

# Benefits of Medicaid Managed Care



*States and enrollees have enjoyed numerous benefits of Medicaid managed care over fee-for-service including...*

- *Predictable costs*
- *Access and care coordination*
- *Delivery system innovation*
- *Fraud and abuse prevention*
- *Quality assurance and improvement*

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## Predictable Costs

One of the largest factors that drive states to Medicaid health plans is the potential cost savings. By transferring financial risk to health plans through capitation, state budgets are not subjected to as much variability experienced with fee-for-service. States have reported cost savings under Medicaid managed care models.

For example, according to a report by the Lewin Group, Medicaid health plans saved Pennsylvania \$2.7 billion over a 5-year period.<sup>i</sup>

## Access and Care Coordination

Medicaid health plans negotiate payment rates with providers that are typically well above fee-for-service provider payments, therefore Medicaid health plan enrollees often enjoy better access to providers than those in traditional Medicaid.

Medicaid health plans coordinate care for Medicaid populations with special needs, including those with multiple chronic conditions and 8 million dual eligibles, through primary care coordination and disease management programs. The capitation arrangement provides different financial incentives to providers versus fee-for-service. Medicaid health plans work with their physician networks to support practice management systems that emphasize prevention, early diagnosis and treatment, and coordinated management of patient care. This “medical home” approach to providing care is not feasible under fee-for-service.

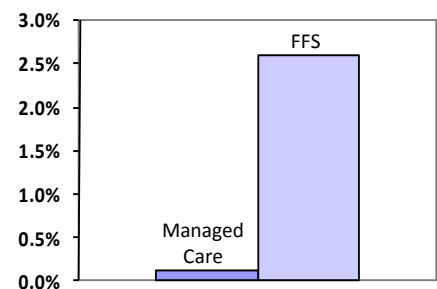
## Innovation in delivery system reform

Collaborating with Medicaid programs and state stakeholders, Medicaid health plans have been able to implement innovative delivery system reforms like patient-centered medical homes, coordinating benefits for dual-eligibles, and state health care coverage expansions. In addition, Medicaid health plans and states partner on disease-specific quality improvement projects and implement best practices.

## Preventing fraud and abuse

Medicaid managed care has also experienced significantly less fraud and abuse than traditional Medicaid fee-for-service. CMS reported that in FY 2008 payment error rates for Medicaid managed care were 0.1% compared to 2.6% for Medicaid fee-for-service.

FY 2008 Medicaid Payment Error Rates



## Quality assurance and improvement

One of the most significant benefits of Medicaid health plans is quality measurement and improvement. Federal regulations require annual quality reviews of Medicaid health plans and specify state oversight expectations. Most states conduct additional reviews of Medicaid health plans to ensure that they meet state rules and regulations in areas such as utilization review and grievances and appeals. The state and federal rules provide additional consumer protections for Medicaid health plans, such as network adequacy and the provision of culturally and linguistically appropriate services, that are unique from commercial health insurance plans.

Medicaid health plans are required to report performance measures, such as HEDIS, to the state. Performance measures provide valuable data to health plans, states, researchers and policymakers for demonstrating the quality of care in Medicaid programs, identifying gaps in care, and creating quality improvement projects. Through performance measurement, the quality of care in Medicaid health plans has improved.

Many states also field the Consumer Assessment of Health Plans Survey (CAHPS) that assesses patient satisfaction with their experience of care. Studies have shown that Medicaid enrollees are more satisfied with the quality and experience of care received through managed care than in fee-for-service.<sup>ii</sup>

About 25% of Medicaid health plans have achieved accreditation by the National Committee for Quality Assurance, meeting a nationally recognized standard for demonstrating the delivery of high quality care. Additional Medicaid health plans are accredited by other organizations.

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### Medicaid Health Plans vs. Primary Care Case Management and Fee-for-Service

	Health Plan	PCCM	FFS
<b>Benefits to Members</b>			
Identification card proving coverage	✓	✓	✓
A designated primary care physician	✓	✓	
Case management of primary care services	✓	✓	
Disease management	✓	✓	
Comprehensive case management	✓		
Quality standards and continuous quality improvement programs	✓		
National accreditation	✓		
<b>Cost Containment</b>			
Claims analysis	✓		
Utilization review	✓		
Improved generic utilization	✓		
Using lower cost service where available	✓		
Cost predictability	✓		

<sup>i</sup> Comparative Evaluation of Pennsylvania's HealthChoices Program and Fee-for-Service Program. The Lewin Group. May 2005.

<sup>ii</sup> Evaluation of Medicaid Managed Care: Satisfaction, Access, and Use. Jane E. Sisk, PhD; Sheila A. Gorman, PhD; Anne Lenhard Reisinger, PhD; Sherry A. Glied, PhD; William H. DuMouchel, PhD; Margaret M. Hynes, PhD. JAMA. 1996;276(1):50-55.

Medicaid beneficiaries under managed care: provider choice and satisfaction. H Temkin-Greener and M Winchell. Health Serv Res. 1991 October; 26(4): 509-529.