The Value of Medicaid Managed Care: States Transition to Managed Care

America's Health Insurance Plans (AHIP) worked with experts at The Menges Group to conduct in-depth research on the impact of Medicaid managed care. A well-respected analysis and consulting firm, The Menges Group is committed to evaluating the highest quality and most cost-effective strategies to deliver care to high-risk, high need populations. The result is this, the final chapter in a series of research studies on Medicaid managed care that AHIP has released throughout 2020.

The findings make clear that Medicaid managed care plans deliver real savings for states and are effective and accountable stewards of taxpayer dollars. When the public and private sectors work together, Americans get the quality and value that they expect and deserve.

Medicaid is the largest health care program in the country, covering about 1 in 5 Americans – including **millions of children, older adults, people with disabilities, and 2 million veterans.**

Two-thirds of Americans enrolled in Medicaid are served in Medicaid managed care programs, a public-private partnership between federal and state governments and managed care plans.

As Medicaid managed care plans take on more care management and administrative services for the states, how are the plans performing financially? Do states recognize the value Medicaid managed care plans deliver? **The answer is a resounding yes.**

Turning to Medicaid Managed Care

States have come to rely on Medicaid managed care plans to provide a variety of care management and administrative services historically performed by the state. Managed care plans assume financial risk for the cost of services and take on many of the routine labor-intensive day-to-day operational activities performed by states with traditional fee-for-service Medicaid programs.

But it's important to note that states do not relinquish control of their Medicaid programs when they opt for managed care. Instead, states shift from active benefits administrators to active contract and oversight management, holding plans highly accountable for the delivery of care to their citizens.

The five major categories of services provided by Medicaid managed care plans include:

Enroll Engagement and Service • Outreach and engagement • Benefits information • Health education • Appeals and grievances	**Provider Access and Availability** • work development and contracting • Provider service and education • Claims processing • Value based arrangements
Care Management • Assessment and care planning • Longitudinal and transitions care management • Utilization management and medical review	**Financial Management and Reporting** • Value based payment arrangements • Service utilization and cost, other financial information • Fraud, waste, and abuse detection, monitoring and reporting
Quality Improvement • Quality metrics data collection and analysis • Quality improvement projects to improve performance	

Some states use managed care to serve all their Medicaid enrollees while others take a more tailored approach. Depending on the state, Medicaid managed care plans assume responsibility for care management and administrative services for:

- Diverse populations, ranging from children and pregnant women to Medicare-Medicaid dual eligibles and people with physical or intellectual disabilities; and
- Diverse benefits and programs, such as acute and preventive medical services, long term services and supports including home and community-based services, services for children in foster care, dental care, integrated physical and behavioral health, substance use disorder services, and prescription drugs.

Recognizing the Value of Medicaid Managed Care

Comprehensive, risk-based managed care programs use prospective, capitated payments under which each Medicaid managed care plan receives a fixed payment per enrolled individual, per month. Managed arrangements facilitate and monitor access to needed care, measure and strengthen quality, and deliver cost-effective care to more than 75% of Medicaid enrollees nationwide. While states determine the extent to which they use capitation payment models in their Medicaid programs within the broader federal requirements for Medicaid managed care, full-risk-risk capitation is the hallmark of Medicaid managed care programs.

Nationwide, the use of capitated arrangements in Medicaid has expanded significantly over the past several years, corresponding to the increase of comprehensive managed care arrangements. That growth can be viewed from a number of different perspectives: the increase in expenditures on capitated programs in terms of total dollars and as a percentage of total; and increases in Medicaid enrollment and percentage of total enrollment in managed, capitated systems. **Figure 1** summarizes changes in these various different perspectives for federal fiscal years (FFY) 2010 and FFY 2018.

Figure 1. Perspectives on Growth in Capitated Arrangements in Medicaid, FFY 2010-2018

Metric	FFY 2010	FF 2018
State Medicaid capitation expenditures in total dollars	$90 billion	$281 billion
Percentage of expenditures through capitated arrangements	23.3%	47.1%
Enrollment in capitated arrangements	25.6 million	54.1 million
Percentage of people enrolled in capitated arrangements	50.9%	76.7%

Spending. In absolute dollar terms, state Medicaid payments in capitated arrangements have more than tripled from $90 billion in FFY 2010 to $281 billion during FFY 2018. Capitated payments represented 47.1% of all Medicaid spending in 2018, more than double the proportion in FFY 2010 (23.3%).

Nationwide in Medicaid during FFY 2010, fee-for-service (FFS) expenditures were roughly three times that of capitated expenditures. Since FFY 2017, however, capitation expenditures have exceeded FFS expenditures. Medicaid is now predominantly a managed care program

Figure 2 shows the breakdown in Medicaid spending by state for FFY 2018, with subtotals for capitation payments, fee-for-service expenditures, and special payments not directly tied to enrollee utilization of service; e.g., graduate medical education (GME), disproportionate share hospital (DSH), and supplemental payments.

State	FFY 2018 Medicaid Spending	Capitation	Fee-For-Service	Supplemental, DSH, and GME Payments	Total
Alabama	$5,687,368,911	0.8%	79.0%	20.3%	100.0%
Alaska	$2,062,268,729	0.0%	99.1%	0.9%	100.0%
Arizona	$12,306,404,598	78.3%	17.3%	4.5%	100.0%
Arkansas	$6,364,871,582	1.4%	91.2%	7.4%	100.0%
California	$86,084,573,663	42.8%	46.7%	10.5%	100.0%
Colorado	$9,032,421,631	15.8%	66.8%	17.4%	100.0%
Connecticut	$8,175,809,143	0.0%	89.9%	10.1%	100.0%
Delaware	$2,243,259,171	78.1%	21.2%	0.6%	100.0%
Dist. Of Col.	$2,848,772,608	34.1%	63.0%	2.8%	100.0%
Florida	$23,192,222,295	63.2%	29.6%	7.3%	100.0%
Georgia	$10,969,903,891	27.5%	63.2%	9.3%	100.0%
Hawaii	$2,276,077,426	87.9%	12.3%	-0.2%	100.0%
Idaho	$1,909,015,354	6.1%	89.4%	4.5%	100.0%
Illinois	$22,414,925,204	56.5%	36.6%	6.9%	100.0%
Indiana	$11,418,894,241	39.7%	50.3%	10.0%	100.0%
Iowa	$4,864,271,691	83.9%	14.0%	2.1%	100.0%
Kansas	$3,466,223,134	84.9%	12.0%	3.1%	100.0%
Kentucky	$9,923,486,252	65.2%	32.4%	2.4%	100.0%
Louisiana	$11,113,062,515	66.9%	20.7%	12.4%	100.0%
Maine	$2,705,393,744	0.0%	95.1%	4.9%	100.0%
Maryland	$11,765,765,319	43.1%	55.6%	1.3%	100.0%
Massachusetts	$17,947,456,968	34.7%	61.4%	3.8%	100.0%
Michigan	$16,519,398,146	60.0%	30.2%	9.8%	100.0%
Minnesota	$12,326,290,831	47.5%	50.5%	2.0%	100.0%
Mississippi	$5,382,353,953	45.0%	50.6%	4.4%	100.0%
Missouri	$10,435,400,500	22.3%	68.9%	8.8%	100.0%
Montana	$1,840,017,487	0.0%	87.1%	12.9%	100.0%
Nebraska	$2,202,347,632	46.9%	50.4%	2.7%	100.0%
Nevada	$3,944,069,916	42.2%	48.0%	9.8%	100.0%

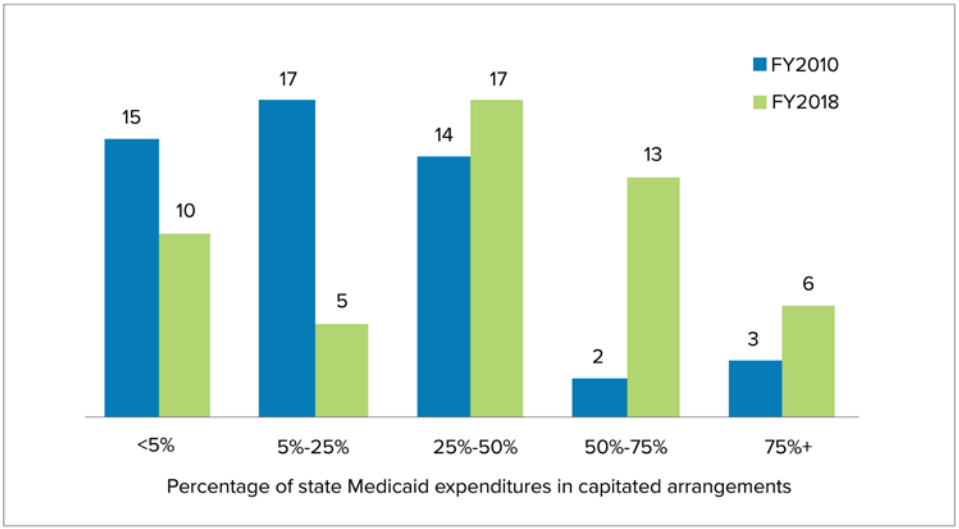
State	FFY 2018 Medicaid Spending	Capitation	Fee-For-Service	Supplemental, DSH, and GME Payments	Total
New Hampshire	$2,183,426,886	39.5%	43.9%	16.5%	100.0%
New Jersey	$15,089,624,439	57.2%	35.1%	7.7%	100.0%
New Mexico	$5,206,954,048	75.2%	20.2%	4.6%	100.0%
New York	$73,794,508,426	53.1%	38.9%	8.0%	100.0%
North Carolina	$13,600,656,846	19.6%	62.4%	17.9%	100.0%
North Dakota	$1,241,241,352	23.4%	76.3%	0.3%	100.0%
Ohio	$22,224,026,829	54.9%	42.2%	2.8%	100.0%
Oklahoma	$4,671,884,870	1.2%	85.7%	13.2%	100.0%
Oregon	$8,981,200,128	53.7%	43.1%	3.1%	100.0%
Pennsylvania	$30,126,192,623	53.0%	40.6%	6.5%	100.0%
Rhode Island	$2,705,181,395	56.0%	38.1%	5.8%	100.0%
South Carolina	$6,169,542,022	42.8%	46.4%	10.9%	100.0%
South Dakota	$888,932,766	0.0%	98.9%	1.1%	100.0%
Tennessee	$9,718,485,871	69.4%	26.9%	3.7%	100.0%
Texas	$38,132,196,596	55.6%	33.0%	11.4%	100.0%
Utah	$2,509,132,107	42.9%	50.8%	6.4%	100.0%
Vermont	$1,608,357,171	0.0%	98.3%	1.7%	100.0%
Virginia	$9,736,906,440	46.0%	45.9%	8.2%	100.0%
Washington	$12,108,672,914	46.1%	51.0%	3.0%	100.0%
West Virginia	$3,878,298,195	40.7%	56.9%	2.4%	100.0%
Wisconsin	$8,875,440,616	45.7%	52.5%	1.8%	100.0%
Wyoming	$598,125,819	0.6%	88.1%	11.3%	100.0%
USA Total	**$595,471,314,894**	**47.1%**	**45.1%**	**7.8%**	**100.0%**

Source: Menges Group tabulations using CMS FMR reports for FFY 2018.

States using managed care models.

Most states are using a mix of managed care and FFS arrangements for the services, populations, and geographic areas covered through their Medicaid programs. Figure 3 compares the distribution of states using the capitated model for a given range of Medicaid spending in FFY 2010 and FFY 2018. Overall, as of FFY 2018, 19 states made 50% or more of their Medicaid expenditures through capitation payments (versus only five states as of FFY 2010).

Figure 3. Numbers of States Using Capitated Arrangements in Medicaid, 2010 and 2018



Source: Menges Group tabulations using CMS financial management reports for FFYs 2010 and 2018. Overall National Percentage of Medicaid Expenditures in Capitation Arrangements.

Figure 4 presents more granular data on the proportion of Medicaid spending through capitated arrangements in each state, for FFY 2010 and 2018. The states are sorted in descending order by the largest percentage change in spending between those dates. 32 states increased their use of capitation-based payments by more than 10 percentage points between 2010 and 2018, with some states – Iowa, Louisiana, Kansas, Illinois, and Kentucky – increasing by more than 50 percentage points.

These changes are due to several factors. Some states adopted managed care for the first time. Some states broadened the geographic footprints of their Medicaid managed care programs. For instance, North Carolina is in the process of implementing its comprehensive Medicaid managed care plan model on a statewide scale for its more than 2 million enrollees. Some states broadened the population groups being served by Medicaid managed care, particularly by extending Medicaid managed care plans to enrollees who use long-term care services and supports, people with disabilities, and individuals dually eligible for Medicaid and Medicare. For example, California, Kansas, New Jersey, and Virginia recently expanded the Medicaid eligibility groups served through capitated Medicaid managed care plans.

State	Percent Capitated 2010	Percent Capitated 2018	Percentage Point Change 2010-2018
Iowa	3.9%	83.9%	79.9%
Louisiana	0.0%	66.9%	66.9%
Kansas	23.3%	84.9%	61.6%
Illinois	1.9%	56.5%	54.6%
Kentucky	13.4%	65.2%	51.8%
Florida	17.0%	63.2%	46.2%
Mississippi	0.0%	45.0%	45.0%
Nebraska	6.4%	46.9%	40.5%
New Hampshire	0.0%	39.5%	39.5%
New Jersey	18.5%	57.2%	38.7%
Texas	18.2%	55.6%	37.4%
New York	19.0%	53.1%	34.0%
Delaware	46.6%	78.1%	31.5%

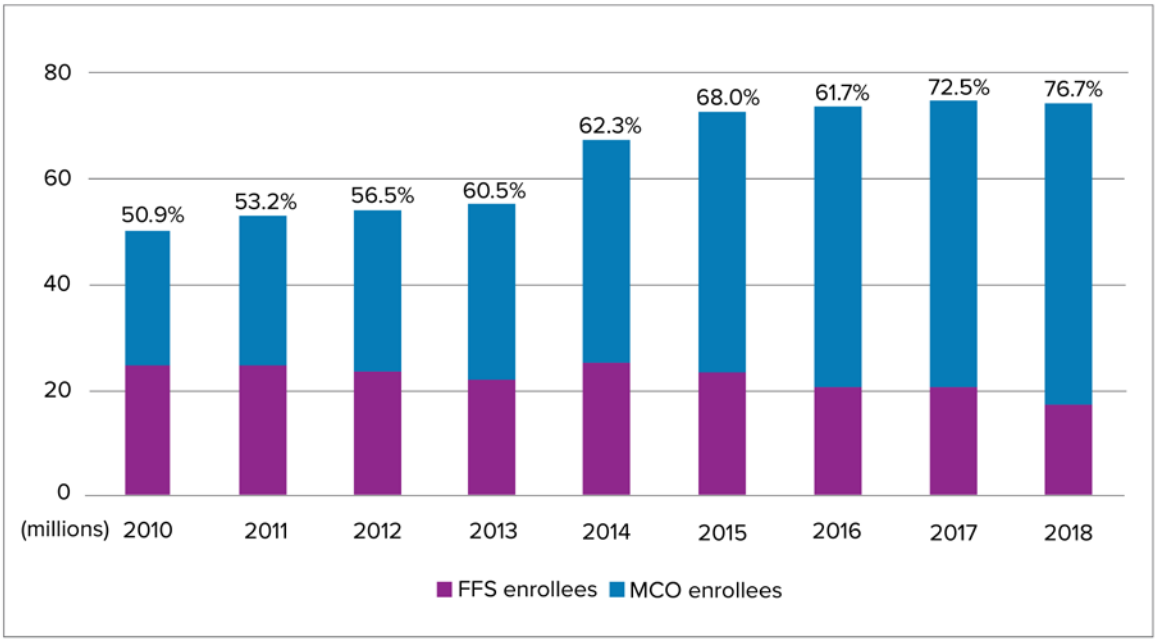
State	Percent Capitated 2010	Percent Capitated 2018	Percentage Point Change 2010-2018
West Virginia	12.7%	40.7%	28.0%
California	15.4%	42.8%	27.4%
Rhode Island	28.9%	56.0%	27.1%
Ohio	29.1%	54.9%	25.9%
USA Total	**23.3%**	**47.1%**	**23.9%**
North Dakota	0.1%	23.4%	23.3%
Nevada	19.2%	42.2%	23.1%
Utah	21.1%	42.9%	21.8%
Virginia	25.3%	46.0%	20.7%
Washington	26.0%	46.1%	20.1%
Indiana	20.6%	39.7%	19.0%
North Carolina	2.0%	19.6%	17.6%
South Carolina	25.3%	42.8%	17.5%
Minnesota	32.6%	47.5%	14.9%
New Mexico	61.4%	75.2%	13.8%
Oregon	41.3%	53.7%	12.5%
Tennessee	57.9%	69.4%	11.5%
D. Columbia	22.8%	34.1%	11.3%
Hawaii	77.2%	87.9%	10.7%
Michigan	49.7%	60.0%	10.3%
Massachusetts	25.4%	34.7%	9.3%
Missouri	13.4%	22.3%	8.9%
Maryland	34.8%	43.1%	8.3%
Pennsylvania	44.9%	53.0%	8.1%
Colorado	9.6%	15.8%	6.2%
Wisconsin	39.8%	45.7%	5.9%
Idaho	1.9%	6.1%	4.2%
Arkansas	0.0%	1.4%	1.4%
Wyoming	0.0%	0.6%	0.6%
Montana	0.0%	0.0%	0.0%
Maine	0.0%	0.0%	0.0%
South Dakota	0.0%	0.0%	0.0%
Alaska	0.0%	0.0%	0.0%
Georgia	28.7%	27.5%	-1.1%
Oklahoma	3.0%	1.2%	-1.9%
Arizona	87.0%	78.3%	-8.8%
Alabama	13.4%	0.8%	-12.6%
Connecticut	13.2%	0.0%	-13.2%
Vermont	82.4%	0.0%	-82.4%

Source: Menges Group tabulations using CMS FMR reports for FFYs 2010 and 2018.

Enrollment. In 2010, approximately 50 million people were enrolled in Medicaid at any given point in time (excluding Puerto Rico and other U.S. territories). Just over half (50.9%) were enrolled in a Medicaid managed care plan. Spurred by Medicaid expansion beginning in 2014, Medicaid enrollment grew by 47% between FFY 2010 to 2018. In the same timeframe, Medicaid managed care plan enrollment more than doubled, increasing by 121%. As of 2018, more than three-quarters of all people with Medicaid coverage (76.7%) were enrolled in a Medicaid managed care plan.

Figure 5 illustrates the growth of enrollment nationally in comprehensive Medicaid managed care programs from FFY 2010 to 2018, in absolute numbers and as a proportion of total Medicaid enrollment.

Figure 5. Comparative FFS and Medicaid Managed Care Plan Enrollment, FFY 2010 to 2018



in Puerto Rico and other territories. Also excludes people enrolled only in stand-alone behavioral health or dental programs. (https://www.kff.org/other/state-indicator/total-medicaid-mco-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D).

Some states exclude or "carve-out" selected high-cost populations or certain high-cost drugs, such as curative hepatitis C drugs, from their Medicaid managed care prescription drug programs. States with carve outs have had significantly higher cost increases than those without carve outs, research from Menges has shown. Many states moved away from benefits carve-outs between 2010 and 2018 in the interest of facilitating focused care management that assesses needs and delivers services for the "whole person." As a result, Medicaid prescription drug coverage moved from a separate "carve-out" model to inclusion in Medicaid managed plan programs in 9 states. Behavioral health services moved from a carve-out to integrated approaches during this timeframe in several states, including Minnesota, South Carolina, and Washington State. And many states increased the use of their Medicaid managed care plan capitated programs through a combination of the above-described approaches.

Of the three states showing a significant drop-off in their use of the capitated model from 2010-2018 (Alabama, Connecticut, and Vermont), only Connecticut discontinued its comprehensive capitated Medicaid managed care program. Alabama and Vermont have never used the Medicaid managed care model.

COVID-19's Impact on Medicaid Managed Care

As we look ahead to the future of Medicaid managed care, we must consider how COVID-19 may impact enrollment and services. As of May 2020, more than 27 million Americans have lost their health insurance coverage following a job loss during the COVID-19 crisis, and many are turning to Medicaid to address the health care needs of not only themselves, but their families as well. Medicaid enrollment could increase by 5 to 18 million individuals by the end of the year, according to research from Health Management Associates.

States are being pushed to the brink by the economic impacts of the COVID-19 crisis. Based on Congressional Budget Office and Wall Street forecasts, states will likely face shortfalls of approximately $650 billion in the next three years. The COVID-19 crisis has highlighted the power of the public and private sector, working together, to lower costs, improve efficiencies, and provide the high-quality health care that Americans deserve.

States recognize the value of Medicaid managed care plans to provide quality care and help control costs, which is especially important as budgets face the strain of COVID-19. And states are able to hold Medicaid managed care plans accountable through strict review processes.

Medicaid managed care plans have taken decisive action to protect patients and health care workers during the COVID-19 crisis. Examples include everything from covering the costs of all COVID-19 related treatments, to expanding telehealth services, to waiving prior authorization requirements.

Medicaid managed care plans have also taken steps to support their communities through grants and donations to clinics and nonprofit organizations that are supporting COVID-19 relief efforts.

Additionally, plans have secured and distributed personal protection equipment to local hospitals and health care providers, and partnered with public and county health systems to administer COVID-19 tests.

Overcoming the COVID-19 pandemic requires a far-reaching and coordinated response, and Medicaid managed care plans are committed to working together with state, federal and local officials in every way possible, from supporting our public health heroes, to offering specific policy and regulatory changes, to assisting governors, legislatures, the Congress and the Administration.

Together, we can and will defeat and overcome the COVID-19 crisis.