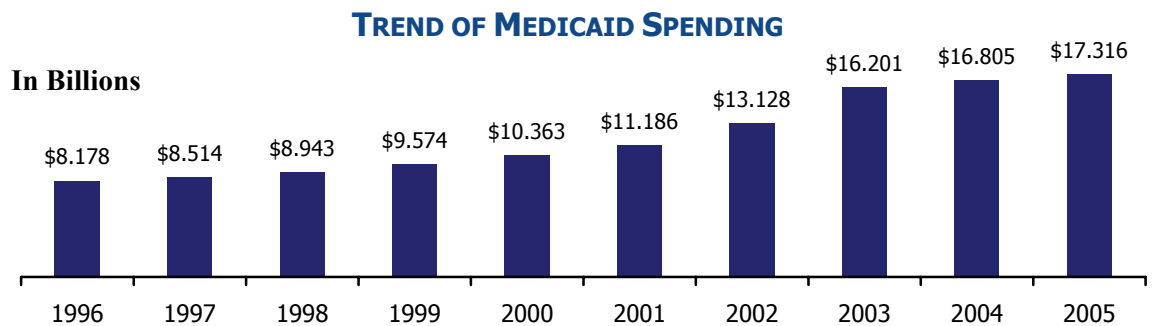


Controlling the Costs of Medicaid: Managed Care at Work

Medicaid: Its Role and the Costs

Since its inception, Medicaid has grown to be an increasingly important and necessary part of the state's health care infrastructure. It plays a critical role in the state's efforts to address the economic and societal costs associated with an expanding uninsured population and rising levels of uncompensated care. Unfortunately, the increasing costs of the program limit the state's ability to more fully use it in addressing the uninsured and uncompensated care issues. The growing demand for program funding has state leaders eager to identify ways to control the costs while maximizing the benefits it affords those it serves.

In fiscal year 2004, state/federal funds for Medicaid comprised 26 percent of the overall state budget.¹ The program's costs have increased from \$8.1 billion in 1996 to \$17.3 billion in 2005 putting Texas in the challenging position of attempting to address a funding trend that many consider unsustainable.² As state leaders work to balance competing state priorities with limited funding, the efficiency of the state's Medicaid program will determine the degree in which it is used to reduce the state's growing uninsured woes, while reducing the burden on local governments brought about by uncompensated care.



Source: Texas Health and Human Services Commission, Texas Medicaid in Perspective, 5th Edition, (2004), Austin, Texas; and Texas Health and Human Services Commission staff

THE TREND TOWARD MANAGED CARE

State leaders are not alone in attempting to address these important public policy questions. In response to rising health care costs, Texas, along with most states, have explored and are incorporating the use of managed care in serving their Medicaid populations. Its use provides states with accountability for the health care services funded, while providing the most effective tool available to contain the costs of the program.

According to a 2005 study conducted by the National Academy for State Health Policy (NASHP), since 1990 managed care has grown to be the dominant delivery system in Medicaid.³ The study found that in 2002 a Medicaid managed care program operated in all but three states (Alaska, Mississippi, and Wyoming), and 58 percent of all Medicaid beneficiaries were enrolled in at least one managed care program. The NASHP study also reports that **providing states with a means of predicting and controlling Medicaid costs is a key motivator for the movement toward managed care.**

A recent report by the Lewin Group reinforces the reasons for the trend toward managed care, indicating that there is a significant opportunity for states, including Texas, to generate large budget savings by using a capitated managed care model to control their Medicaid expenditures. According to the report, **Texas could save approximately \$2.1 billion over five years and \$5.7 billion during a 10-year period**, beyond current savings, by fully using a managed care model to serve the state's TANF and SSI populations (savings include both state and federal dollars).⁴

The report states that "enormous room for expansion of the managed care model exists both in serving additional populations and in some instances by making the capitated benefits package more comprehensive" through discontinuing carve-outs of pharmacy and mental health services.⁵

Medicaid Managed Care: How It Works

In contracting with the state, managed care organizations agree to provide a specific set of services for a fixed, monthly fee for each enrollee within the program. The per-member, per-month (PMPM) rate paid to states is known as capitation. This fee is agreed to at the beginning of the contract and does not change based on the level of services used by a member of the plan. By assuming this level of risk, managed care organizations provide “budget certainty” for the state’s Medicaid expenditures. This also provides states with savings over the traditional fee-for-service method that dominated Medicaid programs before managed care’s arrival. Under the most common fee-for-service programs, not only were the state’s Medicaid expenditures unpredictable, but there was little, if any, service coordination. In addition to the “budget certainty” it provides, managed care organizations in Texas agree to share revenues with the state when savings targets are achieved.

Managed care uses a network of providers who contract with a health plan and agree to serve as the “medical home” for members of the plan while providing them with comprehensive preventive and primary care. In addition to the traditional Medicaid benefit package, Medicaid managed care benefits often include:

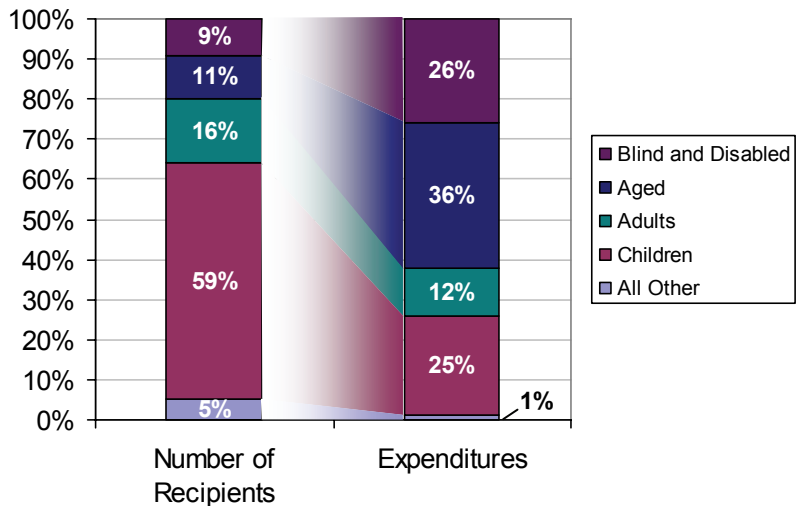
- Unlimited prescription drugs
- Annual adult well checks
- Disease management
- Access to a Primary Care Provider 24 hours
- Access to specialists
- Seven-days-a-week health care
- Use of a 24-hour nurse helpline

Medicaid Managed Care in Texas

In 1991, Texas joined the ranks of states exploring the use of Medicaid managed care. During that year the Legislature directed the state to establish managed care pilot programs, and in 1993 the first pilot, known as STAR, was established in Travis county. Since that time the program has grown and currently includes the more traditional managed care of STAR to the STAR+PLUS program, which integrates the delivery of acute and long-term care services.

While managed care in Texas has expanded in both geography and scope, the state continues to lag – in the amounts of Medicaid spending – behind others that use a capitated managed care model. According to the study by the Lewin Group, of Texas’ \$12.5 billion in Medicaid expenditures paid in 2003, only 10.3 percent were derived from a capitated model.⁶ It is through capitation that most states are able to achieve their optimum level of Medicaid savings.

**TEXAS MEDICAID BENEFICIARIES AND EXPENDITURES
FEDERAL FISCAL YEAR 2002**



Notes: (1) Most recipients included in the category of “All Other” are recipients of long-term care. (2) There are children also accounted for under the “Blind and Disabled” category.

Source: Texas Health and Human Services Commission, *Texas Medicaid in Perspective, 5th Edition*, (2004), Austin, Texas.

STAR

Beginning in 1993, Texas established the State of Texas Access Reform (STAR) program as a means of managing Medicaid costs in a managed care system. In this "capitated" program, clients are enrolled in a health plan, which includes a network of providers whose rates are negotiated. The client then selects a Primary Care Physician (PCP) who will serve as a "medical home" for the client: treating the client's conditions as they arise, providing preventive checkups, and authorizing the services for specialty care as needed. The PCP is required to provide 24-hour coverage for the client in order to provide the appropriate care-coordination.

Medicaid clients are required to enroll in the STAR program if they live in one of the eight service delivery areas (SDA): Bexar, Dallas, El Paso, Harris, Lubbock, Southeast Region, Tarrant, Travis; receive cash assistance (TANF); are pregnant; or have a limited income. This program excludes those who receive Medicare, are in foster care, live in a long-term facility, or are a part of the Medically Needy Program. Individuals who receive Supplemental Security Income (SSI), and live outside of the Southeast Region SDA, have the option to enroll in the STAR program or remain in the regular Medicaid program.

STAR+PLUS

In 1998, Texas health care leaders began piloting STAR+PLUS, a Medicaid managed care program that integrates acute and long-term care. The program was established in Harris county to serve a portion of it's aged, blind, and disabled population. They did so with the recognition that this segment of the population accounts for more than half of the state's Medicaid expenditures (62 percent in 2002), but comprise only one-fifth of the Medicaid population (20 percent in 2002).⁷

Through the STAR+PLUS program each Medicaid managed care member is assigned a service coordinator, has a needs assessment performed, and receives assistance in accessing a primary care doctor, as well as specialty care. Like other Medicaid managed care plans, STAR+PLUS provides patients with a "medical home" in which their medical needs are coordinated to provide both efficient and quality care, using preventive and disease-management programs. The service coordinator links the patient with critical community resources, such as Meals on Wheels, and assists them with accessing and maintaining basic care needs, such as respite care, emergency response services, home modifications, adaptive aids, running water, heating, electricity, food, clothing, beds and related items.

Currently, a modified version of STAR+PLUS, which excludes hospital services, is being expanded across Texas. While this exclusion will greatly limit the state's ability to generate significant savings, the expansion will allow those served to benefit from the enhanced service coordination the program provides. In two counties, Dallas and Tarrant, the state will attempt to implement a concept known as Integrated Care Management (ICM), because of concerns over federal funding known as Upper Payment Limit (UPL).

CHILD HEALTH POLICY REPORT

In 2003 the Institute for Child Health Policy, the state's unbiased External Quality Review Organization, conducted a study of the STAR+PLUS model compared with a matched control group of SSI voluntary participants in a similar - term care coordination achieved in STAR+PLUS.

Because of the unique care coordination provided under STAR+PLUS, the report found the following:

**40 Percent
Reduction**

in Emergency Room Visits

**28 Percent
Reduction**

in in-patient rates

**279 Percent
Reduction**

*in overall health
expenditures*

Decrease

*in the average cost of care
for beneficiaries receiving
long-term care*

**100 Percent
Increase**

*in the number of clients
receiving Community-Based
Alternative Services*

Producing Results for the States

As states turn to Medicaid managed care to help control the costs of the program, the results are paying off. Reports on overall Medicaid spending confirm the efficiencies resulting from the coordination and innovation provided by managed care. According to data compiled by the Centers for Medicare and Medicaid Services, while serving less than half of the total Medicaid population, fee-for-service systems account for 80 percent of all Medicaid spending.⁸

NATIONWIDE SUCCESS OF MEDICAID MANAGED CARE INNOVATIONS	
Access to Care	Medicaid participants served by health plans in New York City report better access to care than patients in the fee-for-service program and are more likely to have a regular source of care and to seek care at a doctor's office rather than in emergency rooms
Prenatal Care	Infant mortality rates in Rhode Island have dropped dramatically – from 4.5 deaths for every 1,000 births to 1.9 for every 1,000 – since health plans began providing care for pregnant women enrolled in the state Medicaid program
Asthma	Children with asthma enrolled in Medicaid health plans in Wisconsin are significantly less likely to require hospitalization than asthmatic children in the state's fee-for-service program
Diabetes	Among Medicaid participants with diabetes in North Carolina , those served by health plans are more than three times as likely to properly monitor and control their blood glucose levels
Substance-Abuse Treatment	Since 1995, when Medicaid participants in Oregon with substance abuse problems began receiving care through health plans, participation in treatment programs has increased nearly 40 percent
Preventive Care	Since 1997, when Kentucky began encouraging Medicaid participants to enroll in health plans, the percentage of Medicaid-covered children receiving early and periodic screening, diagnostic and treatment services has increased nearly 250 percent

Source: AHIP Center for Policy and Research, *Innovations in Medicaid Managed Care* (2005).

The benefits of moving to managed care have prompted several states to pursue measures that would remove obstacles to Medicaid managed care expansion in their states. For example:⁹

- **Florida** – Eliminated the Upper Payment Limit and established a Low-Income Pool (LIP) with an annual allotment of \$1 billion in total expenditures (federal and state) for health care costs incurred by the state, hospitals, clinics, or other provider types in caring for the uninsured
- **California** – Established the Safety Net Care Pool (SNCP), with an annual allotment of \$766 million in federal matching funds, which the state can use to pay for the costs of treating the uninsured

As Texas looks for innovative ways to control the costs of its own Medicaid program, managed care offers the greatest potential in both savings and quality. With this opportunity, there is increasing interest to consider an array of options including an 1115 Medicaid waiver that will allow Texas to expand its use of managed care without compromising federal funding for the state's health care infrastructure.

Whatever course is taken, the facts are clear: Medicaid managed care improves access, continuity, and quality of care, as well as health outcomes for those it serves, at costs far lower than the current fee-for-service model. With determination and innovation, Medicaid managed care can provide the foundation of a comprehensive health care strategy that will allow Texas to control health care costs while addressing the uninsured and uncompensated care issues that the state currently confronts.

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