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Why Per Capita Caps Aren't Just Managed Care for States

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The American Health Care Act (AHCA), as passed by the House of Representatives on May 4, 2016, would overhaul federal financing of state Medicaid programs, and for the first time, would cap federal Medicaid funding. Today, federal funding is guaranteed at a set matching rate for all allowable state Medicaid expenditures. By contrast, under the AHCA, states would receive a fixed allotment of federal dollars paid out through each state's choice of either a per capita cap or block grant.

As policymakers debate the potential implications of per capita caps, it has been suggested that per capita caps are really no different than Medicaid managed care—a concept with which states are fully familiar and well able to manage. This policy brief tests that hypothesis by examining the similarities and differences between the federal per capita cap and a state's per capita "cap" in Medicaid managed care spending.

The first and most obvious similarity between Medicaid managed care capitation rates and state per capita caps is that they are both structured as payments per member for a specified period of time (per month, in the case of Medicaid managed care, and per year, in the case of per capita caps). However, the two types of payments are designed to achieve different aims and employ substantially different methodologies:

- Medicaid managed care capitation rates are intended to be sufficient to cover the cost of services the enrolled population is entitled to receive, while promoting efficient and effective care. To that end, rates are adjusted to reflect demographic and regional variation in health care costs, as well as changes in covered benefits, emerging public health priorities, and new drugs or technologies (see Figure 1).
- Per capita caps are intended to ensure that federal Medicaid expenditures on the enrolled population do not exceed a set amount. Rates are fixed using base year spending and are trended annually by a national trend rate (see Figure 2).

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FIGURE 1. ESTABLISHING PER CAPITA AMOUNTS FOR MANAGED CARE ORGANIZATIONS

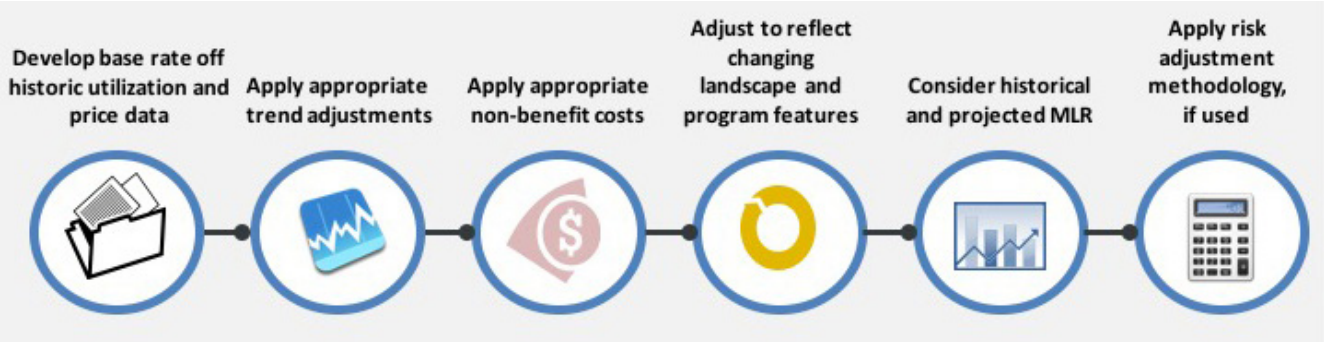
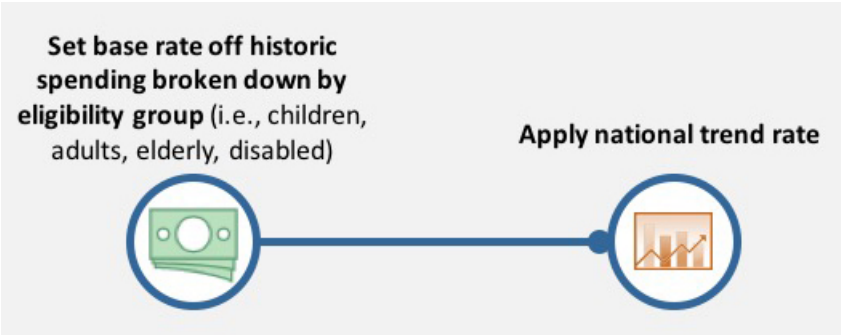


FIGURE 2. ESTABLISHING PER CAPITA AMOUNTS FOR STATES



The remainder of this paper outlines the specific ways in which Medicaid managed care capitation rates and per capita caps differ.

Key differences between Medicaid managed care rates and per capita caps

The statutory and regulatory parameters for setting Medicaid managed care capitation rates and per capita caps differ in several key respects. To compare the two approaches to capitation, we rely on the current Medicaid managed care regulations and the per capita cap methodology set out in the House-passed AHCA.

RATE ADEQUACY

- Managed care rates must be adequate, meaning sufficient to cover "all reasonable, appropriate, and attainable costs that are required under the terms of the contract."[1] In addition to the requirement that actuaries certify the rates as sufficient, medical loss ratio reporting, as is now required by federal rule, provides another check on adequacy. If the medical loss ratio is very high—100 percent or higher, for example—that suggests the rates are not sufficient.

- There is no requirement or guarantee that per capita caps be adequate to cover the "reasonable, appropriate, or attainable costs" of the state's Medicaid program.

RATING CATEGORIES

- Managed care rates are typically set at the "rate cell" level, defined by one or more characteristics including age, gender, eligibility category, and region or geographic area. While states are not required to establish rate cells, most do so to assure a higher degree of rate accuracy. Further, many states have multiple age bands, even within eligibility categories. Wisconsin and Washington state, for example, each have four age bands for children and three for non-disabled adults.[2] Additionally, almost all states use regional rates to account for differences in the cost of services across a state. This ensures that plans are not at risk solely due to the age mix or regional variation within their enrollee population—factors for which they cannot control.

- Per capita caps are set using a more gross approach, generally with no more than four or five rate cells—aged (anyone 65 or older), disabled, children (from newborn to age 18), adults, and expansion adults—set on a statewide basis, with rural and urban regions treated the same. Within each enrollee category, there are no separate caps to take into account the age of an enrollee, even though a 65-year-old and an 85-year-old in the aged category or a 2-month-old and a 12-year-old in

the children category may have vastly different medical costs. Similarly, the caps do not take into account within each enrollee category geographic variation in health care costs or disease burden.

ADJUSTMENTS

- Managed care rates are adjusted to take into account the evolution of the Medicaid program and the larger landscape in which the Medicaid managed care plan is operating. As a result, rates are revised to reflect new benefit requirements, new costs related to drugs and technological innovations, as well as changes in the state minimum wage, taxes, and fees.[3] There is no requirement that these changes be budget neutral across plans. This gives states the flexibility to increase managed care rates to reflect the launch of a new, expensive drug, like hepatitis C drugs, or to adjust to a public health emergency, like HIV or the opioid epidemic. In 2016, for example, Virginia increased its capitation rates to reflect new hepatitis C drugs available in the Medicaid program.[4] New York similarly provided a mid-year rate increase to account for unexpected costs related to new hepatitis C drugs.

- Per capita caps are fixed by Congress; a base year is selected and the per-enrollee costs in that base year are then trended forward by a selected national trend factor; as proposed in the AHCA, there is no adjustment beyond the annual trend.

AGE OF DATA

- Managed care rates must be based on data that is no more than three years old[5] to ensure that the data does not grow "stale" over time, no longer reflecting actual patterns of utilization.

- Based on the AHCA, per capita caps would be set using data from federal fiscal year (FFY) 2016 and FFY 2019. By the time per capita caps take effect in 2020, the initial data will be more than three years old, and it will grow increasingly stale over time.

TREND RATE

- Managed care trend rates are based on historical experience in the state's managed care program as the most accurate predictor of future medical expenses. The rules specify that "[t]rend must be developed primarily from actual experience of the Medicaid population or from a similar population."[6]

- Per capita caps would be trended using a national inflation factor, the medical component of the Consumer Price Index (CPI) (in the AHCA), that may bear little relationship to a state's actual trend experience. For example, between 2015 and 2016, the medical component of the CPI grew by 3.8 percent nationally, but by more than 5.3 percent in the Atlanta area and less than 2.3 percent around Denver.[7]

PREDICTABILITY

- Managed care rates are established by states prospectively, allowing them to allocate state funding for their annual Medicaid expenditures as part of their state budgeting processes and allowing plans to manage care within the capitation rates they receive.

- Per capita caps are retrospective; states would be required to establish their Medicaid budgets up to two years in advance of knowing their per capita caps for the year or the aggregate federal funding that would be available to support their Medicaid programs.

DURATION OF RISK TRANSFER

- Managed care rates transfer risk to the managed care plans for the duration of a contract. If managed care plans believe the rates are insufficient, they can decline to participate in the program in future years.

- Per capita caps are permanent and as such, result in a permanent risk transfer to states, absent an act of Congress to repeal the capped financing mechanism.

Conclusion

Medicaid managed care capitation rates and state per capita caps are intended to achieve different goals and, as a result, use substantially different rate-setting methodologies. Because of these differences, the historic success of Medicaid managed care programs provides little guidance on how states will fare under per capita caps. The experience with Medicaid managed care does not translate to managing a Medicaid program under a federal per capita cap. The similarities between the two begin and end with the fact that they are both "per capita" payments.

Endnotes

[1] 42 C.F.R. § 438.4

[2] For examples of Wisconsin's age bands, see here: *https://www.forwardhealth.wi.gov/WIPortal/content/Managed%20Care%20Organization/Providers/2014RatesPPACAContractAmendment.pdf.spage*. For examples of Washington state's age bands, see here: *https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=Report%20-%202ESHB%202376%20-%20Medicaid%20Managed%20Care%20Capitation%20Rates_b0f23295-8e28-4650-b40d-03b891f691c7.pdf*.

[3] 42 C.F.R. § 438.5(b)

[4] See Virginia's actuarial certification here: *http://www.dmas.virginia.gov/Content_atchs/pr/FY%2017%20Medallion%203.0%20Report%20and%20Exhibits%20HC%202016.07.27.pdf*.

[5] 42 C.F.R. § 438.5

[6] 42 C.F.R. § 438.5(d)

[7] Manatt analysis of Bureau of Labor Statistics, CPI-All Urban Consumers (Current Series), *https://www.bls.gov/data/*.