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Centene Corporation

Medicaid Managed Care Savings Meta-Review

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Prepared by:
Wakely Consulting Group, LLC

Taylor Pruisner, FSA, MAAA
Director and Senior Consulting Actuary

Sam Rickert, FSA, MAAA
Senior Consulting Actuary

Ryan Link, FSA, MAAA
Consulting Actuary

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Executive Summary

This report summarizes the results from Wakely's recent analyses of achieved programmatic savings in four different state Medicaid managed care programs. In each analysis, the capitation rates net of premium taxes were compared to estimated costs for those same members if they had been covered by traditional fee for service (FFS) Medicaid.

Across four Medicaid managed care programs encompassing a total of 30 rating years, Wakely found significant, and increasing, savings relative to estimated costs under a FFS program. These programmatic savings, taken with the ability to generate additional federal funding through premiums taxes, indicate that Medicaid managed care programs offer states significant financial benefits relative to use of a traditional FFS Medicaid model.

Wakely aligned results from the four programs by categorizing each rating year's results based on their relative duration since the implementation of managed care. Table 1 summarizes the net Medicaid managed care program savings for each durational year that was shared by at least three of the four Medicaid managed care programs.[1]

Table 1: Net Medicaid Managed Care Program Savings

	Low Estimate		High Estimate	
Duration Year	**Straight Average**	**Range**	**Straight Average**	**Range**
4	3.7%	-0.5% to 6.7%	5.6%	1.5% to 9.0%
5	4.4%	0.9% to 8.6%	6.4%	3.3% to 10.5%
6	5.7%	2.5% to 9.7%	8.0%	5.4% to 11.9%
7	7.5%	2.9% to 12.4%	10.0%	6.2% to 15.0%
8	9.8%	7.5% to 11.3%	12.8%	11.1% to 14.3%
9	10.3%	8.1% to 12.6%	13.7%	12.1% to 15.3%

Table 1 summarizes net programmatic Medicaid managed care savings, defined as programmatic expenditures under managed care versus estimated FFS program costs, which generally increased over time for duration years 4 through 9. Wakely observed a similar pattern for the other years included in the analyses (duration years 1 through 3, and 10 through 12). For states in which Wakely evaluated longer durational periods, we estimated savings levels as high as 15 percent to 18 percent in later years. The observed increases in savings are likely due to a ramp-up in management activities in the early years of a Medicaid managed care program followed by incremental improvement and innovation in management strategies over time.

[1] Note that durational year was calculated relative to the inception of the managed Medicaid program, but results include all populations and services included in the program at the time (i.e. results reflect populations and services that were carved into the program after inception). There were two common duration years (6 and 7) that were included across all four analyses and there were four duration years (4-5 and 8-9) that were each included in three of the analyses.

MCOs are able to achieve increasing programmatic savings over time through lower service expense trends and efficient use of administrative expenses. MCOs seek to keep service expense trends below those of unmanaged FFS programs through a number of health interventions and care management strategies including but not limited to: reducing inpatient readmissions, reducing the inappropriate utilization of the emergency room, increasing the proportion of vaginal deliveries, increasing pharmaceutical generic dispensing rates (GDR) and reducing inappropriate pharmacy utilization.

In addition to improving the quality and efficiency of care delivery in the Medicaid program, Medicaid managed care programs also enable states the ability to draw federal matching funds on state premium tax dollars which can provide additional financial support for their Medicaid program. Imposing the same tax on providers directly in a FFS program could be more politically challenging for states. Depending on the premium tax level, this can generally create 1 percent to 2 percent in additional savings for the state beyond the programmatic savings estimates shown in Table 1 and discussed earlier. Higher FMAP percentages result in increased benefits to the state as a result of premium tax dollars, all else equal.

Medicaid managed care programs also offer states an opportunity to partner with MCOs that have spent decades providing innovative care management, and often times have experience across several states and other industry sectors (Medicare and Commercial insurance).

Background, Definitions, and Programmatic History

In recent years, some state Medicaid agencies and other stakeholders have questioned the extent to which having a Medicaid managed care program results in budgetary savings to the state relative to fee for service (FFS) programs. Medicaid managed care programs enable state Medicaid agencies to work with managed care organizations (MCOs) to achieve the common goal of delivering high quality, efficient services to Medicaid eligible beneficiaries. MCOs achieve programmatic savings by promoting efficient use of the health care system and eliminating wasteful or inefficient spending by placing an emphasis on health outcomes, preventative care, managing members with chronic conditions, detecting and treating serious illnesses early, and focusing on health outcomes.

In addition to improving the quality and efficiency of care delivery, and providing value added services for members while creating programmatic cost predictability, Medicaid managed care programs also enable states the ability to draw federal matching funds on state premium tax dollars which can provide additional financial support for their Medicaid program. Managed care programs also allow states to transition a significant proportion of their administrative work to contracted MCOs.[2]

[2] Examples include, but are not limited to eligibility, claims processing, provider credentialing, dispute resolution, etc.

Between 2016 and 2018, Wakely performed analyses that evaluated the achieved programmatic savings of four different Midwestern and Southeastern state Medicaid managed care programs in which Centene participates. These four analyses included a total of 30 unique state/rating period combinations and over 418M member months.

We have been retained by Centene Corporation (Centene) to perform a meta-review of this past work, by reviewing and summarizing observations from these past analyses. The underlying analyses compare capitation rates for members enrolled in Medicaid managed care to estimated costs if those same members were enrolled in their respective state's FFS programs.

We relied on data provided by the MCOs within each state as well as capitation rates and rating documentation from state Medicaid agencies and their rate setting actuaries in performing these analyses. The following definitions and information may be helpful in understanding the various assumptions and methodology used in our analysis:

Capitation rates – Capitation rates are the monthly payments made to each MCO for Medicaid enrollees. In general, the state's actuary publishes capitation rates or rate ranges each year that vary by rate cell and geographic region. When rate ranges are used, the Medicaid agency and MCOs agree to contracted rates within the published rate range that may or may not vary by MCO from year-to-year. Risk-adjusted capitation rates were not considered in our analyses, as the composite risk level across all plans is typically 1.0.

Fee for Service Administrative Costs – We have assumed that each state's administrative costs to operate the FFS program are 2 percent higher than their administrative costs to operate the Medicaid managed care programs. This assumption is consistent in all four analyses reviewed for this report. Therefore, our savings estimates are approximately 2 percent higher due to the decreased state FFS administrative costs under Medicaid managed care programs.

Each of the four state Medicaid managed care programs analyzed are unique. The covered populations and services vary by state and impact the estimated savings in each state's analysis. Table 2 provides a comparison of the populations covered.

Table 2: Count of States Covering Each Medicaid Population

Population	# States Covering Population
Temporary Assistance for Needy Families (TANF)	All 4 states
Aged, Blind and Disabled (ABD)	3 of 4 states
Affordable Care Act (ACA) Expansion	2 of 4 states
Children's Health Insurance Program (CHIP)	2 of 4 states

Table 2 generalizes all covered Medicaid populations into four groupings. The included members within each population will vary from state to state based on the differing eligibility requirements and covered sub-populations within each state. For example, some states cover refugees, adopted children, and foster care children within the TANF population or individuals with breast or cervical cancer in their ABD population.

Additionally, states are considered to cover each population in Table 2 if they covered them at any time during the periods analyzed. Each population may not have been covered during the entire historical evaluation period. For example, one state carved-in their coverage of TANF adults approximately two years, and TANF children approximately four years, after implementing their Medicaid managed care program.

The list below provides some notable considerations related to the services covered in the four different analyses.

- Inpatient services were carved-out during the first five years of one state's program. These services were managed through an inpatient savings guarantee program for two of these five years.
- Pharmacy was carved out for approximately two rating periods during the earlier years of the Medicaid managed care program in one state.
- Behavioral health was carved-out during the first two years of one state's program. For another state, behavioral health services and non-emergency medical transportation costs were carved-out during periods analyzed and thus were excluded from our analysis.

Medicaid managed care has a long history in the four states analyzed. A review of the rate setting methodology from historical rating periods was necessary as the actuarial assumptions used to set those rates include the managed care savings required for MCOs to achieve targeted financial performance. The managed care savings adjustments applied by the states' actuaries indicate that managed care significantly reduces inpatient, outpatient, emergency room, and pharmacy utilization and pharmacy unit costs while increasing office visit utilization through member focused care in the most appropriate setting. To develop comparable FFS cost estimates following the implementation of the Medicaid managed care programs, we used rate setting information underlying the historical rating documents.

Methodology, Assumptions, and Results

Wakely estimated Medicaid managed care savings produced by the MCOs by comparing the calculated costs for these members to estimated costs for the same members if they had been enrolled in each state's respective FFS program. We performed the following steps to estimate the savings achieved for each period. Note that this general approach was applied for all four state-specific analyses unless otherwise specified.

(A) Calculate Medicaid managed care program costs to the state

Step 1: Determine aggregate capitation payments made to participating MCOs during each rating period net of taxes and fees. The state's actuaries develop capitation rates or rate ranges for each rating period. When rate ranges were published, Wakely collected data templates from each MCO that outlined their contracted rates throughout the history of the program. We then multiplied contracted rates (net of taxes and fees) by MCO-provided monthly enrollment for each rate cell and region. The capitation rates used in the savings analyses excluded taxes and fees as they represent offsetting cost and revenue items for the Medicaid managed care program.

(B) Estimate FFS costs for Medicaid enrollees had they not been in managed care

Step 2: Determine estimated baseline FFS claims costs by rate cell and region. FFS data was used as base experience for the initial rating periods of the Medicaid managed care program or initial rating periods following the carve-in of specific covered populations or services. As a result, baseline FFS claim costs are assumed equal to the managed care costs assumed in rate setting prior to the application of managed care savings for these periods. Historical FFS to managed care cost differentials were assumed to continue going forward. This includes adjusting implied FFS claims costs to remove the impact of MCO savings and administrative costs.

In instances where state actuaries developed ranges of projected costs, we assumed the weighted average MCO contracted percentile within the range represented the most appropriate aggregate actuarial estimates since these costs underlie what was ultimately paid out through capitation payments.

Step 3: Compare the composite MCO performance for the historical periods to the prospective claims per-member-per-month (PMPM) originally estimated by the state's actuary for those same periods. In two of the four states Wakely relied on medical loss ratios from MCOs' audited financial statements to determine actual performance. In the other two states, Wakely leveraged reported base data included in subsequent rating period documents to determine MCO performance.

If observed MCO costs are lower than estimated by the state's actuary, additional cost savings are accrued since prospective rates will be reduced. If the MCO costs are higher than expected, lower managed care cost savings will be accrued since prospective rates will be increased.

Step 4: Add assumed FFS administrative costs of 2 percent to estimated FFS claims costs as mentioned above.

Step 5: Apply the 0.5 percent FFS versus managed care annual trend differential. Managed care trends are often lower than those observed in an unmanaged FFS environment. As a result, we believe that it is reasonable, and possibly conservative, to assume that annual FFS trends would be 0.5 percent higher than those used in historical Medicaid managed care capitation rate setting. Wakely assumed a 0.5 percent annual trend differential in each analysis to develop the high end of our estimated range in MCO savings. The lower end of our ranges assumed no trend differential.

Savings estimates for Aged, Blind and Disabled (ABD) and Temporary Assistance for Needy Families (TANF) populations were both included in three of the four analyses reviewed. Wakely found that ABD savings were generally at or above the levels observed for the TANF population. Two of the programmatic analyses included an Affordable Care Act (ACA) Expansion population. Those analyses indicated savings levels for the ACA Expansion population that were generally consistent or above those states' TANF and SSI populations.

Final Savings Estimate

To develop the final savings estimates, we compared results of each state's Medicaid managed care program cost calculation (A) to the estimated FFS costs for these same plan enrollees had they not been in managed care (B). Subtracting (A) from (B) results in estimated dollar savings.

To estimate the savings for each rating period, we initially assumed that the base period experience used to develop capitation rates in each state already reflected estimated historical FFS-to-MCO managed care claim cost differentials. These differentials are based on composite MCO experience that generally conformed to projected costs developed by the state's actuary.

Additional State Funding Through Taxes

Similar to FFS, Medicaid managed care programs are eligible for matching funds from the Federal government at the Federal Medical Assistance Percentage (FMAP) rate applicable for the covered population and services. States have the option to implement premium taxes along with several other types of taxes to fund their Medicaid program.

Medicaid managed care regulations require that these taxes be included in the capitation rates paid to the MCOs. As a result, these taxes are partially federally funded at the applicable FMAP rate. However, the state retains the entirety of the tax receipts including the amounts funded by the federal government. These additional funds can then be used by states to help fund their Medicaid managed care program or other state budgetary obligations in future years.

Table 3 illustrates the calculation of this net additional funding to the state assuming a $500 PMPM capitation rate, 3 percent state premium tax, and a 75 percent FMAP.

Table 3: Medicaid managed care Net Premium Tax Funding to State – Illustrative Calculation

				Premium Tax Funding		Premium Taxes Received		
Capitation Rate	Premium Tax Rate	Premium Tax PMPM	FMAP	State	Federal	State	Federal	Net Funding to State
A	B	C = A*B	D	E = C*(1 - D)	F = C*D	G = E + F	H	I = G - E
$500.00	3.0%	$15.00	75.00%	$3.75	$11.25	$15.00	$0.00	$11.25

Table 3 demonstrates that with a $500 PMPM capitation rate, 3 percent premium tax and 75 percent FMAP, a state would generate $11.25 PMPM in net additional funding. The $11.25 PMPM represents 2.25 percent of the total capitation rate, and 9 percent of the state's share of the capitation rate.[3] Note that as the FMAP increases the net funding to the state increases, all else equal.

Standard FMAP rates vary by state and are computed from a formula that takes into account the average per capita income for each state relative to the national average. By law, these FMAPs cannot be less than 50 percent.[4] The Children's Health Insurance Program (CHIP) and the ACA expansion populations receive enhanced FMAP rates. The CHIP enhanced FMAP rates vary by state.[5] The ACA expansion population's enhanced FMAP rate is set at 90 percent for all states in calendar year (CY) 2020 and beyond. CHIP and ACA expansion populations generate a larger portion of net premium tax funding to the state than traditional Medicaid populations as a result of their enhanced FMAP rates.

In addition to the CHIP and ACA expansion populations, CMS also has exceptions for a number of other special territories, populations, providers and services which also receive enhanced FMAP rates.[6]

Disclosures and Limitations

Responsible Actuary. Taylor Pruisner, Sam Rickert, and Ryan Link are the actuaries responsible for this communication. They are Members of the American Academy of Actuaries and Fellows of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report.

[3] In the example presented in Table 3, the state's share of managed Medicaid capitation rate is equal to the $500 PMPM capitation rate times one minus the FMAP (1 - 75%), or $125 PMPM.

[4] Federal fiscal year (FFY) 2021 (October 2020 through September 2021) standard Medicaid FMAP rates vary by state between 50 percent (several states) and 77.8 percent (Mississippi).

[5] FFY 2021 CHIP FMAP rates vary by state between 65 percent (several states) and 88.4 percent (Mississippi).

[6] Refer to the Medicaid and CHIP Payment and Access Commission (MACPAC) website for a full listing of the standard FMAP exceptions: https://www.macpac.gov/federal-match-rate-exceptions/

Scope of Services. Unless otherwise explicitly indicated, Wakely's work is limited to actuarial estimates and related consulting services. Wakely is not providing accounting or legal advice. Centene should retain its own experts in these areas.

Intended Users. This information has been prepared for the sole use of the management of Centene and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary.

Risks and Uncertainties. The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use it and understand the results and the inherent uncertainty. Actual results will likely vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that Centene will attain the projected values included in the report. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

Conflict of Interest. The responsible actuaries and consultants are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to Centene.

Data and Reliance. Wakely relied on data provided by the MCOs within each state as well as capitation rates and rating documentation from state Medicaid agencies and their rate setting actuaries in performing these analyses. We relied on the accuracy of this documentation and the assumptions embedded in the rate development. If those assumptions differ from actual experience, then our estimates will be affected. Actual results will likely vary from our estimates.

We reviewed the results for reasonableness, but have not performed an independent audit or otherwise verified the accuracy of the repricing work. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Subsequent Events. There are no known relevant events subsequent to the date of information received that would impact the results of this report.

Contents of Actuarial Report. This document and the supporting exhibits/files constitute the entirety of actuarial report and supersede any previous communications on the project.

Deviations from ASOPS. Wakely completed the analysis using sound actuarial practice. To the best of our knowledge, the report and methods used in the analysis are in compliance with the appropriate Actuarial Standards of Practice (ASOP) with no known deviations.

Sincerely,

Taylor Pruisner, FSA, MAAA
Director & Senior Consulting Actuary
Wakely Consulting Group, LLC
720.226.9808 | taylorp@wakely.com

Sam Rickert, FSA, MAAA
Senior Consulting Actuary
Wakely Consulting Group, LLC
470.777.3535 | sam.rickert@wakely.com

Ryan Link, FSA, MAAA
Consulting Actuary
Wakely Consulting Group, LLC
704.560.3088 | Ryan.Link@Wakely.com