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NATIONAL HEALTH LAW PROGRAM

Fact Sheet # 3

Medicaid Managed Care: Financing

April 2012 update

Introduction

Managed care plans operate in 47 states and the District of Columbia; enrolling a total of 71% of all Medicaid enrollees. When Medicaid expands in 2014, many of the newly eligible enrollees are expected to enroll in Medicaid managed care plans. This series outlines the principles of managed care financing to help beneficiaries and advocates get the most out of Medicaid managed care and hold the plans and state Medicaid agencies accountable.

This Fact Sheet addresses the following topics: financing basics, estimating risk, managing financial risk, solvency protections, and physician incentive plans.

Financing Basics

The Law Says:

- Providers must accept Medicaid reimbursement as payment in full (42 C.F.R. § 447.15).
- Payment must be sufficient to assure quality care and a sufficient supply of providers (42 U.S.C. § 1396a(a)(30)(a)).
- Medicaid programs can shift their financial risk by contracting health services to private health plans (42 U.S.C. § 1395mm; 42 C.F.R. § 438.2).
- Plans that cover either inpatient hospital care and one other mandatory Medicaid service or three or more mandatory services may not discriminate on the basis of health status and are subject to auditing and inspections (42 U.S.C. § 1396b(m)(2)(a)).
- Managed care organizations must pay providers promptly (42 U.S.C. §1396a(a)(37)(A); 42 U.S.C. § 1396u-2(f).

There Can Be Problems:

- Rates for some providers are below cost.
- Capitation and other risk-based financing models do not guarantee significant savings.
- Managed care plans siphon Medicaid dollars away from system preservation and expansion towards executive salaries and stockholder profits.

- Inadequate rates increase potential for selection bias against needy groups, underservice to enrollees, and financial loss to providers and plans.
- Selection bias occurs when plans place quotas on the number of Medicaid patients they will accept; exclude specialists, tertiary care centers, and minority providers; use door-to-door marketers to scope out potential members.
- Late payments jeopardize smaller scale providers and may result in fewer providers willing to participate in Medicaid managed care.

Consumer Protections Are Needed Now:

- Medicaid rates should correctly account for population- and provider-based risk factors and maintain program integrity.
- States should not overestimate the potential savings of managed care.
- Medicaid contracts with health plans should comply with state competitive bidding requirements.
- State Medicaid agencies must contract only with high quality plans that receive national accreditation and meet federal Medicaid managed care standards.
- Medicaid participating plans must meet state department of insurance standards for HMOs.
- States should apply HEDIS provisions that require disclosure of information on financial stability.

Estimating Risk

The Law Says:

- Managed care contracts must specify the actuarial basis for capitation rates (42 C.F.R. § 438.6(c)).
- Payments to health plans under a risk contract may not exceed the cost of providing the same services on a fee-for-service basis (42 C.F.R. § 447.361).
- Medicaid agencies and managed care plans must provide sufficient patient encounter data to identify delivering providers and track services rendered (42 U.S.C. § 1396b(m)(2)(A)(xi)).
- Payments must be sufficient to provide quality care and an adequate supply of providers (42 U.S.C. § 1396a(a)(30)(A)).

There Can Be Problems:

Capitation based on a percentage of estimated fee-for-service rates (e.g. 95% of fee-for-service) may not:

- accurately reflect either the costs or savings that will be generated in a capitated system;
- account for the dramatic reductions in Medicaid inpatient days that managed care will create;
- predict the costs associated with areas of traditional underservice in fee-for-service setting (like mental health, adolescent services, and EPSDT);

- contemplate potential for states' financial assessments to be biased in order to receive or continue federal waivers;
- ensure that capitation fees go towards patient care rather than profits;
- account for the needs of people with chronic illnesses and people with disabilities in rate setting.

Consumer Protections Are Needed Now:

- Rates must account for population- and provider-based risk factors and move away from percentages of Medicaid fee-for-services payments.
- States should use retrospective modeling and analyze diverse outcomes based on various inputs to predict costs and savings of managed care.
- States should use encounter data extensively to reliably set capitation rates over time.
- States should structure medical forms to ensure collection of accurate encounter data.
- Capitation rates should be reviewed whenever services are added or deleted from the contract.
- Savings from managed care should go towards expanding Medicaid coverage, increasing outreach and education, and improving quality assurance procedures.
- State agencies should require health plans to spend a proscribed minimum of payments on patient care and report expenditures as separate line items.
- Rate-setting add-ons/withholds should be used to reward health plans with high quality care and penalize sub-standard plans.
- States should move cautiously when covering people with disabilities through managed car, adjusting capitation rates and using reinsurance and stop-loss protections.

Managing Financial Risk

The Law Says:

- Rates assigned by state Medicaid agencies must be sufficient to ensure access for the Medicaid population that is at least as extensive as access for the general paying population in the geographic area (42 U.S.C. § 1396a(a)(30)).
- State Medicaid agencies must ensure that payments to managed care plans are computed on an actuarially sound basis (42 C.F.R. § 438.6(c)).
- Risk-based contracts between Medicaid agencies and managed care plans must identify covered populations (42 C.F.R. § 438.6(c)).
- Plans that place physicians at substantial financial risk for services must provide adequate stop-loss protection (42 U.S.C. § 1396b(m)(5)(A)(v), *see also* 42 U.S.C. 1395mm(i)(8)(ii)(I)).
- Medicaid managed care contracts may include disease and service-specific stop-loss protections (42 U.S.C. § 1396b(m)(2)(A)(v); 42 C.F.R. § 438.6(c)(3)(iv)).

There Can Be Problems:

- Capitation payments are insufficient to guarantee access to necessary services, particularly for high-use enrollees.
- Rates inadequately account for increases in plan use by enrollees with special needs.
- High risk populations are exposed to adverse selection bias by Medicaid managed care plans.
- Carelessly defined carve-outs allow health plans to avoid responsibility by moving high-cost/high-need enrollees to carve-out groups.
- High-cost/high-need patients who do not choose a managed care plan but are automatically assigned to a plan are underserved.
- Risk adjustment formulas that ignore family risk factors like homelessness and linguistic differences create barriers to care.
- Some managed care plans use rates to enrich executives and increase shareholder value.

Consumer Protections Are Needed Now:

- Capitation payments need to be adjusted to reflect the health status of the enrolled population, especially people with disabilities.
- State agencies should protect against selection bias by, e.g., establishing risk corridors, requiring stop-loss protection, using retrospective allocations to adjust for increases in plan use by special needs populations.
- If states are going to carve out population groups and/or services, they must carefully define these groups/services and describe responsibilities with respect to them.
- States must work to develop comprehensive risk adjustment formulas which assess family risk factors along with medical risk factors.

- States should describe in payment formulas both allowable and non-allowable costs to be used when determining profit or loss.
- States should use strict accountability requirements for medical loss ratios that ensure that premiums will trickle down to providers and care.

Solvency Protections

The Law Says:

- States must obtain from each contractor proof of financial solvency and adequate protection against insolvency (42 C.F.R. § 438.6(c)).
- The Medicaid agency has the right to audit and inspect the books and records of a plan or its subcontractors relating to the plan's capacity to bear financial loss (42 U.S.C. § 1396b(m)(2)(A)(iv)).
- Plans must ensure that Medicaid enrollees will not be liable for the plan's debts if it becomes insolvent (42 U.S.C. § 1396b(m)(1)(A)(ii); 42 U.S.C. § 1396u-2(b)(6)).
- States must arrange for Medicaid services, without delay, for any Medicaid enrollees whose enrollment is terminated from a managed care plan (42 C.F.R. § 438.62).
- State Medicaid or insurance laws may require plans to maintain a certain net worth or minimum deposits (42 U.S.C. § 1396b(m)(1)(C)(i)).

There Can Be Problems:

- Medicaid payments can be used for expensive marketing campaigns and/or luxury items for plan owners. When people use services, the plan cannot cover the care.
- Some states do not hold Medicaid-participating HMOs to state insurance requirements.
- State Medicaid agencies and departments of insurance do not adequately enforce laws regarding solvency.
- Community health clinics can have a difficult time meeting reserve requirements.

Consumer Protections Are Needed Now:

- Federal solvency standards should be explicitly applied to Medicaid-participating managed care plans in their contracts and subcontracts with providers.
- Medicaid HMOs should be required to meet state department of insurance standards.
- State Medicaid agencies should enter interagency cooperative agreements with the state departments of insurance to ensure the rapid exchange of information and efficient use of staff.
- States should develop programs that ensure that solvency standards will not preclude community health centers from participating in risk-based Medicaid managed care programs.

- States should develop contingency plans to ensure that enrollees' care and access to services will not be adversely affected if their health plan becomes insolvent.

Physician Incentive Plans

The Law Says:

- Physician incentive plans include any compensation arrangements between managed care plans and physicians that may directly or indirectly have the effect of reducing or limiting services. (42 U.S.C. §§ 1396mm(i)(8)(B), 1396b(m)(2)(A)(x)).
- No specific payment may be made directly or indirectly to a physician as an inducement to reduce or limit medically necessary services (42 U.S.C. §§ 1396mm(b)(i)(8)(A)(i),1396b(m)(2)(A)(x); 42 C.F.R. § 438.6(h)).

There Can Be Problems:

- Physician incentive arrangements based on capitation, withholds, and bonuses can discourage rendering of needed services.
- Prior authorization practices spawned by financial incentives delay care, limit referrals for needed specialty care, and may deny necessary care.
- Physician gag clauses which prohibit discussion of financial arrangements taint the doctor-patient relationship.

Consumer Protections Are Needed Now:

- States must ensure that managed care plans do not make payments to physicians as an inducement to ration necessary services.
- Health plans must be discouraged from using insufficient provider payments.
- Health plans need to disclose to HHS, state Medicaid agencies, and enrollees whether and what type of incentives are utilized.
- Plans that place physicians at substantial financial risk must provide adequate stop-loss protection and survey enrolled enrollees to ascertain their degree of access and satisfaction with services.
- Medicaid agencies should require withholds to be structured so that providers are not penalized for caring for high need populations and should prohibit plans from placing providers at financial risk for preventive services, including EPSDT screens.
- State agencies should ensure that prior authorization policies are limited and time sensitive.
- Managed care plans should be prohibited from using gag clauses in their provider contracts.
- Health plans and providers should be required to disclose incentive arrangements to prospective enrollees - including the type of services providers are at risk for. Consumers should ask for this information and share it with their representative organizations.
- Disclosure of financial risks born by physicians should be one performance measure of a comprehensive quality assurance program.

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