



**Texas Conservative Coalition Research Institute**

**Evaluating the Cost-Effectiveness of Medicaid Managed Care**

*A Policy White Paper*

*March 2018*

## Executive Summary

The Texas Legislature first began utilizing Medicaid managed care in the early 1990s. What began as a small regional Medicaid managed care pilot in 1993 has today grown to operate in all of Texas's 254 counties and cover over 90% of the state's Medicaid enrollees.<sup>1</sup> Medicaid Managed Care Organizations (MCOs) are paid billions of taxpayer dollars on an annual basis to care for some of the state's most complex and vulnerable populations. The level of trust and responsibility placed within these plans, as well as the state's significant investment in this model, raises the valid question of whether Medicaid managed care has continued to provide a sound return on investment, both in terms of cost-effectiveness and quality of care. While this question is a very reasonable one to posit, arriving at a quantitative value by which to judge the success of Medicaid managed care is difficult, as determining a baseline for which to compare "would-be" fee-for-service (FFS) Medicaid costs and outcomes becomes problematic. Because Texas has been using the Medicaid managed care model for so long, its savings and efficiencies are assumed within the Medicaid program's budget, thus making it problematic to determine what costs would have been under FFS.

To help analyze available data and verify the cost-effectiveness of the Texas Medicaid managed care model, the Texas Conservative Coalition Research Institute (TCCRI) procured the services of Carruth & Associates, an independent outside firm headed by the former Chief Financial Officer of HHSC. These findings are presented in their entirety in Appendix A.

While that report, and this paper, will focus primarily on cost savings associated with Medicaid managed care, this model has also shown great success in raising the quality of care for Medicaid enrollees. The Carruth & Associates report notes, "[c]ost-[e]ffectiveness is only achieved, in the long-run, through a program that delivers high quality at the lowest cost possible to maintain the value."<sup>2</sup> A true measure of a system's cost-effectiveness does not simply examine the input (i.e. state funds being put into the Medicaid program), but also the output (i.e. the quality of care and health outcomes of enrollees being served).

Key findings of the Carruth & Associates report include:

- When Medicaid caseloads grew by 93 percent between fiscal years (FY) 2002-2016, per member per month (PMPM) Medicaid costs increased only by a total of 17 percent, or just over one percent per year on average. This includes a significant cost increase in 2008, which was the direct result of provider rate increases due to the *Frew v. Hawkins* lawsuit.
- Although Texas has been steadily expanding Medicaid managed care, it was not until FY 2013, when 80 percent of Medicaid enrollees were enrolled in managed care, that just over half of all Medicaid costs were finally under the capitated model. This was achieved after additional enrollees and geographic areas, prescription drug benefits, and nursing facility care were carved into managed

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<sup>1</sup> Texas Health and Human Services Commission, "Fact Book," 2017, p. 39, available at

<https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017-factbook.pdf>.

<sup>2</sup> Carruth & Associates, "Demonstrating Value Through Cost-Effectiveness in Medicaid Managed Care," prepared for Texas Conservative Coalition Research Institute, March 2018, p. 4.

care. Over the past almost 15 years, MCOs have been able to successfully bend the Medicaid cost curve while only controlling a portion of the Medicaid budget. Today, about 70 percent of the total Medicaid spend is within capitation.

- Periods of significant growth in managed care tend to correspond with very low Medicaid PMPM cost growth, and in some cases, even declines:
  - From FYs 2012-2016, after the state underwent a large statewide managed care expansion, overall Medicaid caseloads increased by 11 percent, while total Medicaid costs increased by 17 percent.
  - However, Medicaid PMPM costs increased by less than one percent per year, while national health expenditures during this same time period experienced almost four percent per capita growth.
- Two studies using similar methods, one conducted by HHSC in 2012, and one by Milliman in 2015, arrived at comparable outcomes in validating Medicaid managed care cost savings.
- Both historical cost trend analysis and forecasted studies have demonstrated the cost-effectiveness of the Texas Medicaid managed care program.

Medicaid managed care has been demonstrated as one of the most effective means of bending the ever-increasing Medicaid cost curve and providing high-quality health care coverage. Health plans are able to provide better care by helping coordinate and “manage” an enrollee’s health care to more preventive, lower cost settings, and by utilizing the providers within their networks. Plans also assume financial risk should costs exceed the negotiated PMPM rate, which provides budget certainty for the state.

Since its inception as a small pilot program in the 1990’s, Medicaid managed care has grown into one of the state’s most successful initiatives, allowing Texas to utilize private sector businesses and free market innovation to better deliver government-sponsored programs. As lawmakers further explore the Medicaid managed care model in coming interim committee hearings and form recommendations for the 86<sup>th</sup> Legislative Session, it is imperative that state leaders continue to fully embrace this model and reject policies that would hinder an MCO’s ability to continue providing higher-quality cost-effective care to the state’s Medicaid and CHIP populations.

## ***History of Texas Medicaid Managed Care***

Prior to the 1990s, Texas Medicaid enrollees received their health care services in what is known as a fee-for-service (FFS) system. In FFS, providers are paid per claim directly by the state. While enrollees can access any Medicaid provider in FFS, there is no coordination of care or benefits, which often leads to Medicaid enrollees receiving duplicative or unnecessary services and results in an overall lack of successful management of chronic conditions like asthma and diabetes.

In 1991 the Texas Legislature passed House Bill 7 (72S1), establishing the state's first Medicaid managed care pilot programs, with the goal of seeking innovative methods for providing higher-quality lower-cost health care to the Medicaid population.<sup>3</sup> The first pilot, known as LoneSTAR (State of Texas Access Reform, later shortened to just STAR), was originally implemented in the Travis County and Gulf Coast regions for acute care clients in the early 1990's.<sup>4</sup> Encouraged by the program's success, the Legislature began growing this model, and, by the end of the decade, STAR had expanded to most of the state's major metropolitan areas; the program had also begun serving some long-term services and supports (LTSS) enrollees in the STAR+PLUS program which, for the first time, integrated acute and LTSS care for the state's most complex and high-cost members.<sup>5</sup>

Texas, like other states at the time, originally turned to managed care as an innovative method for controlling skyrocketing Medicaid costs.<sup>6</sup> However, the managed care model also yielded myriad client benefits. Beginning in 1999, HHSC conducted a 15-month review of the state's current Medicaid managed care programs with the input of various stakeholders to assess the model's effectiveness and outcomes. The analysis concluded that:

...implementation of managed care improved access to providers, produced program savings, and resulted in program accountability and quality improvement standards and measurement not found in the traditional fee-for-service (FFS) Medicaid program.<sup>7</sup>

Building upon these accomplishments, the Legislature continued to steadily expand the Medicaid managed care model over the years, both in terms of geography and in the types of clients served, due in equal part to its success in achieving cost savings and improving client outcomes.

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<sup>3</sup> Health and Human Services Commission, "Texas Medicaid and CHIP in Perspective," 11<sup>th</sup> Edition, February 2017, Appendix D, available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Ibid.*

<sup>6</sup> Boben, Paul J. "Medicaid Reform in the 1990s." *Health Care Financing Review* 22.2 (2000): 1–5. Print.

<sup>7</sup> Health and Human Services Commission, "Texas Medicaid and CHIP in Perspective," 11<sup>th</sup> Edition, February 2017, Appendix D, available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>.

## ***Evaluating the Cost-Effectiveness of the Medicaid Managed Care Model***

Today managed care operates in all of Texas's 254 counties, and over 90% of the state's more than 4 million Medicaid enrollees receive their services through Medicaid managed care organizations (MCOs).<sup>8</sup> HHSC contracts with these plans and pays them a capitated per member per month (PMPM) premium to ensure that Medicaid recipients receive all necessary and appropriate services, and plans are at risk for facilitating the provision of an enrollee's services within the PMPM rate. MCOs must maintain provider networks that ensure their members' access to all types of care, e.g. physician, hospital, pharmacy, therapy, etc.<sup>9</sup> Unlike the FFS system, managed care plans must also meet specific access standards, such as how far members must travel to see a provider and how long it takes to get an appointment.<sup>10</sup>

MCOs are paid billions of taxpayer dollars on an annual basis to care for some of the state's most complex and vulnerable populations. The level of trust and responsibility placed with these plans, as well as the state's significant investment in this model, raises the valid question of whether Medicaid managed care has continued to provide a sound return on investment, both in terms of cost-effectiveness and quality of care. While this question is a very reasonable one to posit, arriving at a quantitative value by which to judge the success of Medicaid managed care is difficult, as determining a baseline for which to compare "would-be" FFS Medicaid costs and outcomes becomes problematic.

For instance, Texas has been under some form of Medicaid managed care since 1993.<sup>11</sup> The longer the state is in the managed care model, the more difficult it becomes to draw an apples-to-apples comparison of what costs would have run under a FFS system. In Texas, Medicaid managed care achieves cost savings by negotiating rates with a preferred network of providers, by ensuring that clients receive appropriate levels of care, by improving enrollees' health outcomes so they become less expensive over time (this is particularly true of the LTSS population), and by assuming financial risk should costs exceed the PMPM amount. All of these variables have now been baked into the Medicaid program's cost and budget projections for several years. Thus, it becomes extremely difficult to attempt to determine what expenditures would have been without these cost and quality controls in place. It is also inadvisable to compare one state Medicaid program costs to another, as these vary greatly by state depending on factors such as eligibility levels, benefit packages, the cost of health care by state, and case mix (i.e. the number of less expensive enrollees compared to those who are higher cost and medically complex), among other things.

To help analyze available data and the cost-effectiveness of the Texas Medicaid managed care model, the Texas Conservative Coalition Research Institute (TCCRI) procured the services of Carruth & Associates, an independent entity headed by the former Chief Financial Officer of HHSC. These findings

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<sup>8</sup> Texas Health and Human Services Commission, "Fact Book," 2017, p. 39, available at

<https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017-factbook.pdf>.

<sup>9</sup> Health and Human Services Commission, "Texas Medicaid and CHIP in Perspective," 11<sup>th</sup> Edition, February 2017, p. 129, available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>.

<sup>10</sup> *Ibid.*, p. 129-130.

<sup>11</sup> *Ibid.*, Appendix D.

are presented in their entirety in Appendix A. While that report, and this paper, will focus primarily on the cost savings effectiveness of the Medicaid managed model, it should be noted that the model has also shown great success in raising the quality of care for Medicaid enrollees as well.

As part of its inclusive supervision, HHSC monitors all aspects of an MCOs business and operations, from the robustness and availability of provider panels, how long it takes enrollees to schedule appointments, and the quality of services provided, to the plan's fiscal soundness and staff turnover; HHSC also assesses contractual remedies, including corrective action plans and liquidated damages, when appropriate.<sup>12</sup> The state places a cap on the amount of money that MCOs may use towards administrative expenses, places a percentage of a health plan's premium at risk to ensure certain client quality metrics are met, and enforces a strict limit on the amount of profit these plans can make from Medicaid and CHIP business.<sup>13</sup> Any profit that exceeds this threshold is recovered by the state through an experience rebate process.<sup>14</sup>

The following graphic provides a visual depiction of how a dollar within the Medicaid managed care system is spent, including the average plan's direct enrollee care costs, administrative costs, profit shared with the state, and profit margin.<sup>15</sup> Developed from data within HHSC's financial statistical reports (FSR) filings, the illustration shows that the vast majority of each managed care dollar goes directly to patient care, with emergency room/hospital and nursing facility/LTSS services being the costliest among enrollee services.

The combination of a profit cap and quality measures adds an additional layer of client protection by disincentivizing plans from taking any action that might adversely impact an enrollee's outcome in an attempt to increase profit margins. In addition, HHSC contracts with an independent external quality review organization (EQRO) to assess and report on care provided by MCOs including patient access to providers, quality of care, and overall enrollee experience.<sup>16</sup> These EQRO reports continue to show that the state's Medicaid managed care programs perform well in terms of patient satisfaction and meet or exceed national standards in enrollees' satisfaction both with their health plans, and with the care they receive.<sup>17</sup> A 2016 *Texas Medicaid Performance Study* by the University of Texas School of Public Health

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<sup>12</sup> Health and Human Services Commission, "Review of HHSC's Contract Management and Oversight Function for Medicaid and CHIP Managed Care and Fee-for-Service Contracts," February 2017, available at <https://hhs.texas.gov/sites/default/files//documents/lawsregulations/reports-presentations/rider56-medicaid-chip-contract-management-oversight-feb-2017.pdf>.

<sup>13</sup> Texas Association of Health Plans, "Texas Medicaid Managed Care," October 2015, available at <http://tahp.org/wp-content/uploads/2016/11/TAHP-Fact-Sheet-Medicaid-Managed-Care-Saving-Dollars-Saving-Lives-October-2015.pdf>.

<sup>14</sup> Health and Human Services Commission, "Review of HHSC's Contract Management and Oversight Function for Medicaid and CHIP Managed Care and Fee-for-Service Contracts," February 2017, available at <https://hhs.texas.gov/sites/default/files//documents/laws-regulations/reports-presentations/rider56-medicaid-chip-contract-management-oversight-feb-2017.pdf>.

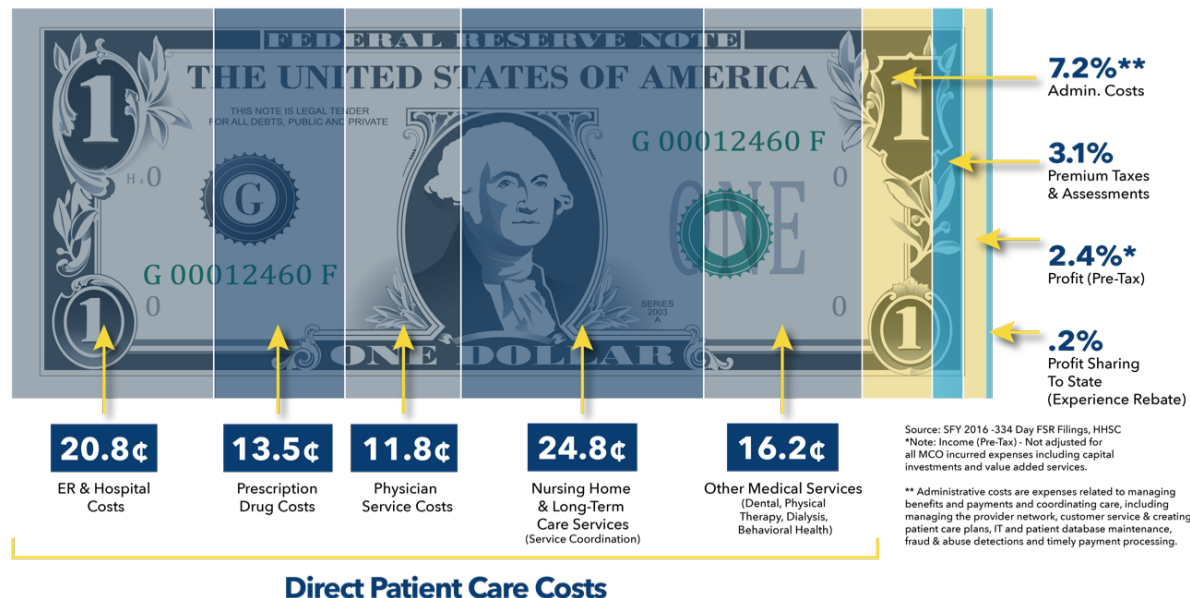
<sup>15</sup> This visual was developed by the Texas Association of Health Plans and is derived from data within HHSC's managed care financial statistical report filings.

<sup>16</sup> The Institute for Child Health Policy, "Texas Medicaid Managed Care and Children's Health Insurance Program External Quality Review Organization Summary of Activities and Trends in Healthcare Quality," Contract Year 2015, p. 1, available at <https://hhs.texas.gov/sites/hhs/files/eqro-medicaid-managed-care-insurance.pdf>.

<sup>17</sup> The Institute for Child Health Policy, "Texas Medicaid Managed Care and Children's Health Insurance Program: EQRO Summary of

also found that under managed care, access to, and quality of, care for Medicaid enrollees is not only superior to the FFS system, but also on par with, and in some cases better than, private coverage.<sup>18</sup>

### HOW A MEDICAID DOLLAR IS SPENT:



Source: Texas Association of Health Plans

The Carruth & Associates report notes that “[c]ost-[e]ffectiveness is only achieved, in the long-run, through a program that delivers high quality at the lowest cost possible to maintain the value.”<sup>19</sup> This point cannot be overstressed- while detractors of managed care allege that cost savings are reached simply by denying or rationing care, the model actually relies on ensuring that enrollees receive the right care, at the right time, and in the right setting, and the data supports this fact. A true measure of a system’s cost-effectiveness does not simply examine the input (i.e. state funds being put into the Medicaid program), but also the output (i.e. the quality of care of health outcomes of enrollees being served).

Activities and Trends in Healthcare Quality,” Contract Year 2015, submitted January 8, 2016, pp. 110, 167, 170-171, available at <https://hhs.texas.gov/sites/default/files//egro-2015-summary-of-full-report-Activities-and-Trends-in-Healthcare-Quality.pdf>.

<sup>18</sup> University of Texas School of Public Health and Methodist Healthcare Ministries of South Texas, “Texas Medicaid Performance Study,” 2016 Final Report, available at <http://www.mhm.org/library/policy-publications/texas-medicaid-performance-study>.

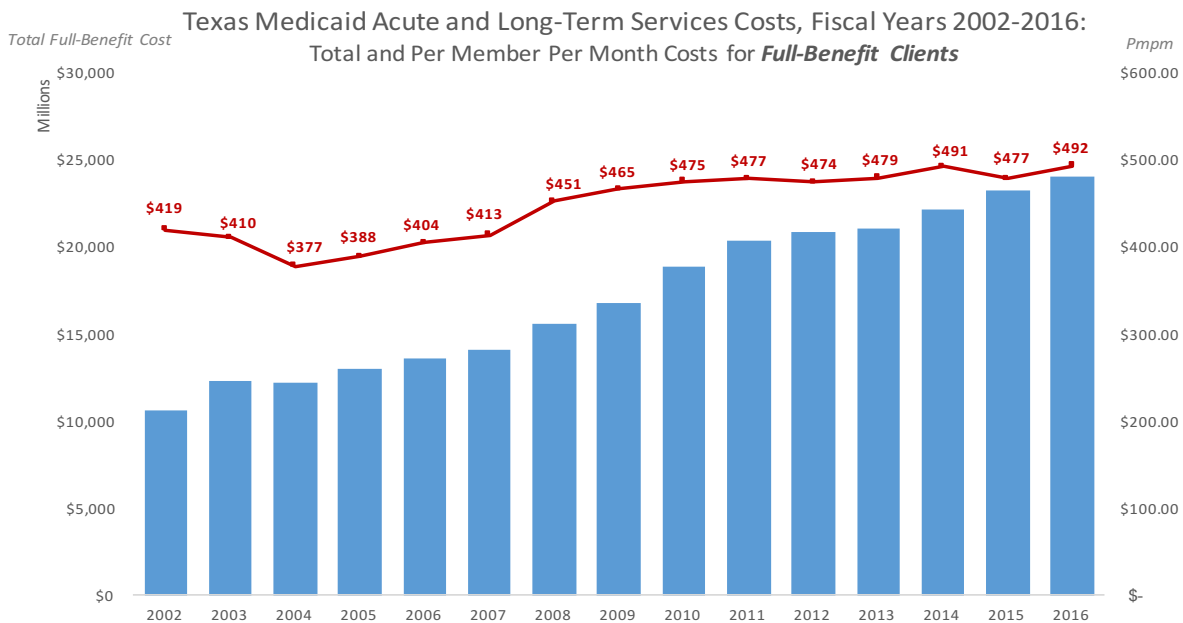
<sup>19</sup> Carruth & Associates, “Demonstrating Value Through Cost-Effectiveness in Medicaid Managed Care,” prepared for Texas Conservative Coalition Research Institute, March 2018, p. 4. See Appendix A.

**Key Findings of Carruth & Associates Report**

- While Medicaid caseloads grew by 93 percent between fiscal years (FY) 2002-2016, PMPM Medicaid costs increased only by a total of 17 percent, or just over 1 percent per year on average.

Table 1, below, shows a historical look at monthly costs per client (PMPM) from 2002 to 2016. The PMPM costs shown in this graph represent all full-benefit Medicaid enrollees, not just those in managed care.

**Table 1. Historical Medicaid Caseload and PMPM Costs**



	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
RMs	2,103,972	2,489,061	2,683,730	2,779,936	2,792,597	2,832,848	2,878,126	3,005,620	3,298,099	3,543,057	3,655,930	3,658,629	3,746,124	4,056,702	4,060,564
RM Trend	12%	18%	8%	4%	0%	1%	2%	4%	10%	7%	3%	0%	2%	8%	0%
PMPM	\$419	\$410	\$377	\$388	\$404	\$413	\$451	\$465	\$475	\$477	\$474	\$479	\$491	\$477	\$492
trend	4%	-2%	-8%	3%	4%	2%	9%	3%	2%	1%	-1%	1%	3%	-3%	3%

Source: Carruth & Associates Report sourced from HHSC Financial Services, May 2017.

Though overall Medicaid costs have continued to grow, this is primarily due to caseload increases, which are driven by sclerotic federal policy, such as the relaxation of Medicaid eligibility standards mandated by the Affordable Care Act (ACA). Other factors have also contributed to costs increases. For instance, the *Frew v. Hawkins* lawsuit, which led to significant provider rate increases in 2008,<sup>20</sup> increased both the overall Medicaid budget and per-person costs. However, despite the influence of these outside cost drivers, managed care has consistently been able to hold the PMPM cost trend at a steady continuum.

<sup>20</sup> *Ibid.*, p. 15.

See also, Texas Medical Association, "A Historic Increase," July 2007, available at <https://www.texmed.org/Template.aspx?id=5873>.



- Although Texas has been steadily expanding Medicaid managed care, it was not until FY 2013 when 80 percent of Medicaid enrollees were enrolled in managed care, that just over half of all Medicaid costs were finally under the capitated model.

After its initial start as a pilot for pregnant women and acute care children in the early 1990s,<sup>21</sup> Texas has been progressively expanding the number and types of enrollees served within the Medicaid managed care program. By FY 2008, after expanding both STAR (acute care program) and STAR+PLUS (LTSS program), just over 70 percent of Texas Medicaid enrollees were being served by managed care.<sup>22</sup> However, as depicted in Table 2, only about 30 percent of the total Medicaid spend was under the capitated model at this time. This means that even though MCOs were responsible for a majority of Medicaid enrollees, and were containing costs at an impressive rate, they were doing so with only about 30 percent of total Medicaid costs under their purview.

It was not until FY 2012, after Texas rolled out STAR and STAR+PLUS statewide and carved in pharmacy and nursing facility care, that just over half of the total Medicaid spend was flowing through managed care. Today, after further extending the program to individuals with developmental disabilities (IDD) and disability-related children, the program covers over 90 percent of enrollees and almost 70 percent of costs.<sup>23</sup>

**Table 2. Texas Medicaid Enrollees and Spend Within a Capitated Model**

<b>Caseloads</b>	<b>FY 1994</b>	<b>FY 2004</b>	<b>FY 2008</b>	<b>FY 2012</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016*</b>	<b>FY 2017*</b>
Fee-for-Service	1,975,244	1,571,728	838,786	761,964	733,859	532,121	490,153	361,444
<i>% Total</i>	<i>97%</i>	<i>59%</i>	<i>29%</i>	<i>21%</i>	<i>20%</i>	<i>13%</i>	<i>12%</i>	<i>9%</i>
Managed Care	58,243	1,112,002	2,039,340	2,893,965	3,012,265	3,524,581	3,570,411	3,725,876
<i>% Total</i>	<i>3%</i>	<i>41%</i>	<i>71%</i>	<i>79%</i>	<i>80%</i>	<i>87%</i>	<i>88%</i>	<i>91%</i>
Total Full-Benefit Clients	2,033,488	2,683,730	2,878,126	3,655,930	3,746,124	4,056,702	4,060,564	4,087,321
<b>% Total Medicaid Spend Capitation</b>	<b>0%</b>	<b>15%</b>	<b>31%</b>	<b>45%</b>	<b>51%</b>	<b>58%</b>	<b>62%</b>	<b>69%</b>

Notes: Capitation percentage does not include Primary Care Case Management (PCCM) costs, which ended in FY 2013  
 Significant rollouts include: 1997-2000; 2006-2008; 2012; 2015; 2017  
 Total Medicaid Spend includes expenditures for Non Full-Benefit Clients, but not Supplemental Payments (e.g. Disproportionate Share).

Source: Carruth & Associates Report sourced from March 2017 HHSC data.

<sup>21</sup> Health and Human Services Commission, “Texas Medicaid and CHIP in Perspective,” 11<sup>th</sup> Edition, February 2017, Appendix D, available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>.

<sup>22</sup> Carruth & Associates Report, pp. 8-9, see Appendix A.

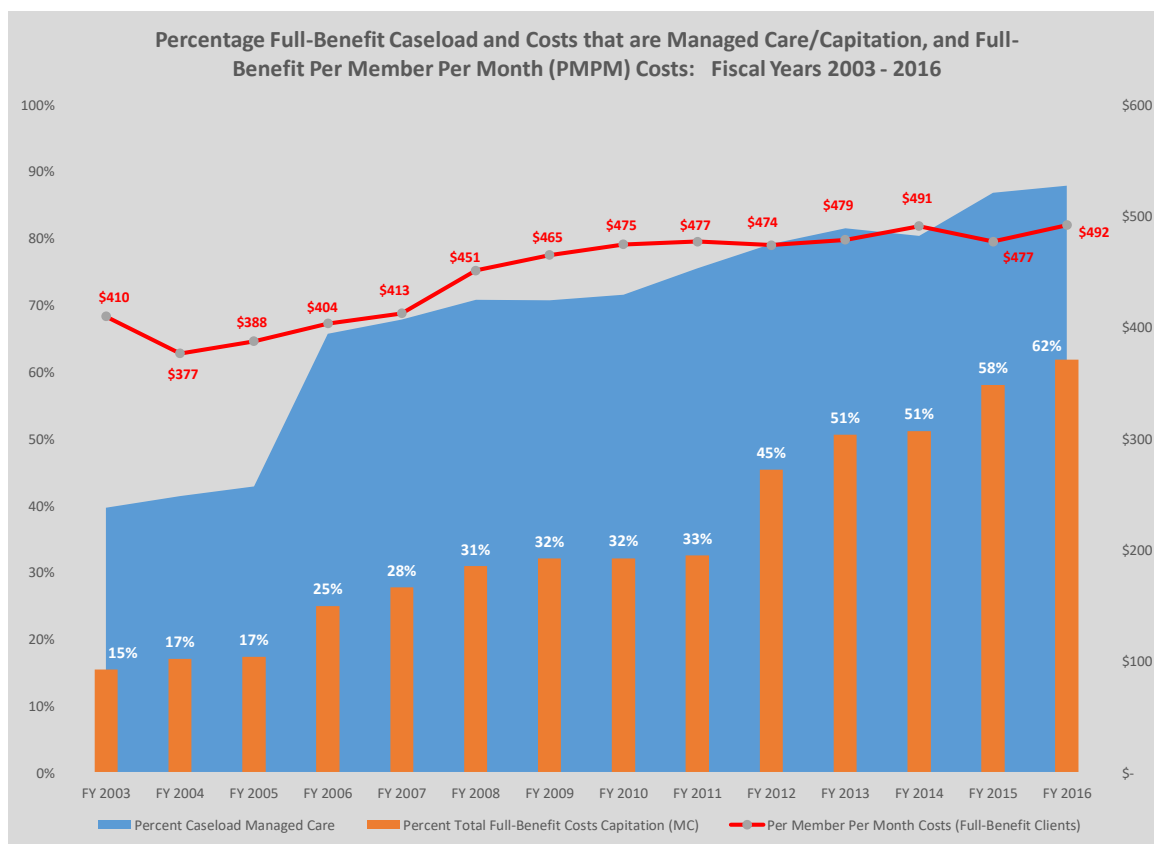
<sup>23</sup> Examples of Medicaid costs that were not included in these capitation figures include Emergency Medicaid (this program pays for emergency services only for individuals who do not qualify for Medicaid generally based on citizenship status); the Medicaid Breast and Cervical Cancer Program; and adoption subsidies (the latter two programs have since been carved into the capitated model).

While this may at first glance appear to be merely a budget detail, the takeaway from this finding is impressive: Over the past almost 15 years, MCOs have been able to successfully bend the Medicaid cost curve while only controlling a portion of the Medicaid budget.

- Periods of significant growth in managed care tend to correspond with very low Medicaid PMPM cost growth, and in some cases, even declines.

Table 3, below, combines the data from Tables 1 and 2 to show the historical trend in Texas Medicaid PMPM costs, as well as the percentages of Medicaid enrollees and costs that were included within the capitated system from FYs 2003-2016.

**Table 3. Percent of Caseload and Spend in Managed Care and Historical PMPM Costs**



Source: Carruth & Associates Report sourced from HHSC Financial Services, May 2017.

In FY 2012, Texas underwent its largest managed care expansion, rolling out the program to every county in the state and included additional populations and services, such as nursing facility care and prescription drugs.<sup>24</sup> From FYs 2012-2016, the Medicaid caseload increased by 11 percent, and total Medicaid expenditures grew by 17 percent.<sup>25</sup> However, even though overall caseloads and costs grew

<sup>24</sup> Health and Human Services Commission, "Texas Medicaid and CHIP in Perspective," 11<sup>th</sup> Edition, February 2017, Appendix D, available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf>.

<sup>25</sup> Carruth & Associates Report, p. 16, see Appendix A

(due in part to aforementioned factors of federally required changes and provider rate increases), Medicaid PMPM costs increased an average of less than 1 percent per year; national health expenditures during this same time period experienced almost four percent per capita growth.<sup>26</sup>

- Two studies using similar methods, one conducted by HHSC in 2012, and one by Milliman on behalf of the Texas Association of Health Plans in 2015, arrived at comparable outcomes in validating Medicaid managed care cost savings.

In July 2012, HHSC submitted the *Medicaid Managed Care Expansion Cost Savings Report* to the Legislature in compliance with House Bill 1, Article II Rider 51 (82R). This report, looking only at managed care expansion in the 2012-2013 biennium, determined a \$650 million all funds (AF) savings; it did not take into account the impact of any prior managed care initiatives.

A 2015 study prepared by the Milliman Group on behalf of the Texas Association of Health Plans estimated that over the six-year period of state fiscal years 2010-2015, Medicaid managed care resulted in nearly \$4 billion in all funds, and \$2 billion in general revenue savings to the state.<sup>27</sup>

While these studies differed some in the magnitude of savings based on different timeframes and some differing assumptions, they arrived at similar conclusions and validated managed care cost savings.<sup>28</sup>

- Both historical cost trend analysis and forecasted studies have demonstrated the cost-effectiveness of the Texas Medicaid managed care program.

Over the remainder of this legislative interim, and going into the 86<sup>th</sup> Legislative Session, there is sure to be much discussion about the “value” of managed care. The 85<sup>th</sup> Legislature directed HHSC to contract with an outside entity to “conduct a comprehensive evaluation” of the Medicaid managed care program, to review contract oversight and the rate-setting process, and to conduct an audit of MCO administrative expenses.<sup>29</sup> The results of these reviews are due by September 1, 2018. While it is imperative to continually evaluate government programs, the focus for Medicaid managed care should be on how the system can evolve to continue to build upon its proven effectiveness. The program has already been proven to be cost-effective by years of empirical data and two separate studies.

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<sup>26</sup> *Ibid.*

<sup>27</sup> Milliman Client Report, “Texas Medicaid Managed Care Cost Impact Study,” 2015, prepared for the Texas Association of Health Plans, available at [http://www.tahp.org/images/reports/Milliman\\_Texas\\_Medicaid\\_Managed\\_Care\\_Cost\\_Impact\\_Study\\_20150211.pdf](http://www.tahp.org/images/reports/Milliman_Texas_Medicaid_Managed_Care_Cost_Impact_Study_20150211.pdf).

<sup>28</sup> Carruth & Associates Report, pp. 19-20, see Appendix A.

<sup>29</sup> HB 1 (85R), Article II, HHSC, Rider 61.

## ***Conclusion***

Medicaid managed care has been demonstrated as one of the most effective means of bending the ever-increasing Medicaid cost curve and providing high-quality health care coverage. Health plans are able to provide better care by helping coordinate and “manage” an enrollee’s health care to more preventive, lower cost settings, and by utilizing the providers within their networks. Plans also assume financial risk should costs exceed the negotiated per PMPM rate, which provides budget certainty for the state.

Since its inception as a small pilot program in the 1990’s, Medicaid managed care has grown into one of the state’s most successful initiatives, allowing Texas to utilize private sector businesses and free market innovation to better deliver government-sponsored programs. As lawmakers further explore the Medicaid managed care model in coming interim committee hearings and form recommendations for the 86<sup>th</sup> Legislative Session, it is imperative that state leaders continue to fully embrace this model and reject policies that would hinder an MCO’s ability to continue providing higher-quality cost-effective care to the state’s Medicaid and CHIP populations.

# Demonstrating Value Through Cost-Effectiveness in Medicaid Managed Care

LISA CARRUTH, CARRUTH & ASSOCIATES

PREPARED FOR TEXAS CONSERVATIVE COALITION RESEARCH INSTITUTE

## Overview: Medicaid Caseload and Expenditures in Texas

- Medicaid full-benefit caseload averaged 4.06 million clients per month in fiscal year 2017.
  - ✓ Medicaid caseload has remained stable since fiscal year 2015, increasing only slightly after strong growth from 2009 – 2015, due to the impact of the economic recession and Affordable Care Act policies.
- Medicaid Expenditures totaled slightly more than \$30 billion in fiscal year 2016.
  - ✓ Full-benefit expenditures account for approximately 80 percent of the total, or \$24 billion.
  - ✓ Managed care expenditures were just less than \$19 billion.
  - ✓ Preliminary fiscal year 2017 expenditures show slight growth from 2016, and a shift in managed care capitation costs to just below \$22 billion.

Data source: Health and Human Services Commission, Financial Services. FY 2017 data not final

# Determining Medicaid Costs and Cost-Effectiveness

Given the volume and magnitude of both the Medicaid caseload and expenditures, how can cost-effectiveness be measured?

➡ Using clearly-defined constructs that allow comparison to national health care costs, and other states' Medicaid cost.

Considerations:

- Medicaid has multiple funding streams and provides services or payments for differing levels of benefits and types of clients.
  - ✓ Major funding streams include state funds, matching federal funds, and supplemental funding for health services, providers, and hospitals that combines local funds (via intergovernmental transfer, or IGT) and matching federal dollars.
  - ✓ Medicaid clients include those receiving full (comprehensive) benefits, as well as clients receiving limited benefits/services or having only Medicare premiums paid.

March 7, 2018

CARRUTH & ASSOCIATES

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# Determining Medicaid Costs and Cost-Effectiveness

- Cost per-member per month (pmpm):
  - ✓ Measured as the Per-Member Per-Month (pmpm) cost of Medicaid full-benefit clients and services
  - ✓ Calculated using published Medicaid client service costs, and removing all non-full benefit and supplemental expenditures, as well as the non-capitated administrative components, and dividing by the average monthly full-benefit clients in a fiscal year.
  - ✓ Medicaid costs for non-full benefit clients, Medicare Part A and B premiums, Medicare Part D giveback, and supplemental payments to hospitals and health service providers are not included in the pmpm calculation.
- Total cost is driven by the number of clients (volume) and the cost per client
  - ✓ Cost for Medicaid full-benefit clients and services comprise approximately 80% of total Medicaid costs (not including supplemental costs such as Disproportionate Share Hospital and Uncompensated Care)
- While cost is a primary concern of budget writers, other factors such as Quality, Access to Care, and Efficacy of Care are necessary for successful service delivery, and ultimately cost-effectiveness
- Cost-Effectiveness is only achieved, in the long-run, through a program that delivers high quality at the lowest cost possible to maintain the value.

*Data source and methodology: Health and Human Services Commission, Financial Services*

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# Medicaid Funding: Constructs and Definitions – Client Types

- **Full-Benefit** clients receive comprehensive benefits and services
  - ✓ Aged and Medicare-Related clients are considered ‘full-benefit’, however much of their acute care costs are paid by Medicare, with Medicaid paying any wrap-around costs and costs for Long-Term Services and Supports or services not covered by Medicare.
  - ✓ Other Full-Benefit clients include Adult Parents and Pregnant Women, Disability-Related Adults and Children (Non-Medicare SSI), and Non-Disability-Related Children, including Newborns. Clients who are eligible based on certain conditions, such as Breast and Cervical Cancer (Medicaid Breast and Cervical Cancer Program, or MBCC), Adoption Subsidy Clients and Foster Care Clients are all full-benefit. The term of coverage differs based on risk group and eligibility category.
  - ✓ All Per-Member-Per-Month costs provided are for Full-Benefit Clients and Services, in order to provide a standard comparison.
- **Non-Full-Benefit** clients receive limited benefits and services, whether time-limited or based on specific payments or services.
  - ✓ Examples include Emergency Services for Non-Citizen clients, who are only provided services for emergent conditions (life-threatening) for the duration of time as needed, and partial dual eligible clients, who receive the benefit of Part A and/or Part B Medicare Premium payments made by Medicaid (only).

Data source and methodology: Health and Human Services Commission, Financial Services

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# Medicaid Funding: Constructs and Definitions – Service Delivery Types

- **Managed Care**
  - ✓ A monthly capitation is provided for those Full-Benefit clients to cover the comprehensive services they receive through Medicaid. Clients’ medical care is managed and coordinated through a health plan via a primary care physician, with referrals to specific (specialty) providers as necessary. The overall goals of Managed Care are to provide optimal health outcomes and contain costs through care coordination and utilization management.
- **Fee-for-Service**
  - ✓ Claims are paid as services are provided, through the claims management vendor. There are requirements for referrals and prior authorizations, but the structure and utilization review differs from capitated managed care.
- **Supplemental Payments for Health Services**
  - ✓ Payments to hospitals for Disproportionate Share Hospital (DSH), for hospitals serving a disproportionate share of low-income clients.
  - ✓ Payments to hospitals for Uncompensated Care, currently comprised of Hospital Medicaid and Uninsured shortfalls (including Charity Care), as well as the non-hospital components of Physician, Clinic, Pharmacy uncompensated costs.
  - ✓ Delivery System Reform Incentive Payments (DSRIP), Uniform Hospital Rate Increase Program (UHRIP), Network Access Improvement Program (NAIP), and other supplemental payment programs (e.g. Minimum Payment Amount Program, or MPAP or its successor QIPP for Nursing Facilities) all use local or public funds to provide a match with which to draw down federal dollars, ultimately enhancing Medicaid payments or providing services to low-income persons otherwise unable to obtain care.
  - ✓ Presently, all Supplemental Payment programs are considered “off-budget”, as state funds are not used to match the federal funds. Federal match is drawn down via local IGT.
  - ✓ Clients served through supplemental payment programs may include but are not limited to Medicaid clients, thus these funds are not used in the calculation of the comprehensive, full-benefit client pmpm.
  - ✓ In 2017 Supplemental Payments totaled approximately \$8 billion

Data source: HHSC Financial Services

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# Texas Medicaid Managed Care: Timeline

- Texas Medicaid provides services through either Fee-for-Service or Managed Care delivery models, with the majority of full-benefit clients now served via Managed Care.
  - ✓ Since initial implementation in August 1993, Managed Care has grown from a small portion of clients in a few counties to more than 90 percent of full-benefit clients served statewide, with managed care capitation estimated at approximately 69 percent of the total Medicaid costs for fiscal year 2017.
  - ✓ From the initial implementation of managed care in Medicaid, the overarching goals have been to improve the health outcomes of clients and to contain costs, through the mechanisms provided through a managed care rubric: coordination of care, utilization management, contracting efficiencies, etc.
  - ✓ With most managed care rollouts or implementations, expected savings have been built-in and taken initially, with the expectation that these savings will be achieved through care coordination and utilization management.

Source: Health and Human Services Commission "Texas Medicaid and CHIP in Perspective", 11<sup>th</sup> Edition, February 2017, Appendix D

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# Texas Medicaid Managed Care: Timeline

- Significant periods of expansion in managed care include (not all inclusive):
  - ✓ 1997 – 2000 (fiscal years), as the STAR (State of Texas Access Reform) program serving non-disability-related adults and children expanded into most large urban counties in the state, and STAR+Plus, which provides services (including long-term services and supports) to Disability-Related and Aged clients was implemented in Harris County.
  - ✓ 2006 – 2008, as both STAR and STAR+Plus expanded to other urban areas and a non-capitated Primary Care Case Management (PCCM) model began serving clients in some rural areas.
  - ✓ 2012, as STAR replaced PCCM in the rural areas, and services such as vendor drugs were carved in to the managed care capitation. This marks the beginning of the 1115 demonstration waiver, aimed at delivering managed care statewide to all populations and providing health services for underserved populations.
  - ✓ 2015, as STAR+Plus expanded to all areas of the state, and non-dual eligible clients with IDD (Intellectual and Developmental Disability) waivers and Nursing Facility benefits were carved in to STAR+Plus,
  - ✓ 2017, as STAR Kids is created for Disability-Related clients under 21, including both acute care and long-term services and supports

Source: Health and Human Services Commission "Texas Medicaid and CHIP in Perspective", 11<sup>th</sup> Edition, February 2017, Appendix D

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# Texas Medicaid Managed Care: Timeline

<b>Caseloads</b>	<b>FY 1994</b>	<b>FY 2004</b>	<b>FY 2008</b>	<b>FY 2012</b>	<b>FY 2014</b>	<b>FY 2015</b>	<b>FY 2016*</b>	<b>FY 2017*</b>
Fee-for-Service	1,975,244	1,571,728	838,786	761,964	733,859	532,121	490,153	361,444
<b>% Total</b>	<b>97%</b>	<b>59%</b>	<b>29%</b>	<b>21%</b>	<b>20%</b>	<b>13%</b>	<b>12%</b>	<b>9%</b>
Managed Care	58,243	1,112,002	2,039,340	2,893,965	3,012,265	3,524,581	3,570,411	3,725,876
<b>% Total</b>	<b>3%</b>	<b>41%</b>	<b>71%</b>	<b>79%</b>	<b>80%</b>	<b>87%</b>	<b>88%</b>	<b>91%</b>
Total Full-Benefit Clients	2,033,488	2,683,730	2,878,126	3,655,930	3,746,124	4,056,702	4,060,564	4,087,321
<b>% Total Medicaid Spend Capitation</b>	<b>0%</b>	<b>15%</b>	<b>31%</b>	<b>45%</b>	<b>51%</b>	<b>58%</b>	<b>62%</b>	<b>69%</b>

Notes: Capitation percentage does not include Primary Care Case Management (PCCM) costs, which ended in FY 2013

Significant rollouts include: 1997-2000; 2006-2008; 2012; 2015; 2017

Total Medicaid Spend includes expenditures for Non Full-Benefit Clients, but not Supplemental Payments (e.g. Disproportionate Share).

Source: Texas Health and Human Services Commission, March 2017 data. \*Fiscal Years 2016-2017 not final

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## Demonstrating Value: Cost-Effectiveness

*Given the current status and history of Managed Care in Texas – how do you show value of managed care in terms of cost effectiveness?*

- With almost 70% of total expenditures paid, and greater than 90% of full-benefit clients served through a managed care delivery system – which equates to approximately \$22 billion annual spend and more than 3.6 million clients served monthly in fiscal year 2017\* - there is still debate about the cost-effectiveness – the value - of the managed care model in Texas
- How do we move beyond the debate?

\*2017 data is preliminary. Source: Health and Human Services Commission, Financial Services

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# Demonstrating Value: Cost-Effectiveness

- Historical Analyses
  - ✓ Can be demonstrated through straightforward, historical trends, showing growth/decline over time, with comparisons to national/regional health care trends
- Forecast Models
  - ✓ Can be demonstrated statistically through more complex methods and projection models, but varying assumptions can result in differing conclusions
  - ✓ Comparison of managed-care cost growth to other delivery models – “as if” other delivery methods were used
    - Example: Forecast continued fee-for-service (FFS) cost to compare with managed care
  - ✓ Forecast methods rely heavily on assumptions, thus conclusions will vary based on assumptions

# Demonstrating Value: Cost-Effectiveness

Method of Evaluating Effectiveness	Pros	Cons
<b>Historical Trends</b>	<ul style="list-style-type: none"> <li>✓ Accessible data</li> <li>✓ Face validity</li> <li>✓ Comparable to other states or programs</li> </ul>	<ul style="list-style-type: none"> <li>✓ Case-mix and other external factors not fully controlled</li> <li>✓ Explanatory but not definitive</li> </ul>
<b>Forecast Methods</b>	<ul style="list-style-type: none"> <li>✓ Statistically valid – can control for other explanations/impacts</li> </ul>	<ul style="list-style-type: none"> <li>✓ Assumption-driven: differing assumptions can impact findings (replicability)</li> <li>✓ Difficult and costly to perform</li> </ul>



# Demonstrating Value: Historical Data and Trends

	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
RMS	2.10 m	2.49 m	2.68 m	2.78 m	2.79 m	2.83m	2.88 m	3.01 m	3.30 m	3.54 m	3.66 m	3.66 m	3.75 m	4.06 m	4.06 m
<i>RM Trend</i>	12%	18%	8%	4%	0%	1%	2%	4%	10%	7%	3%	0%	2%	8%	0%
PMPM	\$419	\$410	\$377	\$388	\$404	\$413	\$451	\$465	\$475	\$477	\$474	\$479	\$491	\$477	\$492
<i>PMPM Trend</i>	4%	-2%	-8%	3%	4%	2%	9%	3%	2%	1%	-1%	1%	3%	-3%	3%

Full-benefit clients and expenditures only (does not include partial benefits, supplemental payments, or pass-through payments). Data obtained from CMS-37 Medicaid History Report and HHSC.

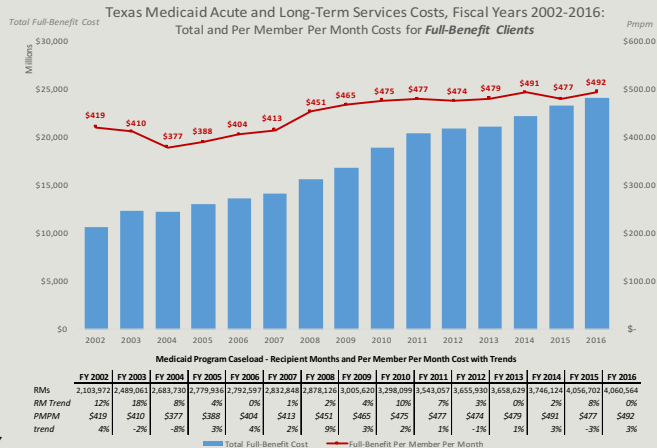
Source: HHSC Financial Services, May 2017

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# Demonstrating Value: Historical Data and Trends



Source: HHSC Financial Services, May 2017

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# Demonstrating Value: Historical Data and Trends

## Key Takeaways, Fiscal Years 2002 - 2016:

- **93% caseload growth**
  - ✓ Significant periods of growth include fiscal years 2002-03 (Medicaid simplification), 2010-11 (recession), and 2015 (Affordable Care Act growth).
- **127% total growth (total costs)**
  - ✓ Growth is a combination of both caseload and cost per client, and may result from significant increases in volume (caseload) or rates (e.g. Frew lawsuit increases in 2008).
- **17% pmpm growth (cost growth), or 1.2% per year, on average**
  - ✓ Only 2008 shows significant change (growth), all other years decline or grow at less than 4 percent.
  - ✓ Pmpm declines may be a result of diluted case mix – when caseloads increase with more lower-cost populations such as children (exception is 2008 with rate increases due to Frew lawsuit when children drove cost growth). Conversely, this is true for pmpm increases and case-mix changes due to an influx of higher-cost populations.

Data source: HHSC Financial Services, May 2017

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# Demonstrating Value: Historical Data and Trends

- ➔ Periods of significant growth in managed care tend to correspond with very low cost growth (pmpm)

## Fiscal Years 2012 - 2016:

- Managed Care caseload grew 53%
  - ✓ Overall caseload grew 11%
- Managed Care capitation (total dollars) grew 59%
  - ✓ Medicaid expenditures (total, full-benefit) grew 17%
- Pmpm grew by 3.8%
  - ✓ On average, 0.9% per year growth
    - Comparisons to recently released National Health Expenditures show NHE per capita cost growth, on average nationwide, at 3.8% per year. These are total health care expenditures of all persons in the population.
  - ✓ PMPM includes both managed care and fee-for-service costs, however managed care is the dominant model in these years
- See chart on following page for visual depiction

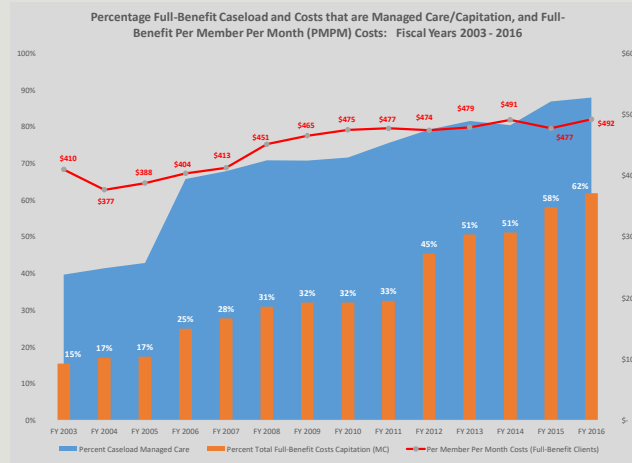
Data Source: HHSC Financial Services, May 2017; National Health Expenditures source: Centers for Medicare and Medicaid, NHE Fact Sheet, February 14, 2018

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# Demonstrating Value: Historical Data and Trends



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# Demonstrating Value: Forecasted Studies

- Medicaid Managed Care Expansion Cost Savings Report, HHSC, July 2012. (H.B. 1, 82<sup>nd</sup> Legislature, Regular Session, 2011, Article II, Rider 51)
  - ✓ Estimated \$650 million AF savings for 2012-13 biennium (\$263 M General Revenue)
  - ✓ Annualized 2012 savings would bring estimated AF savings just under \$900 M (*note - premium tax revenues in excess of \$200 M*)
  - ✓ Study assumed savings for biennium only - NO impacts for prior managed care implementations
  - ✓ Overall, managed care accounted for a 2% savings in pmpm, whereas cost-containment policies enacted during the biennium, combined with managed care, accounted for a 6% savings.

**Crux: Can FFS cost containments realistically continue in the long term? What assumptions for sustainability (or degradation) can/should be made?**

Source: HHSC Financial Services, May 2017

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# Demonstrating Value: Forecasted Studies

- Texas Medicaid Managed Care Cost Impact Study, Milliman, February 2015. (Prepared for Texas Association of Health Plans)
  - ✓ For comparison, estimated \$1.22 billion AF savings for 2012–13 Biennium
  - ✓ Overall savings for a six-year period, 2010 – 2015 are estimated to be \$3.8 B

## Bottom Line:

- Same conclusions for both studies (and similar methods) – but the magnitude of savings differs based on start dates (baseline) and assumptions

Source: Milliman Client Report, Texas Medicaid Managed Care Cost Impact Study, Prepared for TAHP, February 2015

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# Moving Beyond the Debate

- Do the data presented demonstrate value in terms of cost-effectiveness?

## ➡ Narrative

- ✓ Historical data show steady pmpm cost trends/growth, particularly in times of growth or expansion of managed care and services under the capitation. These pmpm trends are lower than national per capita trends during the same time period.
- ✓ Forecasted studies conducted by HHSC and commissioned by the Texas Association of Health Plans (performed by Milliman) both show savings resulting from the implementation of managed care in the 2012-13 biennium.
  - ✓ These studies have similar findings, but differ in the magnitude of savings and have slightly different timeframes and assumptions.
- Bottom line: Both historical trend analysis and forecasted studies have shown demonstrated cost-effectiveness of managed care in Texas Medicaid.

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# Questions?

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*Data is sourced from the Health and Human Services Commission, Financial Services Division, or where otherwise cited (e.g. National Health Expenditures, Milliman/TAHP). All fiscal year 2017 data, and the financial components of fiscal 2016, are preliminary.*

*All analyses and conclusions of the data provided by HHSC and CMS are the responsibility of the author.*

