



# Medicaid managed care: Costs, access, and quality of care

By Sarah Goodell, M.A.,<sup>1</sup> and Michael Sparer, Ph.D.<sup>2</sup> based on a research synthesis by Sparer

<sup>1</sup> The Synthesis Project  
<sup>2</sup> Columbia University, Mailman School of Public Health

## SUMMARY OF KEY FINDINGS

- > **There is little evidence of national savings from Medicaid managed care, but a few states have had some success.** The states that did realize cost savings were more likely to be states with relatively high reimbursement rates under fee-for-service.
- > **Medicaid managed care has had mixed success in improving access to care.** There is some evidence of increased likelihood of a usual source of care and reduced emergency department visits, but pregnant women were generally no better off under managed care than fee-for-service.
- > **Quality of care in Medicaid managed care has not been well studied.** This is surprising given that states require performance measures for health plans.

## Why are policy-makers interested?

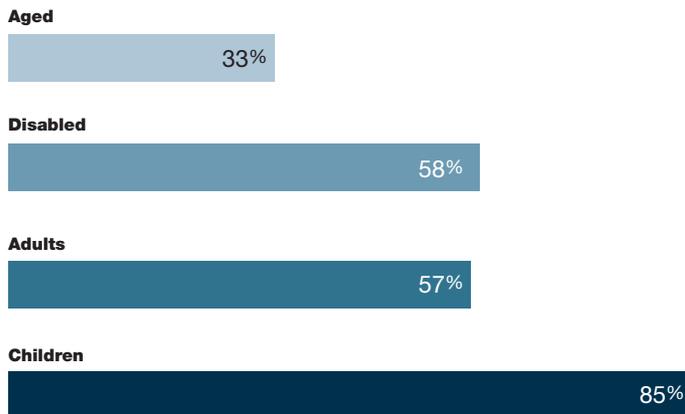
- The Affordable Care Act encourages states to implement a major expansion in Medicaid eligibility. Many of the new beneficiaries will be enrolled in Medicaid managed care. In addition, states will need to coordinate Medicaid managed care with their state insurance exchanges.
- At the same time as the unprecedented expansion of eligibility, states increasingly are looking to managed care to cover more high-cost populations and services. In addition to potential savings, states value the budget predictability that comes from managed care.
- Consumer advocates and providers have expressed concerns about network adequacy, access to care and quality of care, especially as states move the high-cost populations to managed care.

*This brief includes risk-based managed care organizations, primary care case management, and limited benefit plans (see next page) in the definition of Medicaid managed care plans.*

## Who is enrolled in managed care?

**Seventy percent of Medicaid beneficiaries are enrolled in managed care, but spending on managed care accounts for only about 20 percent of all Medicaid spending.** This incongruence is due, in part, to states enrolling children in managed care in high numbers, leaving more adults, disabled, and elderly in fee-for-service (Figure 1).

Figure 1: Managed care enrollment by eligibility category, 2008



Source: MACPAC, June 2011 (Reference 1)

# States are moving more of their Medicaid populations to managed care.

## VARIATIONS IN MEDICAID MANAGED CARE

States have taken a variety of approaches to Medicaid managed care:

**Risk-based managed care organizations (MCO):** MCOs provide a comprehensive set of benefits to their Medicaid population and are usually paid on a capitated basis. Thirty-five states and D.C. use risk-based MCOs for some portion of the Medicaid population (Reference 2). Nationally, nearly 50 percent of the Medicaid population is enrolled in a risk-based MCO (Reference 3).

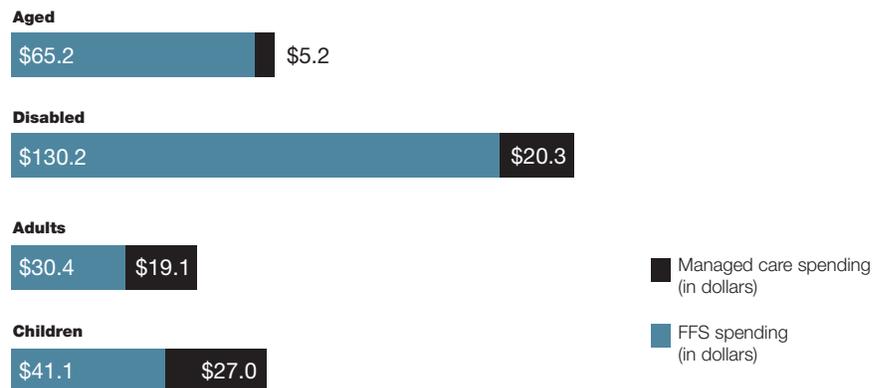
**Primary care case management (PCCM):** Under a PCCM model, states pay primary care providers an additional fee to provide case management services to their enrollees. PCCM is more common in rural states that do not have the population to support risk-based MCOs. Thirty-one states use PCCM, accounting for almost 15 percent of the Medicaid managed care enrollment (Reference 4). In addition, eight states are using enhanced PCCM models in which the state serves as the hub of the care management initiative.

**Limited benefit plans:** States use these plans, also known as “carve out” plans, to provide services such as dental care or mental health treatment, often in addition to MCOs and PCCM programs. Thirty-four states and D.C. use limited benefit plans (Reference 4).

Many states use a combination of managed care arrangements. The wide array of approaches to managed care complicates evaluation efforts to determine how well managed care works for the Medicaid population.

**States are increasingly looking to expand their Medicaid managed care programs to other populations.** California, Illinois, Louisiana and New York are among the states with major initiatives to expand managed care to more aged and disabled adults. These high-cost populations give states more opportunity for potential cost savings through managed care (Figure 2), but arguably present greater challenges in terms of access and quality of care.

Figure 2: Medicaid spending: Managed care vs. fee-for-service, 2008 (dollars in billions)



Source: MACPAC, June 2011 (Reference 5)

Note: Managed care includes comprehensive managed care plans, PCCM, and limited benefit plans. The Centers for Medicare and Medicaid Services includes only the management fee portion of PCCM in total managed care spending.

## Have states saved money through Medicaid managed care?

**Medicaid managed care does not result in significant cost savings on the national level (Reference 6).** Peer-reviewed studies find wide variation in the success of managed care plans to contain costs, but the weight of the evidence suggests any potential savings will not be significant. Several studies conducted by consulting firms on behalf of health plan associations have found more consistent cost savings, but the potential bias of these studies leads us to give greater weight to the peer-reviewed literature.

**A few states have had some success in achieving cost savings through managed care (Reference 7).** The successful states appear to be those with relatively high provider reimbursement rates in their fee-for-service program. The cost savings generally are due to reductions in provider reimbursement rates rather than managed care techniques (Reference 8).

# Medicaid managed care has had mixed success in improving access.

## There are several reasons cost savings have not been more significant from managed care:

- Fee-for-service rates are already so low that it is hard to get additional price discounts.
- States were using prior authorization and utilization review even before moving enrollees to managed care.
- Co-payments for Medicaid beneficiaries are low, making it more difficult to incentivize care-seeking behavior.
- Health plans have limited ability to change traditional delivery systems or address the social determinants of health, both of which play a large role in the fragmented care Medicaid enrollees receive.

## Does Medicaid managed care improve access to care?

**Medicaid managed care can provide beneficiaries with improved access, but the scope and extent of such improvements are often state specific.** Studies from California, New York, Ohio and Wisconsin find improved access under managed care relative to fee-for-service (Reference 13). The positive findings come from studies measuring access by usual source of care, reduction in emergency department visits, and reduction in ambulatory sensitive care hospitalizations (Reference 14). Although there were a few exceptions, national studies generally did not find improved access to care under managed care (Reference 15).

**Access to prenatal care for pregnant Medicaid managed care enrollees is no better or worse than under fee-for-service.** The findings on access to prenatal care are conflicting. While some studies find improvements (Reference 16), other studies find either no change (Reference 17) or worse access for pregnant women under Medicaid managed care (Reference 18) than fee-for-service.

## Does Medicaid managed care improve quality of care?

**Despite the performance measures required by state Medicaid programs for managed care plans, the research using these measures to evaluate quality is slim.** Surprisingly, there have been no peer-reviewed studies on care management programs in Medicaid managed care, even though the programs are proliferating. Several small case studies have found improved clinical outcomes through the use of care management techniques (Reference 19).

**Pregnant managed care enrollees are no more likely to deliver a healthy baby than pregnant women in fee-for-service Medicaid.** Studies find no increase in birthweight or improvement in infant mortality rates from Medicaid managed care (Reference 20). Results did not depend on whether the managed care initiative improved or reduced access to prenatal care.

## THE AGED AND THE DISABLED IN MMC

Medicaid directors are struggling to balance significant increases in overall enrollment with significant declines in state tax revenues. In an effort to respond to this difficult balancing act, state officials are increasingly moving their aged and disabled to some form of managed care. These two populations account for 28 percent of Medicaid enrollment, but 66 percent of Medicaid expenditures (Reference 9). State Medicaid agencies see the potential for cost predictability and perhaps cost savings by enrolling these populations in managed care. Little research on the effects of managed care for these beneficiaries exists, however.

Arizona, the first state to require all Medicaid recipients to enroll in managed care, offers some perspective. Since 1989, Arizona has enrolled elderly and disabled beneficiaries in the Arizona Long Term Care System (ALTCS) program. Early evidence found beneficiaries compared favorably with fee-for-service beneficiaries in New Mexico, and costs under the first five years were about 16 percent lower than under fee-for-service (Reference 10).

Similar to the research on Medicaid as a whole, there is no evidence of managed care cost savings for the aged and the disabled on the national level, however (Reference 11).

Despite the lack of evidence on managed care for the aged and disabled populations, states are quickly enrolling these populations in managed care. These initiatives have become both an economic and a political reality for states. As one state Medicaid director said, states are going to “need the federal government to take a leap of faith” with these populations (Reference 12).

# Policy Implications

**Medicaid policy-makers across the country are implementing divergent managed care initiatives. State budget shortfalls, the need for predictability in Medicaid costs, and the expansion of Medicaid under the ACA are leading states to increasingly turn to managed care. This push to managed care has implications for policy-makers, including:**

- > **Estimates of likely savings from Medicaid managed care should be fairly conservative given the existing evidence.** In addition, there are trade-offs between lower costs and improved access or quality. Programs that improve access and/or quality are less likely to save money, especially in a program with already low reimbursement rates.
- > **Although moving high-cost beneficiaries into managed care may result in cost savings, the needs of this frail population also pose access and quality concerns.** So far, the ability of managed care to achieve cost savings while improving, or at least maintaining, access and quality for this population is uncertain.
- > **There is a need for more and better research on Medicaid managed care, including research that uses available quality performance measures as well as multistate research.** The evaluation requirement of Medicaid waivers is an opportunity to better understand the effects of managed care in Medicaid, but not all evaluations are publicly available and there are few multistate evaluations. These evaluations represent a missed opportunity.

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## PROJECT CONTACTS

David C. Colby, Ph.D., the Robert Wood Johnson Foundation  
Katherine Hempstead, Ph.D., the Robert Wood Johnson Foundation  
Sarah Goodell, M.A., Synthesis Project

## SYNTHESIS ADVISORY GROUP

Linda T. Bilheimer, Ph.D., Congressional Budget Office  
Jon B. Christianson, Ph.D., University of Minnesota  
Paul B. Ginsburg, Ph.D., Center for Studying Health System Change  
Jack Hoadley, Ph.D., Georgetown University Health Policy Institute  
Haiden A. Huskamp, Ph.D., Harvard Medical School  
Julia A. James, Independent Consultant  
Judith D. Moore, Independent Consultant  
William J. Scanlon, Ph.D., National Health Policy Forum  
Michael S. Sparer, Ph.D., Columbia University

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P.O. Box 2316  
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E-Mail: [synthesisproject@rwjf.org](mailto:synthesisproject@rwjf.org)  
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