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Medicaid Managed Care: What's Ahead in 2015



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Managed care is the dominant delivery model in state Medicaid programs, and is rapidly growing with the Affordable Care Act bringing over 8 million new beneficiaries into Medicaid in 2014. Today, 39 states (including the District of Columbia)¹ enroll beneficiaries in comprehensive managed care plans and

¹ Paradise, Julia. Kaiser Family Foundation, *Key Findings on Medicaid Managed Care: Highlights from the Medicaid Managed Care Market Tracker*, (Dec. 2014), available at <http://files.kff.org/attachment/key-findings-on-medicaid-managed-care-highlights-from-the-medicaid-managed-care-market-tracker-report>.

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more than half of all Medicaid beneficiaries are now covered through such plans.² Medicaid managed care will enter a particularly dynamic period in 2015 as Medicaid enrollment surges, more services and populations move into capitated arrangements, states try to marry managed care with value-based purchasing initiatives, and the Centers for Medicare & Medicaid Services (CMS) issues the first new major Medicaid managed care regulation in a decade.

This article highlights emerging trends in Medicaid managed care and considers their implications for health plans, providers, states and beneficiaries.

New Populations in Managed Care

Initially, Medicaid managed care focused on serving mothers and their children: a relatively young and healthy population. As states have gained experience with health plans, states are increasingly shifting their medically needy and higher-cost beneficiaries from fee-for-service to managed care.

In recent years, many states have moved beneficiaries with serious mental illnesses along with the mental health services they require into managed care. While the integrated model is gaining favor,³ some states continue to carve out mental health services, relying on contractual linkage requirements to overcome care silos. States are likewise beginning to shift individuals with substance abuse disorders and also the develop-

² Kaiser Family Foundation, *Medicaid Moving Forward*, (Jan. 2015), available at <http://files.kff.org/attachment/factsheet-medicaid-moving-forward>.

³ See New Mexico Human Services Department, Centennial Care 1115 Waiver Amendment Request, (Apr. 25, 2012), available at http://www.hsd.state.nm.us/uploads/FileLinks/f1a11ad705c94ea59ef5107bb672075a/Centennial_Care___Waiver_Submission_to_CMS.pdf.

mentally disabled into managed care, seeking to take advantage of both the care coordination and fiscal certainty promised by the best managed care programs.⁴

Beneficiaries who qualify for both Medicaid and Medicare are also being shifted into managed care. As of 2012, less than 15 percent of these dual eligibles were enrolled in managed care organizations (MCOs),⁵ but this too is changing. While state and federal policymakers have long sought to use managed care as a vehicle to reduce the disproportionate expenses incurred in serving dual eligibles, the presence of separate Medicaid and Medicare payment streams and rules has complicated the transition away from fee-for-service. CMS has sought to overcome this obstacle through its Financial Alignment Initiative, commonly referred to as the Duals Demonstration, under which dual eligibles enroll in a managed care plan that is responsible for covering both Medicaid and Medicare benefits.⁶ In October 2013, Massachusetts became the first state to begin enrolling beneficiaries into Duals Demonstration plans. Last year demonstrations began in California, Illinois, Ohio, and Virginia, and in 2015 Michigan, New York, South Carolina, Texas, and Washington are launching their programs. Almost 1.5 million people are or will be eligible for enrollment in Duals Demonstration MCOs by the end of 2015.⁷ Still, the ultimate success of the program has yet to be determined. Unlike most Medicaid managed care programs which mandate managed care enrollment for eligible beneficiaries, in order to comply with Medicare rules the demonstrations must give dual eligibles the right to opt out of enrollment. Notably, some states are reporting higher than expected opt-out rates.⁸

The enrollment of more vulnerable populations into managed care poses several challenges to states, beneficiaries, and plans. Some states and consumers express concern as to whether managed care is the most appropriate model for more vulnerable patients, noting that plans may impose more restrictions on care than states' fee-for-service programs. One potential answer is to carve out certain services from managed care contracts allowing enrollees to access them on a fee-for-

service basis. However, that solution has its own costs, as leaving important services out of a managed care contract makes it more difficult for plans to coordinate the care of patients who most need coordinated care. And, contractual linkage requirements are awkward at best.

From a managed care organization's (MCO) perspective, caring for these sicker populations may require developing expertise in new care management areas and contracting with new types of providers. And, states are imposing additional requirements on plans in an effort to assure positive outcomes for enrollees. For instance, New York requires Health and Recovery Plans (HARPs), which provide care to individuals with a serious mental illness or substance abuse disorder, to meet more extensive behavioral health staffing requirements than those imposed on other MCOs.⁹ HARPs must also contract with non-traditional provider types such as peer counselors. Under New Mexico's behavioral health integration, MCOs now must cover community health workers and methadone treatment.¹⁰ Structuring contracts with, and managing the services of, these new provider types may be a challenge for MCOs. MCOs must also become adept at navigating complex eligibility, care management and utilization review rules and regulations that have been specially developed for the new programs. The upcoming federal managed care regulations may impose additional requirements in this area.¹¹

Network Adequacy

The adequacy of MCO provider networks has recently received renewed attention at both the federal and state levels. Current federal Medicaid managed care rules on network adequacy are not prescriptive, requiring MCO networks to be "sufficient to provide adequate access" to covered services.¹² It is left to the states to define "sufficient"; not surprisingly, state definitions vary widely. For example, Wisconsin requires MCOs to include at least one primary care provider in their network for every 100 enrollees, while Delaware requires only one primary care provider for every 2,500 enrollees.¹³

These issues were brought to the spotlight in a report issued by the Department of Health and Human Services Office of Inspector General (OIG) in September

⁴ Deborah Bachrach et al., *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment*, The Commonwealth Fund, at 12-13 (Aug. 2014), available at <http://www.commonwealthfund.org/publications/fund-reports/2014/aug/state-strategies-behavioral-health>.

⁵ Deborah Bachrach et al., *High-Performance Health Care for Vulnerable Populations*, The Commonwealth Fund, at 16 (Nov. 2012), available at <http://www.commonwealthfund.org/publications/fund-reports/2012/nov/high-performance-for-vulnerable-populations>.

⁶ The Financial Alignment Initiative also consist of a managed fee-for-service model, under which states take a more active role in managing the care of dual eligibles. The managed-fee-for-service model is less common than the capitated model involving MCOs; so far only Colorado and Washington have received approval for the fee-for-service model.

⁷ MaryBeth Musumeci, *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS*, Kaiser Family Foundation (July 24, 2014), available at <http://kff.org/medicaid/issue-brief/financial-alignment-demonstrations-for-dual-eligible-beneficiaries-compared/>.

⁸ Howard Gleckman, *Why Are So Few Low-Income Seniors Enrolling in Managed Care Plans?* Forbes (Dec. 12, 2014), available at <http://tinyurl.com/lweme5a>.

⁹ Deborah Bachrach et al., *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment*, The Commonwealth Fund, at 14 (Aug. 2014), available at <http://www.commonwealthfund.org/publications/fund-reports/2014/aug/state-strategies-behavioral-health>.

¹⁰ Teresa A. Coughlin et al., *Are State Medicaid Managed Care Programs Ready for 2014?*, The Urban Institute (May 2013), available at <http://www.urban.org/UploadedPDF/412826-Are-State-Medicaid-Managed-Care-Programs-Ready-for-2014.pdf>.

¹¹ CMS seems particularly interested in developing new rules for the managed long-term care population. See Laura Joszt, *A Look at the Future of Medicaid and Rate Setting*, American Journal of Managed Care (Oct. 1, 2014), available at <http://www.ajmc.com/newsroom/A-Look-at-the-Future-of-Medicaid-and-Rate-Setting>.

¹² 42 C.F.R. § 438.206(b)(1).

¹³ Department of Health and Human Services Office of Inspector General, *State Standards for Access to Care in Medicaid Managed Care*, at 26-27 (Sept. 2014), available at <http://oig.hhs.gov/oei/reports/oei-02-11-00320.pdf>.

2014. The OIG found that access standards varied widely among states and were often not enforced. The OIG observed that states rarely conducted “secret shopper” surveys to determine if providers listed in MCO directories were actually serving Medicaid patients, and as a result, few states identified network adequacy violations.¹⁴ The OIG called on CMS to more strongly enforce network adequacy rules. Accordingly, it seems reasonable to expect that the new CMS regulations will provide more detail on network adequacy.

MCO Payment Rates

In 2010, the United States Government Accountability Office (GAO) issued a report criticizing CMS’s review of the capitated rates paid to MCOs.¹⁵ The GAO found that rate review practices among CMS’s regional offices varied significantly, with regional offices differing in their level of enforcement of federal requirements that MCO rates be “actuarially sound.”¹⁶ The GAO also concluded that some payments were made to MCOs without an actuary certifying that the rates were sound.

In response to questions about the rate review process, last year CMS began requiring states to submit information on the data used to develop capitation rates, the quality of that data, and assumptions and methodologies used to develop projections¹⁷ which is used by CMS’s Office of the Actuary to review state premium proposals.¹⁸ In addition, concerned about states’ lack of experience with the Medicaid expansion population, CMS issued guidance to states in 2013 on factors that states should consider in developing rates for the new adult population.¹⁹ It is anticipated that the new CMS managed care regulations will revise the actuarial soundness standards, codifying the Office of the Actuary’s role in rate review and signaling a more active role for CMS in determining actuarial soundness in the future.

Value-Based Purchasing

Managed care provides a framework for changing the economic model for delivering care to Medicaid beneficiaries. With a capitated payment, plans have the incentive to manage and coordinate care and the flex-

ibility to increase payment rates above Medicaid fee-for-service levels and deploy value-based provider payments. In practice, however, alternative payment mechanisms are not yet the norm, with most MCOs continuing to pay providers on a fee-for-service basis.²⁰

In an effort to hasten the transition away from fee-for-service, states are adding provisions to their contracts with MCOs that either require plans to adopt value-based purchasing arrangements with their providers or encourage them to do so. New Hampshire, for example, requires MCOs to participate in a “Payment Reform Plan” under which MCOs must share risk with providers, establish a pay-for-performance program, or undertake other “innovative provider reimbursement methodologies.” New Hampshire withholds one percent of the MCO’s capitation payments until the MCO can demonstrate it has achieved certain milestones related to the implementation of this reform plan.²¹ Minnesota requires its MCOs to share savings with Integrated Health Partnership (IHP) entities, provider organizations that serve Medicaid beneficiaries in the state and are similar to Accountable Care Organizations (ACOs).²² Under the Minnesota demonstration, if an IHP helps reduce costs and is therefore entitled to shared savings from the state, the MCO must pay for the portion of the shared savings attributable to the MCO’s enrollees in that IHP.²³ The program does not require MCOs to contract with IHPs, but it gives MCOs an incentive to work cooperatively with IHPs so that MCOs benefit from savings generated by the IHP.

These types of value-based contractual provisions are becoming more common in state contracts and CMS is likewise advancing them. New York is one of several states in the midst of implementing a Delivery System Reform Incentive Payment (DSRIP) waiver under which providers are given incentive payments to collaborate on patient care in ACO-like provider arrangements called Performing Provider Systems. New York has set a goal of requiring that 90% of managed care payments to providers use value-based purchasing methodologies, and CMS is requiring New York’s Medicaid program to amend its MCO contracts to require MCOs to “reward performance consistent with DSRIP objectives and measures.”²⁴

¹⁴ *State Standards for Access to Care in Medicaid Managed Care*, at 14.

¹⁵ Government Accountability Office, *Medicaid Managed Care: CMS’s Oversight of States’ Rate Setting Needs Improvement* (Aug. 2010), available at <http://www.gao.gov/assets/310/308487.pdf>.

¹⁶ See Social Security Act § 1903(m)(2)(A), 42 C.F.R. § 438.6(c).

¹⁷ Centers for Medicare & Medicaid Services, *2015 Managed Care Rate Setting Consultation Guide* (Sept. 2014), available at <http://medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2015-medicaid-manged-care-rate-guidance.pdf>.

¹⁸ See Virgil Dickson, *Reform Update: Actuarial Study Could Affect Medicaid Managed-Care Rates*, Modern Healthcare (May 27, 2014), available at <http://www.modernhealthcare.com/article/20140527/NEWS/305279964>.

¹⁹ Centers for Medicare & Medicaid Services, *2014 Managed Care Rate Setting Consultation Guide* (Sept. 2013), available at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2014-managed-care-rate-setting-consultation-guide.pdf>.

²⁰ In 2013, an analysis by Catalyst for Payment Reform found that only 11% of payments by all payers (not just Medicaid) were “value oriented,” with “value oriented” payments including shared savings, pay for performance, bundled payment, and full capitation. With the implementation of the ACA in 2014, that number jumped to 40% in 2014. Specific data on Medicaid MCOs, however, is not available. See Catalyst for Payment Reform, 2013 and 2014 National Scorecard on Payment Reform, available at <http://www.catalyzepaymentreform.org/how-we-catalyze/national-scorecard>.

²¹ See New Hampshire Department of Health and Human Services, *New Hampshire Medicaid Care Management Contract, SFY2015 at § 9*, available at <http://www.dhhs.state.nh.us/ombp/caremgmt/contracts.htm>.

²² See Minnesota Department of Human Services, *2015 Families and Children Contract*, at § 4.8.3, available at <http://tinyurl.com/4fb7g92>.

²³ For example, if an IHP is entitled to a shared savings payment of \$50,000, and 20% of the beneficiaries assigned to that IHP are enrolled in a particular MCO, then that MCO must pay \$10,000 to the IHP.

²⁴ Centers for Medicare & Medicaid Services, *Delivery System Reform Program Description and Objectives*, at § 39,

Direct Contracting with ACOs

Under a value-based purchasing system, MCOs still are at the center of managing care for Medicaid beneficiaries. Organizations such as Health Homes and ACOs may take on some of the responsibilities that have traditionally been carried out by MCOs, but MCOs retain primary responsibility for overall quality improvement and cost management.

In lieu of value-based contracting mediated through MCOs, some states are exploring alternative models under which the state contracts directly with an ACO or an ACO-like organization. Oregon adopted this approach in 2012, terminating its MCO contracts and instead turning to Coordinated Care Organizations (CCOs), ACO-like organizations comprised of providers and other entities that assume responsibility for providing care to the state's Medicaid beneficiaries. Following Oregon's model, Alabama plans to shift from a fee-for-service system to one that relies on Regional Care Organizations (RCOs), another type of ACO-like organization, in 2016. Both Oregon and Alabama turned to this model in an effort to cut costs and improve quality.

A key issue in administering the direct contracting model is determining when an ACO-like organization has assumed financial risk at a level where it should or must be regulated as an MCO. If an ACO assumes some downside risk for the cost of medical care, states will likely seek to impose minimum reserve requirements, which begins to blur the line between ACOs and MCOs. Alabama, for example, exempts RCOs from the insurance law and its reserve standards but nevertheless imposes separate reserve requirements on RCOs.²⁵ Similarly, New York has stated that if ACOs contract directly with the state and take on risk through capitation payments, they must be licensed as insurers and maintain minimum reserves.²⁶

Another question that must be answered is whether an ACO-type entity that does not lock beneficiaries into a contracted network can effectively manage cost and quality. If the "leakage" outside the ACO's network is substantial, the ACO may have limited control over how care is delivered to the beneficiaries for which it is responsible. To the extent states seek to address this obstacle by allowing ACOs to impose network restrictions on beneficiaries, the distinction between ACOs and provider-sponsored MCOs once again becomes murky.

Finally, even in the direct contracting model, there may still be an important role for MCOs. Providers lack expertise on many of the back-end functions associated with managing care, such as utilization review, member services, and appeals and grievances. ACO-like organizations have turned to MCOs to assist them with these tasks. In Oregon, some MCOs teamed up with providers to create CCOs; doing so allowed the CCOs to take advantage of the MCOs' existing provider networks and infrastructure.²⁷ Similarly, in Alabama, RCOs are estab-

lishing relationships with MCOs to provide administrative services.

The Medicaid Managed Care/Qualified Health Plan Continuum

While the ACA establishes a continuum of subsidized coverage for individuals with incomes up to 400% of the Federal Poverty Level, patients may be required to change health plans and providers as their income fluctuates above and below 138% of the FPL and they move from Medicaid coverage to Marketplace coverage and back again. States are pursuing different policies aimed at reducing the impact of churning. Arkansas and Iowa have enacted a "private option" for their Medicaid programs under which Medicaid-eligible expansion adults enroll in qualified health plans in the Marketplace, with Medicaid covering premiums and cost-sharing, thereby allowing beneficiaries to stay in the same plan even as their income fluctuates above and below Medicaid eligibility levels. New Hampshire and Utah are likewise pursuing this approach.

Plans have recognized the importance of having a presence in both the Medicaid and the ACA Qualified Health Plan (QHP) markets. Aetna, UnitedHealthcare and Anthem (previously known as WellPoint) continue to move more aggressively into the Medicaid managed care market. Traditional Medicaid managed care companies have similarly entered the Marketplaces. More than 40 percent of issuers offered both a Medicaid managed care plan and a QHP last year, and states may encourage more plans to offer products in both markets.²⁸

Efforts to address churning are likely to continue. CMS and the states may focus on aligning standards applied to Medicaid managed care plans and QHPs: if MCOs are required to offer the same provider networks in their Medicaid plans as they do for their QHPs, then beneficiaries who change plan types but remain with the same MCO will be able to see the same providers after the switch. States may also experiment with imposing the same quality standards on Medicaid MCOs and QHPs. And with states allowed to implement State Innovation Waivers starting in 2017, some states may seek to use those waivers to smooth subsidies across Medicaid MCOs and QHPs across benefits, cost sharing, provider networks, rates, and quality and care management requirements.

Conclusion

Medicaid managed care has changed dramatically over the last 15 years, and many of the issues that states confront today are very different than those that dominated the policymaking agenda when the Medicaid managed care regulations were last revised. With Medicaid managed care now playing a central role in our nation's health care system, more scrutiny from government—through new CMS regulations and other types of rulemaking—seems inevitable.

available at https://www.health.ny.gov/health_care/medicaid/redesign/docs/special_terms_and_conditions.pdf.

²⁵ Ala. Code § 22-6-51.

²⁶ 10 N.Y.C.R.R. § 1003.11.

²⁷ Deborah Bachrach et al., *High-Performance Health Care for Vulnerable Populations*, The Commonwealth Fund, at 14-15 (Nov. 2012), available at <http://>

www.commonwealthfund.org/publications/fund-reports/2012/nov/high-performance-for-vulnerable-populations.

²⁸ Association for Community Affiliated Plans, *Overlap Between Medicaid Health Plans and QHPs in the Marketplaces: An Examination* (Dec. 13, 2013), available at <http://www.communityplans.net/Portals/0/Policy/Medicaid/ACA%20Act/ACAP%20QHP%20Analysis%20Brief.pdf>.