Medicaid MCOs and Quality, Access – What the evidence says

May 22, 2024

Governor Lamont is reportedly considering a plan to have private insurance managed care plans (MCOs) run Connecticut's Medicaid program. From 1996 through 2011, Connecticut Medicaid was run by MCOs, and it was deeply troubled. The program ended under pressure from advocates, providers, and legislators. Since the MCOs left Connecticut Medicaid, access and quality of care have improved, and the state has saved billions of taxpayer dollars.

Findings from the literature:

The evidence does not support Medicaid MCOs improving either access to healthcare services or the quality of care provided to members.
According to MACPAC, Medicaid's federal oversight commission, the National Conference of State Legislators, and the National Association of Medicaid Directors, despite many studies, independent evidence does not support MCOs' promises to improve access or the quality of healthcare for members. Syntheses of independent, peer-reviewed studies, cited below, also do not find evidence of improved quality or access.

Quality of care in Connecticut Medicaid is much better across dozens of measures than most states, which have MCOs. According to Medicaid.gov, the quality of care in Connecticut is much better than in other states.
Just one study published this year found the rates of early-stage cancer diagnosis and survival among Medicaid members were substantially better in Connecticut, without MCOs, than in New Jersey, a demographically comparable state that still has MCOs. Rates were comparable between the states until 2012, but when Connecticut removed MCOs from our Medicaid program our rates steadily improved. New Jersey Medicaid's rates did not change.

Sources:

According to Medicaid.gov in 2022: (accessed 5/2/2024)

- 73.3% of Connecticut children and adolescents had a checkup, compared to 54.2% national average
- Child health -- Connecticut scored better than the national average in 16 of 22 priority adult quality measures, Connecticut was in the top quarter of states for 13 of those measures
- Adult health -- Connecticut scored better than the national average in 20 of 28 priority adult quality measures, Connecticut was in the top quarter of states for 17 of those measures.

P Sunkara, et al, Association of Medicaid Privatization With Patient Cancer Outcomes, *JCO Oncology Practice* (2024) 31:OP2300297
Researchers compared Connecticut and New Jersey Medicaid programs for rates of early-stage cancer diagnosis and survival for ten common solid cancers with documented disparities. Connecticut Medicaid ended MCOs in 2012, while New Jersey continued MCOs into the present. The two states have similar sociodemographic profiles and similar cancer profiles before 2012. Since 2012, early-stage cancer diagnosis increased 4% and survival increased by 8%. There was no change in New Jersey's Medicaid program.
https://pubmed.ncbi.nlm.nih.gov/38295328/

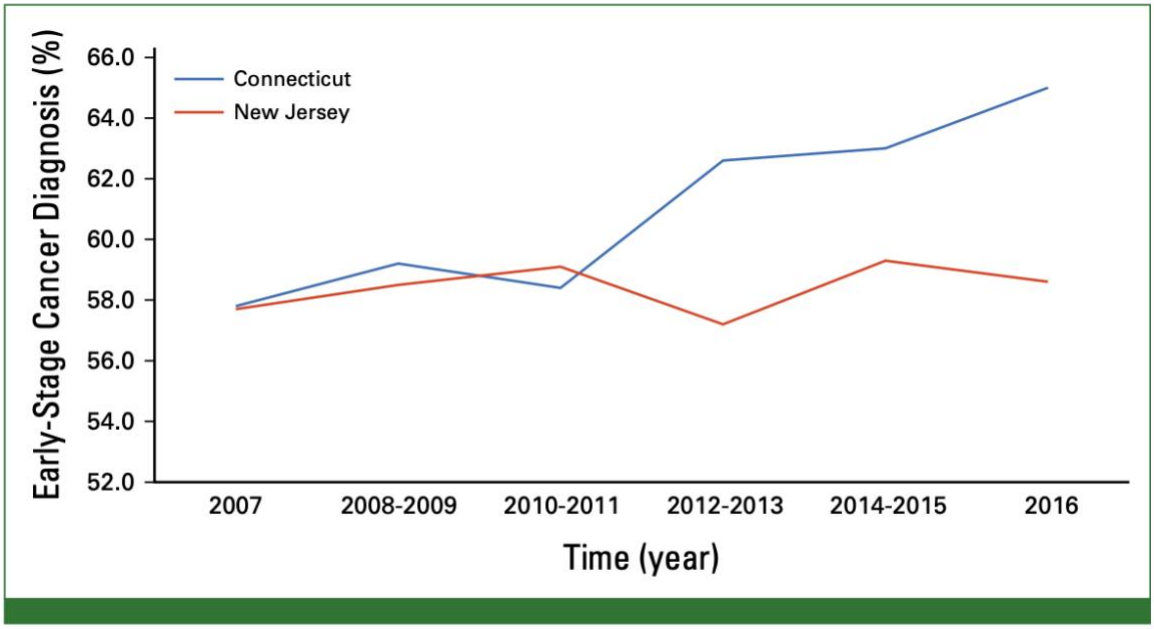

FIG 1. Early-stage change diagnoses over time.

(Shared with permission from the author)

CT Medicaid child checkup rates jumped when HMOs were fired, *CTHPP* (2019)
"Well-child screenings increased twelve percent for HUSKY children between FY 2001 and FY 2012, according to a new report from the Government Accounting Office."
"It is important to note that on January 1, 2012 Connecticut Medicaid payment shifted from capitation through private managed care companies to our current managed fee-for-service program that supports care coordination, quality improvement, and patient-centered medical homes. Connecticut EPSDT screening rates increased from 52% in FY 2011 before the switch to 64% in FY 2012. Rates in Connecticut continued to rise over the next five years, while national rates declined."
https://cthealthpolicy.org/ct-medicaid-child-checkup-rates-jumped-when-hmos-were-fired/

E Hinton et. al. State Delivery System and Payment Strategies Aimed at Improving Outcomes and Lowering Costs in Medicaid, *KFF* (2022)
Connecticut's current program, without MCOs, has adopted all the available tools MCOs use to control costs or improve quality and access to care. We don't have to share any savings with MCOs.
Connecticut has implemented every quality reform cited by other states. Connecticut Medicaid has also implemented four of five payment reforms and is in the process of implementing the last one.
https://www.kff.org/medicaid/issue-brief/state-delivery-system-and-payment-strategies-aimed-at-improving-outcomes-and-lowering-costs-in-medicaid/

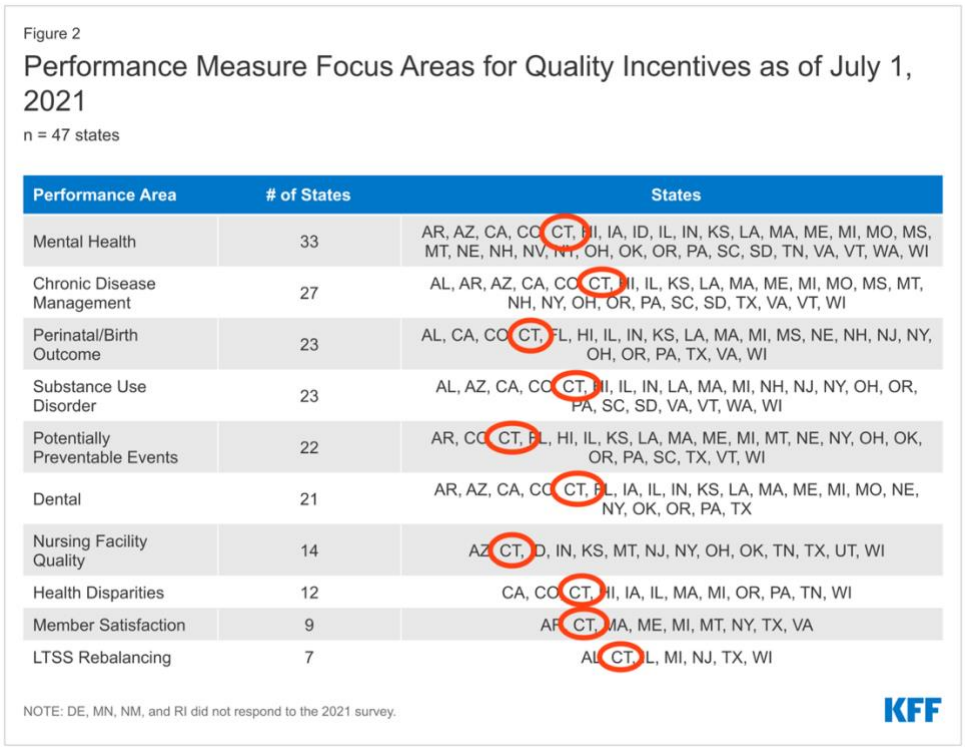

Figure 2

Performance Measure Focus Areas for Quality Incentives as of July 1, 2021

n = 47 states

Performance Area	# of States	States
Mental Health	33	AR, AZ, CA, CO, CT, HI, IA, ID, IL, IN, KS, LA, MA, ME, MI, MO, MS, MT, NE, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, VA, VT, WA, WI
Chronic Disease Management	27	AL, AR, AZ, CA, CO, CT, HI, IL, KS, LA, MA, ME, MI, MO, MS, MT, NH, NY, OH, OR, PA, SC, SD, TX, VA, VT, WI
Perinatal/Birth Outcome	23	AL, CA, CO, CT, FL, HI, IL, IN, KS, LA, MA, MI, MS, NE, NH, NJ, NY, OH, OR, PA, TX, VA, WI
Substance Use Disorder	23	AL, AZ, CA, CO, CT, HI, IL, IN, LA, MA, MI, NH, NJ, NY, OH, OR, PA, SC, SD, VA, VT, WA, WI
Potentially Preventable Events	22	AR, CO, CT, FL, HI, IL, KS, LA, MA, ME, MI, MT, NE, NY, OH, OK, OR, PA, SC, TX, VT, WI
Dental	21	AR, AZ, CA, CO, CT, FL, IA, IL, IN, KS, LA, MA, ME, MI, MO, NE, NY, OK, OR, PA, TX
Nursing Facility Quality	14	AZ, CT, ID, IN, KS, MT, NJ, NY, OH, OK, TN, TX, UT, WI
Health Disparities	12	CA, CO, CT, HI, IA, IL, MA, MI, OR, PA, TN, WI
Member Satisfaction	9	AR, CT, MA, ME, MI, MT, NY, TX, VA
LTSS Rebalancing	7	AL, CT, IL, MI, NJ, TX, WI

NOTE: DE, MN, NM, and RI did not respond to the 2021 survey.

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Managed care's effect on outcomes, *MACPAC*, accessed 4/18/2024
According to MACPAC, Medicaid's federal oversight commission, there is no evidence that MCOs save money for states or improve access or quality of care. "While much research has been conducted on whether managed care delivery systems result in better outcomes than traditional fee for service (FFS), there is no definitive conclusion as to whether managed care improves or worsens access to or quality of care for beneficiaries."
https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/

E Hinton et al, 10 Things to Know About Medicaid Managed Care, *KFF* (2024)
"While there is some evidence of positive impacts from state use of financial incentives to engage managed care plans around quality and outcomes, the results are more mixed and limited at the provider level."

https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care

Medicaid Managed Care 101, *NCSL* (2023)
"Key Takeaways -- States and territories have increasingly relied on managed care organizations, or MCOs—commercial insurance companies contracted by the state—to manage state Medicaid systems. While there is mixed evidence on managed care's impact on quality and costs, it is the predominant Medicaid delivery system."
https://www.ncsl.org/health/medicaid-managed-care-101

Why did they do it that way? Understanding managed care, *NAMD*
"Interestingly, the academic research on outcomes associated with managed care models is mixed; some studies have found improved quality and access under managed care models, while other studies have found no impact or worse outcomes."
https://medicaiddirectors.org/resource/understanding-managed-care/

Montoya et al, Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update, *Annual Review of Public Health* (2020) 41:537-549
Review of 32 peer-reviewed studies found no evidence of savings, improved access to care or quality. "Early proponents of managed care argued that private insurers would be more effective at delivering higher-quality care and at reducing the cost of care. States also desired budget predictability. While there are incidences of success, research evaluating managed-care programs show that these initial hopes were largely unfounded."
https://www.annualreviews.org/content/journals/10.1146/annurev-publhealth-040119-094345

M Sparer, Medicaid managed care: Costs, access, and quality of care, KFF (2012)
This review of peer-reviewed literature finds little evidence of either improved access or quality of care from Medicaid MCOs. "There are some national studies with positive findings, especially with respect to access to a usual source of care."
"There are, however, several studies that reach a very different conclusion, finding that access to care is either reduced or unchanged."
The author gives ten reasons that Medicaid MCOs are unlikely to improve either the quality or access to healthcare.
http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106

Goldsmith et al, Medicaid Managed Care: Lots Of Unanswered Questions, *Health Affairs Forefront* (2018)
'"Findings on Medicaid managed care quality outcomes are scarce and have mixed results. Based on a review of the literature prior to 2012, there is also limited evidence that managed care improves quality of care relative to Medicaid FFS."'
https://www.healthaffairs.org/content/forefront/medicaid-managed-care-lots-unanswered-questions-part-2

Has Medicaid Managed Care Delivered On Its Promise? *Tradeoffs* (2021)

"Despite the lack of evidence that managed care has achieved its goals, it continues to grow in its dominance of Medicaid, with more states making the switch and states adding more complex populations into these plans. Some states have responded, changing their programs in varying ways to try to achieve better value, but experts stress that more rigorous research is necessary to measure the impact of these changes." The article notes that Connecticut is one the states moving away from MCOs, and four years later, patient costs were down 7% while the number of physicians participating the program grew by 7%.
https://tradeoffs.org/2021/11/04/medicaid-managed-care/

M Geruso, et al, What Difference Does a Health Plan Make? Evidence from Random Plan Assignment in Medicaid, *National Bureau of Economic Research* (2020) Working Paper 27762
Researchers studying Medicaid managed care members in New York City , the nation's second largest Medicaid managed care market, found that members of low-spending plans used less low-cost, high-value services that benefit members' health, such as diabetes and cancer screenings. They also reduced use of high-value drugs to treat diabetes, asthma, antidepressants, antipsychotics, and contraceptives. Members of low spending plans were more likely to experience avoidable hospitalizations. MCOs' narrow networks reduced spending by reducing utilization of both high and low value care.
https://www.nber.org/papers/w27762

JC Hu, et. al., State-Level Variation in Medicaid Managed Care Enrollment and Specialty Care for Publicly Insured Children, JAMA Open Network (2023) 6(10):e2336415.
A study comparing care for children in Medicaid, especially children with special healthcare needs, found no improvement in access to specialty care or fulfilling unmet needs. However, they did find more frustration in finding care among caregivers and less mental health care access for children with special healthcare needs.
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2810191

L Bendicksen, et al, Anticipated efficiencies, real costs: Medicaid managed care organizations and the pharmacy benefit, *Journal of Managed Care & Specialty Pharmacy*, (2022) 28(3):354-361
A survey of states before and after integrating Medicaid pharmacy into MCOs found it "affected the ability of states to meet the needs of their Medicaid beneficiaries." They warn that "much of the literature that does exist on the effects of these policies [MCOs administering pharmaceutical benefits] is outside of the medical literature and is funded by organizations with financial interests at stake." They outline mis-matched incentives under MCOs that led to higher costs. For example, "Faced with a choice between filling a script for a new drug that costs $10 or an older drug for the same indication that has a list price of $20 but a post-rebate cost of $8, MCOs that maintain an independent PDL have an incentive to steer patients towards the newer drug, despite its higher net cost to government payers."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10373034/

Medicaid Long Term Services and Supports: Access and Quality Problems in Managed Care Demand Improved Oversight, *GAO* (2020)

"Through various monitoring approaches, six selected states identified significant problems in their MLTSS programs with managed care organization (MCO) performance of care management, which includes assessing beneficiary needs, authorizing services, and monitoring service provision to ensure quality and access to care. State efforts may not be identifying all care management problems due to limitations in the information they use to monitor MCOs, allowing some performance problems to continue over multiple years."
https://www.gao.gov/assets/gao-21-49.pdf

L Kern, et al, Health Care Fragmentation in Medicaid Managed Care vs. Fee for Service, *Population Health Management* (2020) 223(1): 53-58
Researchers found that Medicaid managed care patients averaged fewer outpatient visits but were cared for by a larger number of providers causing greater fragmentation of care. The authors state "Less utilization is not necessarily more efficient care; a smaller number of visits spread across a larger number of providers creates more challenges for care coordination."
https://pubmed.ncbi.nlm.nih.gov/31140914/

A Azier, et al, Does Managed Care Hurt Health? Evidence from Medicaid Mothers, *The Review of Economics and Statistics* (2007) 89(3): 385-399
Researchers found that among births in California Medicaid, MOCs were associated with lower quality prenatal care and higher low birthweight, higher prematurity, and neonatal death compared with Medicaid fee-for-service births to the same women.
https://direct.mit.edu/rest/article-abstract/89/3/385/57689/Does-Managed-Care-Hurt-Health-Evidence-from

Kuziemko, et al, Does Managed Care Widen Infant Health Disparities? Evidence from Texas Medicaid, *American Economic Journal: Economic Policy* (2018) 10:255-2083
This study found MCOs increased care disparities in Medicaid – Black mortality rose by 15% and pre-term births rose 7%. The authors state that their results support adverse selection and suggest that capitated managed care plans provide worse care to high-cost clients to avoid them in the future.
https://kuziemko.scholar.princeton.edu/publications/%E2%80%9Cdoes-managed-care-widen-infant-health-disparities-evidence-texas-medicaid%E2%80%9D

M Burns, Medicaid Managed Care and Health Care Access for Adult Beneficiaries with Disabilities, *Health Services Research* (2009) 44(5 Pt1): 1521-1541
"Mandatory MCO enrollees are 24.9 percent more likely to wait more than 30 minutes to see a provider, 32 percent more likely to report a problem accessing a specialist, and 10 percent less likely to receive a flu shot within the past year."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2754546/

Are disparities in mental health care for Medicaid beneficiaries lower in managed care? *Healthcare* (2024) Article 100734
"Medicaid managed care has not improved the inequitable allocation of mental health care across racial and ethnic groups."

https://www.sciencedirect.com/science/article/pii/S2213076424000010?via%3Dihub

K Nasseh, et al, The effect on dental care utilization from transitioning pediatric Medicaid beneficiaries to managed care, *Health Economics*, (2022) 31(6):1103-1128
Pediatric dental care access declined in Indiana, Missouri, and Nebraska when Medicaid coverage moved from fee-for-service to MCOs, especially compared to states that did not move to MCOs.
https://pubmed.ncbi.nlm.nih.gov/35322488/

M Toseef, et al, Medicaid managed care and preventable emergency department visits in the United States, PLoS One (2020) 15(10):e0240603
This study found no difference between MCOs and FFS Medicaid rates of preventable ED visits. This indicates that MCOs do not improve quality on this critical metric for Connecticut Medicaid patients that needs to be addressed.
https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0240603

C. Ndumele, et. al., Network Optimization And The Continuity Of Physicians In Medicaid Managed Care, *Health Affairs* (2018) 37(6): 929-935
Researchers found high primary care physician turnover rates in MMC plans (34% left in three years) and even higher rates in skinny network plans.
https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.1410

A Ludomirsky, et al, In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians, *Health Affairs* (2022) 41(5): 760-768
Only a third of providers listed on Medicaid MCOs' plan lists see more than ten Medicaid patients in a year. One quarter of primary care physicians and specialists provided 86% and 75% of the care, respectively.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01747

K Holgash et al, Physician Acceptance Of New Medicaid Patients: What Matters And What Doesn't, *Health Affairs Forefront* (2019)
A national study found that there was no difference in physician acceptance of new Medicaid patients between managed care and fee-for-service programs.
https://www.healthaffairs.org/content/forefront/physician-acceptance-new-medicaid-patients-matters-and-doesn-t

Physician Acceptance of New Medicaid Patients: Findings from the National Electronic Health Records Survey, *MACPAC* (2021)
The rate of physicians accepting Medicaid patients between 2014 and 2017 in Connecticut was very similar than the US average (74.2% and 74.0%, respectively). As most states used MCOs during that period and Connecticut did not, there was no difference with MCOs.
https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf

A Berman, et al, Directory Accuracy and Timely Access in Maryland's Medicaid Managed Care Program, *Journal of Care for the Poor and Underserved* (2022) 33(2):597-611
Researchers found that MCO provider directories in Maryland were very inaccurate. Only 46% of listed providers in 2018 and 56% in 2019 could be verified. They found significant variation between MCOs and in different years.
https://pubmed.ncbi.nlm.nih.gov/35574863/

J Zhu et al., Phantom Networks: Discrepancies Between Reported And Realized Mental Health Care Access In Oregon Medicaid, *Health Affairs* (2022) 41(7):1013-1022
"Overall, 58.2 percent of network directory listings were 'phantom' providers who did not see Medicaid patients, including 67.4 percent of mental health prescribers, 59.0 percent of mental health nonprescribers, and 54.0 percent of primary care providers."
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9876384/

High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care, *HHS, OIG,* July 2023
The Inspector General raised concerns that Americans in Medicaid managed care plans may not be getting necessary care. The office found prior authorization rates in Medicaid MCOs were twice the rate for Medicare Advantage plans. They found little state oversight of Medicaid prior authorizations and members had limited access to external medical reviews. The problems affected people with cancer or cardiac conditions, the elderly, and people with disabilities who need in-home care or medical devices.
https://oig.hhs.gov/oei/reports/OEI-09-19-00350.asp

California Handed Its Medicaid Drug Program to One Company. Then Came a Corporate Takeover, *KFF Health News* (2022)
California bid out management of their Medicaid drug program to Magellan Health, which had experience in running similar programs well. However, after the contract was awarded, Magellan was purchased by Centene, a Medicaid managed care company with a troubled history. Thousands of members were left without access to critical medications for weeks and waited hours on hold to talk with the company. Centene had been accused by nine states of overbilling Medicaid for medications.
https://kffhealthnews.org/news/article/california-medicaid-centene-magellan-drug-program-overbilling-states/

C. Andrews, et al, Medicaid Managed Care Prior Authorization For Buprenorphine Tied To State Partisanship And Health Plan Profit Status, 2018, *Health Affairs* (2024) 43(1): 55-63
Buprenorphine is a critical medication for treatment of opioid disorder, reducing risks of overdose, relapse, and death. However, only 28% of patients can get the drug. This study found that for-profit Medicaid managed care plans are twice as likely to require prior authorization for buprenorphine. Connecticut's current managed fee-for-service Medicaid program has no prior authorization requirement for buprenorphine.
https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00288

Medicaid Demonstrations: Evaluations Yielded Limited Results, Underscoring Need for Changes to Federal Policies and Procedures, *GAO* (2018)
Federal evaluators found both state and CMS evaluations of Medicaid 1115 waivers (usually based on MCOs) were not credible. They found only one with evidence of savings.
https://www.gao.gov/assets/d18220.pdf