COMPARING PERFORMANCE: MANAGED CARE AND FEE-FOR-SERVICE

January 2015
MANAGED CARE IN MISSOURI

Size of Populations

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC</td>
<td>420,443</td>
<td>48%</td>
</tr>
<tr>
<td>MC – like – FFS</td>
<td>219,132</td>
<td>25%</td>
</tr>
<tr>
<td>ABD - FFS</td>
<td>233,263</td>
<td>27%</td>
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</table>
CONFLICTING ARGUMENTS REGARDING THE IMPACTS OF MANAGED CARE

- **Cost**
  - Managed Care (MC) reduces cost by better management
  - MC increases cost due to administrative overhead

- **Utilization of Services and Provider Access**
  - MC improves access and properly manages utilization by better rates and coordinated strategy
  - MC reduces access by closed panels and burdensome prior authorizations

- **Clinical Quality**
  - MC fosters quality through care management
  - MC impairs quality by restricting services
COMPARING PERFORMANCE: COST
Review last done by Mercer for SFY 2009 found MC saved 2.7% ($38 million) compared to FFS

Compared MC and FFS costs with adjustments
- MC total cost = capitation payments + FFS services carved out + MHD admin costs of managing contracts
- FFS total costs = FFS costs + MHD admin costs for operating FFS

Compared MC eligibility groups with the same eligibility groups in FFS in non-MC parts of state
CATEGORIES OF SERVICES REVIEWED

MC covers standard benefit minus carved-out services provided through FFS

- Medical Services Covered under MC
  - Inpatient, outpatient, physician services, dental, mental health, transportation, etc.

- Medical Services Carved out from MC
  - Pharmacy, specialty mental health, some adult dental and transplants

- Other Medical Transactions Included
  - FQHC and RHC wrap-around

- Other medical costs transactions excluded
  - Hospital direct payment and waiver services
5% GEOGRAPHIC ADJUSTMENT

- Rationale: Medical care is more expensive in urban areas than in rural areas
  - The previous Mercer report comparing MC to fee-for-service (FFS) costs in 2008 used a 5% adjustment factor
  - For the ABD population the rural/urban difference for CY2005-2008 was 9.6%
  - When managed-care expanded in the central region and 2008 Mercer’s total adjustment was 6%.
    - 3% adjustment area
    - 3% lower cost in the central region than the Eastern and Western regions
  - Medicare per capita expenditures or St. Louis and Kansas City are 4.6% higher than the surrounding rural areas
- The current SFY 2010 – 2013 analysis uses a 5% adjustment factor
RE-ALLOCATION ADJUSTMENTS

- Retroactive Eligibility and the first 15 days allowed for MC plan enrollment
- Special health care needs opt out population
- Specialty Behavioral Health Services - CPR, CSTAR, TCM
- Pharmacy and Transplants
- MHD Administrative and IT services supporting MC contracting and payments
### MC & FFS Retrospective Costs

**Amounts Reflect Total GR and Federal Expense**

<table>
<thead>
<tr>
<th></th>
<th>SFY 2010</th>
<th>SFY 2011</th>
<th>SFY 2012</th>
<th>SFY 2013</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fee for Service (FFS)</strong></td>
<td>$1.524 Billion</td>
<td>$1.517 Billion</td>
<td>$1.579 Billion</td>
<td>$1.644 Billion</td>
<td>$1.566 Billion</td>
</tr>
<tr>
<td><strong>Managed Care (MC)</strong></td>
<td>$1.501 Billion</td>
<td>$1.481 Billion</td>
<td>$1.578 Billion</td>
<td>$1.596 Billion</td>
<td>$1.539 Billion</td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td>23 Million</td>
<td>36 Million</td>
<td>2 Million</td>
<td>48 Million</td>
<td>27 Million</td>
</tr>
<tr>
<td><strong>Percent</strong></td>
<td>1.5%</td>
<td>2.4%</td>
<td>0.1%</td>
<td>2.9%</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

*Source: MANAGED CARE COST AVOIDANCE MODEL - December 2014*
**KEY FINDINGS**

- Annual savings in MC ranged from 0.1% to 2.9% ($2 to $48 million) over the four-year period. Much of the variation between years is due to rate increases.
- The four year average annual savings was 1.7%
  - $5.33 PMPM
  - $27 million average
- Compared to FFS, MC....
  - Reduces medical costs/payments to providers by $23.81 PMPM (8% decrease)
  - Increases administrative costs by $18.48 PMPM (149% increase)
- For every $1 PMPM of reduced state costs due to MC, medical costs/payment to providers is reduced by $4.47 PMPM and administrative costs are increased by $3.47 PMPM
HOW DOES MISSOURI COMPARE?

- Mercer reports that “typical” MC savings are 3-6%
- Why lower savings in MC?
  - Missouri carves-out specialty behavioral health services and pharmacy services.
  - Missouri runs a FFS program with strong management of pharmacy and Health Homes, similar to MC.
  - Missouri’s unique reimbursement structure for facilities may impede the ability of MC to manage cost and utilization.
  - FFS provider rates that are already as low or lower than MC provider contract rates.
ESTIMATING PROSPECTIVE IMPACT OF EXPANDING MC IN CY 2015

- Mercer estimated 2.2% savings ($14.2 million) for a typical and mature MC program expanded to serving the remaining non-elderly, similarly participating women and children currently in FFS.
- Expected savings would be lower for at least the first two years of program.
- The estimate deducts from savings 2.814% factor due to administrative costs of the ACA health insurer fee.
- Mercer also noted that achieving “typical” MC savings levels would be limited by:
  - Missouri’s policy of carving out certain services such as specialty behavioral health and
  - FFS provider rates that are already as low or lower than MC provider contract rates.
COMPARING PERFORMANCE: UTILIZATION
UTILIZATION AND QUALITY COMPARISONS

- The results following our initial analysis by MHD in the process of being cross checked by MERCER

- The cause of the variation in results could be due to several different explanations

- Further analysis is in process (e.g. Behavioral Health)
Compared to the same eligibility groups in FFS, MC enrollees are:

- **Admitted less** – Enrollees with hospital admissions (5.4% vs. 6.8%)

- **Discharged more quickly** – Shorter average length of stay (4.1 days vs. 5.6 days)

- **Re-admitted more often** – Higher portion of persons discharged re-admitted within 30 days (6.4% vs. 5.2%)
## FFS VS. MC COMPARISON: HOSPITAL ADMISSIONS

<table>
<thead>
<tr>
<th>Group</th>
<th>% of Patients with a Hospital Admission</th>
<th>Average Length of Stay</th>
<th>% of Patients with a Re-Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO</td>
<td>5.41%</td>
<td>4.12 days</td>
<td>6.43%</td>
</tr>
<tr>
<td>FFS*</td>
<td>6.79%</td>
<td>5.63 days</td>
<td>5.20%</td>
</tr>
</tbody>
</table>

*For similar population as MCOs*
FFS VS. MC COMPARISONS: ER UTILIZATION

Compared to the same eligibility groups in FFS, MC enrollees are:

- **Use the ER more, per enrollee** – Higher overall ER use (0.75 vs. 0.70 visits per all enrollees)

- **Use the ER more, as a percent of total population** – Higher portion of all enrollees who use the ER (38.7% vs. 35.5%)

- **Use the ER multiple times, less** – Lower intensity of ER use among those who go to the ER (1.94 vs. 1.95 ER visits per enrollees who use the ER)
## FFS VS. MC COMPARISONS: ER UTILIZATION

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage of Patients with an ER Visit</th>
<th>ER Visits per patient</th>
<th>ER Visits per patient using ER</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO</td>
<td>38.7%</td>
<td>0.75</td>
<td>1.94</td>
</tr>
<tr>
<td>FFS*</td>
<td>35.5%</td>
<td>0.70</td>
<td>1.96</td>
</tr>
</tbody>
</table>

*For similar population as MCOs*
FFS VS. MC COMPARISONS: OFFICE VISITS (E&M)

Compared to the same eligibility groups in FFS, MC enrollees are:

- **Visit the office less, per enrollee** – Lower overall outpatient use (2.40 vs. 2.93 visits per all enrollees)

- **Visit the office less, as a percent of total population** – Lower portion (63.7% vs. 69.5%)

- **Visit the office multiple times, less** – Lower intensity of outpatient use among those who use any outpatient (3.76 vs. 4.20 outpatient visits per enrollees who use any outpatient)
## FFS VS. MC COMPARISONS: OFFICE VISITS (E&M)

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage of Patients with Outpatient Visit</th>
<th>PCP Visits per patient</th>
<th>Visits per patient using Outpatient</th>
</tr>
</thead>
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<tr>
<td>MCO</td>
<td>63.7%</td>
<td>2.40</td>
<td>3.76</td>
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<td>69.5%</td>
<td>2.93</td>
<td>4.20</td>
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*For similar population as MCOs*
COMPARING PERFORMANCE: CLINICAL QUALITY
MC QUALITY BETTER THAN FFS

Breast Cancer Screenings

<table>
<thead>
<tr>
<th></th>
<th>MC</th>
<th>FFS</th>
</tr>
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<tbody>
<tr>
<td>40.6%</td>
<td>33.8%</td>
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MC: Meme Care
FFS: Fully Funded

MC quality is better than FFS with a 40.6% success rate compared to 33.8% for FFS.
FFS QUALITY BETTER THAN MC

- **Persistent Meds - Anticonvulsants**: 
  - MC: 60.2%
  - FFS: 70.3%

- **Persistent Meds - ACE Inhibitor**: 
  - MC: 47.5%
  - FFS: 49.8%

- **Alcohol & Drug Treatment Initiation**: 
  - MC: 63.3%
  - FFS: 70.6%

- **Diabetes Care**: 
  - MC: 47.5%
  - FFS: 49.8%

- **Postpartum Care**: 
  - MC: 39.4%
  - FFS: 43.0%
QUALITY COMPARISONS UNDER DEVELOPMENT

- Cervical Cancer Screening
- Chlamydia Screening
- Diabetes Care – Cholesterol (LDL)
- Alcohol & Drug Treatment Engagement
- Follow up in 7 & 30 Days after Psych Hospitalization
- Persistent Meds – Diuretics
- Antidepressant Adherence – Acute & Continuation
- Antipsychotic Adherence for Schizophrenia
- Adult Body Mass Index (BMI)
ACTUAL MC PERFORMANCE

- **Cost**
  - Lower overall cost (1.7%)
  - Higher care management and administrative costs (149%)

- **Utilization of Services and Provider Access**
  - Fewer hospital admissions and shorter length of stay
  - More readmissions after discharge and more ER visits
  - Fewer outpatient visits

- **Clinical Quality**
  - Lower on 5 of 6 clinical quality measures
    (12 more pending)