Payment Policy in Medicaid Managed Care

As discussed throughout this Report, there are three primary arrangements through which states typically provide and pay for services in Medicaid managed care: comprehensive risk-based plans, primary care case management (PCCM) programs, and limited-benefit plans. Medicaid managed care payment amounts and methodologies to set rates vary depending on the scope of services and populations covered by these programs as well as whether the plans are at risk for the cost of services.

Medicaid managed care programs, including all comprehensive risk-based plans and many limited-benefit plans, often involve risk-based contracts, which are the primary focus of this section. Under a risk-based contract, the managed care plan assumes financial risk for the cost of covered services and plan administration; the plan could incur a loss if these expenses exceed the payments that the state makes to the plan. Other managed care arrangements may operate under non-risk contracts and therefore are not at risk for a loss based on the cost of services used by enrollees.

States typically pay for risk-based managed care services through fixed periodic (usually monthly) payments for a defined package of benefits. These payments are commonly known as capitation payments; they are typically made on a per member per month (PMPM) basis. Risk-based plans typically negotiate with providers to provide services to their enrollees, either on a fee-for-service (FFS) basis, or through arrangements under which they pay providers (e.g., primary care providers (PCPs)) a fixed periodic amount to provide services. In the case of PCCM programs, providers typically receive a small monthly payment to provide case management services to enrollees in addition to FFS payments for other care rendered.

This section:

- provides an overview of the federal statutes and regulations that govern states' payments to Medicaid managed care plans;
- describes various approaches to managed care payment; and
- explains how states determine capitation rates.

Statutory and Regulatory Overview

Federal statute requires that Medicaid payments be consistent with efficiency, economy, and quality; avoid payment for unnecessary utilization; and are sufficient to enlist enough providers (§1902(a)(30)(A) of the Social Security Act (the Act)). Additionally, the Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) added the requirement that capitation payments to risk-based managed care plans be made on an actuarially sound basis (§1903(m)(2)(A)(iii) of the Act).

Prior to 2002, federal regulations provided little guidance regarding actuarial soundness, limiting capitation payments to an upper payment limit (UPL) equal to the cost of providing the same services in FFS Medicaid to an actuarially equivalent population group (42 CFR 447.361 [repealed]). While the statute required the rates to be actuarially sound, the UPL placed more emphasis on setting a ceiling for rates rather than establishing a floor.

Under the UPL requirement, states used baseline FFS data to compare to expenditures under managed care. However, after several years of providing services through managed care plans for large segments of their Medicaid population, many states were finding it increasingly difficult to make meaningful comparisons to FFS Medicaid since recent FFS data were no longer available (CMS 2001). In addition the FFS data may not have been useful for comparison purposes. For example, FFS data may have reflected lower levels of preventive screenings and services such as vaccinations than were typical for managed care plans (American Academy of Actuaries 2005).

To address these issues, CMS replaced the UPL requirement in 2002 with regulations codifying the statutory requirement that states' capitation rates under risk contracts be actuarially sound (42 CFR 438.6(c)). The regulations require that state Medicaid managed care rates be developed in accordance with generally accepted actuarial principles and practices, appropriate for the population and services, and certified by qualified actuaries.

The regulations further require that, in setting actuarially sound rates, states must apply the following (or explain why the requirements are not applicable) (42 CFR 438.6(c)(3)):

- base utilization and cost data for the applicable Medicaid population or, if not, adjusted to make the data comparable to the Medicaid population;
- adjustments to smooth data and to account for factors such as medical trend inflation, incomplete data, and utilization;
- rates specific to eligibility category, age, gender, locality/region, and diagnosis or health status (if used); and
- other mechanisms and assumptions that are appropriate for individuals with chronic illness, disability, ongoing health care needs, or catastrophic claims, using risk adjustment, risk sharing, or other appropriate cost-neutral methods.

These requirements apply to comprehensive risk-based Medicaid managed care plans as well as risk-based limited-benefit plans, such as those providing only oral or behavioral health benefits.

States must demonstrate their compliance with the actuarial soundness requirements to CMS by documenting their rate-setting methodology and the base utilization data used to set rates. CMS staff use a checklist to verify states' compliance with these requirements. The checklist includes statutory and regulatory citations for specific requirements, descriptions of methods for complying with requirements, and a place for CMS staff to indicate whether or not requirements have been met. Sections covered by the checklist include:

- general requirements (e.g., actuarial certification, contracting process);
- base year utilization and cost data;
- adjustments to the base year data;
- rate category groupings (e.g., age, gender, locality);
- data smoothing, special populations, and catastrophic claims;
- stop-loss, reinsurance, or risk-sharing arrangements; and
- incentive arrangements.

A recent study by the Government Accountability Office (GAO) found that CMS' oversight of states' compliance with actuarial soundness requirements and data quality for rate setting could be improved (GAO 2010). The GAO noted that CMS used elements of the checklist inconsistently and that the depth of CMS reviews varied. CMS concurred with the report's findings and indicated that steps were already being taken to address them, including the development of new protocols, a revised checklist, and formal sub-regulatory guidance, as well as expanded data collection and quality reviews.

The American Academy of Actuaries (the Academy) is also working to improve rate setting in Medicaid managed care programs. Although no actuarial standard of practice (ASOP) applies specifically to Medicaid managed care rate setting, the Academy published a practice note in 2005 that defined actuarial soundness for Medicaid. Under this definition rates are actuarially sound if they "provide for all reasonable, appropriate, and attainable costs" that are incurred by plans (American Academy of Actuaries 2005). The Academy has also convened a task force to begin developing an ASOP for Medicaid managed care rate setting.

Non-risk-based managed care plans are typically paid a fixed administrative fee, rather than a capitation payment. These payments must be no more than what the state would have paid for services under traditional FFS plus the net savings of administrative costs the Medicaid agency achieves by contracting with the plan (42 CFR 447.362). Federal matching payments for administrative fees are limited to the federal matching rate for administrative expenses (typically 50 percent). However, the amount states pay for medical assistance under a non-risk contract is subject to the state's federal medical assistance percentage (FMAP).

Approaches to Managed Care Plan Payment

The approaches that states use for determining capitation payments to comprehensive risk-based plans depend on the methods that they use to contract with these plans. In general the following approaches are used to establish rates:

- **Administered pricing.** With administered pricing, capitation payments are determined by the state; plans determine whether or not they wish to apply for participation in the program.

- **Competitive bidding.** In this approach, states typically issue a request for proposals (RFP) and then select managed care plans based on an evaluation of their proposed rates and services.

States may also use hybrid approaches, such as setting a range of rates and then asking plans to bid competitively within that range, or negotiating with plans based on the administered pricing or their competitive bids.

Information on state contracting approaches is somewhat dated, with the most recent surveys of states occurring in 2001 and 2006. Based on the 2001 survey, administered pricing was the most common, used by 19 of the 36 states that responded. Ten states reported using competitive bidding, and seven states indicated that they negotiated with plans individually (Holahan and Suzuki 2003). In the 2001 survey, several states that had reported using competitive bidding in a 1998 survey had switched by 2001 to administered pricing. That trend continued in 2006, when a survey of states and plans found that only five of 21 responding states used competitive bidding (Catterall et al. 2006).

Administered pricing allows states to set rates at the lower end of an actuarially sound range, rather than having to accept a competitive bid potentially at the higher end of the range. States may use administered pricing, for example, when faced with budgetary limitations.

When considering whether to participate in Medicaid managed care, plans may also consider factors other than payment rates. For example, some states use auto-assignment to assign a portion of enrollees to participating plans. This could encourage plans to participate even at a potentially lower payment rate because auto-assignment assures that these plans are able to enroll a portion of those individuals that do not select a plan. Both statute (§1932(a)(3) of the Act) and regulations (42 CFR 438.52) generally require that enrollees be given a choice of managed care plans (there is an exception for rural area residents). However, states may auto-assign individuals that do not make a choice within specified time limits.

Rate Setting

In determining capitation rates, states and plans use data and adjustment factors to predict enrollees' use of health care services and the expected cost of these services. Setting rates typically involves consideration of a number of factors, including:

- baseline data;
- expected trends;
- state fiscal conditions;
- services that are carved out of managed care;
- payments in addition to the base capitation rate; and
- incentives.

Baseline data. Depending on the type of contracting method that a state chooses, states or plans typically set rates based on either FFS or managed care services and utilization data (known as encounter data) if available, or both. In general, when a state first establishes a managed care program, recent FFS utilization and spending data are available to estimate rates.

Over time, as more enrollees move into managed care and these programs become more established, current FFS claims are less available and less reliable as a benchmark for establishing capitation rates. Instead many states and plans have come to rely more on encounter data or aggregate spending by service type, as well as financial reports submitted by the plans, to project utilization and spending in the coming year. Depending on data availability and quality, states and plans may prefer to use encounter and financial data to reflect more

precisely the health status of and spending for individuals enrolled in managed care plans. States may also use a combination of FFS, encounter, and financial data.

Expected trends. States and plans establish capitation rates by trending baseline spending and utilization data (either FFS or encounter data) forward to establish an expected per member per month amount. Rates incorporate expected costs to administer the plan (including care management activities not routinely conducted under FFS) and may also explicitly allow for some profit margin for the plan.

Some states also adjust rates to account for efficiency factors. Efficiency factors adjust the capitation payment for services that managed care plans are expected to manage, thus creating an incentive to reduce the use of these services over time. Payment rates may be adjusted to account for better management of services, including reductions in emergency department (ED) services, unnecessary inpatient admissions, or the use of brand name drugs when a generic substitute is available.

State fiscal conditions. While rates are required to be actuarially sound regardless of state budget pressures, states have proposed reductions in managed care payments when faced with budget limitations. For example, states may set managed care rates assuming reductions in profit margins, marketing costs, and other factors. In addition to the decisions that states make directly about managed care rates, decisions about FFS provider payment rates can also have an indirect effect on managed care rates. For example, FFS rate reductions could result in a reduction in managed care payments in a state that bases managed care rates on FFS rates.

Carve outs. Payments to plans take into account spending for any carve outs or benefits that are excluded from the managed care program (e.g., behavioral health, transportation, oral health). Medicaid managed care enrollees may still be able to access these services through FFS Medicaid or through a limited-benefit plan that is contracted to provide these services.

Additional Payments. In addition to rate adjustments for carve outs, some states make additional payments for certain services to managed care plans, commonly known as "kick payments." These payments (often one-time, fixed payments) allow plans to cover particular services without assuming the financial risk for their use. The costs for these services are then excluded from the capitation rate setting process. Maternity kick payments are commonly made to Medicaid managed care plans as Medicaid is a major payer for these services. These kick payments minimize the financial risk to plans of women enrolling in plans late in their pregnancies. Most of the states surveyed in 2001 reported making direct payments to plans for the expected cost of maternity services (Holahan and Suzuki 2003). In some states these payments are increased for low birth weight infants. Some states also make kick payments for transplant services, rather than include the cost of these services in capitation rates.

Incentives. Some states also include incentive payments in their rate setting process. For example, the New York State Medicaid program may make incentive payments of up to 3 percent of per member per month payments to plans with high ratings on performance measures. Participating plans that earn the quality bonus may also be rewarded for high performance by receiving the auto-assignment of enrollees who did not select a plan upon enrollment (New York State Department of Health 2007).

Risk Adjustment

As previously mentioned, federal regulations (42 CFR 438.6(c)(3)) require states to account for the following factors (or explain why they are not applicable): eligibility category, age, gender, locality/region, and diagnosis or health status in their capitation rates and to apply techniques such as risk sharing and risk adjustment to account for individuals with higher health care costs. Traditionally states have adjusted plan payment rates for demographic factors such as those above, for example, by paying higher rates for older enrollees. Over time, however, demographic factors alone have been shown to be relatively weak predictors of spending and service use, especially compared to factors based on diagnosis and health care history (Winkelman and Damler 2008). A growing number of states have begun to adjust rates based on enrollee health status to reflect a plan's mix of enrollees and their expected care needs and expenditures.

Risk adjustment helps assure that health plans receive payment sufficient to cover the costs of delivering and arranging care efficiently without compromising quality and access. Ultimately, the accuracy of risk adjustment can affect plans' willingness to participate in Medicaid managed care, particularly for more complex populations (e.g., those dually eligible for both Medicaid and Medicare (dual eligibles) or those with disabilities and/or mental health conditions). These methodologies can also protect against creating unintended incentives for adverse selection or "cherry picking" healthier enrollees within some of these complex populations.

Risk adjustment uses a variety of factors including both demographics and health status to refine rates and to pay more for individuals who are likely to have higher health care costs. Some risk adjustment methodologies include health status information gathered from medical claims or encounter data to develop risk-based weights for a variety of different enrollees. Others use pharmacy data to risk adjust rates. Some of the methodologies used by states for risk adjustment include the Chronic Illness and Disability Payment System (CDPS), Adjusted Clinical Groups (ACG), Diagnostic Cost Groups (DxCG), MedicaidRx, and a Clinical Risk Groups pharmacy add on (CRxG).

While risk adjustment is a common practice throughout the private insurance markets and Medicare, there may be particular factors that need to be taken into account in developing accurate risk adjustment mechanisms for Medicaid. For example, Medicaid enrollees have a higher incidence of behavioral health issues than is prevalent in the general population. Regardless of whether behavioral health services are included within Medicaid managed care plan benefits, including the use of behavioral health services in the risk adjustment methodology may be helpful because mental health conditions can exacerbate other medical conditions (Winkelman and Damler 2008).

In the case of dual eligibles, because acute care services are primarily paid for by Medicare, risk adjustment techniques are specifically needed to estimate the use and costs of long-term services and supports in Medicaid. Wisconsin, for example, uses information on enrollees' activities of daily living, other characteristics such as level of care, and expenditures to develop payment adjustments (Kronick and Llanos 2008).

Risk Sharing

In some cases states have incorporated contract provisions in which the state shares some of the risk borne by managed care plans. These may include risk corridors, stop-loss or reinsurance provisions, and other similar arrangements.

BOX D-1. Challenges in Comparing Medicaid Managed Care Rates

It is difficult to compare Medicaid managed care rates across states and the results of such comparisons may not be informative regarding the appropriateness of rates. Studies have shown more than a two-fold variation in managed care rates across states (Holahan and Suzuki 2003); however, this does not necessarily mean that individual states are overpaying or underpaying for managed care services. Reasons for variation in managed care rates include the following:

- State programs include different benefit packages; decisions to include or exclude benefits such as prescription drugs and behavioral health services have a significant impact on rates.
- Programs that cover only lower-cost enrollees such as mothers and children have much lower rates than those that include older and/or disabled populations.
- In some states, maternity costs are included in the capitation rate while in others these costs are paid through "kick payments".
- Medical costs vary across states and affect the rates that plans are able to negotiate with providers.
- Other market dynamics, such as the number of practitioners competing for business, affect the rates at which plans are able to contract with providers.

As a result of these and other factors, Medicaid managed care rates can vary significantly without necessarily resulting in variations in actuarial soundness. However, the numerous factors that result in variation in rates also limit state and federal regulators' ability to evaluate the suitability of rates or to isolate the impact of individual cost drivers.

Risk corridors. In a risk corridor arrangement, plans may be responsible for absorbing only a certain percentage of losses if aggregate spending for services exceeds the plan's capitation payments. The state will reimburse the plan for the remainder of the losses. If, on the other hand, payments for services are less than the amount paid by the state in capitation payments, plans are able to retain the savings up to a certain percentage, beyond which they are required to return a portion of the savings to the state. Because risk-sharing techniques are required by federal regulation to be computed on an actuarially sound basis, there are federal limits on the amount of savings that plans can retain (42 CFR 438.6(c)(5)).

Stop-loss/Reinsurance. Some contracts also contain "stop-loss" or "reinsurance" provisions that protect plans from losses beyond predetermined thresholds on an individual basis (e.g., $50,000 in payments for a single enrollee). Beyond the specified threshold, states will assume some or all of the enrollee's cost of care. When states use such thresholds, capitation rates are adjusted to account for the reduced risk that the plans bear. Managed care plans may also choose to purchase reinsurance in the private market. As an alternative to stop-loss, states may keep enrollees with high-cost health conditions (e.g., hemophilia, HIV/AIDS) out of managed care programs to lower the risk borne by plans.

No up-to-date source of comprehensive information currently exists regarding the payment approaches, risk adjustment, incentives, and other arrangements used by states in contracting with comprehensive risk-based plans for Medicaid services. As part of the Commission's work to better define the Medicaid payment landscape, we plan to work to understand these methods.

PCCM Payment

Under PCCM programs, PCPs are typically paid a monthly amount (e.g., $3 per enrollee) to coordinate services and to influence the appropriate use of specialists and hospital services. These providers are still paid on a FFS basis for the medical services that they provide. Under a PCCM program, the state continues to bear the financial risk for the cost of services provided to enrollees, a key distinction between PCCM programs and risk-based plans.

Increasingly, states have been adopting a type of PCCM program generally referred to as "enhanced PCCM". In these programs states may provide incentive payments to promote quality, increased care coordination, and management of complex chronic conditions. For example, Oklahoma, Pennsylvania, and Indiana all use predictive modeling software to identify enrollees most likely to benefit from enhanced care coordination. Each of these states then seeks to coordinate care for a range of these enrollees' health needs, rather than focusing on individual conditions (Verdier et al. 2009).

BOX D-2. Implications of Upper Payment Limit Payments for Medicaid Managed Care

As discussed in the Commission's March 2011 Report, some states make supplemental payments to hospital and other institutional providers under FFS arrangements, above what they pay for individual services. States make these payments under the federal Upper Payment Limit (UPL) regulation (42 CFR 447) and claim federal matching dollars. These UPL supplemental payments may be a large revenue source for hospitals and other institutional providers, especially safety-net providers. These payments have implications for state expansion of Medicaid managed care. Since the UPL is based on only FFS days in a hospital or institutional setting, transitioning populations from FFS to managed care would mean fewer FFS days and lower UPL supplemental payments.

States have had to consider this potential reduction in supplemental payments and federal matching funds as they look to expand managed care to additional populations and services (McKethan and Menges 2006). According to federal requirements (42 CFR 438.60), services covered by Medicaid managed care plans must be considered "paid in full" through the capitation payment to the managed care plan. Thus, supplemental payments are not permitted within risk-based managed care.

If the shift in inpatient days from FFS to managed care is large enough, the loss of federal matching dollars for UPL payments can offset savings that may be realized through managed care, resulting in a net loss to states and a significant reduction in total payments to hospitals. This issue may be greater for more complex populations that use more days in an institutional setting, such as SSI enrollees. Because the UPL is based on the number of days of care, moving higher-use populations to managed care has a larger impact on UPL payments. On the other hand, enrolling populations like children and parents who typically use fewer inpatient days has less of an impact on supplemental payment amounts and has not been a major factor in enrolling these populations in managed care.

A few states have delayed implementation or expansion of Medicaid managed care because of the potential loss in federal matching dollars for supplemental payments, and in some cases have applied for Section 1115 waiver authority to address this issue. In 2005, Florida was granted a waiver that preserved some amount of their hospital supplemental payments. In Texas, the state carved out inpatient care from the Star Plus program to preserve supplemental payments and is developing a Section 1115 waiver to address this issue as part of a managed care expansion.

In addition to paying individual providers for services, some states have contracted with vendors to provide additional care management or disease management activities. Some states have also placed a portion of disease management payments at risk, based on the level of savings that vendors are able to achieve. Examples include Pennsylvania's Access Plus program and Texas' Medicaid Wellness Program.

A number of PCCM programs include HEDIS-based clinical quality measurement of PCPs and also offer performance-based incentive payments. Oklahoma includes a performance-based payment component for providers that meet quality targets in areas including immunizations, breast and cervical cancer screenings, generic drug prescribing, ED use, and inpatient admissions (OKHCA 2011). Pennsylvania's pay-for-performance program includes bonus payments to providers for supporting program participation as well as clinical measures in a variety of areas including chronic disease management, women's health, and pediatric health (APS Healthcare 2010). In Indiana, a portion of care management organization payments is withheld and paid out based on measures related to ED utilization, preventive care, and chronic disease management. A portion of these payments must be reinvested as incentive payments to providers and members (Verdier et al. 2009).

Recent Payment Provisions

The Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) as amended by the Health Care and Education Reconciliation Act (P.L. 111-152) includes several provisions that will affect Medicaid managed care payment. One provision requires states to pay 100 percent of the Medicare payment amount for primary care services provided by family medicine, general internal medicine, or pediatric medicine physicians participating in Medicaid during calendar years 2013 and 2014. Medicaid managed care plans must also make payments to physicians consistent with these new minimum payment amounts.

CMS also recently published a final rule implementing the PPACA requirement that states reduce or prohibit payments to providers for services that result from certain preventable health care acquired illnesses or injuries. The new rule requires states to include these payment restrictions in their managed care contracts (CMS 2011).

PPACA also includes provisions to encourage the use of health care service delivery models such as health homes and accountable care organizations (ACOs). The adoption of such models by states and their managed care plans may require modifications to existing payment approaches and, in some cases, the development of new approaches. The Commission will continue to examine these and other aspects of managed care payment moving forward.

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