Medicaid Cost Concerns: Managed Care and Challenges at the State Level

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MCOs: Cost, Access, and Quality

• Michael Sparer, RWJF study:
  • “There is little evidence of national savings from Medicaid managed care, but a few states have had some success. The states that did realize cost savings were more likely to be states with relatively high reimbursement rates under fee-for-service.”
  • “Medicaid managed care has had mixed success in improving access to care. There is some evidence of increased likelihood of a usual source of care and reduced emergency department visits, but pregnant women were generally no better off under managed care than in fee-for-service.”
MCOs: Cost, Access, and Quality

• Michael Sparer, RWJF study:
  • Cost:
    • Fee-for-service Medicaid low starting point
    • Delivery reforms unclear
    • Cost of regulatory and oversight infrastructure
    • Actuarial soundness req’ts lead to higher rates
  • Access / Quality:
    • Increasing access to primary care, decreasing utilization of inpatient / ER care
    • Limited networks
    • No evidence of care quality improvement

Recent Regulatory Changes

CMS Final Rule

May 6, 2016
Regulatory Changes

• Aligns regulation of Medicaid Managed Care plans to match Medicare Advantage (MA) plans and Qualified Health Plans (QHPs) sold on the ACA exchanges

• Network adequacy requirements (continuity of care requirements for transitions, LTSS adequacy requirements)

• Written quality strategies, quality ratings

• Procedural: Notice, internal review, external review

• Encourages states to implement new value-based payment models

• Enrollment protections (90 days to change plans)

• New program integrity requirements (screening for certain providers)
Regulatory Changes

• MLR Changes
  • Set medical loss ratio (MLR), direct regulation of actuarial value, at 85 percent, for rate periods starting on July 1, 2019
  • Plans that do not meet the 85 percent MLR give states ability to seek remittances (no federal remittance)
  • Studies have found about 75 percent of MCOs in 2015 had a MLR at or above 85 percent
    • The importance of defining quality improvement activities
“CMS intends to use our enforcement discretion to focus on working with states to achieve compliance with the managed care regulations when states are unable to implement new and potentially burdensome requirements of the final rule by the required compliance date”
Medicaid Managed Care Bidding Basics

• Regarding rate-setting and the bidding process, states can elect
  • **State-established / administered capitation rates** (fixed offer),
  • **Competitive bid capitation rates** (RFP), or
  • **Hybrid model** (range and soliciting bids)

• Considerations:
  • Must be actuarially sound (42 CFR 438.6(c))
  • States must give beneficiaries a choice of managed care plan (42 CFR 438.52), except in rural areas
  • Determining the estimate: Baseline data (FFS, financial data), trends, carve outs, incentives
Spotlights:

Illinois (Bidding, Reorganization / Access), Kansas (Access and Quality) and Iowa (Bidding, Access, and Cost)
Illinois

• Managed care “reboot”
• Seeking to expanding services and cap insurers, focused on Central Illinois
• Governor Bruce Rauner selected six carriers in August (down from 12)
• Complicated by Illinois’ budget crisis ($3 billion owed Medicaid managed care carriers)
• **Quality concerns:** the problem of finding beneficiaries $\rightarrow$ funds continue to flow per beneficiary (but miss quality benchmarks)
Illinois

- Legislature had concerns about bid procurement process (effort to make MCO bidding subject to Illinois Procurement Code)
- Bill that would have required competitive bidding process for Medicaid managed care was vetoed by Gov. Rauner on Oct. 13
- Rauner: legislation would cause duplication, add $1 billion in health care costs
- Override?
Criticizing Kansas, feds deny extension of KanCare privatized Medicaid program

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TOPEKA — Federal officials have rejected Kansas’ request to extend its privatized Medicaid program, KanCare, saying it has failed to meet federal standards and risked the health and safety of enrollees.

Kansas is “substantively out of compliance with Federal statutes and regulations, as well as its Medicaid State Plan” based on a review by federal investigators in October, according to a letter sent to the state Jan. 13 from the Centers for Medicare and Medicaid Services.

The state’s failure to ensure effective oversight of the program put the lives of enrollees at risk and made it difficult for them to navigate their benefits, the investigators found. They cited concerns about the program’s transparency and effectiveness.
Kansas

- CMS denied waiver and extension application in 2017 for CY 2018
- CMS: Kansas is “substantively out of compliance with Federal statutes and regulations as well as its Medicaid State Plan”
- Lack of compliance and oversight following federal investigation that put patient health and safety at risk
- CMS: Kansas allowed companies to create their own appeals process, failed to track critical incidents, unexpected death investigations
Kansas

- Lt. Gov. Jeff Colyer: “an ugly parting shot from the Obama administration at Governor Brownback on their way out the door. It is politically motivated pure and simple”
- **October 2017:** CMS approval subject to Obama administration corrective action plan (including data collection, network adequacy)
Did politics taint Iowa Medicaid bid process?

JASON CLAYWORTH jclayworth@dmreg.com 8:51 p.m. CT Oct. 29, 2015

A private company that ultimately won a contract to help manage Iowa’s $4.2 billion Medicaid program asked two former state lawmakers for assistance in determining who was on the committee that would be evaluating the bids and how it might influence their decisions, according to evidence presented in court on Thursday.

That company, WellCare, also sought information and received a response from a key member of Gov. Terry Branstad’s staff during a so-called “blackout” period when bidders were prohibited from making contact with state employees about the project, the documents show.

The evidence was submitted as part of a legal challenge from three companies — Aetna, Meridian and Iowa Total — who were not among those chosen to get the lucrative state contracts and who claim the public bid process behind the largest government privatization effort in state history was riddled with errors and nepotism.
Iowa

- WellCare allegedly “asked two former state lawmakers for assistance in determining who was on the committee that would be evaluating the bids and how it might influence their decisions”
- The lawmakers allegedly responded, including providing “best guesses” of who was on committee
- WellCare also was also allegedly in contact with members of Gov. Terry Branstad’s staff during bid “blackout” period

Iowa

- Aetna, Meridian, and Iowa Total sued based on the fact that the bidding process was “riddled with errors and nepotism,” lost the litigation, court found no abuse of discretion in selecting bids
- WellCare was ultimately selected as one of four companies to manage Iowa’s Medicaid program
- In the meantime, WellCare was removed from consideration for Iowa’s Medicaid privatization plan due to an alleged failure to disclose past false claims fines and a corporate integrity agreement as part of the bidding process (WellCare’s appeal denied)
Iowa

- Feds approved Medicaid privatization plan with multiple delays (concern about network adequacy, media continue to report that services have been cut)
- Medicaid privatization took place on Apr. 1, 2016
- July 2016: providers reporting payments were not being made on time
- By August, managed care organizations had lost tens of millions in six months (AmeriHealth Caritas, $42.6 million, Amerigroup Iowa, $66.6 million)
Iowa

- **October 2016:** state increased funding to the plans
- **February 2017:** amended the program to establish risk corridor arrangement with federal government
- **March 2017:** reportedly requested CMS to provide about $225 million to fund the risk corridors
- **March 2017:** Reportedly, managed care companies lost a combined, “catastrophic” $450 million based upon allegedly faulty projections
Editorial: Privatized Medicaid is worst prank ever

Saturday was the first anniversary of Gov. Terry Branstad’s Medicaid privatization experiment. On April 1, 2016, Iowa abandoned state management of the $4 billion health insurance program for more than 500,000 poor Iowans and hired three for-profit insurers to take over.

One year later, the entire ordeal is like an April Fool’s joke with no end.

The joke is on low-income Iowans who have lost access to health services. These include home-bound, disabled people (story/news/health/2017/03/16/disabled-iowans-say-medicaid-firms-cutting-home-help/99143798/) who rely on daily visits from caregivers.

The joke is on numerous health care providers underpaid or not paid by the managed care companies. These include an Iowa nursing home forced to borrow $150,000 (story/opinion/editorials/2016/07/16/editorial-providers-medicaid-nightmare-becomes-reality/87023948/) while waiting for reimbursements, a mental health facility owed $300,000 (story/opinion/editorials/2017/01/04/editorial-if-medicaid-fixed-issues-why-providers-still-owed-money/96108098/), and a family planning clinic that finally had no choice but to close (story/opinion/editorials/2016/11/17/editorial-branstads-medicaid-not-working-iowa/93927240/) its doors. One insurer recently notified patients (story/opinion/editorials/2017/03/16/editorial-profit-seeking-medicaid-insurers-vs-iowans/99132682/) it may stop covering services at Mercy Health Network, which has more than 200 hospitals and clinics across the state.

The joke is on taxpayers funding insurers’ administrative costs to the tune of hundreds of millions of dollars annually. Taxpayers will also bankroll the additional $130 million (story/news/politics/2016/10/31/branstad-pumps-33-million-more-into-medicaid-privatization/93052804/) Iowa agreed to pay MCOs in October after they complained about losing money.
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