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 then in fee-for-service."

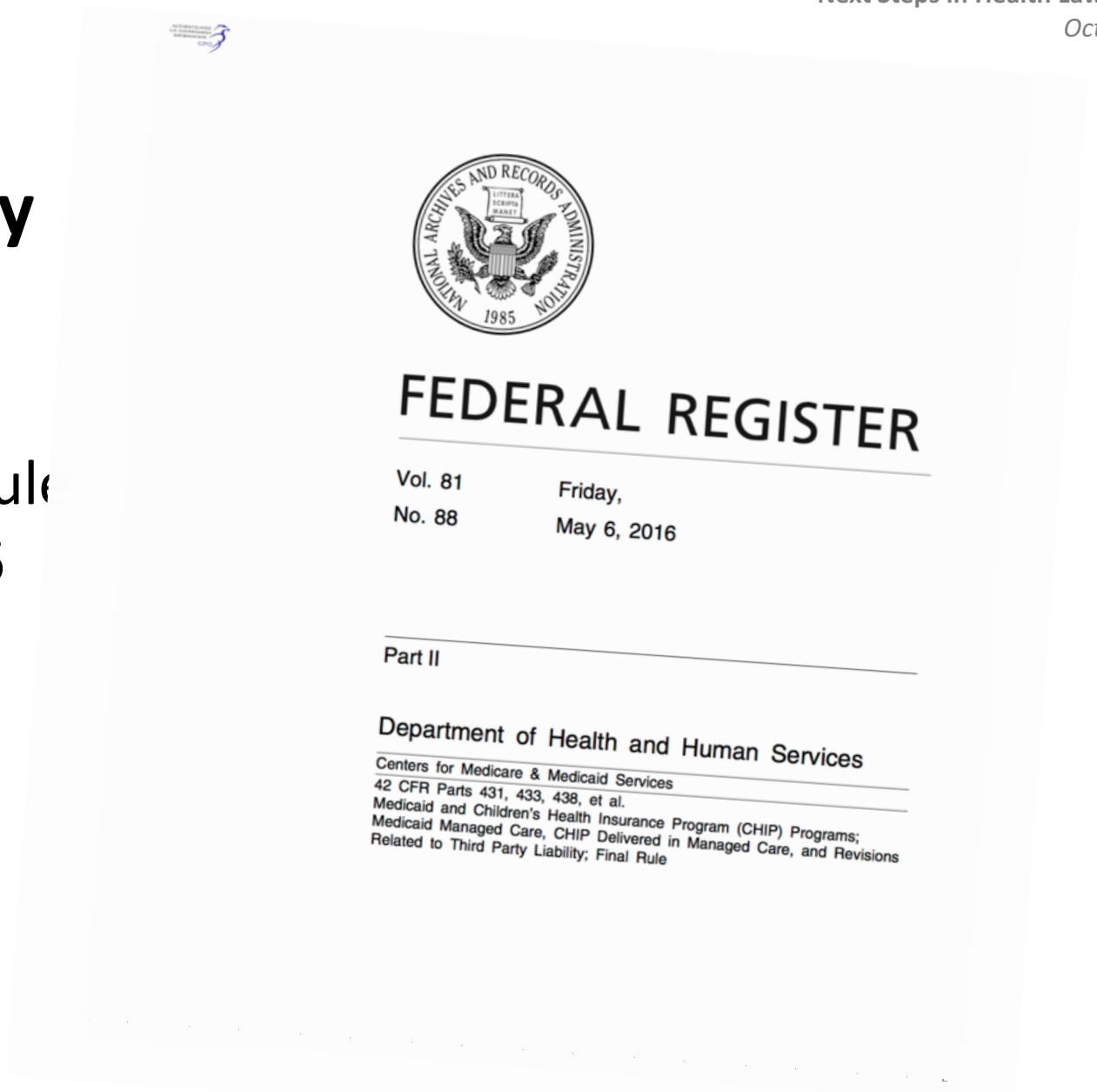
MCOs: Cost, Access, and Quality

- 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

Michael Sparer, *Medicaid Managed Care: Costs, Access, and Quality of Care*, RWJF, 2013, *publicly available* at http://media.khi.org/news/documents/2013/01/14/managed-care-rwjf.pdf.

Recent Regulatory Changes

CMS Final Rule
May 6, 2016



FEDERAL REGISTER

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Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services
42 CFR Parts 431, 433, 438, et al.
Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule

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

Regulatory Changes

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: June 30, 2017

FROM: Brian Neale, Director
Center for Medicaid and CHIP Services

SUBJECT: **Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates**

The Centers for Medicare & Medicaid Services' (CMS) Medicaid managed care final rule[1] includes several provisions that have a compliance date beginning with the rating period for managed care contracts that start on or after July 1, 2017. States and managed care plans are required to comply with these provisions; however, as states have noted, there can be administrative challenges associated with updating states' managed care contracts and operational procedures. These challenges can prevent timely compliance with the new July 1, 2017 requirements.

Health and Human Services Secretary Thomas E. Price, M.D. and CMS Administrator Seema Verma, MPH, issued a letter to the nation's Governors on March 14, 2017[2], affirming the continued HHS and CMS commitment to partnership with states in the administration of the Medicaid program and noting key areas where we will improve collaboration with states and move towards more effective program management. In that letter, CMS committed to a review of the managed care regulations in order to prioritize beneficiary outcomes and state priorities. Any modifications or changes to the Medicaid managed care final rule will generally necessitate rulemaking as required by the Administrative Procedure Act[3] (APA). However, while we conduct this thorough review, 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, particularly provisions with a compliance deadline of contracts beginning on or after July 1, 2017. This use of enforcement discretion will be applied based on state-specific facts and circumstances and focused on states' specific needs.

"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

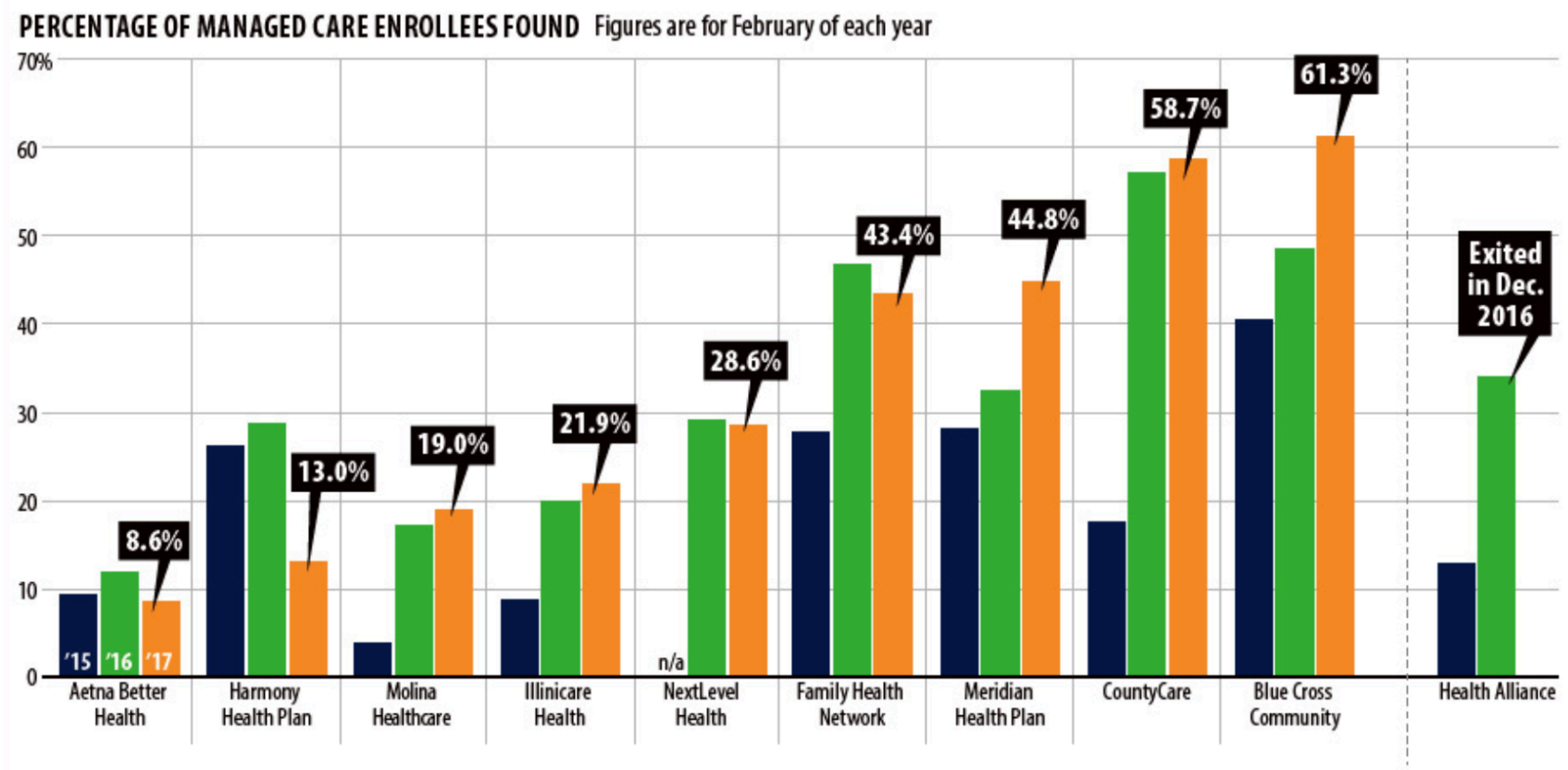
- Regarding rate-setting and the bidding process, states can elect
  - **State-established / administered capitation rates** (fixed offer),
  - **Competitive bid capitation rates** (RFP), or
  - **Hybrid model** (range and soliciting bids)
- Considerations:
  - Must be actuarially sound (42 CFR 438.6(c))
  - 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 → funds continue to flow per beneficiary (but miss quality benchmarks)



Source: Kristen Schorsch and Sabrina Gasulla, *The Problem in Illinois No One is Talking About*, Crain's Chicago Business, July 8, 2017, *publicly available at* http://www.chicagobusiness.com/article/20170708/ISSUE01/170709929/the-problem-in-illinois-no-one-is-talking-about

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?

Kansas

Criticizing Kansas, feds deny extension of KanCare privatized Medicaid program

BY BRYAN LOWRY
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AND HUNTER WOODALL
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JANUARY 19, 2017 10:45 AM

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.

AD ASTRA PER ASPERA
KanCare

January 19, 2017

Contact:
Angela de Rocha
785 806-7482

KANCARE RENEWAL PROCESS REMAINS ON TRACK

TOPEKA – Lt. Governor Jeff Colyer, M.D. today said and that the CMS decision to deny Kansas' request that the current KanCare program be extended for one year is politically motivated and that the findings of a CMS audit of KanCare, the State of Kansas' Medicaid managed care program, are largely without substance.

"This is simply an ugly parting shot from the Obama administration at Governor Brownback on their way out the door," Lt. Governor Jeff Colyer, M.D. said. "It is politically motivated pure and simple, and we expect this situation to be resolved quickly once the new administration in Washington comes into office."

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)

Iowa


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Did politics taint Iowa Medicaid bid process?
Jason Clayworth , jclayworth@dmreg.com
8:51 p.m. CT Oct. 29, 2015
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(Photo: Michael Zamora/The Register)
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.
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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

Jason Clayworth, Did Politics Taint Iowa Medicaid Bid Process?, Des Moines Reg., Oct. 29, 2015.

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

The Register's editorial 5:02 p.m. CT April 1, 2017

(Photo: Jason Clayworth/Register file photo)

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 now 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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