Evidence Is Needed to Understand the Effects of Managed Care

Background
Rising healthcare costs and budget pressures have led states to pursue implementation or expansion of Medicaid managed care. Through these arrangements, states seek to limit financial risk by contracting with managed care organizations (MCOs) to provide services for enrollees in exchange for a set prospective capitation amount from the state per enrolled beneficiary. There is a widely held view that providing coverage through a managed care model may lead to improved coordination and cost savings through reductions in utilization. However, research on the effects of managed care on reducing costs and improving outcomes is limited, and the few evaluations conducted to date indicate that results are mixed.1,2

States have long used Medicaid managed care to deliver services to children, families, and pregnant women while beneficiaries with complex needs, such as the seriously mentally ill, aged, and disabled remained in traditional fee-for-service (FFS). Recently, states have increased the scope of Medicaid managed care by expanding eligibility to these high-cost and high-need populations and/or increasing the number and types of services that are part of the managed care benefit package. Between 2003 and 2014, nationwide enrollment in comprehensive risk-based managed care increased from 40 percent of Medicaid eligible individuals to 61 percent.3,4 By 2020, MCO enrollment is expected to account for nearly 85 percent of Medicaid beneficiaries.5

Increasingly, states are transforming the payment and delivery of Long-Term Services and Supports (LTSS) by shifting to Managed Long Term Services and Supports (MLTSS) models. The number of states implementing MLTSS programs has increased significantly in recent years, from eight6 states with operational programs in 2004 to more than half of states either operating, developing or considering MLTSS programs in 2017.7 Several other states have proposals either under development or awaiting CMS approval. As discussed above, state managed care experience has typically included only children and healthy adult populations; lack of familiarity with LTSS populations may result in compromised access to and quality of care for a large number of beneficiaries.5

As states continue to transition, it is critical to ensure that states and plans are equipped and able to provide high quality and cost-effective care for complex patients with varying needs. Limited plan data, inconclusive literature, and challenges faced by states implementing MLTSS programs to date suggest that additional evidence is needed before policymakers, states, and plans can guarantee that MLTSS programs will safeguard or improve outcomes, maintain access to care and reduce costs.

Key Challenges
Due to the unique characteristics of each state’s Medicaid program, approaches to MLTSS programs and policies vary across states. However, policymakers, states, and plans can learn from the challenges and opportunities identified in states with established programs and can use that information to determine whether managed care is appropriate for other states and to identify the elements necessary to ensure program effectiveness. Available literature and state experience suggest that there are several key issues that must be addressed as managed care increases in popularity and scope. Several of these challenges are highlighted below.

Uncertainty Concerning Effects on Quality and Outcomes: Most of the data available to researchers emphasizes process measures rather than outcome measures, making it difficult to adequately measure the impact of Medicaid managed care on beneficiary outcomes. In addition, quality measures can vary across states and plans, creating challenges in comparing quality across plans and evaluating differences in quality between managed care and FFS.8

Lack of Adequate State and Plan Readiness Review Procedures: Many MCOs have little or no experience with Medicaid managed care, particularly with LTSS populations. Although states require plans to meet certain criteria to ensure beneficiary needs are met, there is limited information about the state’s processes for verification and validation of plan attestation. One state official advised other states to “look at everything and trust no one... not the providers, not the MCOs, not the subcontractors. You have to verify everything.”9 In addition, providers across states have noted that, despite meeting readiness review requirements, plans were unprepared for program implementation, leading to hiccups in claims processing, payment delays, and inaccuracies in beneficiary enrollment verification process. These issues can lead to significant disruptions to beneficiary care.

1 Sparer M. Medicaid Managed Care: Costs, Access, and Quality of Care. Robert Wood Johnson Foundation. September 2012
8 Sparer M. Medicaid Managed Care: Costs, Access, and Quality of Care. Robert Wood Johnson Foundation. September 2012
**Unclear Beneficiary Resources for MLTSS Education:** The transition to managed care creates uncertainty, confusion, and concern for many beneficiaries, and can be especially challenging for individuals with low health literacy and/or cognitive impairments. In a recent beneficiary survey of KanCare, the Kansas MLTSS program, survey respondents indicated that “frequent and confusing mailings” were “problematic and overwhelming.”

**Unnecessary Prior Authorization Requirements and Challenging Independent Grievance and Appeals Processes:** MCOs may employ utilization management tools and other protocols in making coverage determinations which may inappropriately emphasize cost rather than quality of care. Beneficiaries and providers must have sufficient avenues to appeal decisions made by an MCO and to file complaints about issues or concerns with an MCO’s operations.

**Barriers to Service Access:** MCOs often experience difficulty recruiting physicians willing to accept lower rates. According to a Kaiser Family Foundation survey, over two-thirds of managed care states reported that beneficiary access to specialists a challenge, which is particularly problematic for the needs of the LTSS population.

**Inconsistent Coordination of Care:** MCOs vary significantly in their approaches to designing and implementing care coordination models which can create confusion for providers attempting to adhere to care coordination requirements for multiple organizations.

**Mixed Medicaid Budgetary Research Findings:** Researchers have found that state Medicaid managed care initiatives have no effect on overall Medicaid spending. States with more generous Medicaid reimbursement prior to MLTSS implementation realized greater cost savings, primarily due to reductions in provider reimbursement rates rather than managed care plan practices. In addition, the administrative costs of contracting with MCOs can be significant. In 2012, Connecticut officials determined that the administrative costs outweighed quality improvements and ended contracts with MCOs in order to reallocate those funds to increase primary care provider payments and other care improvement initiatives.

**Need for Improved Stakeholder Engagement and Transparency:** The level of collaboration among state officials and other stakeholders vary significantly across states. Beneficiaries, providers and other stakeholders must have sufficient opportunity to prepare and respond to a state’s decision to develop and/or modify an existing MLTSS program.

**Increased Administrative Complexity:** Lack of uniformity in plan policies and standards creates administrative burden for both providers and patients, which can result in delays in patient care and provider reimbursement.

**Further Erosion of Provider Rates:** Already in Medicaid FFS, provider rates are inadequate. In 2015, the national average projected nursing home shortfall was $22.46. As mentioned above, MCOs often seek to reduce reimbursement rates to its providers in order to contain costs. Should MCOs further reduce rates, providers will be unable to adequately deliver needed services.

**Conclusion**

The health care delivery landscape is undergoing a major transition as the vast majority of states are expanding use of MCOs to deliver the full spectrum of Medicaid services. In light of the limited pool of evidence and issues raised in states that have implemented managed care, the Association is concerned about the scale and pace at which states are shifting from Medicaid FFS to MLTSS. In order to ensure beneficiary access to quality care is not compromised, the Association believes that CMS should cease expansion of managed care until more conclusive evidence concerning cost, quality and outcomes is available.

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12 Gifford, K. et al., A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey. Kaiser Family Foundation, September, 2011
15 Sparer M. Medicaid Managed Care: Costs, Access, and Quality of Care. Robert Wood Johnson Foundation. September 2012
17 Eljay LLC. A Report on Shortfalls in Medicaid Funding for Nursing Center Care. April 2016.