Insight

Benefits and Challenges of Medicaid Managed Care

ROBERT BOOK | OCTOBER 19, 2012

On paper, Medicaid is the best health plan anywhere. It covers almost every imaginable service, with zero payment due from the patient. In practice, the reality of Medicaid is quite different. Patients have insufficient access to health care providers and lack of coordination and continuity of care, mainly because of low payment rates; despite this, states and the federal government face rapid growth in total program costs. Beginning in 1982 and accelerating in the 1990s, states began to address these problems by contracting with private health insurance companies to provide care for at least some Medicaid beneficiaries through capitated contracts with what became known as Medicaid Managed Care Organizations (MCOs). By 2010, these MCOs provided coverage for 53% of all Medicaid beneficiaries in 35 of the 50 states, plus DC and Puerto Rico. A new report (disclosure: by this author) details some of the benefits of MCOs and challenges in setting appropriate capitated payment rates.

Individual beneficiaries select the MCO plan of their choice, so to attract beneficiaries many MCOs provide additional benefits beyond what Medicaid requires. MCOs have the ability to provide some services that cannot generally be provided in the fee-for-service framework, such as disease management and innovations in care coordination. These additional services can significantly benefit patients. In addition, MCOs can improve access to care for beneficiaries. Evidence suggests that, compared to state-run fee-for-service, managed care can reduce overall Medicaid program costs, while providing better patient outcomes. A review by the Lewin Group of studies in 24 states found that all states studied experiences a reduction in per-beneficiary spending due to Medicaid managed care.

Actuarial Soundness

“Actuarial soundness” is the concept that the monthly rates paid are sufficient for a health plan to meet its obligations to its population, taking into account all necessary costs including patient care and necessary administrative costs, and the need to maintain reserves for high-cost years. This concept applies equally to commercial health plans as well as Medicaid MCOs. States regulate private health plans to ensure that rates are sufficient to meet their obligations to patients, in order to avoid a situation in which insurance companies offer low rates to attract customers, then go bankrupt leaving customers unprotected in the event that costs or utilization turn out to be higher than anticipated. Similarly, in the case of MCOs, there is a concern that in their desire to protect taxpayer dollars, state Medicaid administrators might set rates too low, driving MCOs into bankruptcy or encouraging them to limit care for patients in some way.

In the case of private plans, state insurance commissioners are charged with verifying that rates are certified as actuarially sound. Generally they require certification by a Member of the American Academy of Actuaries that the capitation rates meet the requirements of the Actuarial Standards Board. In the case of Medicaid managed care, the Centers for Medicare and Medicaid Services (CMS) is charged with approving rates states pay to MCOs based on an actuary’s certification that the rates meet the appropriate requirements.

Of course, actuarial soundness is much easier to define in theory than to evaluate in practice. Actuaries must

develop statistical estimates of patients' utilization of health care services, based on a variety of information including demographic and diagnostic information on the relevant population and assumptions or forecasts of how these factors may change over time. They must then combine these estimates of utilization with estimates of payment rates to produce a statistical distribution of required payouts. If complete and accurate information is unavailable, it might turn out that payment rates certified as actuarially sound *ex ante* might not turn out to be actuarially sound in practice, and could turn out to be inadequate *ex post*.

Setting Actuarially Sound Rates

The importance to beneficiaries of setting actuarially sound rates cannot be overstated. Clearly, overly generous rates would waste taxpayer funds. However, rates that are too low also carry substantial adverse consequences. For example, insufficient rates encourage MCOs to reduce payment rates to providers. This impairs access to care by making it more difficult to enroll providers and thus negates one of the main benefits of Medicaid managed care compared to Medicaid FFS. Low rates might also encourage MCOs to take steps to cut utilization below the optimal level, and cut back on services not required by the state plan, such as disease management, on-call nurse hotlines, and additional benefits. If MCOs are not able to make up the difference by reducing utilization, payment rates, and benefits, they may withdraw from the Medicaid program, or even go bankrupt altogether. And of course, if health insurers know that rates will be too low, they may decline to enter the Medicaid business in the first place. As discussed above, it is critical for states to use the best and most relevant actuarial data available when calculating capitation rates.

In general, states have several options when it comes to setting rates. In order to prevent MCOs from "cream-skimming" by finding ways to disproportionately attract healthy enrollees, it is necessary to do some sort of risk adjustment. The idea is for the state to pay appropriately higher rates for enrollees who, based on their demographic or other observable characteristics, are likely to have higher costs, and likewise lower rates for those likely to have lower costs.

One way states accomplish this adjustment is to establish "risk cohorts" for patients with similar observable demographic characteristics and similar average health care needs. For example, the Medicaid-eligible population may be divided into cohorts based on age range, disability status, gender, and similar factors. A rate would then be established for each cohort. For example, there might be a rate for "age 18-45, female, non-disabled, TANF-eligible" and a different rate for "age 45-65, male, disabled." There could also be different rates for "infants" (age 0-1) and "children" (age 1-17). pregnant women, as well as different rates for residents of different parts of the state based on regional variation in costs.

Another approach is to do risk-adjustment at the individual patient level, based on known diagnoses for specific patients deduced from their past claims. In this approach, there would be adjustment factors applied based not only on demographic factors, but also on diagnoses such as diabetes, heart disease, and other conditions that affect costs in a somewhat predictable way. Because this requires detailed health information on individuals, patients new to Medicaid might have to be rated initially based on their cohort, and then re-rated after a period of time when their claims can be observed and analyzed.

In both approaches, the overall goal is to adjust payments based on factors not under the control of the MCO, but allow the MCO to control other factors that can result in better care at lower costs. Aside from setting adjustment factors based on beneficiary characteristics, most states set "take-it-or-leave-it" rate schedules for each cohort, and others negotiate individually with each prospective MCO.

Rate Basis

An important consideration is the choice of a fee schedule on which to base payment rates. It might be relatively straightforward to estimate (say) the average number of office visits in a particular rate cohort, but to convert this to dollars requires some sort of assumption about the price of office visits. While most states have price schedules for their Medicaid FFS programs, these prices may or may not apply to MCOs.

In many cases, complete and accurate information about the relevant population might not be available, requiring actuaries to make assumptions based on data for populations that are thought to be similar. For example, when a state begins a new MCO program, the data available may be based on that state's fee-for-service history. Estimates based on that history might turn out to be incorrect if, for example, it turns out that MCO enrollees differ from non-enrollees in systematic ways, if enrollment in an MCO changes patients' propensity to use health care services, or if MCO payment rates turn out to be significantly different from fee-for-service rates. The state's fee-for-service data might be supplemented by MCO data from neighboring or demographically similar states, but other states might have different supply conditions or different regulatory environments.

In the case of states with mature MCO programs, it may be possible to use utilization data from the MCO population (excluding the fee-for-service population, if any) to obtain more accurate actuarial estimates. However, relying too naively on data from existing MCOs can result in a feedback loop, as, for example, MCO provider payment rates are used to determine MCO capitation rates, which in turn affect provider payment rates.

If monthly rates are based on existing Medicaid fee-for-service payments combined with more optimistic utilization rates due to MCO services (such as disease management), there is the danger that monthly rates might turn out to be too low to overcome existing barriers to access. State Medicaid programs need to understand that access problems are partly the result of low payment rates, and MCOs must have the flexibility to retain some of the benefits of lower utilization in order to increase payment rates and pay for MCO services.

In addition, it is important that rates be based on the most accurate and complete utilization data available, keeping in mind that Medicaid utilization patterns may differ from those of private-sector health plans, and MCO utilization patterns may differ from those of Medicaid FFS programs.

Risk-Sharing

Setting specific per-patient monthly rates transfers the risk of statistical variation in health care needs from the state and the federal governments to the MCOs. While this is a benefit for the governments, it is a downside for the MCOs. As a result, MCOs must require rates that take into account, and compensate for, the additional risk that they take on..

A compromise between the two extremes involves risk-sharing, in which the Medicaid program and the MCO share the risk of variation in utilization outside a specified "risk corridor." For example, an expected utilization level could be calculated for a particular MCO based on its enrollment (including characteristics of its enrolled population). In the event that actual utilization exceeds the expected level by more than a specified percentage, the MCO would receive additional payments to make up for part or all of the difference. Conversely, if actual utilization is below the expected level by more than a specified percentage, the MCO would have to provide a partial refund to the Medicaid program.

Conclusion

Medicaid managed care has the potential to significantly improve access to health care and health outcomes for the Medicaid population. It may also have the potential to reduce program costs. However, these goals can be achieved only if payment rates are set at appropriate, actuarially sound, and sustainable levels. Policymakers are understandably concerned that high payment rates might result in above-market profits for health insurers who participate in Medicaid MCO programs. However, an excessive desire to cut rates and limit profit may be counterproductive, as it may reduce quality and access and drive health insurers out of the MCO business.

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