Medicaid Managed Care Value Proposition

January 2025

Medicaid Managed Care Organizations (Medicaid MCOs) provide value to consumers, state partners and providers by increasing access to high-quality care, centering the consumer experience, managing costs to ensure people get the right care when and where they need it across the health care system and providing benefit and budget predictability. This approach ultimately enhances the health care experience for individuals facing economic and social barriers.

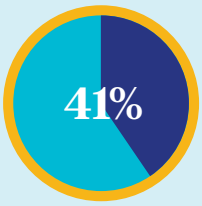
UnitedHealthcare

Medicaid is a foundational piece of America's health delivery ecosystem — serving almost 73 million Americans and accounting for 18% of total health care expenditures.[1,2]

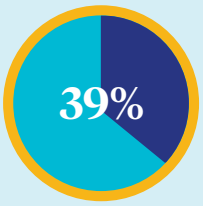
Medicaid is a collaborative effort between states and the federal government that guarantees enrollees access to essential benefits. It grants states the flexibility to design programs tailored to their specific priorities, providers and populations.

In the U.S., Medicaid covers:

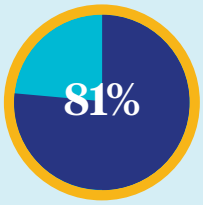
1 in 5 of all Americans[3]



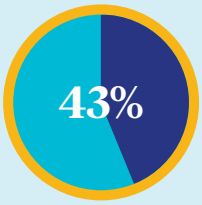
of all births[4]



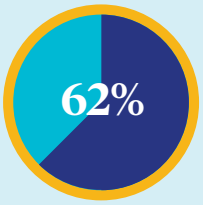
of all children[3]



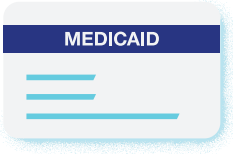
of low-income children



of non-elderly adults with a disability



of nursing home residents[5]



Medicaid plays a vital role by offering coverage to individuals who would otherwise be uninsured and as a payer for providers.

- In 2022, Medicaid accounted for **$133B in total net revenue** for providers, representing approximately 14.1% of payer mix distribution.[6]
- In 2022, the nationwide uninsured rate reached a **record low at 9.6%**, driven by the combination of Affordable Care Act (ACA) coverage expansions along with pandemic-era polices for continuous enrollment and enhanced Marketplace subsidies.[7]
- After the launch of the ACA, the nationwide **uninsured rate fell 35%**, and nationwide hospital **uncompensated care costs fell by about 30%** as a share of hospital budgets — **a $12B drop**.[8]
- Studies continue to show substantial reductions in uncompensated care costs for states that have expanded Medicaid under the ACA; in 2019, **uncompensated care costs in expansion states were less than half** of those in non-expansion states as a percent of hospital operating expenses.[9]

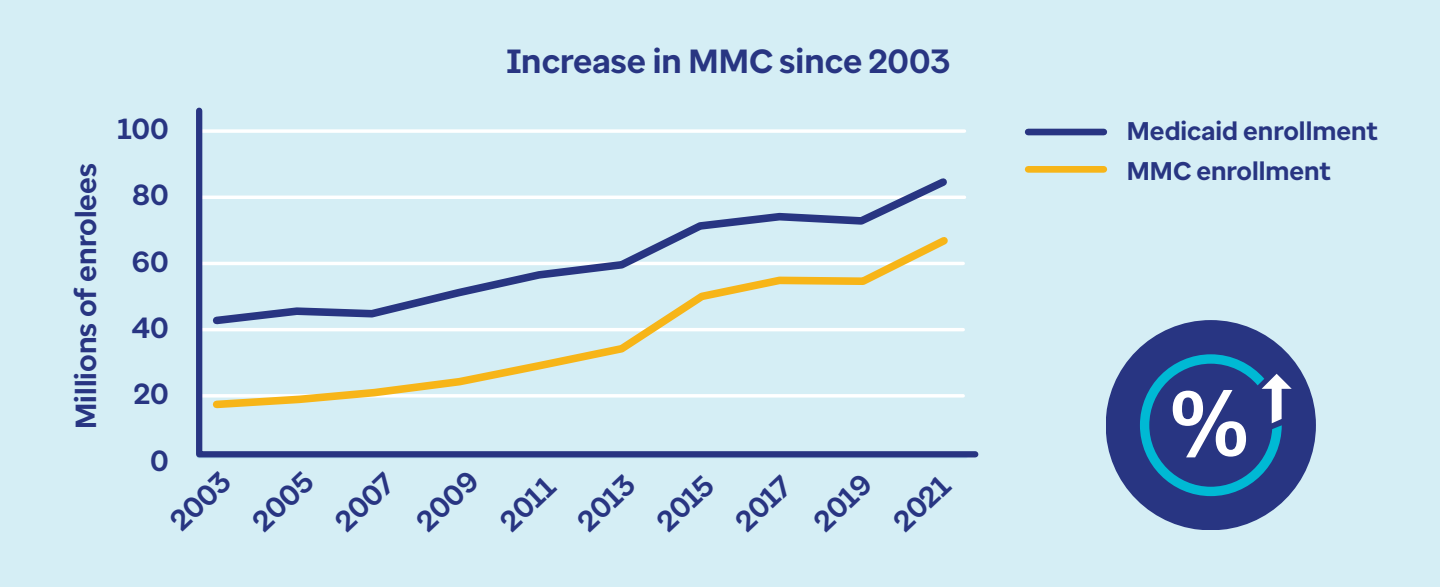
Medicaid Managed Care (MMC) – a partnership between states and private health care companies – is the primary strategy chosen by states to efficiently deliver Medicaid services.

The most prevalent MMC structure is a comprehensive risk-based arrangement. In this model, a state pays MMC organizers with a fixed monthly amount per member to deliver services to their Medicaid population.

- 45 states use MMC for some or all populations and benefits[10]
- 75% of enrollees utilize MMC and account for over 50% of total Medicaid spending
- The percentage of Medicaid enrollees covered under MMC continues to steadily increase as states reach out to new populations

MMC enables the customization of programs to effectively address the unique needs of each population, while simultaneously reducing costs and ensuring improved health outcomes.

States can administer Medicaid benefits through fee-for-service or managed care. The state pays providers directly for each service a Medicaid member receives in FFS.



Note. Since 2003, MMC enrollment has increased by approximately 50%. From NHE Fact Sheet (2024, June 12). *CMS.gov*. NHE Fact Sheet | CMS and Total Medicaid MCO Enrollment | KFF.[2,11]

At its core, MMC provides:

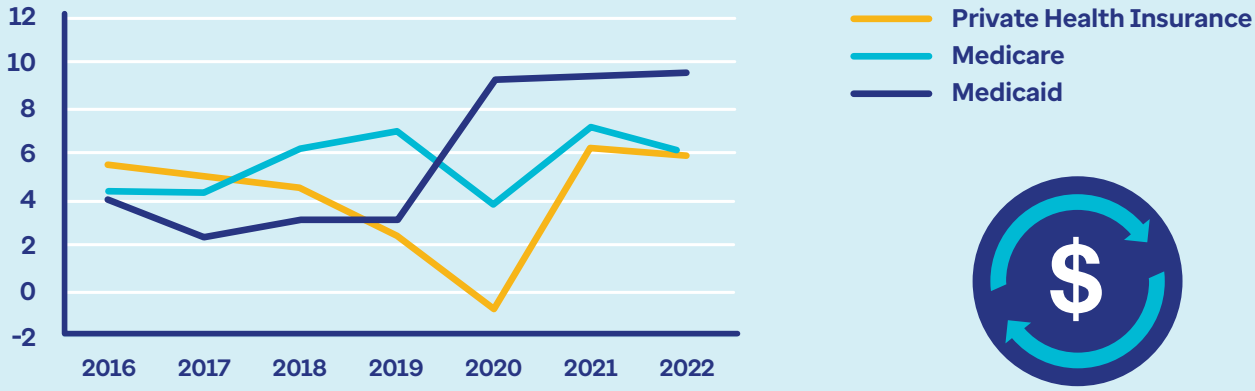
1. The most cost-effective means of providing safety net coverage for low-income individuals
2. Budget predictability, savings and flexibility for states to tailor their program to their state's needs
3. Access to high-quality care for enrollees
4. A positive, person-centered experience for enrollees
5. The ability for states to address public health issues

1 Medicaid is the most cost-effective solution for providing coverage to individuals whose incomes are below the federal poverty level, with MMC playing a key role.

Efficiency and effectiveness

The extensive reach and scale of Medicaid programs help maintain per-enrollee costs and growth rates at levels comparable to or lower than other types of insurance. Medicaid is instrumental in addressing poverty – protecting recipients from high out-of-pocket medical expenses that often lead to or exacerbate financial instability.

Growth in health expenditures by source of funding



Note. Medicaid has had the highest rate of enrollment since 2020 when compared to Medicare and private health insurance. From: NHE Fact Sheet (2024, June 12). *CMS.gov*. NHE Fact Sheet | CMS.[2]

Medicaid can reduce out-of-pocket medical spending per enrollee by over 50% (from $871 to $376).[12] Expanding access to coverage improves quality of care.

State snapshot: Kansas

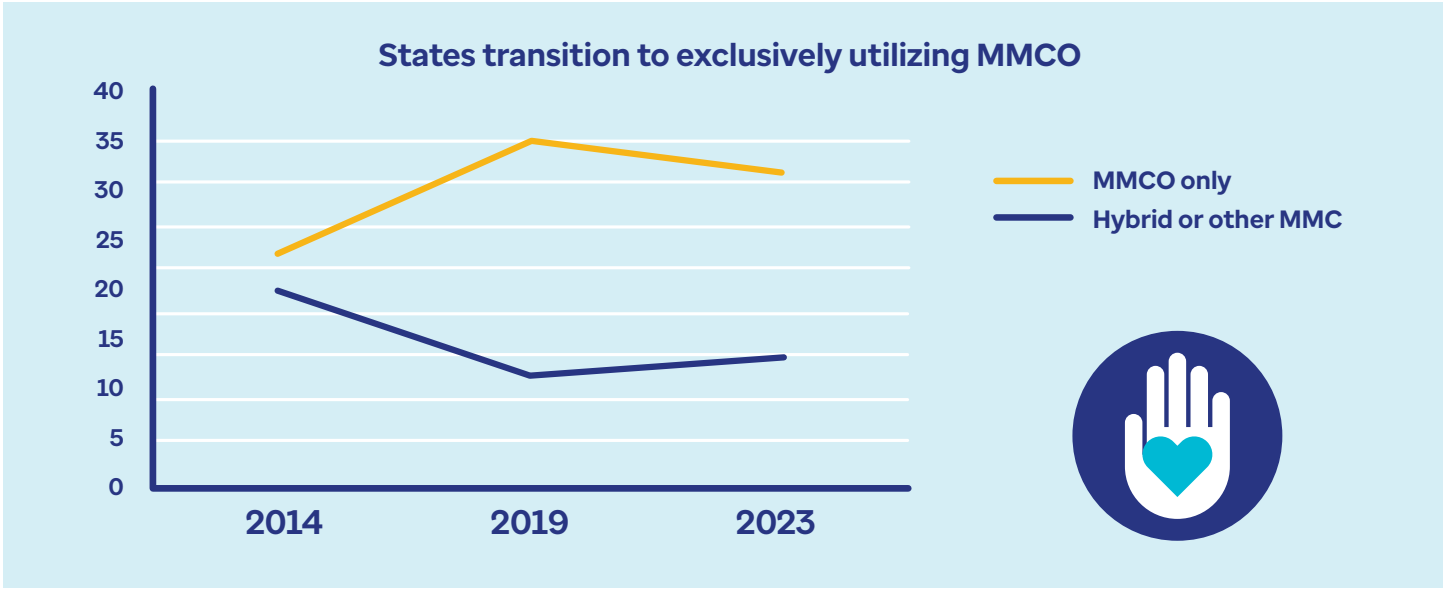
After Kansas transitioned to an MMC model, quality of care trends showed significant improvements across several performance measures. For example:

- **Increased** rates of adolescent well care visits (ages 12–21 years)[13]
- **Improved** rates of follow-up after hospitalization for mental illness
- **Improved** rates of comprehensive diabetes care
- **Increased** number of KanCare members utilizing inpatient mental health services

State support for MMC

MMC plays a key role in delivering ongoing value and quality for states.

MMC is the preferred delivery model for states, driving financial value, utilizing private sector expertise to address public health needs and fostering innovation within the health care delivery system. Currently, 45 states have implemented comprehensive MMC programs, with a growing trend towards adopting MMCOs as the primary Medicaid delivery model.[3] As of December 2022, 75% of all Medicaid beneficiaries received their care through comprehensive risk-based MCOs.[14]



Note. The number of states exclusively using MMCOs has been higher than the number using hybrid or other MMC models for the past decade. From Comprehensive Medicaid Managed Care Models (2014, October 14). *KFF*. Comprehensive Medicaid Managed Care Models | KFF, A View from the States: Key Medicaid Policy Changes: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2019 and 2020 (2019, October 18). *KFF*. A View from the States: Key Medicaid Policy Changes | KFF and 10 Things to Know About Medicaid Managed Care (2024, May 1). *KFF*. 10 Things to Know About Medicaid Managed Care | KFF. [3,15,16]

States carving in additional benefits

States can design their Medicaid programs to fully incorporate all health services into their managed care plan (fully integrated care) or they may have a separate contract or provider network for certain services (known as 'carving out').

- Pharmacy benefits
  - 32 states[3]
- Contracting with Prepaid Health Plans to provide behavioral health care, dental care, vision care, non-emergency medical transportation or long-term services and supports (LTSS)
  - 27 states[17]
  - Dental
  - Behavioral health
  - Medical prescriptions
  - LTSS

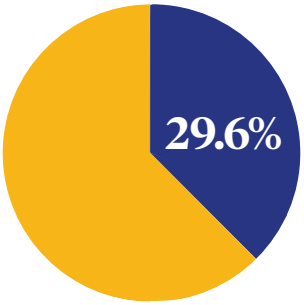
States leveraging MMC vs. fee-for-service (FFS) to deliver LTSS have seen improved care through[16]:

- **5-6X more** people transitioning from nursing facilities to community settings such as home and community-based services, Pace programs and day programs
- **~2X more** individuals receiving care in the setting of their choosing
- **Stable program costs**, which can help increase the number of individuals served

2 MMC creates budget predictability, savings and flexibility for states.

Cost control and predictability

MMC funding methodology manages costs and provides predictability by shifting risk to payers, rather than to states.



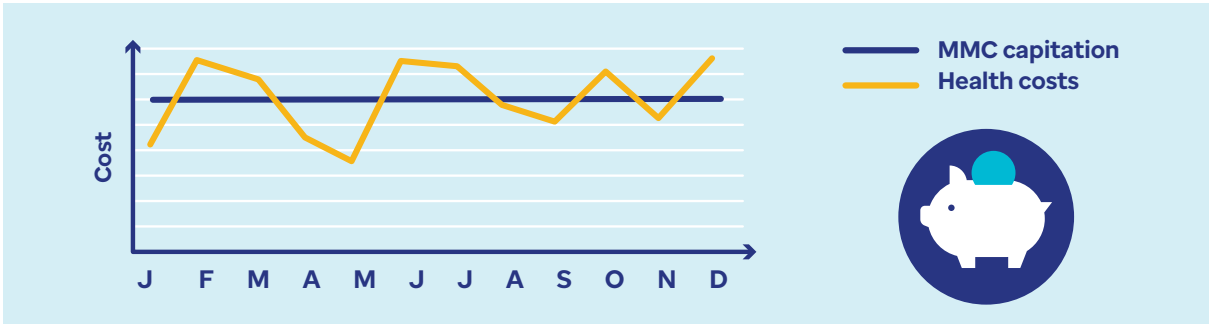
of state budgets dedicated to Medicaid; often the single largest budget item.[18]

$94.4B in savings from existing MMC over 10 years

$63.2B in savings if existing FFS is transitioned to MMC

0.00% improper payment rate for MMC in 2023, compared to 6.90% for FFS[17]

MMC organizations take on the risk of fluctuations in utilization and cost. Through annually set capitation rates, states can achieve budget predictability.



Note. Over a 12-month period, MMC capitation remains steady while health costs vary.

Nationally, current MMC programs contribute ~$7.1B in savings on an annual basis.

State snapshots:

Kansas avoided **$2B in costs** over six years[19]

Texas saved **up to $13B** over six years[2]

Tennessee managed care has led to **sustainable** cost trends and effective utilization management.[21]

Program flexibility

Through collaboration with MMCOs, states can develop customized programs that meet the needs of their unique populations. This includes:

- Optional benefit design
- Optional eligibility groups
- Waivers and block grants

This flexibility facilitates the integration of essential services, including behavioral and mental health care, and has a significant impact on the Medicaid population. In 2021, 19% of adults with Medicaid or Children's Health Insurance Program coverage reported regularly experiencing symptoms of anxiety, and 10% reported that they regularly experienced symptoms of depression.[22]

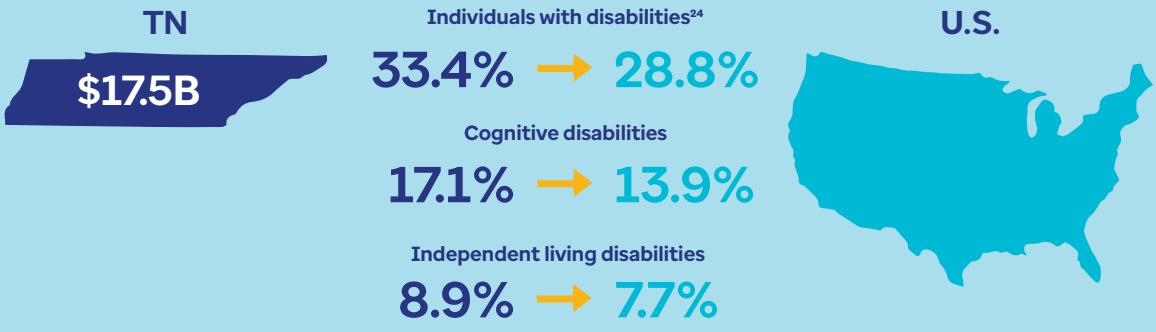
MMC:

- Allows for integration of physical and behavioral health, as well as pharmacy
- Can decrease fragmentation of care, improve health outcomes and reduce costs

State snapshot: Tennessee

Tennessee has a larger-than-average population of individuals with intellectual and developmental disabilities and was associated with a significant amount of health care expenditures. To address these unique needs effectively, the TN ECF CHOICES program was developed specifically to meet the requirements of both the individuals served and the state's health care system.

TN $17.5B disability-associated health care costs were ~38% of total TN health care expenditures.[23]



3 MMC ensures enrollees have access to high-quality care, driven by value-based payments.

Access to care

Through the MMC model, MCOs help states strengthen and maintain access to care by ensuring primary and preventive care is available over the long term.

MMC:

- Includes time and distance standards to limit how long and/or how far an enrollee has to travel to get to a provider
- Provides additional integrated services and benefits such as dental, vision and transportation services
- Helps coordinate care for members with complex health conditions

MMCOs build comprehensive provider networks and help simplify provider administration because they often offer other insurance products (such as commercial, Medicare or Exchange products). This improves access compared to FFS.

State snapshots:

Florida: Implementing MMC doubled primary care providers in each network.[25]
Louisiana: MMCOs improved access as compared to prior FFS program.[26]

MMC evaluates member needs, formulates personalized care plans and facilitates access to necessary health care services.

For example:

Care management:

- 3.15M assessments (in ICUE and CC in 2023)
- In 2023, 2,458 individual transitions from nursing facilities to home and community based services (per Idaho RFP proof point)

Maternity:

- 4% improvement in timeliness of prenatal care and 5%+ improvement in timeliness of postpartum care for enrollees in UHC C&S's Healthy First Steps High Risk program
- Positive birth outcomes (+7% increase in timely prenatal appts, +14% increase in comprehensive postpartum visit, -35% decrease in NICU) for UHC C&S members utilizing doula services
- Provided 180 scholarships ($198K total investment) to two equity-focused doula training and certification organizations supporting workforce development
- $500K provided by UHC C&S to fund 11 OB Emergency Trainings to support rural and critical access hospital competence and comfort in managing OB emergencies with community partners

Non-emergent rides/transportation:

- 2.6M C&S rides (legs) for 2023 (between both vendors MTM and Modivcare)
  - Modivcare: 2,170,254 rides
  - MTM : 435,000 rides
  - Total: 2,605,254

Quality and value-based care

MMC collaborates with providers to promote and support the transition from volume-based to value-based care models.

- In 2022, 73% of MMC states required MCOs to implement value-based payment (VBP) models with providers, and 65% of MMC states defined the types of VBP models that MCOs were required to implement[27]

Unlike FFS, MMCOs:

- Have the capacity and infrastructure to offer providers more risk-based alternative payment options
- Provide capitated or shared savings arrangements based on capabilities and patient populations
- Offer benefits such as increased potential earnings or stable cash flow

MMCOs also support rural providers through quality incentives and capacity payments that help expand technology such as telehealth and electronic health records.

State snapshot: North Carolina

In July 2021, almost **1.6 million** Medicaid beneficiaries in North Carolina transitioned from FFS to MMC. One year later, North Carolina for Better Medicaid, a coalition of dedicated health care advocates from across North Carolina, released a report demonstrating impressions among Medicaid beneficiaries.

82% of Medicaid beneficiaries say they have a favorable view of MMC[28]

68% of North Carolinians support Medicaid expansion[29]

4 MMC provides a positive, person-centered experience for members.

Support for enrollees to engage in care

MMC provides flexibility and scale to customize programs to meet enrollee and community needs.

MMCOs: Support providers through real-time data that helps manage patient care and identifies care gaps, proactively encouraging members to get care.

VS.

FFS: Do not have capacity or ability to offer the necessary level of support and expertise, placing burden on both providers and enrollees to seek out opportunities for care.

MMCOs have the capability to collaborate and innovate locally, integrating clinical care with social services to identify and address barriers that hinder individuals from achieving better health outcomes.

- **10-15%** of preventable morbidity may be the result of clinical care[30]
- **60%** of preventable mortality has social drivers of health (SDOH) as a factor

MMCOs frequently manage various coverage programs, such as Medicare and commercial insurance, and operate across multiple states and markets. This broad experience enables them to implement innovative programs, technologies and communication strategies that can be adapted to Medicaid programs, thereby offering enhanced services and value for both enrollees and states.

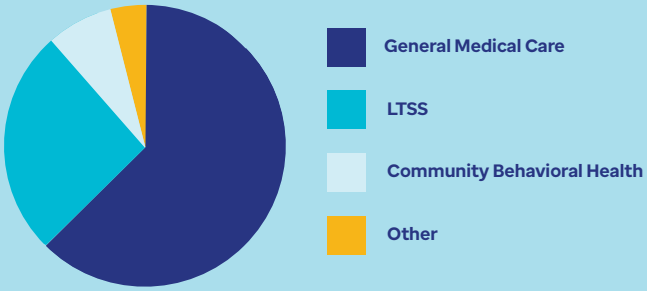
State snapshot: Virginia

Virginia's Medicaid expansion in 2019 had several positive impacts for newly enrolled Medicaid members, with more members using primary care (+18 ppts) and fewer members using emergency rooms (-14 ppts) and hospitals (-4 ppts).[31]

Building on this success, Virginia recently merged their Medicaid FFS and MMC programs into a single program that allows for improved care management.[32] This change enables more Medicaid members to access services including:

- Addiction and recovery services
- Behavioral health services
- LTSS in community and nursing facilities
- Maternal, newborn and infant services
- Medical and preventive services
- Transportation

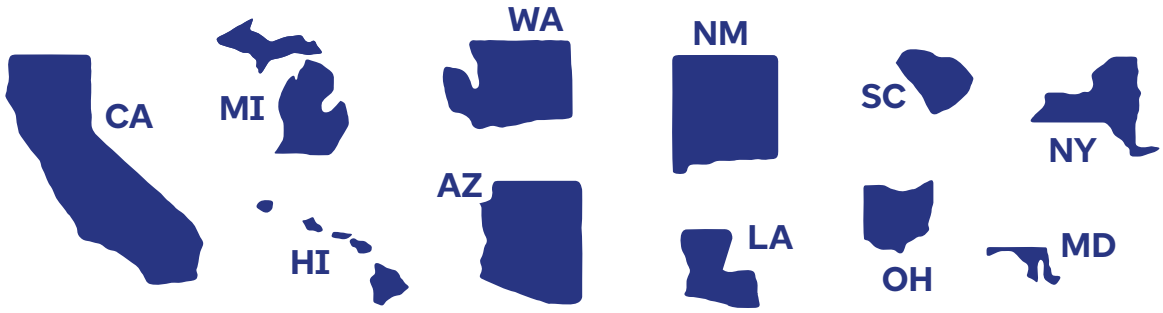
Virginia MCO Expenditures by Category[33]
(FY2023)



Enrollees in MMC programs have choice, which encourages competition between MMCOs and results in higher enrollee satisfaction.

Individuals are empowered to take control of their health care experience by comparing health plan quality, performance and customer service to select the most suitable program for their needs. In contrast, most Medicaid FFS programs lack comprehensive quality and experience reporting.

- 34 states have publicly available reporting on MMCO performance
- 11 states use quality performance measures as part of auto-assignment algorithms



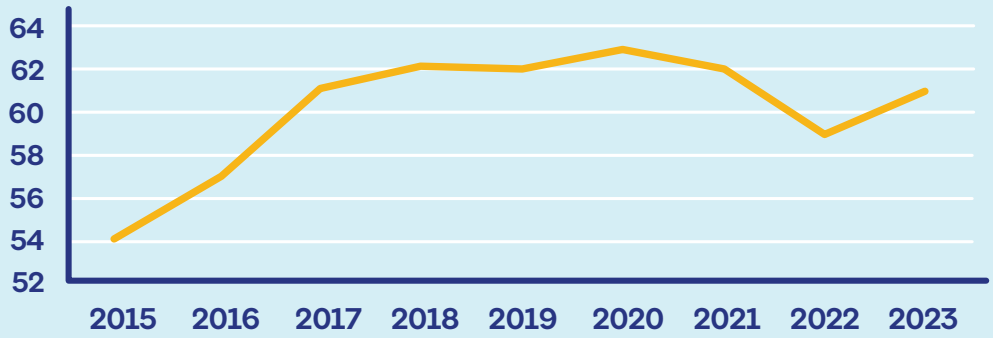
Approximately 80% of Medicaid recipients surveyed were satisfied with their health plan's overall performance, giving a "good" or "excellent" rating.[34]

MMC programs actively measure enrollee satisfaction and drive towards continuous improvement.

Average Net Promoter Score (NPS) comparisons:

- Drug stores/pharmacies: **43**
- Grocery/supermarkets: **36**
- Online shopping: **40**
- Banking: **34**

C & S Medicaid NPS Aggregate Score



Average NPS comparison:

Online Retailers: **40**
Supermarkets: **36**
Banking: **34**

5 Through MMC, states can address key public health issues and strengthen the Medicaid health safety net.

Partner in public health

Maternal health

Medicaid funds 41% of U.S. births; most are covered by MMC.[4]

MMCOs engage women in prenatal care, SDOH screenings and community resources. For UnitedHealthcare, this has included:

- ↓ **18% decrease** in total cost of care in baby's first 3 months for enrollees in UHC's Healthy First Steps program
- ↓ **5.7% decrease** in utilization of emergency rooms by Healthy First Step participants
- ↑ **$2.5M** provided by UHC to fund work in hospitals challenged by severe maternal morbidity and mortality and disparities in outcomes

Opioid epidemic

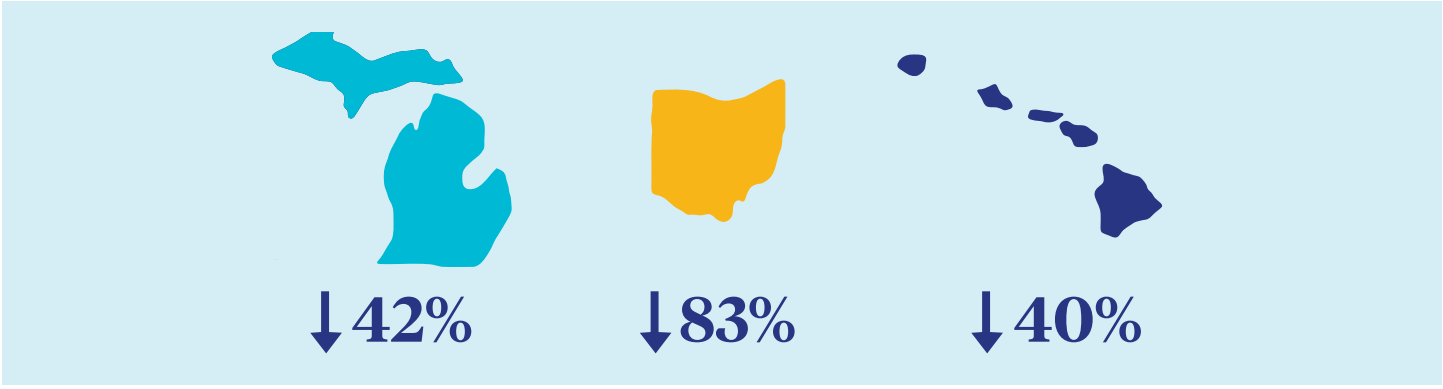
A study of Georgia's Medicaid population found that people using opioids in MMC had **69% lower odds of death** vs. those in FFS Medicaid.[35]

MMCOs collaborate proactively with states and CMS to prevent Opioid Use Disorder (OUD), mitigate adverse events associated with OUD and connect affected individuals to evidence-based treatments and supportive services. Efforts include:

- Point-of-sale pharmacy interventions
- Prescriber outreach and education
- Proactive member outreach

Health equity

MMCOs use comprehensive data and insights to create and deploy targeted solutions to address health disparities. When excess medical care expenditures and lost labor productivity are taken into consideration, inequities affecting racial and ethnic minoritized populations represent an estimated **$421–$451B** for U.S. society.[36]



UnitedHealthcare Community Plans launched initiatives to reduce postpartum disparities by closing gaps in care for Black women in Michigan, Ohio and Hawai'i.

Social supports

MMC works with neighborhood-level care providers and support organizations to improve the overall well-being of individuals and the communities in which they live.

- **75%** of MMCOs reported programs focused on reducing health disparities in 2023[37]
- **36 states** have SDOH-related policies required in MMC[38]

MCOs are most focused on identifying and addressing these social drivers of health:

- Housing
- Behavioral health
- Substance abuse
- Food security

How can MMC better address health equity?

- MMC has the potential to significantly advance health equity by offering comprehensive, coordinated care that addresses SDOH. By tailoring services to meet the diverse needs of Medicaid beneficiaries, MMCOs can improve access to quality care for underserved populations and low-income communities. These organizations can implement culturally competent care practices, integrate behavioral health services and provide community-based interventions to reduce health disparities. For more information on MMC and health equity, explore resources from the Centers for Medicare & Medicaid Services and the National Academy for State Health Policy.

- MMC collaborates with safety net providers and community-based organizations enhance the ability of Medicaid MCOs to engage members and serve members. Many MMCOs seek Health Equity Accreditation from the National Committee for Health Quality Assurance (NCQA).
    - As of August 2024, 17 UnitedHealthcare Medicaid plans achieved NCQA Health Equity Accreditation for meeting or exceeding rigorous requirements for health equity

What is the difference in cost/care/quality in private vs. nonprofit MCOs?

- Most private MCOs have a greater ability to pay for updated technology and medical equipment as well as better facilities. More advanced equipment enables better quality of care.[39]

- Those using non-profit MCOs may experience administration challenges and longer wait times for care

- Nonprofit MCOs are not required to offer services to individuals whose incomes are below the federal poverty level or to offer emergency care services to their local communities. Therefore, they can over charge in increasingly concentrated markets, resulting in consumers financing the very system that is over charging them.[40]

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