



MEDICAID MANAGED CARE: A Fiscally Responsible Pathway to a Healthier Texas

Texas is a national leader in the use of managed care to increase access to care, manage costs, and improve health care quality in its Medicaid and CHIP programs. The managed care private market approach drives innovation through flexibility and competition, reduces health care costs and holds managed care organizations (MCOs) accountable for providing access to quality care.

Managed care is a proven cost-effective delivery model:

- Provides the state **budget certainty** because MCOs assume the financial risk of care delivery
- Provides **budget savings** to the state while delivering quality care
- Promotes **preventive care and continuity of care** through the establishment of medical homes and networks of specialists
- Offers access to a **full spectrum of medical services** plus additional **cost-effective benefits** not available under traditional fee-for-service Medicaid/CHIP
- Provides **accountability** through rigorous oversight including audits, contractual requirements, performance guarantees and penalties, transparency, and outcomes
- Promotes **innovative solutions** to health care access issues
- Provides **integration of services** through care coordination

*“Over the past 20 years
managed care has revolutionized
the delivery of Medicaid health
care services in Texas.”*

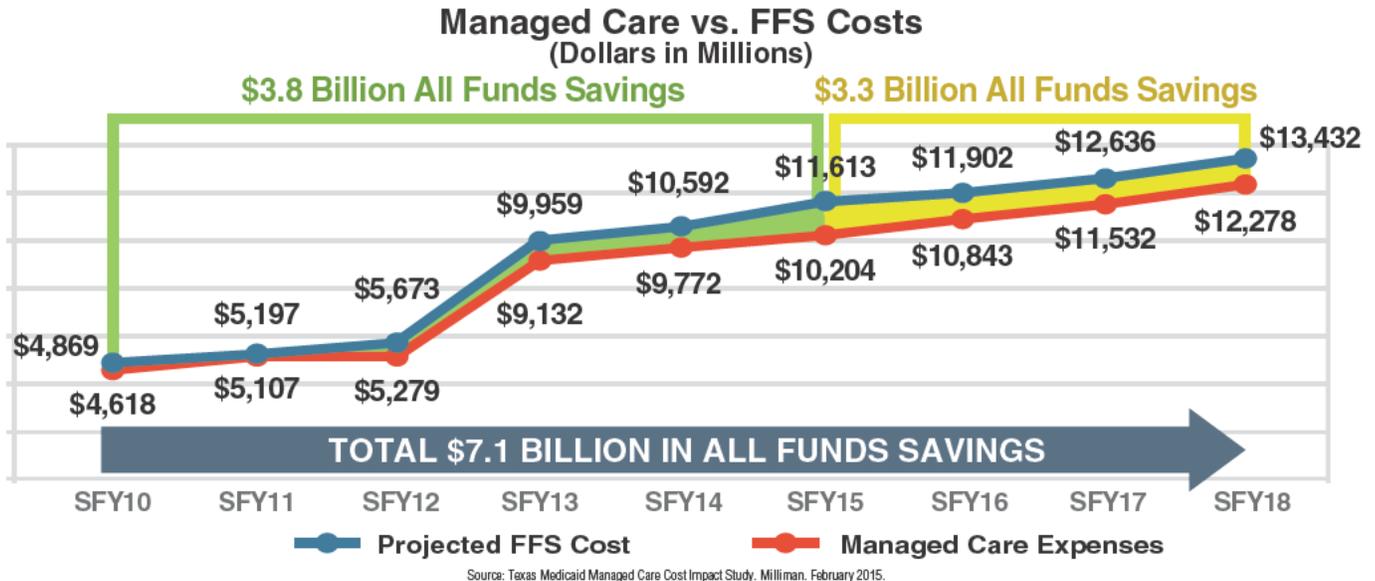
—Sellers Dorsey,
Medicaid Managed Care in Texas, February 2015

Medicaid MCO Success

- **Estimated \$7.1B All Funds cost-savings** for FY10-FY18 compared to FFS model
- **28.4% All Funds cost-savings** for Dental Managed Care program since FY13
- **No wait list to access community care** allowing individuals to stay in the community rather than institutions
- **Surpassed national performance expectations on child well visits** and childhood immunizations
- **Significant reductions in hospital admissions** for asthma, diabetes, GI infections, UTIs, and bacterial pneumonia
- **High level of consumer satisfaction**—83% of families with children in managed care report an overall positive experience with their MCO
- **93% of families with children in Medicaid managed care report having access** to their PCP when needed

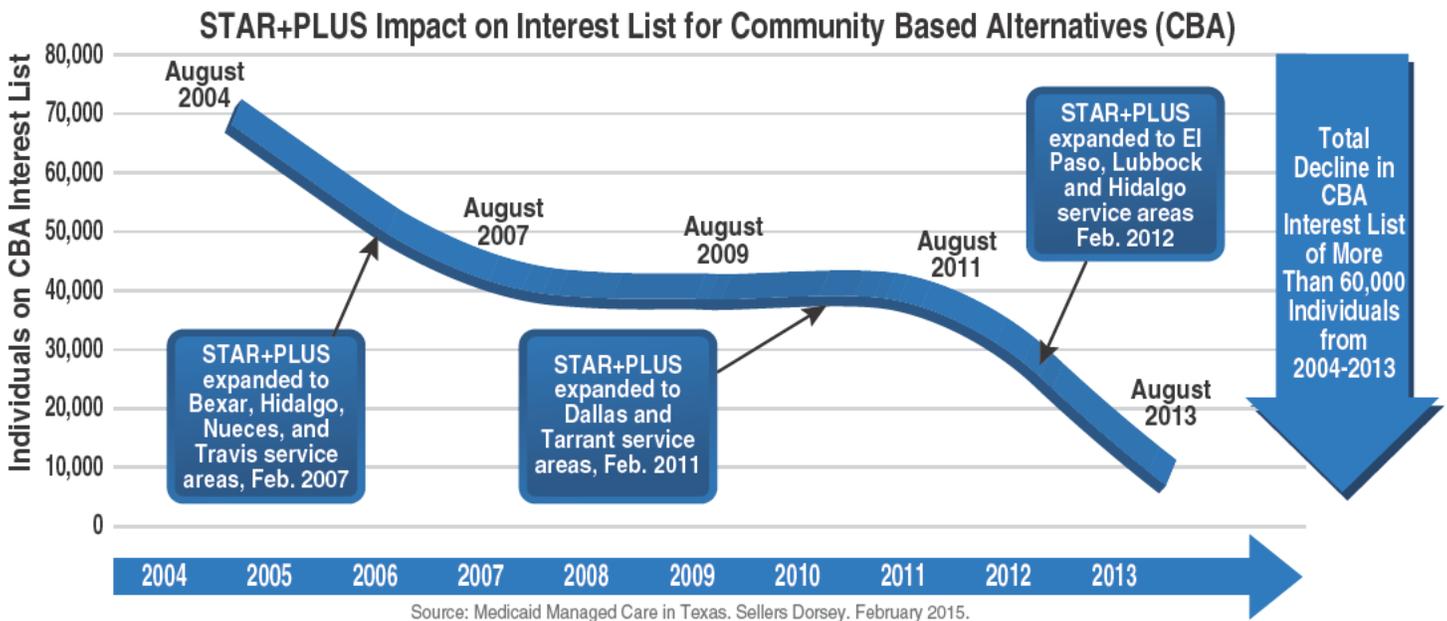
Managed Care Cost Savings

Between SFY 2010 and SFY 2015, actuaries estimate that managed care **reduced Medicaid All Funds costs by 7.9%, or nearly \$3.8 billion**, when compared to the traditional fee-for-service model. This trend is expected to yield an **additional \$3.3 billion in All Funds savings through SFY 2018**. Medicaid Dental managed care has experienced the highest percentage of **total program savings: 28.4%** since SFY 2013 on an All Funds basis.



Improved Access to Care

Managed care provides enhanced access to care compared to FFS. At no additional cost to the state, MCOs have dramatically reduced the interest list for long term services and supports (LTSS) through STAR+PLUS. On average, 93% of child and adolescent members report having a primary care provider (PCP) when they need one.



Improved Quality of Care

Due to care coordination and better access to preventive services, MCOs have also improved quality of care and outcomes for Medicaid patients.

Between 2009 and 2011, MCOs reduced hospital admissions for:

- Asthma by 22% in STAR
- Diabetes by 37% in STAR and 31% in STAR+PLUS
- GI infections by 37% in STAR
- UTIs by 20% in STAR and 31% in STAR+PLUS
- Bacterial pneumonia by 19% in STAR+PLUS

Consumer & Taxpayer Protections

MCOs provide a higher level of accountability to members than traditional FFS Medicaid. For example, Medicaid MCOs and HHSC track complaints and consumer satisfaction. Medicaid MCOs have a high level of consumer satisfaction with 83% of child members reporting overall positive experience with their MCO.

MCOs are also held to stronger standards than under the traditional FFS Medicaid, which ensures that both Medicaid clients and taxpayer dollars are protected. These safeguards include:

- Strong financial solvency requirements
- Multiple agency oversight (HHSC and TDI)
- Value-based contracts and network adequacy requirements
- Consumer satisfaction surveys
- Performance standards with financial implications, quality measurements and program reporting requirements
- Audits for claims, financial reporting and operations
- Contract negotiations and oversight
- Corrective action plans, fines, sanctions, and liquidated damages for failure to meet contractual requirements
- Caps on administrative costs and profits

The continued benefits of managed care in Texas rely on maintaining a regulatory environment that fosters innovation, allowing full integration of services, ensuring a collaborative and transparent rate development process, and reducing administrative complexity whenever possible.

Recommendations

Innovation

The Texas Medicaid MCOs have brought many best practices to the communities they serve. The **ability to innovate is critical to being able to provide the highest quality services to Medicaid members** while being responsible partners to the Texas Medicaid program. Maintaining this crucial ability requires a careful balance between necessary regulatory requirements and flexibility to experiment with new initiatives to improve care delivery and cost-effectiveness of the Medicaid program.

Integration

Further service integration within managed care will reduce Texas Medicaid costs and increase quality. By having all benefits administered by a single managed care plan, members are able to receive all of their health care and support needs through one individualized plan of care, which should raise questions when any services are proposed for “carve out” of managed care in the future. Integrating the formulary into managed care will save more than \$64 million a biennium and will improve care coordination.

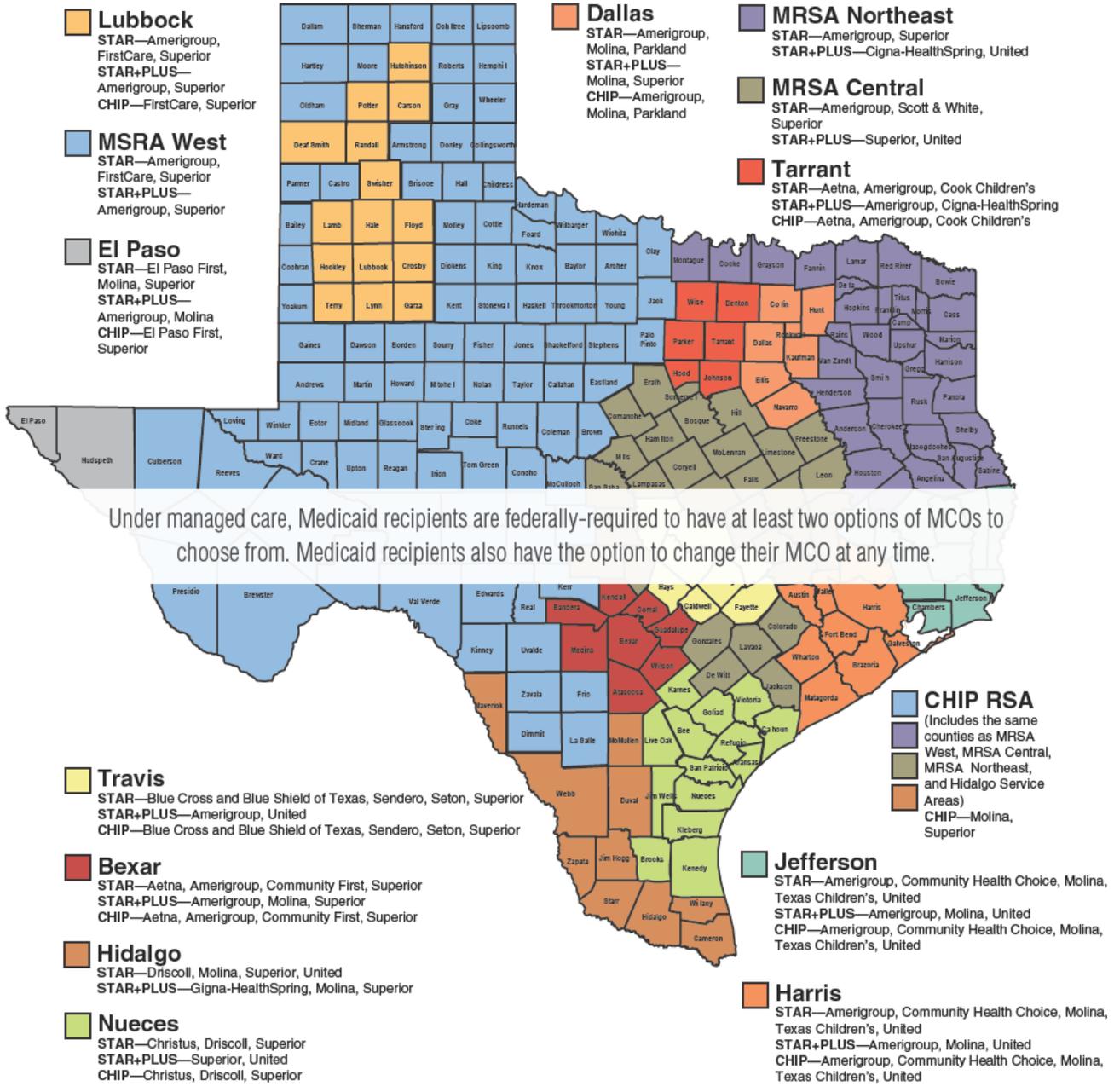
Transparency

To operate effectively and provide the state budget predictability, the MCOs and HHSC must establish a **rate-setting process that is collaborative and transparent**. The principles guiding such a process are timeliness, reliable data, and greater transparency on rate setting assumptions and cost trends to include policy changes and the addition of new treatment modalities (e.g. Sovaldi in 2014) to provide a basis for establishing actuarially sound rates. There are many factors that influence the cost of providing health care and services to the Medicaid population and these factors are constantly evolving.

Administrative Simplification

While Medicaid is a complex program, those complexities should not translate into administrative burdens for providers, consumers and health plans. Over the last several years there has been a tremendous increase in the MCO regulatory environment. Although some of the new regulations have been welcome, some may have unintended consequences. As highlighted by the Sunset Commission 2014 report, the vast amount of information providers and MCOs are administratively required to submit to HHSC results in an information overload that makes it difficult for the agency to use the data for program monitoring and improvement. TAHP will work with HHSC on future **opportunities to reduce administrative complexity wherever possible**.

A Competitive Landscape in Texas



Under managed care, Medicaid recipients are federally-required to have at least two options of MCOs to choose from. Medicaid recipients also have the option to change their MCO at any time.



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