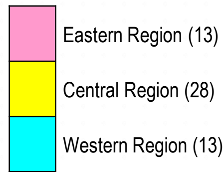
COMPARING PERFORMANCE:

MANAGED CARE AND FEE-FOR-SERVICE

January 2015

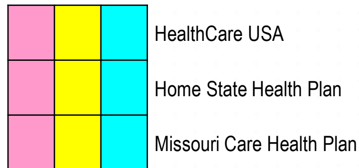
MANAGED CARE IN MISSOURI

Number of Counties



Eastern Region (13)
Central Region (28)
Western Region (13)

Current Health Plans



HealthCare USA
Home State Health Plan
Missouri Care Health Plan

Size of Populations		
MC	420,443	48%
MC – like – FFS	219,132	25%
ABD - FFS	233,263	27%

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

RETROSPECTIVE COST COMPARISON BY MERCER

- 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

	SFY 2010	SFY 2011	SFY 2012	SFY 2013	Average
Fee for Service (FFS)	$1.524 Billion	$1.517 Billion	$1.579 Billion	$1.644 Billion	**$1.566 Billion**
Managed Care (MC)	$1.501 Billion	$1.481 Billion	$1.578 Billion	$1.596 Billion	**$1.539 Billion**
Savings	23 Million	36 Million	2 Million	48 Million	**27 Million**
Percent	1.5%	2.4%	0.1%	2.9%	**1.7%**

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)

FFS VS. MC COMPARISON: HOSPITAL ADMISSIONS

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

Group	% of Patients with a Hospital Admission	Average Length of Stay	% of Patients with a Re-Admission
MCO	5.41%	4.12 days	6.43%
FFS*	6.79%	5.63 days	5.20%

**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

Group	Percentage of Patients with an ER Visit	ER Visits per patient	ER Visits per patient using ER
MCO	38.7%	0.75	1.94
FFS*	35.5%	0.70	1.96

**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)

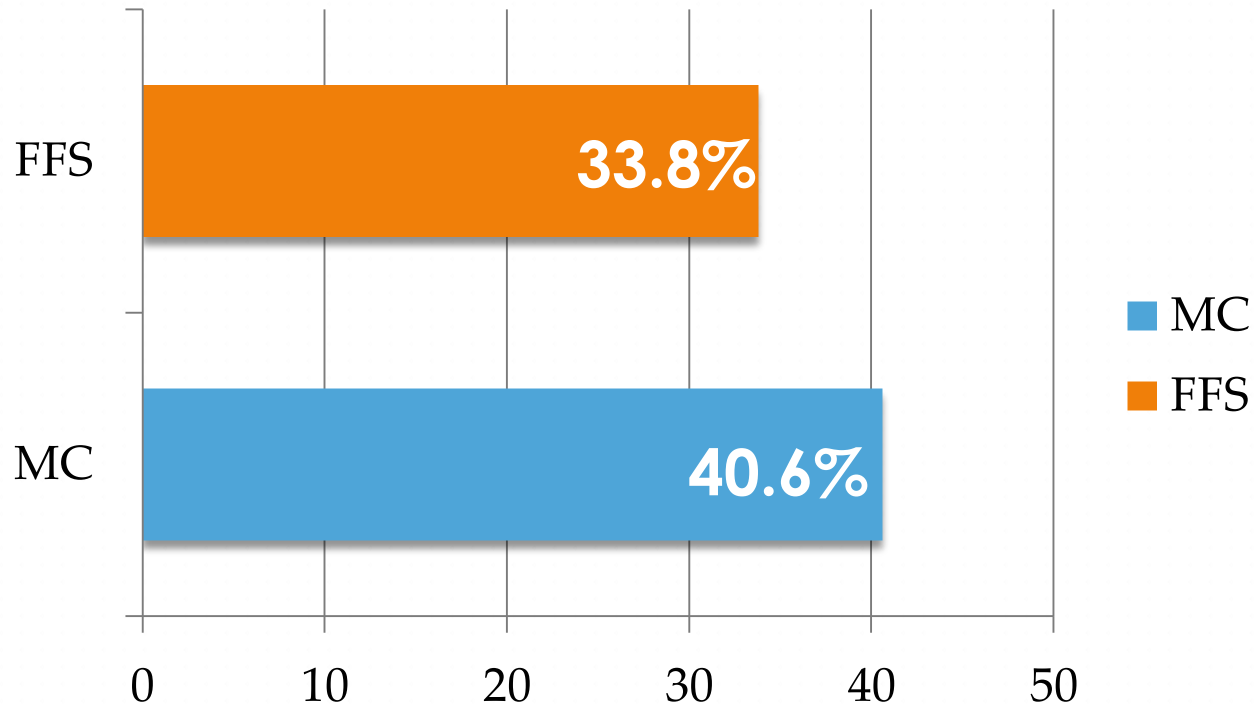
Group	Percentage of Patients with Outpatient Visit	PCP Visits per patient	Visits per patient using Outpatient
MCO	63.7%	2.40	3.76
FFS*	69.5%	2.93	4.20

**For similar population as MCOs*

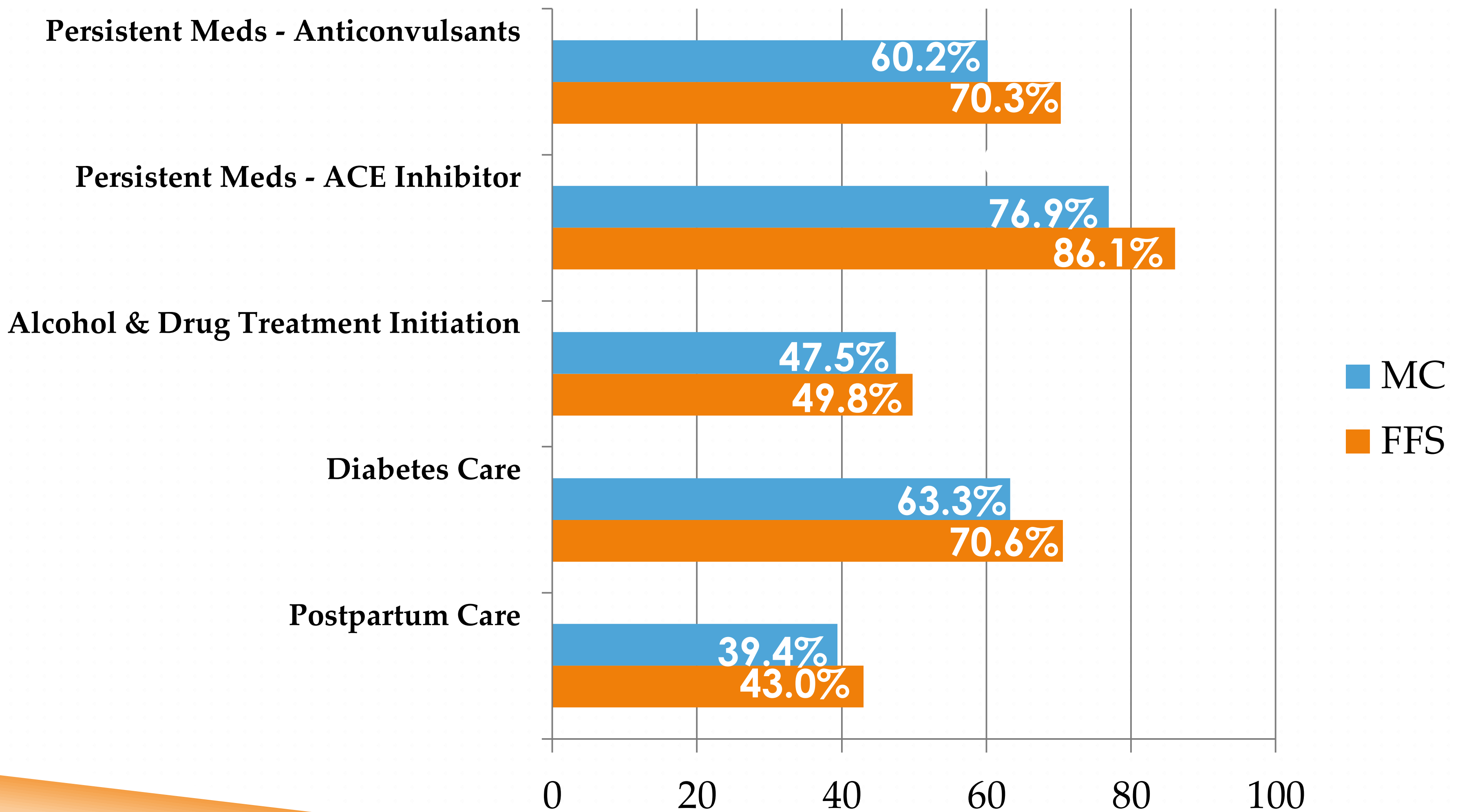
COMPARING PERFORMANCE:

CLINICAL QUALITY

MC QUALITY BETTER THAN FFS



FFS QUALITY BETTER THAN MC



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)