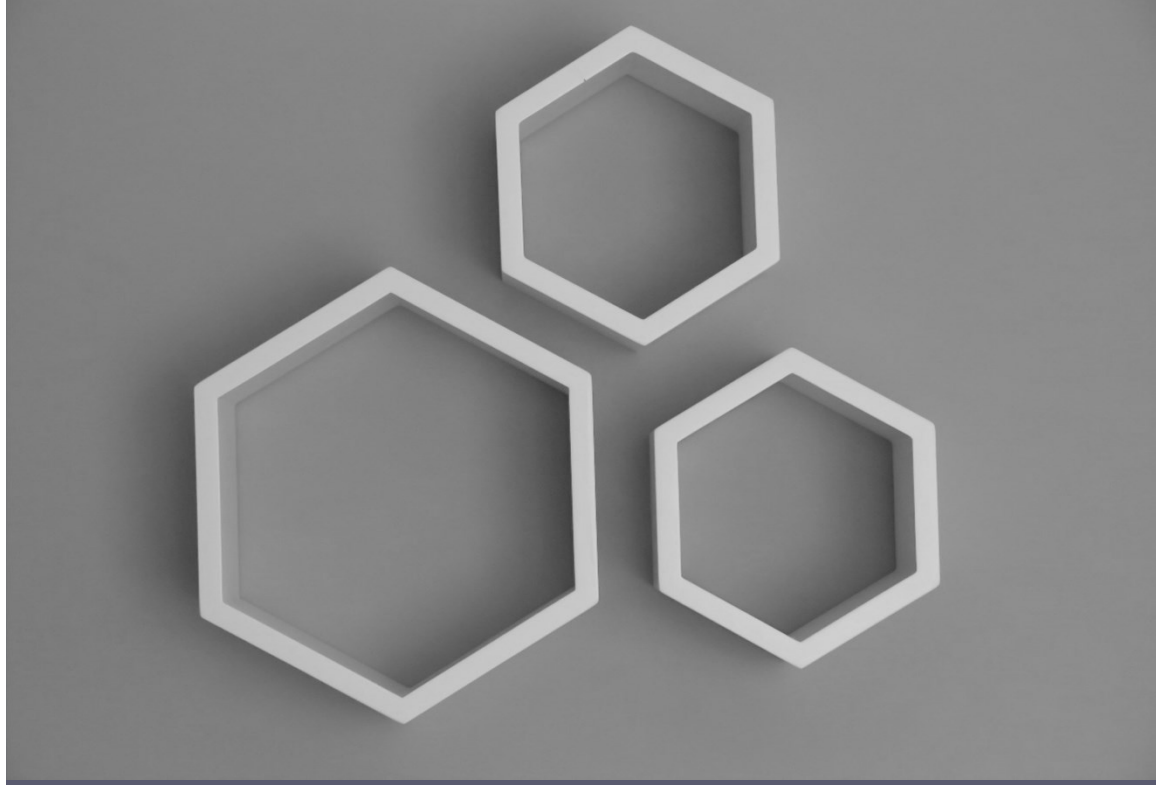
Estimates of the state’s administrative costs range from 2.8% - 4.2% but fall below national averages.

Oklahoma

Ended comprehensive MCO model due to budget pressures and lack of health plan participation

Transitioned to PCCM model with behavioral health integrated

A study of the transition to the PCCM model found increased access, improved quality and decreased hospitalizations and emergency department visits



Legislative Role and Considerations for Delivery System Transition

Legislative Role in Delivery System Transitions

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All Delivery Systems

- Funding and appropriations
- Delegation of authority or clawback from Medicaid agency
- Establishing state standards
- State oversight and audits
- Accurate and complete data collection and reporting

MCOs

- Contract negotiation and terms
- Bidding processes
- Penalties and incentives

Considerations for Delivery System Transition

Who and What: Covered People and Benefits	Where and How Many: Procurement [2]	Oversight and Accountability
• Population enrolled in MCOs • Benefits covered by MCOs	• Geographic service area • Number of MCOs per geographic area • Procurement process	• Costs and rate setting • Quality • Data collection and reporting • Penalties and incentives • Agency role in oversight and reporting to legislature

Considerations for Delivery System Transition

Timing and Agency Capacity

Budget Impact

- Transition costs
- New agency functions

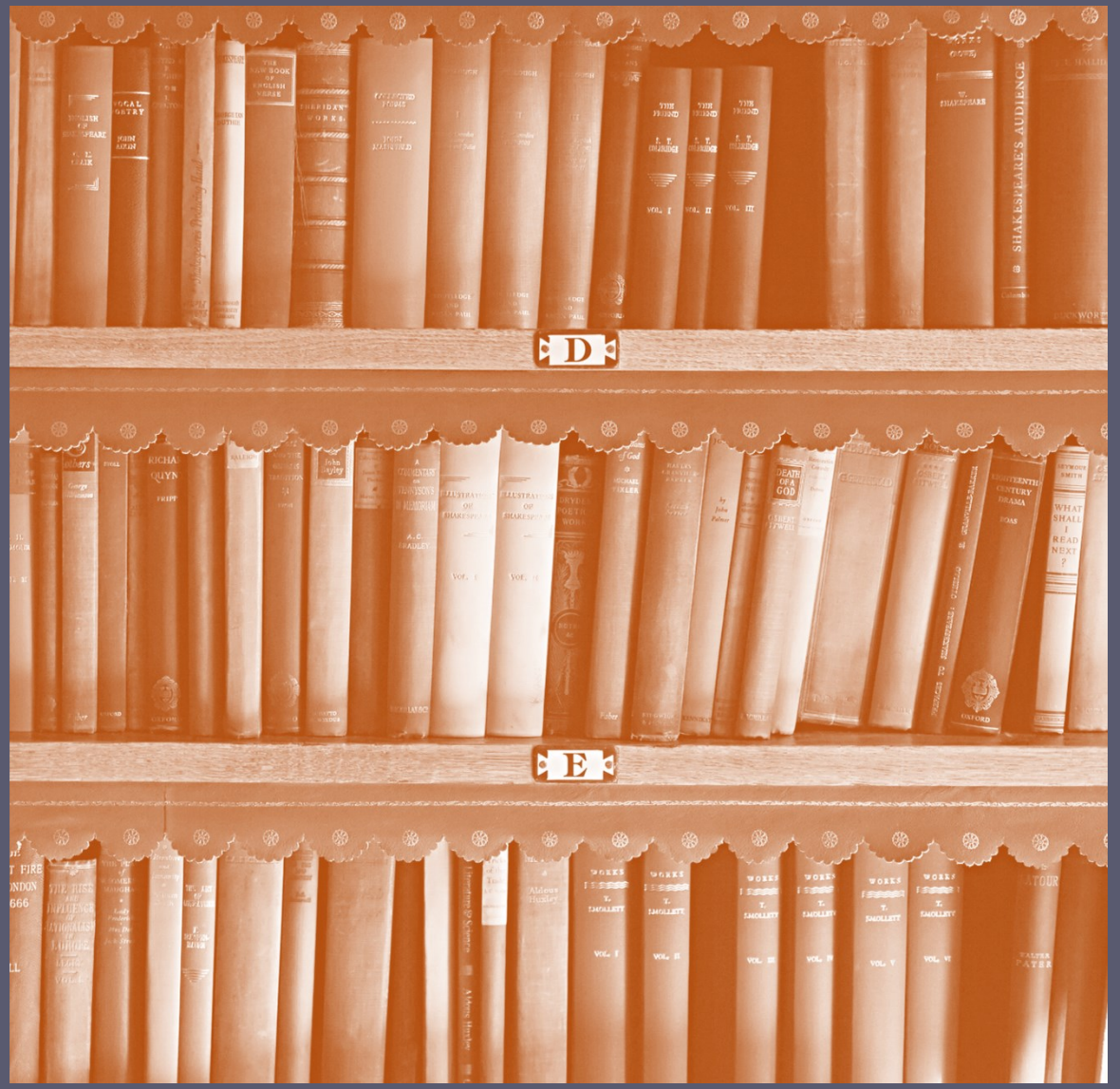
Communication with Stakeholders and Transition Planning

- Beneficiaries – access to services and current providers post-transition, contact with MCO, changes in benefits.
- Providers – billing and payment, enrollment and credentialing, network participation, payment rates.
- MCO – transition planning and processes to handle all of the above.

Source: Health plan shake-up could disrupt coverage for low-income Californians (September 28, 2022); Were you enrolled in Delaware First Health? (January 31, 2023).

Resources

- Health Costs, Coverage and Delivery State Legislation, NCSL Database
- Introduction to Value-Based Care, NCSL
- Research requests, technical assistance, publications, webinars and more!



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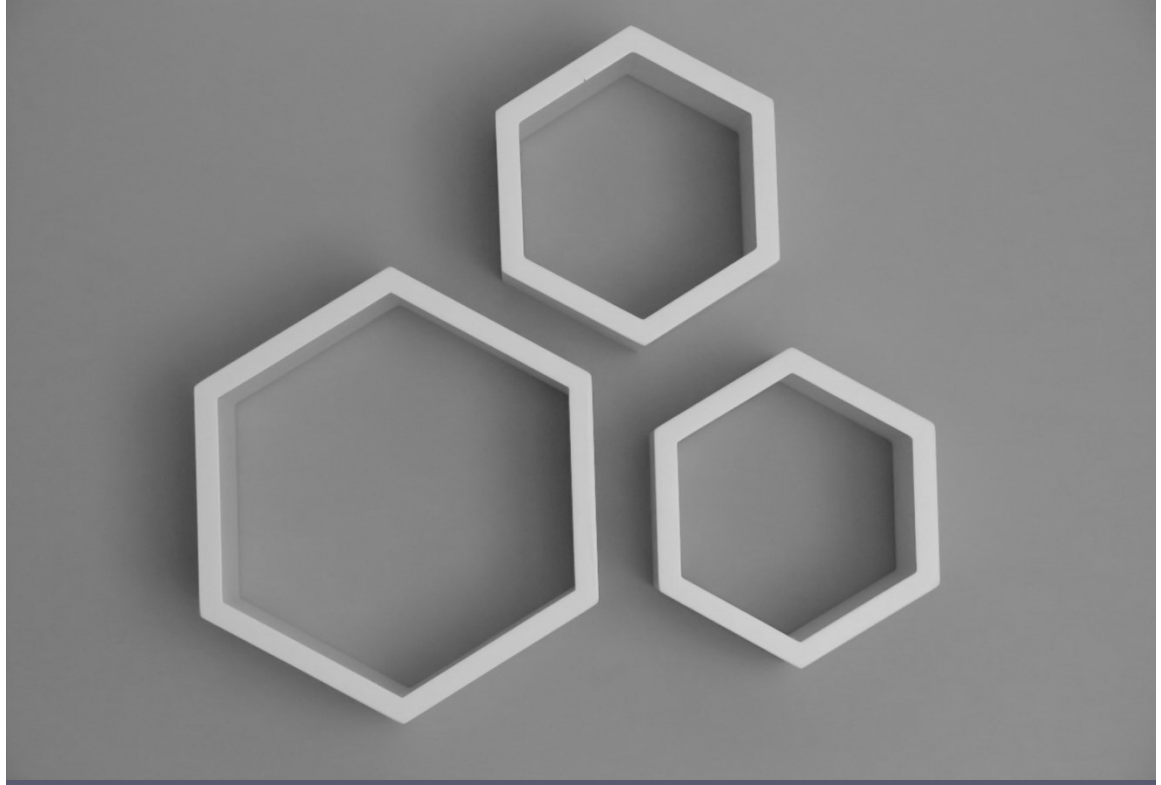

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Questions?

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