TEAM KENTUCKY

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THE EFFECT OF MARKET CHANGES ON KENTUCKY MEDICAID: UTILIZATION AND COST SAVINGS FOR THREE CHRONIC DISEASES-CANCER, DIABETES, AND CVD

Summary Prepared by the Office of Data Analytics Division of Analytics

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What is Known on This Topic?

Medicaid managed care is the most prominent mechanism for delivering Medicaid services to in the United States. The goals of this approach are, broadly, to lower healthcare costs while improving population health outcomes. The research literature is largely inconclusive as to whether Medicaid managed care successfully achieves these goals for state Medicaid programs.

What Did this Project Do?

This project compared the patterns of healthcare services utilization across time among three groups of Medicaid beneficiaries with chronic conditions. Utilization patterns were compared before and after the implementation of Medicaid managed care in Kentucky to estimate whether significant changes were observed as a result of the policy change.

What Could Medicaid Do with These Conclusions?

This study found that the implementation of Medicaid managed care was associated with broad reductions in utilization of many categories of healthcare services (e.g., hospitalizations and outpatient physician visits). Medicaid may consider investigating whether these reductions were associated with significant changes in the health status of beneficiaries.

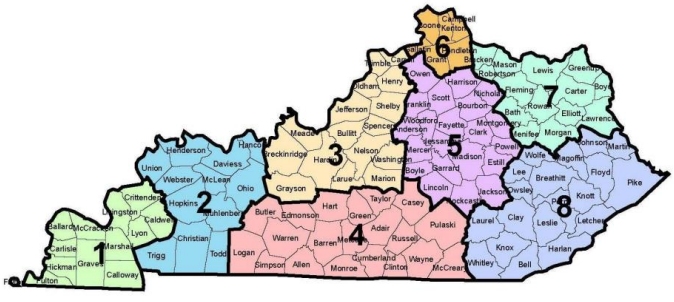
Introduction

The central challenge of Kentucky's Medicaid program is to find ways to ensure that beneficiaries receive the healthcare services that they need while simultaneously mitigating the growth in program costs.[1] Present healthcare industry thinking is driven by the belief that the most effective way to achieve better health outcomes and lower healthcare costs is to direct health services towards prevention-oriented care and the cultivation of wellness. This line of reasoning assumes that, if healthcare systems can help populations gradually move towards higher rates of successful disease management, cultivation of healthy lifestyles and mitigation of the challenges of poverty, then lower aggregate healthcare cost growth will result.

This approach is especially relevant to the Medicaid program, where the financial risk of providing healthcare coverage to beneficiaries is borne by state government agencies. This financial responsibility is considerable as well as consequential. For most states, the Medicaid budget is in the top three largest line items in the overall state government expenditures, and roughly between one in four and one in three residents relies on the program to access healthcare services.[2] The most prominent mechanism for delivering the Medicaid program in the United States is for state agencies to contract with commercial health insurance firms under managed care models. The firms that operate these contracts and pay for health services are known as managed care organizations (MCOs). Nationally, over seventy percent of beneficiaries receive their Medicaid coverage within a managed care framework.[3]

Kentucky began to shift the majority of its Medicaid beneficiaries to MCOs in 2011. One exception was Kentucky Medicaid Region 3, which contains Louisville. Region 3 shifted to a not-for-profit MCO called Passport in 1997, which operated as the sole MCO in the region until the framework was rolled out several years later. This resulted in a reality where many beneficiaries were shifted from state-administered fee-for-service (FFS) Medicaid benefits to MCOs. This reality was used by the study outlined in this brief to estimate the impact of managed care in the regions of the state outside of region 3 (the term used by the research team was "not-region 3").

Figure 1. *Kentucky's Medicaid Regions*



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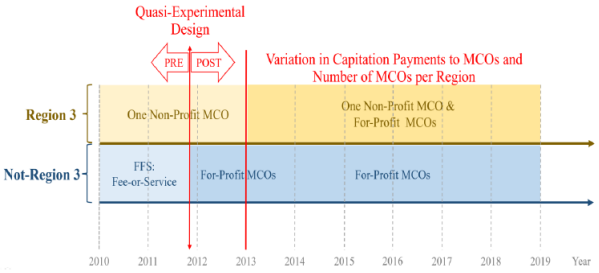
Project Methods & Results

To investigate the effects of Kentucky's implementation of MCOs, the research team followed adult Medicaid beneficiaries with three chronic diseases (cancer, diabetes, and cardiovascular disease) and observed changes in their medical care utilization. Analyses of both health services utilization and costs for twenty-four categories of medical care services were conducted before and after implementation of MCOs. Claims and encounters data from 2010-2019 were used to conduct these analyses. The study authors noted that their method allowed for longitudinal comparisons of two differently structured Medicaid markets across this time period; one that maintained a managed care framework (Region 3) throughout and one that switched into managed care in 2011. The research team also conducted cross-sectional analyses to estimate whether the Medicaid market change in 2011 had differential effects on the utilization of medical care by beneficiary race. Figure 2 describes the changing dynamics of the two Medicaid markets across time to illustrate the method that was used to estimate the effects of Medicaid managed care.

Figure 2. *Statistical Identification Strategy*



Results of this study suggest that utilization of many types of care consistently decreased in not-Region 3 after the implementation of Medicaid managed care. These decreases were most pronounced amongst the high-cost types of care, such as inpatient hospitalizations. The researchers also observed declines in utilization of pharmaceutical services, dental care and outpatient physician visits. Results also noted an increase in the utilization of nurse practitioners and physician assistants following the implementation of Medicaid managed care. Notably, these reductions were more pronounced in not-Region 3 in 2011 (i.e., the newly implemented MCO regions of the state) when compared to Region 3.

The study authors estimate that these reductions in utilization following the implementation of managed care were associated with reduced costs to the Kentucky Medicaid program. However, they voiced concern that the observed reductions in prevention-oriented care, such as laboratory services and outpatient physician visits, may have deprived many beneficiaries of services that would be in the long-term interests of their health. Figure 3 illustrates this result by displaying changes to utilization of office-based visits to nurse practitioners and physician assistants.

Figure 3.

Office Based Services Pre & Post-Managed Care

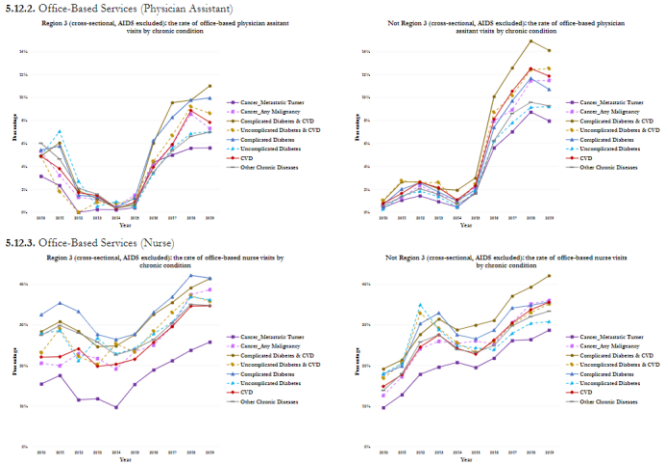


Figure 3 here appears as Figure 5 in the authors' final report

Conclusion

There are three primary ways that healthcare payers can decrease system-wide costs. The first is to deny services or reduce the scope of covered services to beneficiaries. The second is to bid down prices so that the care that is provided is less expensive. The third (and most challenging) is to steer beneficiaries towards the services that will help keep them well and reduce the likelihood that they will need higher-cost care. Since the Affordable Care Act was passed into law, health insurance organizations that partner with state Medicaid agencies have been incentivized to pursue strategies that reduce costs by preventing severe illness and promoting wellness. The study authors suggest that their results indicate that Kentucky's implementation of Medicaid managed care has saved money largely by reducing utilization of services and shifting utilization from higher-cost services to lower-cost services.

Whether this result suggests a successful implementation of Medicaid managed care in Kentucky is not entirely clear. While the estimation of cost savings implies that some elements of implementation were successful, the study authors urge further study into whether the reduction in health services utilization was associated with any adverse effects on the health status of beneficiaries.

References

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