Medicaid Health Plan Rate Setting Recommendations:

An Enhanced Public/Private Partnership

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EXECUTIVE SUMMARY

The National Association of Urban-Based HMOs, Inc., (NAUMO) is a non-profit corporation, established in1993, comprised of health plans with a mission of service to vulnerable populations. Historically, many of these populations faced numerous inadequacies in the quality of care they received and sufficient access to providers, resulting in increased health risks and costs. Consequently, NAUHMO is committed to ensuring the highest level of care and service to these populations. The states' development and implementation of inadequate Medicaid payment rates, however, are undermining this commitment. **NAUHMO, on behalf of its members, is requesting that HCFA take a more proactive role in the oversight of the states' rate development processes for programs that cover Medicaid managed care beneficiaries.** This paper presents an overview of issues and recommendations related to the Medicaid rate setting process.

Inadequate payment rates are currently causing a crisis in Medicaid managed care. At an increased disadvantage are those health plans that are primarily located in urban and rural areas. Established and fairly new health plans are experiencing substantial losses on Medicaid which they are unable to sustain. Consequently, plans are exiting the Medicaid managed care market, placing an increased financial strain on those health plans remaining in the market. The dilemma is aggravated by states using rate setting approaches that appear to be driven solely by budget targets rather than actuarially determined costs of providing the mandated levels of services and benefits.

The impact of inadequate rates on health plans that serve Medicaid beneficiaries is enormous. It has a significant effect on the health plans' ability to: 1) maintain a desired level of managerial and administrative infrastructure; 2) recruit and contract providers; and, 3) manage the business to meet solvency and viability requirements. The effect of the rate inadequacy is also clearly demonstrated as commercial insurers are electing business strategies that restrict access for this vulnerable population. They are instituting caps on enrollment or simply exiting the market as a means to remain fiscally solvent. Community based not-for-profit plans with majority Medicaid enrollment (80-100%) are compromised in their ability to continue their community economic development initiatives as well as maintain their commitment to community health education and outreach campaigns.

In response to the issues related to inadequate rates, NAUHMO is suggesting several strategies and/or recommendations. First, NAUHMO proposes that the Health Care Financing Administration (HCFA) play a more aggressive role in reviewing the fiscal soundness of states' rate structures. Secondly, NAUHMO proposes that HCFA require states to open their rate setting processes to public scrutiny. It is believed that having an open rate setting process which involves all key stakeholders in a mandatory managed care initiative will produce a more fair rate as well as provide certain assurances to health plans to foster their stability in the marketplace. An improved rate setting process will facilitate a better product to serve Medicaid beneficiaries and build an enhanced public/private partnership.

ABOUT NAUHMO

The National Association of Urban Based HMOs (NAUHMO) is a non-profit corporation and a membership organization of health plans with a combined managed care enrollment of over one million Medicaid beneficiaries in urban and rural areas throughout the United States. Formed in 1993 (incorporated in 1995), the association's primary focus is to provide research, analysis and organized forums that support the development of effective policy solutions that promote/enhance the delivery of quality healthcare by organized health systems serving the needs of vulnerable and underserved populations.

The association initially coalesced around the issue of national health care reform, and as the debate changed from national health care reform to national managed care reform initiatives the areas of focus shifted to the changes in Medicaid managed care. In recent years, the areas of focus for the organization have included: review and comment on the proposed HCFA Medicaid regulations; research in quality measures for vulnerable populations in managed care; educational and training forums for member plans (i.e., Accreditation Readiness, Balanced Budget Act, etc.); training of minority managed care professionals in partnership with the American Association of Health Plans (AAHP); and partnering with various groups such as the National Black Caucus of State Legislators (NBCSL) and the National Medical Association (NMA) to provide education and training to ensure that community leaders and providers are "managed care" ready.

NAUHMO provides a unique and specialized voice in Medicaid managed care. Many association members have been in the business for over a decade, and a few member plans have been in existence for more than two and a half decades. Most NAUHMO members have Medicaid managed care experience in both a voluntary and mandatory managed care environment. Many association member plans grew out of primary care initiatives from the Federally Qualified Health Center (FQHC) environment and most continue to enjoy a partnership with Community Health Centers that extends beyond merely a contracted provider arrangement.

Several of the NAUHMO plans have distinguished themselves as community leaders by exemplifying creative community partnership initiatives and community investment. This leadership has garnered participating health plans' finalist status in the annual "Community Leadership Award" competition sponsored by AAHP. The Community Leadership Award was initiated by AAHP in 1996 as an incentive for, and opportunity to highlight, health plan initiatives that represent community investment, leadership and added value to the community at large in addition to benefiting their enrolled population.

Three of the NAUMNO member plans have been listed among the top 25 Medicaid HMOs in the publication, "InterStudy Competitive Edge," based upon the size of their Medicaid enrollment. NAUHMO compiled a database of enrollment data from the "The InterStudy Competitive Edge Part I: HMO Directory" (Issues 7.2, September 1997 which reflects HMO enrollment effective January 1997 and 8.1, March 1998 which reflects HMO enrollment effective July 1997) to perform its own analysis. Thus, NAUHMO found that of those plans that enroll Medicaid beneficiaries:

- Less than half, 43%, of the total 649 HMOs listed in the March 1998 InterStudy HMO directory reported Medicaid enrollment. For those plans that enrolled Medicaid beneficiaries, on average Medicaid accounted for 34.04% of total plan enrollment, as compared with on average >90% for NAUHMO health plans.

- There is a total of 31 multi-state chains (exclusive of the Blue Cross/Blue Shield Plans) that control over one-third (38.6%) of the nation's 7.4 million 1998 Medicaid managed

care enrollment. Inclusive of the 38 Blue Cross/Blue Shield health plans this number increases to over half, 58.34%, of the total chain control of Medicaid managed care enrollment.

- Just under half (43.39%) of the 281 plans reporting Medicaid enrollment are listed as "independents" or report no chain affiliation. The independents controlled 41.66% of the Medicaid managed care market. On average, Medicaid accounts for 43.52% of total health plan enrollment for those Medicaid plans reporting no chain affiliation.

OVERVIEW OF CURRENT SITUATION

STATEMENT OF THE PROBLEM

Member plans of NAUHMO have observed and are experiencing the inadequacy in the payment rates that is currently causing a crisis in Medicaid managed care. This dilemma is similar to that which is being evidenced in the Medicare managed care arena (i.e., health plans terminating their Medicare contracts). The net effect of this crisis is: 1) plans are exiting the business, and 2) plans that are staying in the business are struggling financially. Examples include:

- New Jersey, two-thirds of plans have left the Medicaid program;
- Pennsylvania, three plans have left the Medicaid program;
- California, several commercial plans have left the program, leaving the remaining health plans with inadequate rates. This situation has an even greater impact on non-profit Medicaid only/majority health plans;
- Georgia and Alabama have lost their only Medicaid HMOs;
- New York has commercial plans which have exited the Medicaid market and the Medicaid only plans are forced to accept inadequate rates;
- Chicago, Illinois, one of the Medicaid plans, Unity, pulled out of the market;
- Southeast Michigan, eight plans exited the Medicaid market;
- Mississippi, all plans have exited the Medicaid market; and,
- Tennessee, several plans have left or are now considering leaving the Medicaid program. Additionally, one of the three largest TennCare[sm] contracted plans is now in State receivership due to financial difficulty.

Inadequate rates are a function of the following two problems, the latter of which is the primary focus for NAUHMO's policy recommendations:

- UPL (Upper Payment Limit) calculations in states with high managed care enrollment are establishing payment ceilings that do not reflect the cost of providing care; and,
- States are using rate-setting approaches that do not reflect the cost of providing care.

CURRENT RATE SETTING STRATEGIES

States are using the rate-setting approaches that appear to be overly aggressive in predicting the level of cost savings that can be achieved by managed care. In both Pennsylvania and New York, for example, the states' rate setting approaches were subjected to a legislatively mandated independent review. In both cases, after actuarial review performed by Arthur Andersen Consultants, rates were determined to be set too low. The same was found to be true in Tennessee as reported by Coopers and Lybrand. In Michigan,

the Office of Management and Budget (OMB) found the competitive bidding process used to set their rates to be flawed.

Another strategy that is being questioned is the validity of the rate setting assumptions used in states that mandate HMO coverage for their Supplemental Security Income (SSI) populations. The concern is that often the states have presumed a level of cost savings that has not been substantiated by experience and thus, the assumptions prove to be very unrealistic. This results in contracting plans assuming risk without sufficient information, such as experiential historical benchmarks, to support their budgeting and planning processes.

NAUHO also has observed that even when it has been concluded and reported that the rate development methodology and/or assumptions are flawed and that the rates are inadequate, states are slow, and/or fail to react. As states acquire new information based upon experience with their managed care initiatives, there should be a process that incorporates such new and better information into the rate development process. This process should accommodate contracting plans both retroactively, when necessary and appropriate, and prospectively for subsequent contract years.

Another NAUHMO observation is that states are reluctant to share their methodologies and assumptions used to establish rates with the plans. This creates an impression among plans, providers and consumers that rate setting may be driven more by state budget needs rather than by actuarial soundness. In such "closed" rate setting environments, plans often are forced to accept rates without a complete understanding of the associated level of risk.

An equally critical point is that there appears to be a great deal of variation among states on how to account for key issues in their rate setting process. This variance leads to additional pressures as plans try to understand and truly maximize their rates of payment . This pressure is aggravated further for health plans having contracts in multiple states. If a more open rate setting environment were adopted, states would enjoy the benefit of an exchange of information that would better inform and enhance their rate development processes.

IMPACT OF CURRENT SITUATION

DIRECT IMPACT OF INADEQUATE RATES ON MEDICAID HMOS

Some plans are exiting the business and the plans that remain face a number of pressures that threaten their on-going participation. NAUHMO has observed the following three critical areas wherein these pressures threaten a plan's ongoing participation.

Managerial/Administrative: Inadequate rates affect the health plans' ability to establish, maintain and/or enhance its infrastructure such as information and phone systems. These rates also affect the health plans' ability to recruit specialized managerial talent for vulnerable populations and sufficient staffing for key service areas (i.e., for member services, marketing and claims processing). Inadequate rates often also result in staff reduction, consolidation and/or reorganization. In addition to these areas, the health plans in border states such as California, Florida, New York and Texas find themselves in a challenging position as they meet the needs of a more ethnically diverse population. The many complexities involved in these issues have a direct impact on health plan resource requirements and reinforce the need for adequate rates in order to fulfill the administrative requirements of the Medicaid contracts.

Although quality measures such as NCQA and HEDIS are critical to the success of our programs, the cost of such mandated measures should be reflected/included in the rates paid to plans in order to better ensure their implementation. In addition, many states have substantially increased the level of reporting required of health plans therefore increasing costs relating to administrative necessities without increasing the rate of payment. State capitation rates to plans should reflect the actual cost of providing care and mandated services as well as the cost of meeting quality standards and complying with reporting requirements.

Medical and Health Care Services: Inadequate rates affect health plans' medical and health services in the recital area of provider recruitment and contracting. A health plan's ability to effectively recruit and contract appropriate provider networks is affected by low/noncompetitive capitation to primary care providers and low/noncompetitive reimbursement to specialty and tertiary care providers. There is no incentive for the providers to service the Medicaid patients, thus the scope and capacity of the health plan's provider network is negatively impacted. In addition, inadequate rates do not support appropriate health plan medical and health services policy decisions (i.e., maternity length of stay).

Viability/Solvency: Inadequate rates affect the health plans' ability to manage the business (process and pay claims), meet regulatory and statutory net worth and reserve requirements, and in short to remain solvent. In many instances, plans have used investment income to subsidize their Medicaid programs. This subsidy, however, directly affects the financial capital available to plans to enrich provider network infrastructure systems, personnel staffing rates and other benefits and services available to the health plan membership/enrollment. Essentially, plans are forced to subsidize the government in providing care for this vulnerable population. This forces traditional commercial insurers with established ROI/ROE (return on investment/return on equity) profit mandates out of the Medicaid line of business and it forces traditional community based Medicaid plans completely out of business.

DIRECT IMPACT ON THE COMMUNITY AT LARGE

NAUHMO also has observed significant losses to the community at large when Medicaid health plans fail or leave the program. The following three areas demonstrate how the community suffers from the inability of a health plan to remain in the market.

Access to Primary Care and Other Health Care Services: When faced with increasing economic and regulatory pressures, commercial HMOs with a profit mandate may elect business strategies that effectively limit community choice and access to care. Such strategies may include: 1) pulling out of the Medicaid market when that product line adversely impacts the company book of business/profile; and/or, 2) restricting or capping their Medicaid enrollment level. Both strategies limit the community's choice of care as well as access to care.

Community based Medicaid health plans are often forced out of the market because of increasing regulations and decreasing funding. Just under one-half (43%) of the country's health plans have Medicaid enrollment and on average Medicaid is only 34% of a plan's total enrolment. By contrast, community based Medicaid health plans, such as NAUHMO's members, with a commitment of service to vulnerable populations as their core business, have Medicaid enrolment averaging more than 90% of their total enrollment. When these health plans are forced out of business, there is often no willing and able source of care for Medicaid beneficiaries. These vulnerable populations are finding themselves without choice as well as without care in some instances.

Community Economic Development: Many community based not-for-profit Medicaid health plans have served as major employers in the community and have invested in community education and

training through primary and secondary schools as well as colleges, universities and vocational training programs. Community based health plans have traditionally partnered with other community businesses, schools, social and civic service agencies and governmental agencies to implement innovative training and employment programs. Therefore, once these organizations leave the communities, there is a direct impact on not only the community development, but also on the job placement of those living in these communities. What gets lost is the residents' reinvestment in their own communities as they work and recycle the wealth and services their affiliation with these health plans afforded them.

Community Health Education and Wellness: Community based Medicaid health plans have developed, implemented and maintained community based outreach efforts providing health education and health screenings free of charge to the community at large (not just their members). Most health plans have done so not only on their own, but also in partnership with community health providers, social service agencies and civic groups. With the withdrawal of the Medicaid health plans, the community definitely suffers in the health education and wellness of the residents. Rate inadequacy leads to decreased access and reduction of necessary services, and ultimately to increased levels of illness in the community.

SUGGESTED RATE SETTING STRATEGIES AND RECOMMENDATIONS

There are two areas in which NAUHMO believes the rate setting process can be improved:

- Currently there is no standard mechanism for HCFA to conduct an in-depth review of a state's rate setting process. We propose that HCFA play a more aggressive role in reviewing the soundness of a state's rate structure.

- Currently rate setting is not a public process. Plans have a limited ability to review and comment on the rate setting assumptions used by the states. We propose that HCFA require states to open their rate setting process to public scrutiny.

Proposed HCFA Role in Rate Setting

NAUHMO suggests a more proactive role for HCFA to provide significant oversight in the states' rate development process:

- NAUHMO recommends that states be required to submit their proposed rates to HCFA for review and that there is a "concurrent review" of the proposed rates through an open public comment and review period. In this proactive oversight role, HCFA would reserve the right to reject those proposed rates that do not evidence actuarial soundness. HCFA would establish two separate rate development methodologies (with defined parameters for inclusion and exclusion, etc.) for the following two scenarios: 1) voluntary managed care, and 2) mandatory managed care. NAUHMO also proposes that HCFA play an oversight review role in the competitive bidding process wherein managed care organizations as prospective contractors bid against undisclosed state-established target ranges.

- NAUHMO proposes that HCFA have an established standard time frame for review of state rate submissions and that the HCFA review provide a definitive response as to the rejection or non-rejection of rates.

- NAUHMO proposes that HCFA require that states submit rates for review and approval at least one quarter in advance of contract renewal in order to allow sufficient time for HCFA review and concurrent public review, of rates, as well as to allow health plans sufficient time for their budgeting processes.

ESSENTIAL ELEMENTS IN A HCFA RATE REVIEW PROCESS

NAUHMO proposes that HCFA review the following key elements associated with a state's rate submission:

- Do the rates adequately reflect the cost of programmatic and administrative requirements that are not present in FFS?
- Are the states using plans' actual experience in establishing administrative cost and medical loss ratios? Many states exclusively use a "bring forward" of FFS approach ignoring significant plan experience related to the true cost of meeting the state's contractual requirements.
- Have the states documented the managed care cost savings assumptions through state specific evidence or research of other states' experiences?
- Have the states documented the underlying assumptions for cost trend factors? Have they compared those assumptions with overall health plan marketplace trends in their markets?
- Have the states' rate setting processes accounted for new program changes or legislative mandates, and have they documented the basis of the cost projection of these changes?
- Have the states provided a mechanism to protect from the potential of adverse selection?
- Have the states required risk, adjusted rates or risk corridors when states mandate enrolment of the SSI population?
- Have the states considered "network-add on" capitation rates for provider networks with tertiary/academic components that tend to attract adverse selection?
- For consistency across states, and for ease of administration for multi-state contractors and health plans, HCFA should recommend a standard tool for risk adjustment methodology.

ISSUES & RECOMMENDATIONS RELATED TO REVISING THE UPPER PAYMENT LIMIT (UPL)

The calculation of the upper payment limit (UPL) is a critical first step in the rate setting process because it established the rate ceiling. But, as is the case of the development of specific rates, there is very little health plan, provider and consumer input and review. NAUHMO would like to present the following key issues and recommendations related to revising the UPL.

- NAUHMO recommends that the UPL be set by a three-member panel of independent actuaries – one appointed by the State; one appointed by the health plans; and one appointed jointly by the State and Plans. The UPL should reflect actual plan experience and include medical and administrative expenses.

- Alternatively, in states in which the majority of Medicaid beneficiaries have been in managed care for more than two years, we recommend that HCFA adopt market based "UPL" approaches that reduce dependence on outdated FFS data.

- NAUHMO appreciates the efforts of HCFA in addressing the Medicaid rate setting process through the drafting of a checklist, "Actuarial Soundness of Rates," for industry review and comment. NAUHMO supports AAHP (American Association of Health Plans) comments related to the checklist and looks forward to further discussion on this matter towards the development of the final draft and implementation of the checklist.

OTHER ISSUES

Even rates developed in an actuarially sound way may fail to predict the actual cost of providing services through a well-run managed care plan. In markets where aggregate plan losses exceed 2% of premium, NAUHMO recommends that HCFA both establish a retroactive rate review process and require that an independent actuary be engaged to review rates. If rates were found to be set too low, HCFA would require a state to retroactively readjust its rates accordingly, subject to any UPL restraints.

CONCLUSION

As the industry copes with the inadequacy of Medicaid rates and the pressures of providing care without compromising quality, NAUHMO health plans are taking a proactive stance. NAUHMO is recommending the discussed changes as a means to alleviate some of the burdens currently faced in the Medicaid managed care market. NAUHMO recognizes that without some change in either the rate structure or health plan cost adjustments or both, many community-vested health plans may be unable to continue their participation in the Medicaid program. As the states continue to lower Medicaid rates and even fewer dollars are available to spend on management of care, data collection comprehensive compliance programs and health outcomes reporting, it is imperative that these challenges are addressed now. Without these changes, the viability and solvency of many participating health plans will be jeopardized.

In closing, NAUHMO applauds HCFA's efforts in fostering a public-private partnership approach to managed care through open communication with health plans such as NAUHMO's membership. We believe that open communication, allowing for the mutual exchange of expertise, perspectives and information is essential to the success of Medicaid managed care initiatives and we look forward to future ongoing discussions with HCFA on critical issues.

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