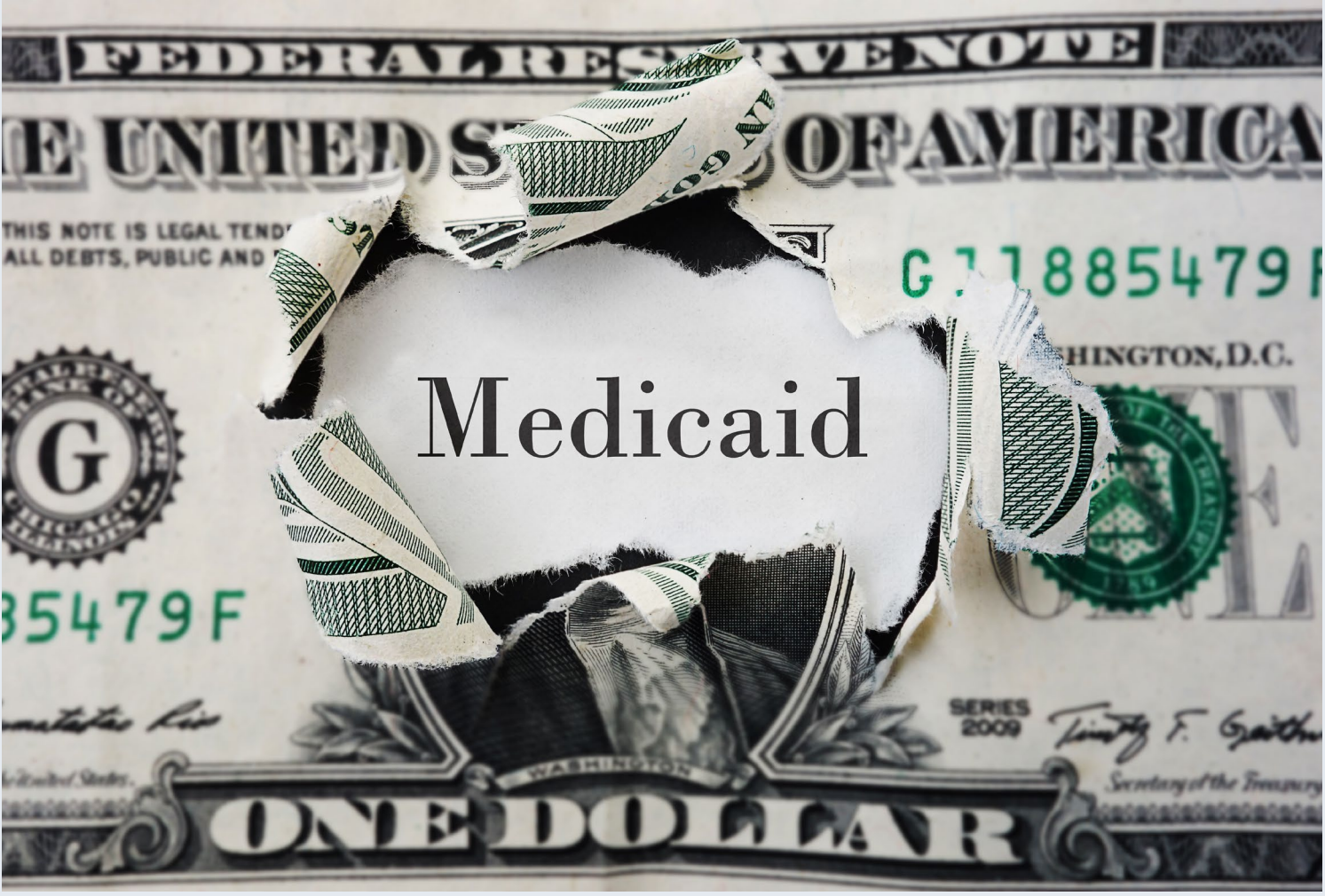

Medicaid Managed Care: Promises and Realities

A CCLP issue brief

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Key findings

- States often shift to "managed care" models of Medicaid delivery in the attempt to reduce costs. Managed care is a model by which healthcare providers are paid limited funding up-front, under the assumption that doing so will incentivize providers to keep patients healthy, avoiding costlier services.
- The available evidence from Colorado and other states indicates that managed care costs states more than the traditional Medicaid fee-for-service model.
- Managed care programs provide far less transparency than fee-for-service models. States that have implemented managed care programs have reduced oversight into access and quality of care.
- Evidence is lacking about the overall impact of managed care on healthcare outcomes. For some populations, the transition to managed care appears to have resulted in poorer health and higher mortality.
- In light of Colorado's billion-dollar budget shortfall, driven by disastrous TABOR revenue restrictions, Colorado must avoid the false promises and significant costs of the inefficient managed care model.

Overview

As Colorado faces a billion-dollar budget shortfall, spending for Colorado Medicaid is in jeopardy. Because Medicaid costs about a third of the state budget[1], strategies for controlling cost sound appealing — even though Medicaid is the most efficient form of health coverage available[2] and per capita spending in Colorado is already less than the national average.[3]

The squeeze on costs comes primarily from the Taxpayer's Bill of Rights, or TABOR, a 1992 constitutional amendment limiting taxation and spending. Since its enactment, TABOR has progressively ratcheted down spending on the things Coloradans care about and rely on state government for, creating crises in not just Medicaid, but also K-12 education[4], assistance with childcare[5] and more.

States often shift to managed care in search of a fiscal solution. The managed care model proposes that by giving an entity limited funding up-front, the entity will be incentivized to keep patients healthy and avoid more costly services, like emergency room visits and inpatient care. Where Medicaid is concerned, states that look to managed care may also aim to relieve themselves of the administrative burden of enrolling providers, coordinating care, creating formularies, undertaking utilization management, and communicating about the Medicaid program.

Despite these theoretical advantages, as demonstrated below, research shows that states do not save with managed care and struggle to provide meaningful oversight.

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[1] "Explore the Colorado State Budget." *Colorado General Assembly*, Colorado Legislative Council, https://leg.colorado.gov/explorebudget/. Accessed 10 Mar. 2025.

[2] Katch, Hannah, et al. *Frequently Asked Questions about Medicaid*. Center on Budget and Policy Priorities, 24 Sept. 2013, www.cbpp.org/research/correcting-seven-myths-about-medicaid. Accessed 10 Mar. 2025.

[3] In 2022, the most recent year available, average per-capita spending in Colorado Medicaid was 15.6% below the national average, placing Colorado 14th lowest of the 53 states and territories.
"Medicaid and CHIP 2024 Scorecard." Medicaid.gov, Centers for Medicare & Medicaid Services, https://www.medicaid.gov/state-overviews/scorecard/measure/Medicaid-Per-Capita-Expenditures?measure=EX.5&measureView=state&stratification=463&dataView=pointInTime&chart=map&timePeriods=%5B%222022%22%5D. Accessed 10 Mar. 2025.

[4] In 1985, Colorado schools met 180 days per year. Today, the school year is 160 days for 40% of districts, and 60% use a four-day week, attending only 144 days per year. Compared to 1985, parents must pay for one to almost two additional months of childcare for their school-age children.
Brundin, Jenny. *Is the four-day school week in many Colorado school districts helping students and teachers?* CPR News, 13 Aug. 2024. https://www.cpr.org/2024/08/13/colorado-four-day-school-week-study/. Accessed 10 Mar. 2025.

[5] Glassman, Suzie. *Enrollment freeze in state's Child Care Assistance Program leaves families without options*. Colorado Community Media, 5 Feb. 2025. https://coloradocommunitymedia.com/2025/02/05/enrollment-freeze-in-states-child-care-assistance-program-leaves-families-without-options/. Accessed 10 Mar. 2025.

Additionally, evidence is lacking that managed care improves health outcomes. In addition, because most managed care entities are for-profit corporations, those scarce state dollars devoted to Medicaid go to pad the profits of for-profit entities, rather than to health care services.

Colorado is already a managed care state, though only a minority of Medicaid enrollees (what the state calls "members") are in fully capitated managed care entities. Most Medicaid members get only their behavioral health services and care coordination through managed care, while medical, surgical and pharmaceutical benefits are provided more directly by the state through a "fee-for-service" system. Those behavioral health managed care entities are confusingly called by a variety of names: Regional Accountable Entities, or Regional Entities, or RAEs ("rays"), and as a whole, the Accountable Care Collaborative. Colorado now has seven RAEs and is moving to four on July 1, 2025.[6]

Reality #1: Managed care fails to reduce costs

A simple comparison with state spending on Medicaid suggests that the use of fully capitated managed care, also known as MCOs, is not less expensive than either a fee-for-service model or Colorado's current mixed model. Colorado ranked 14th lowest for expenditures per person[7] in the most recent year available, below most of the 39 states that offered MCOs statewide.[8] Neighboring states with statewide MCOs had significantly greater per capita costs, with Kansas spending 31% more, Nebraska 34% more, Utah 21% more, and New Mexico 16% more. (Wyoming is not an MCO state).

One reason that managed care is unlikely to save costs is that administrative costs tend to be greater for managed care entities than they are for state agencies. After using a variety of managed care structures from 1995-2010, Connecticut returned to the use of fee-for-service Medicaid. A recent report found that costs are now below those of

[6] "Preparing for Accountable Care Collaborative Phase III." *Colorado Department of Health Care Policy & Financing*, State of Colorado. https://hcpf.colorado.gov/accphaseIII. Accessed 10 Mar. 2025.

[7] "Medicaid and CHIP 2024 Scorecard: Medicaid Per Capita Expenditures." *Medicaid.gov*, Centers for Medicare & Medicaid Services. https://www.medicaid.gov/state-overviews/scorecard/measure/Medicaid-Per-Capita-Expenditures?measure=EX.5&measureView=state&stratification=463&dataView=pointInTime&chart=map&timePeriods=%5B%222022%22%5D. Accessed 10 Mar. 2025.

[8] Hinton et al. *Amid Unwinding of Pandemic-Era Policies, Medicaid Programs Continue to Focus on Delivery Systems, Benefits, and Reimbursement Rates: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2023 and 2024*. KFF, 14 Nov. 2023. https://www.kff.org/report-section/50-state-medicaid-budget-survey-fy-2023-2024-delivery-systems/. Accessed 10 Mar. 2025.

neighboring states while many quality measures are above national averages.[9] A significant finding was that Connecticut's total administrative costs were far lower in the absence of managed care. In fact, the Connecticut report found that if the state used managed care and had to cover the average managed care overhead, the state would have been out an additional $240 million annually.

Although the Department of Health Care Policy and Financing reports overhead at just 4%[10], this fails to account for the average 9.4% overhead in managed care (let alone the 15% overhead permitted by contract with the RAEs). Adding in the estimated administrative costs of our RAEs, which were paid $1.028 billion in 2023-2024 for behavioral health services and care coordination[11], Colorado may in fact be spending an additional $96.6 million on administration costs and profits under the RAEs that it does not include when reporting overhead.

A 2017 report by the Colorado Health Institute[12] similarly found reason to doubt that Colorado would see cost savings with managed care. While some studies have seen a shift away from higher-cost services for specific groups of patients[13], an expansive national 2013 study found that when states shifted to managed care, spending increased.[14] That effect was more pronounced when the shift was to fully capitated MCOs.

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[9] Connecticut Department of Social Services. *Medicaid Landscape Analysis, December 2024*. https://portal.ct.gov/dsshome/-/media/dss/ct_dss_medicaid-landscape-analysis_final-report_1252024_v2.pdf. Accessed 10 Mar. 2025.

[10] *CO Medicaid Insights & Potential Federal Medicaid Reduction Impact Estimates*. Colorado Department of Health Care Policy and Financing, Feb 2025. https://hcpf.colorado.gov/sites/hcpf/files/Abbreviated%20Fact%20Sheet-HCPF%20CO%20Medicaid%20Insights%20and%20Potential%20Federal%20Reduction%20Impacts-February%202025.pdf. Accessed 10 Mar. 2025.

[11] *FY 2023-24 Medical Premiums Expenditure and Caseload Report*. hcpf.colorado.gov. Colorado Department of Health Care Policy and Financing. https://hcpf.colorado.gov/sites/hcpf/files/2024%20July%2C%20Joint%20Budget%20Committee%20Monthly%20Premiums%20Report.pdf. Accessed 10 Mar. 2025.

[12] Johnson, et al. *Managing Medicaid in Colorado: The Promise of Medicaid Managed Care*. Colorado Health Institute, 20 Nov. 2017. https://www.coloradohealthinstitute.org/research/managing-medicaid-colorado. Accessed 10 Mar. 2025.

[13] Montoya, Daniela Franco, et al. "Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update." *Annual Review of Public Health*, vol. 41, no. 1, Apr. 2020, pp. 537–49. https://doi.org/10.1146/annurev-publhealth-040119-094345. Accessed 10 Mar. 2025.

[14] Duggan, Mark, and Tamara Hayford. "Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates." *Journal of Policy Analysis and Management*, vol. 32, no. 3, Mar. 2013, pp. 505–35, https://doi.org/10.1002/pam.21693. Accessed 10 Mar. 2025.

Reality #2: Managed care reduces transparency and accountability

A 2023 report by the Department of Health and Human Services' Office of the Inspector General (OIG) raised concerns about states' ability to oversee managed care entities' delivery of care.[15] In a review of the seven largest MCOs across 37 states, the OIG found that many had unusually high rates of denials and most states failed to routinely review or monitor data on utilization management decisions. Like Colorado, more than half the states reviewed offered no option for an external medical review in Medicaid managed care. When those decisions are outsourced to for-profit entities, oversight of those subcontractors is still more challenging, as California found.[16] In Colorado, as in many other states, few individuals appeal decisions made by managed care entities.

Similarly, states struggle to oversee the adequacy of managed care networks. Whereas fee-for-service networks typically take any willing and qualified provider, managed care entities tend to establish narrower networks. A study of four states found that Medicaid managed care networks are weak indicators of access because just 25% of providers in both primary care and specialty networks provided 86% and 75% of care, respectively.[17] A comprehensive study from 2012 found mixed results for networks after a shift to managed care, with provider participation and use of preventive services increasing or decreasing, depending on the state.[18] A 2014 study by the U.S. Department of Health and Human Services Office of the Inspector General found that more than half of Medicaid providers in managed care networks could not offer appointments to enrollees, and a third were not at the listed location.[19] Wait times were extensive.

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[15] DeFraga, et al. *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care*. Department of Health and Human Services' Office of the Inspector General. https://oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf. Accessed 10 Mar. 2025.

[16] Terhune, Chad. *Coverage Denied: Medicaid Patients Suffer as Layers of Private Companies Profit*. KFF Health News, 3 Jan. 2019. https://kffhealthnews.org/news/coverage-denied-medicaid-patients-suffer-as-layers-of-private-companies-profit/. Accessed 10 Mar. 2025.

[17] Ludomirsky, Avital B., et al. "In Medicaid Managed Care Networks, Care Is Highly Concentrated among a Small Percentage of Physicians." *Health Affairs*, vol. 41, no. 5, May 2022, pp. 760–68, https://doi.org/10.1377/hlthaff.2021.01747. Accessed 10 Mar. 2025.

[18] Sparer, Michael, and Robert Wood Johnson Foundation. *Medicaid Managed Care: Costs, Access, and Quality of Care*. Robert Wood Johnson Foundation, 2012. https://www.cancercarediff.org/wp-content/uploads/2020/12/managed-care-rwjf.pdf. Accessed 10 Mar. 2025.

[19] Nudelman et al. *State Standards for Access to Care in Medicaid Managed Care*. U.S. Department of Health and Human Services Office of Inspector General. https://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf. Accessed 10 Mar. 2025.

Reality #3: Managed care can worsen health outcomes

Evidence is lacking that managed care improves health care outcomes on the whole, with the Medicaid and CHIP Payment and Access Commission (MACPAC) reporting mixed results.[20] While managed care provides financial incentives to reduce high-cost services, entities can save or increase profit by restricting access to necessary care. Some states' shifts to managed care have had disastrous results for particular populations. In Texas, after counties switched to managed care, Black-Hispanic maternal mortality and pre-term births increased 69% and 45% respectively.[21]

Understanding of the impact on quality is also limited in part because transparency into managed care performance is often inadequate.[22] In Colorado, although data on key performance indicators[23] and managed care audits[24] are posted on state web pages, it is challenging to find and challenging to understand.

Overall, there is minimal evidence for quality improvements under managed care, as described in the 2012 Robert Wood Johnson study as well as in the 2023 report from MACPAC.

As Dr. Andrew Bindman, the former director of the Agency for Healthcare Research and Quality, stated in 2018, "We haven't been holding plans to the level of scrutiny they need. This system is ripe for profit taking, and there is virtually no penalty for performing badly."[25]

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[20] "Managed care's effect on outcomes." *MACPAC.gov*, Medicaid and CHIP Payment and Access Commission, 12 Sept. 2023. https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/. Accessed 10 Mar. 2025.

[21] Ibid.

[22] Hinton, Elizabeth and Raphael, Jada. *10 things to know about Medicaid managed care*. KFF.org, KFF, 27 Feb. 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/. Accessed 10 Mar. 2025.

[23] "Accountable Care Collaborative public reporting." Hcpf.colorado.gov, Colorado Department of Health Care Policy & Financing. https://hcpf.colorado.gov/accountable-care-collaborative-public-reporting. Accessed 10 Mar. 2025.

[24] Health Services Advisory Group, Inc. *FY 2023–2024 External Quality Review Technical Report for Health First Colorado (Colorado's Medicaid Program)*. Hcpf.colorado.gov, Colorado Department of Health Care Policy & Financing, Jan 2025. https://hcpf.colorado.gov/sites/hcpf/files/2024%20External%20Quality%20Review%20Technical%20Report%20for%20Health%20First%20Colorado.pdf. Accessed 10 Mar. 2025.

[25] Terhune, Chad. *As Billions In Tax Dollars Flow To Private Medicaid Plans, Who's Minding The Store?* KFF Health News, KFF, 19 Oct. 2018. https://kffhealthnews.org/news/as-billions-in-tax-dollars-flow-to-private-medicaid-plans-whos-minding-the-store/. Accessed 10 Mar. 2025.

Conclusion

In light of Colorado's budget shortfall and the increasing pressures on Medicaid spending, the touted promises of managed care are undoubtedly appealing. Unfortunately, the evidence does not support the claimed benefits of the model. As compared to fee-for-service Medicaid delivery, managed care fails to deliver on cost savings. Administrative overhead and profit-taking in managed care systems tends to be higher than in fee-for-service models, and the reported savings from managed care are often illusory when factoring in these additional expenses.

Moreover, transitioning to managed care may actually reduce provider accountability, decrease access to services, and worsen overall health outcomes. With the risks of decreased state oversight, narrower provider networks, and higher rates of denials, the promise of better coordination and improved health outcomes is likely to go unfulfilled.

As Colorado faces difficult decisions about its Medicaid program, it is essential to prioritize evidence-based approaches that protect both fiscal responsibility and the well-being of our most vulnerable residents, rather than relying on unproven managed care models that do not deliver on their promises.