Medicaid Managed Care:

Perspectives of the National Association of Insurance Commissioners
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INTRODUCTION

Presently, nearly one quarter of all Medicaid beneficiaries receive their health care through a managed care arrangement. This movement toward managed care within the Medicaid program has occurred predominantly over the last decade. With its emphasis on early intervention and preventive care, many states have looked to managed care as a means to improve access to primary care and reduce reliance on emergency rooms as a site of care. In addition, many states have hoped that managed care would help contain spiraling Medicaid costs.

State insurance regulators, together with other state officials, have significant experience in regulating managed care plans which serve the commercial population. In fact, in several states, insurance departments have exclusive regulatory authority over these plans. In others, jurisdiction is split with state health departments, or retained within a separate state agency. In either case, oversight of plan financial solvency and market practices is frequently lodged within the insurance departments. The recent and expedited shift to managed care systems for the Medicaid population has raised numerous challenges for the state and federal government. State insurance regulators note that some of these challenges parallel early experiences and problems in the developing stages of managed care systems for commercial populations. Other challenges reflect the unique characteristics of the Medicaid population.

The knowledge gained from the establishment of managed care for commercial enrollees as well as earlier efforts in developing Medicaid managed care programs has provided insight into those regulatory requirements which are relevant for managed care programs for Medicaid beneficiaries. The similarities involved in developing managed care programs for enrollees whose care is supported with private or public sector funds, warrant considering the application of state licensure requirements to commercial plans serving the Medicaid population. However, the unique characteristics of the Medicaid population, may also require that requirements specific to the needs of the Medicaid population also be applied to Medicaid managed care programs. This latter set of issues goes beyond the traditional regulatory authority of state insurance departments.

In developing Medicaid managed care programs, states must consider a broad range of issues. In this white paper, the National Association of Insurance Commissioners’ (NAIC) State and Federal Health Insurance Legislative Task Force has identified several considerations primarily related to financial solvency, for policymakers involved in the design and implementation of Medicaid managed care programs. The paper also reviews changes to the Medicaid program which are currently under consideration by Congress and discusses their implications for state regulation of Medicaid managed care plans. The paper is not intended as an advocacy piece in favor of certain programs, nor does it seek to make any recommendations concerning the appropriate state regulatory body to oversee such programs. Rather, the paper seeks simply to identify and highlight areas within the expertise of NAIC members where careful and thoughtful planning and oversight are particularly warranted.

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1 Medicaid and Managed Care: Lessons from the Literature, Kaiser Commission on the Future of Medicaid at ix, 1995. (Hereinafter referred to as “KFF”)

2 Id. at 8 citing that in 1983 only three percent of the Medicaid population was enrolled in managed care.
Background

Medicaid is a joint federal and state entitlement program which provided payment for medical services to over 32 million beneficiaries in FY 1994. The program is state administered with the costs shared between the federal and state governments. The federal government provides matching funds at a percentage determined annually by the federal government generally based on each state's per capita income. Currently, the federal match for Medicaid services is set at a minimum of 50 percent and a maximum of 83 percent. Over the past few years federal funds have accounted for 57 percent of total Medicaid expenditures. Medicaid spending has increased from $41 billion in 1985 to $138 billion in 1994.

The states have broad federal guidelines to follow in determining eligibility and coverage standards, but each state designs and administers its own Medicaid program. Medicaid beneficiaries qualify for coverage when determined to be either categorically needy or medically needy. Categorically needy persons include those receiving Aid to Families with Dependent Children and most persons on Supplemental Security Income. All of the states cover individuals in those categories. More than 75 percent of the states also provide benefits to the “medically needy”; the “medically needy” are individuals whose resources exceed the income eligibility standards for the categorically needy but who meet a separate state determined income standard. The medically needy include pregnant women, certain children, the aged, disabled, families with dependent children and those persons who “spend down” their income and assets due to large health care expenses.

Because the Medicaid program is swiftly becoming most states’ largest budget item, averaging 19.4% of the average state’s total expenditures in 1994, states are implementing strategies designed to control Medicaid costs. According to recent surveys, states are reducing expenses for health care services by maintaining or diminishing reimbursement rates as well as curtailing covered services. States are also converting their programs to managed care. More than half the states responding to a recent survey are implementing or expanding managed care programs as a way to control costs while insuring quality and access.

While most Medicaid programs are still similar to fee-for-service indemnity insurance with the state and federal government at risk for expenditures, many states have begun to seek waivers from federal Medicaid requirements in order to experiment with managed care. Under Sections 1115 and 1915(b) of the Social Security Act, the Secretary of Health and Human Services may waive certain requirements to facilitate states’ use of managed care for Medicaid beneficiaries. The mechanism through which most states have enrolled Medicaid beneficiaries into managed care programs has been Section 1915(b) program waivers. Under Section 1915(b) waivers, the Secretary may waive the requirement that states

give beneficiaries freedom of choice of providers so that states may require Medicaid beneficiaries to enroll in managed care arrangements. States have also been granted Section 1115 research and demonstration waivers. Research and demonstration waivers provide states with greater flexibility than Section 1915(b) waivers, enabling them to change a broader array of Medicaid requirements such as those related to eligibility and the scope of services available. Section 1115 waivers also impose greater administrative burdens on states so that the federal government, through an independent contractor, can evaluate the impact of the demonstration project on such matters as utilization, cost of services, as well as access and quality of the care received. In addition to shifting the traditional Medicaid population into managed care, Section 1115 waivers enable states to extend Medicaid benefits to certain individuals and families not currently eligible for Medicaid coverage.

As of October 1995, 14 Section 1115 waivers have been granted, to Arizona, Delaware, Florida, Hawaii, Illinois, Kentucky, Massachusetts, Minnesota, Ohio, Oregon, Rhode Island, South Carolina, Tennessee, and Vermont. In November 1995, managed care demonstration waivers were pending in 12 other states, Alabama, Georgia, Illinois, Kansas, Louisiana, Missouri, Montana, New Hampshire, New York, Texas, Utah, and the District of Columbia. As of June 1995, all but a few of the remaining states have received Section 1915(b) waivers, in all or a portion of their states.

It should be noted that states may develop a managed care program without obtaining a waiver from the federal government under certain circumstances. To do so, enrollment in the program must be voluntary and the programs must operate statewide. No more than 75 percent of the enrollees in the HMO can be eligible for Medicaid or Medicare. In addition, the benefits provided to the enrollees must be comparable to the benefits the state is required to provide to all eligibility categories under federal law. While this option is available, the programs developed by most of the states require a federal waiver.

In June 1994, over 7.5 million beneficiaries were enrolled in some form of managed care, more than double the number who were served in managed care arrangements just two years earlier. The majority of these enrollees, almost 75 percent, were enrolled in plans with at least some capitation. Due to the diversity in the evolution of managed care across the country, different states have adopted different models of Medicaid managed care.

State Medicaid managed care programs fall under three broad classifications: full-risk capitation plans, partial capitation plans, and primary care case management programs.

Under full-risk capitation, states contract with a managed care plan for a fixed payment per person. The fee covers either inpatient hospital care plus at least one other mandatory service, or three or

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9 KFF, at 9.
11 Id. at 12.
12 Id.
more mandatory services. Full-risk contracting is characteristic of federally qualified and state-certified health maintenance organizations (HMOs), health insuring organizations (HIOs), and insurer-operated, network-style managed care organizations. Frequently, in full-risk plans that do not operate as staff model HMOs, providers and other members of practice networks are expected to bear a certain amount of the financial risk for the cost of care. In partially capitated plans, the state Medicaid program reimburses plans for a more limited set of services on a fixed payment basis and reimburses for all other services on a fee-for-service basis.

Under the primary care case management model (PCCM), states transfer almost no risk from the Medicaid program because the providers are paid a case management fee and receive fee-for-service reimbursement for all needed medical services. Under this model, primary care physicians are responsible for approving and monitoring the provision of virtually all covered services to plan enrollees.

According to a recent study by Lewin-VHI, there are some important differences in the type of managed care arrangements used in Medicaid programs versus those used in the private sector. This study points out that both state Medicaid programs and the private sector utilize HMOs, but that Medicaid programs also use partial capitation and PCCM models not usually found in the private sector. Furthermore, Preferred Provider Organization (PPO) plans and Point of Service (POS) plans that are common in the private sector are not utilized in Medicaid managed care primarily due to statutory limitations on a state's ability to use significant cost-sharing methods. It should be noted that numerous studies indicate low-income persons tend to not access medical services when cost-sharing is required.

**The Importance of Finanancially Sound Medicaid Managed Care Plans**

Medicaid managed care programs increase the financial risk to plans which contract with the state to serve Medicaid beneficiaries and decrease the financial risk traditionally held by the government. The increased element of risk to managed care plans requires that states place as much emphasis on the financial stability of Medicaid managed care plans, and their subcontractors, as they do in the regulation of managed care plans which provide for or arrange the provision of care for commercial patients. Traditionally, state Medicaid agencies have administered the Medicaid program without the assistance of state insurance regulators. Insurance regulators and other state officials have significant experience in licensing commercial HMOs and determining whether they meet solvency and capital requirements. The shift in the Medicaid program to managed care may prompt state Medicaid agencies, departments of insurance or other state agencies responsible for the regulation of managed care plans to capitalize on their respective expertise by collaborating in the evaluation and development of Medicaid managed care program proposals.

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13 Id. at 10.
14 States as Payers: Managed Care for Medicaid Populations, National Institute for Health Care Management, February, 1995. (Hereinafter referred to as "Institute").
15 KFF at 10.
16 Institute.

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In addition to shifting the financial risk in the Medicaid program from the state and federal governments to the managed care plan, states may need to consider other elements of Medicaid managed care that may impact plan financial status. Because of the range of benefits provided under the Medicaid program, managed care plans may be required to provide or arrange for the provision of services they do not typically provide. For example, while many plans are familiar with the care required for young women and children who are Medicaid beneficiaries, an increased use of managed care programs for low-income senior citizens and individuals with chronic disabilities may present new challenges. The additional services which may be required to meet the needs of these populations will necessitate that plans incur costs to expand their management and treatment capacity. Additionally, where Medicaid programs, carve-out certain services from the comprehensive benefit program, plans may be asked to manage beneficiaries' health care without control over all of the care the beneficiaries may receive. It will be important for states to evaluate the impact of carve-out strategies on costs incurred by health plans as well as upon community of care for beneficiaries. States should also carefully design their Medicaid managed care program to avoid incentives that will encourage plans to shift costs to non-capitalized programs.

States have begun to focus more closely on the financial stability of Medicaid managed care plans and the various factors which may threaten plan financial stability. For example, Tennessee's experience with its Medicaid managed care program, TennCare, has raised a number of issues for review, many of which are directly tied to participating plans' solvency. Soon after being sworn in, Tennessee's Governor Don Sundquist, appointed a new deputy insurance commissioner to monitor the quality and financial stability of TennCare's 12 managed care organizations (MCO) and an advisory panel to make recommendations on how to improve the program. One of the essential recommendations made by the advisory committee was to establish a formal mechanism for checking the financial soundness of the TennCare MCOs.

In Florida, concerns also have been raised regarding the soundness of the prepaid plans participating in its Medicaid program. Florida initially granted plans serving the Medicaid program population a three year waiver from state HMO licensure requirements. As a result of financial and quality concerns related to prepaid Medicaid plans, Florida's Agency for Health Care Administration now contractually requires plans to obtain a commercial license from the Department of Insurance by January 1, 1996. Because prepaid Medicaid plans have not been subject to state HMO licensure requirements, they have not had to conform with the same level of capital and surplus requirements applied to commercially licensed plans. Legislative efforts are currently underway to require that prepaid Medicaid plans meet the same capital and surplus requirements as commercial plans at the time they seek commercial licensure.

Through the experiences of these states and others, it has become apparent that when states experiment with Medicaid managed care it is imperative that the participating plans have managed care experience, actuarial proficiency and the critical capital reserves to ensure their longevity. The rapid enrollment of significant numbers of Medicaid beneficiaries in managed care plans has caused fierce competition and an enormous new market for managed care plans. The risk of health plan insolvency is especially present given the evolving nature of many Medicaid managed care arrangements. Such insolvencies could harm 17 Health Care Reform Week, January 30, 1995.

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the ability of beneficiaries to receive needed health care services, delay payment to and potentially bankrupt providers, and adversely impact state budgets already experiencing fiscal constraints.

**Solvency Regulation**

The Health Care Financing Administration (HCFA) requires states to monitor health plans’ financial solvency. HCFA requires strict quality control mechanisms to be in place before Medicaid managed care programs can be implemented\(^\text{18}\). To provide guidance to states in developing financial solvency standards, HCFA recently published guidelines, *Medicaid Managed Care Solvency Guidelines for Risk-Based Managed Care Plans* in January 1995.

As suggested by the experience of states which have implemented Medicaid managed care plans as well as the outcome of various studies and the guidelines recently published by HCFA, states should be diligent in applying solvency standards and oversight procedures when designing and implementing Medicaid managed care plans. As the General Accounting Office (GAO) stated in one report,

> financial oversight of participating health plans is critical to the success of any managed care program because the financial condition and viability of a plan directly affects its ability to provide continued services. Also, a plan in financial trouble has increased incentives to underserve beneficiaries.

Together, the appropriate regulatory authorities can implement mechanisms designed to limit the risk for plans’ insolvency. Mechanisms which states should strongly consider include\(^\text{19}\):

- **Capital and Surplus Reserves**

  Insurance regulatory agencies in every state currently require that managed care plans accepting risk establish certain levels of capital reserves and solvency standards. States should set such reserve standards at a level that reflects the amount of risk being transferred to the plans. Some states, such as Arizona and Oregon, successfully carve out Medicaid managed care plans from their state licensure requirements. If a state chooses not to apply its licensure requirements to Medicaid managed care plans, it should structure its program carefully to ensure adequate monitoring of capital and surplus reserves.

- **Careful Plan Selection**

  States must also be careful in deciding what type of plans may participate in their Medicaid managed care programs. Strict adherence to a prior set of criteria must be met. The criteria by which they are judged can be very broad ranging from financial standards to managerial and quality standards.

  Furthermore, states may want to require that all plans meet the same specifications as do commercially licensed HMOs. However, in setting such strict standards for participation, each state must take into account the existence and penetration of managed care in their state and in various regions of the state.


\(^{19}\) Much of this section is based on the work of the National Institute for Health Care Management's white paper entitled "Health Plan Solvency Issues Under Health Care Reform", May, 1994.
While it is important to set meaningful standards, it is also important that the state not create prohibitive standards to participation.

- **Risk Adjustment**

Each state may also want to look at the use of risk adjusters in setting its payment rates for health plans. Risk adjusters, such as age, gender, and eligibility category (e.g., chronically disabled) are mechanisms that change the payment levels received by the plans contingent upon the risk characteristics of the beneficiaries enrolled in each plan. It should be noted that while risk adjusters may help to protect a particular plan's solvency when the plan's population has an exceptionally high percentage of high risk enrollees, they may also create a disincentive for proper utilization management if the payment rates go beyond a differential reflective of the higher risk.

- **Actuarially Determined Payment Rates**

When setting the payment rate for Medicaid managed care plans, states should set the rate at levels that reflect the cost of providing the benefits. States should also consider to what extent the payment should reflect the savings and efficiencies derived from the plans' ability to manage and control costs as determined by actuarial standards. Payment levels that are set too low can result in numerous detrimental consequences. Such consequences include plan insolvency, provider bankruptcy and lack of access for beneficiaries.

- **Reinsurance/Stop-Loss coverage**

States may also want to require that newly emerging and smaller plans which wish to participate in Medicaid managed care purchase some form of reinsurance or stop-loss coverage in order to transfer some of their risk into broader pools of risk. Through reinsurance, the plans can protect themselves either from costs above a certain threshold or from certain determined catastrophic and chronic illnesses. Such reinsurance and stop-loss protection spreads the risk for extremely high costs among other insurance arrangements. As part of this effort, it is important to set thresholds to ensure appropriate risk-sharing between health plans and reinsurers. Since some segments of the Medicaid population are likely to incur significant or catastrophic expenses because of the nature of their medical condition, reinsurance/stop-loss coverage is a particularly important form of protection. When deciding whether it is necessary to require that newly emerging and smaller plans purchase such coverage, states should evaluate this element in the context of the panoply of solvency protections available in that state.

- **Transitions Periods**

Commentary indicates that the rapid speed in which Medicaid managed care programs have been implemented has contributed to many of the problems which Medicaid managed care programs have encountered. The complexity in the design and implementation of these programs requires that states set up reasonable transition periods to enroll the beneficiaries in to managed care plans. An appropriate transition period would give states time to build community support, educate beneficiaries about their new health care system and allow providers the opportunity to become familiar with managed care expectations. Furthermore, a proper transition period will enable states to gain more experience in managed care, gather more reliable data with which to set correct rates, and facilitate appropriate infrastructure developments. A well-planned transition from a traditional Medicaid program to Medicaid

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managed care also requires the commitment of staff who have developed the appropriate expertise in the critical elements of planning and implementing managed care programs.

Hold Harmless Provisions

Federal law requires that Medicaid beneficiaries are held harmless from financial liability if a plan becomes insolvent. States must ensure that HMOs which contract with the state to provide services to Medicaid beneficiaries are required to make adequate provision against the risk of insolvency and to assure that Medicaid enrollees are in no case held liable for debts of the HMO in the case of insolvency.

Additional Considerations

While the financial solvency of Medicaid managed care plans is of paramount importance to departments of insurance, Medicaid agencies, and other agencies which regulate Medicaid managed care plans, other related considerations must also be considered. The section below does not exhaust the range of issues of concern to regulators, providers and enrollees. It does provide an overview of business and contractual issues with which states must be concerned to facilitate effectively their goal of providing medical assistance beneficiaries with access to quality, cost-effective health care services.

Marketing Issues

While marketing activities can be an important component of the process of educating the patient about health plans, it is critical that managed care marketing practices are non-coercive and are designed to provide beneficiaries with accurate information. Federal law requires that states have procedures to monitor enrollment practices of managed care plans. It also requires that prepaid health care contracts specify how the HMO will ensure that the marketing materials that it distributes are accurate and not misleading. To ensure compliance with these and other provisions, many states have developed parameters to regulate Medicaid managed care marketing practices. In August 1994, HCFMA developed a set of voluntary guidelines, Medicaid Managed Care Marketing Guidelines for States, to assist states which allow health plans to engage in marketing activities.

Commercial health insurance companies may use direct and mass marketing strategies to encourage enrollment in their plans within the limitation of state statutes. In the Medicaid managed care context, door-to-door marketing has been found to be subject to abuse and has been prohibited by most states. Recently, the state of New York, one of the minority of states which still permitted door-to-door marketing, has decided to ban the use of the practice by HMOs which contract to serve Medicaid patients.

Many Medicaid managed care plans use mass marketing practices and offer incentives and inducements for enrollment while mass marketing. States may wish to examine the impact of offering inducements on the integrity of the enrollment process as well as the impact of mass marketing at times other than open enrollment periods.

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20 GAO at 38.
The regulation of marketing practices is an important component of both state and health plans’ efforts to protect consumers and to communicate the objectives of a Medicaid managed care arrangement. States should, however, be attuned to the broader impact that some marketing regulations will have on enrollment practices of plans, such as their ability to determine the populations for which they will provide or arrange health care services.

♦ Issues related to auto-enrollment

Educated consumer choice is key to the success of a managed care program. The automatic assignment of individuals either because the beneficiary did not select at all or because their first selection is closed has the potential to lead to high levels of consumer dissatisfaction and noncompliance. For Medicaid managed care programs where beneficiaries are mandated to receive care from a managed care provider, many states have measured the success of their education efforts by reviewing the assignment rate of Medicaid beneficiaries. Low assignment rates tend to indicate that beneficiaries are more content with the care provided in the program.21 States should strive to develop and implement consumer education programs which maximize beneficiary participation.

States may also want to examine practices related to the assignment of auto-enrollment populations to low bid plans. Efforts to increase the number of enrollees assigned to a low bidder may minimize the positive benefits to the program derived from consumer choice.2 This process also may have implications relating to the relative health risk of auto-enrolled vs voluntarily enrolled populations, with concomitant financial implications.

♦ Consequences of disenrollment trends and applicability of portability requirements

A fundamental premise of managed care is the promotion of primary and preventive health services, plans and payors seek to achieve cost savings through this preventive investment. However, Medicaid managed care enrollments are by definition short term (half of all Medicaid enrollees lose coverage within 12 months).22 Federal Medicaid law enables states to guarantee eligibility for a specific period of time beyond changes in a beneficiary’s financial status.23 Some states have taken advantage of this option. When considering whether to guarantee eligibility for a specific length of time, states may need to weigh the costs of guaranteeing longer eligibility against the adverse incentives that could result from shorter enrollment periods.

Several states with insurance portability requirements applicable to the commercial sector have also acted to encourage or require commercial plans to “count” Medicaid coverage when considering whether the imposition of preexisting condition limitations or waiting periods are appropriate. Ohio, for example, has a statute which recognizes all forms of health plans as satisfying the preexisting


22 "Ten Key Issues for States Under Medicaid Managed Care", George Washington University Center for Health Policy Research.

23 Id.

24 General Accounting Office at 25.

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condition period. Such requirements encourage portability for health care consumers among a broader army of plans.

♦ Health plan standards

As the health care market evolves, states regularly examine their applicable laws and regulations and suggest updates and revisions. To help facilitate state efforts in this area, the NAIC's health plan accountability working group currently is working on an effort, "CLEAR" (Consolidated Licensure for Entities Assuming Risk) which involves an examination and suggested restructuring of existing NAIC health-related and managed-care-related model laws. In addition, the working group is developing several model laws and regulations which will form a part of the "CLEAR" effort. These include models in the areas of utilization review, provider credentialing, provider contracting/access, quality assurance, data reporting, confidentiality and grievance procedures. These model laws, although tailored for the general, commercial population, may also serve as a resource for states as they develop their regulatory structures for Medicaid managed care.

♦ Consideration of the needs of special populations

The Medicaid population is a culturally diverse population consisting of persons whose lives may be disrupted by poverty, substance abuse, mental illness and chronic illness. These individuals are likely to require additional services such as outreach, language interpretation, transportation, case management, social services and child care in order to access health care provided by managed care plans. When considering the contractual and operational structure of managed care arrangements, states should acknowledge the important role these activities play in ensuring access to quality health care.

♦ Public health and managed care

When designing Medicaid managed care programs, states may also want to consider including various community-based organizations as managed care providers if they meet the statutory requirements. Such entities have relationships with local communities that can assist in the development of community-based support for Medicaid managed care programs and can facilitate state efforts to reach beneficiaries effectively. Additionally, the inclusion of community-based organizations in a plan's provider arrangements can assist plans in making its services accessible to plan enrollees.

♦ Nonurgent use of the emergency room

One of the principal objectives of states in designing Medicaid managed care programs is to reduce the inappropriate utilization of emergency rooms for nonurgent care by Medicaid patients. A recurrent problem with the Medicaid and uninsured populations has been the use of hospital emergency rooms for nonurgent care. Most studies have concluded that the nonurgent use of emergency room care does decline under Medicaid managed care. States may need to address emergency room provider

[Note: The citation is not visible in the image, but it is implied that there are notes or citations following the text.]

National Association of County Health Officials "Managed Care, Medicaid and the Public Health System".

Id.

KFF at 16.

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concerns which may be raised when a Medicaid beneficiary inappropriately goes to a non-participating hospital's emergency room. Hospital emergency rooms are required by federal law to determine which patients who enter their emergency room have an emergent condition and to stabilize any critically ill patient. Hospitals may seek to have the costs of such determination reimbursed and obtain assurances that the health plan will pay for the emergency care received by the Medicaid patient. Likewise, health plans may seek to ensure that they are only responsible for the cost of out-of-plan care in a true emergency. States should be aware of how payment determinations related to emergency treatment impact both hospitals' emergency providers and managed care plans.

Impact of Federal Medicaid Reform

The House and the Senate have recently passed a budget reconciliation bill which President Clinton has vowed to veto. This legislation includes substantial changes to the Medicaid program. The Congressional provisions repeal Medicaid and create a new MediGrant program. Through this approach, Congress seeks to eliminate the federal entitlement status to Medicaid and convert federal payments to states into a block grant.

Under the Congressional block grant plan, states would be provided with considerable flexibility to define eligibility and benefits. The bill specifically grants states the power to decide which items or services will be covered under the MediGrant program. It does require that states include coverage for immunizations for children. States are mandated to provide medical assistance to pregnant women and children under age 13 who live in families under 100 percent of the poverty level, and to any individual who is disabled. The state would be responsible for defining the term disability. All other categories of eligible individuals will receive services at the discretion of the state. However, the bill does require the states to set aside a certain percentage of funds to be devoted to services provided to low-income families, low-income elderly and low-income disabled, as well as federally qualified health centers and rural health clinics.

The Congressional plan also enables states to design innovative program delivery structures, including managed care arrangements, without having to undergo a waiver process.

The bill does impose some requirements upon states which contract with capitated health care organizations28. If a state contracts with capitated health care organizations to provide medical care to Medicaid recipients, and the organization is under full financial risk, the state must require that the organization meet the solvency standards established by the state for private organizations. If the capitated health care organization is not at full financial risk, the state must require that it meets solvency standards established under the state's MediGrant plan. This requirement is not applicable to public entities or those entities whose solvency is guaranteed by the state.

28 A capitated health care organization is defined as "a health maintenance organization or any other entity (including a health maintenance organization, managed care organization, prepaid health plan, integrated service network, or similar entity) which under state law is permitted to accept capitation payments for providing (or arranging for the provision of) a group of items and services including at least inpatient hospital services and physicians' services. See. 2124 (e)(1).

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If a state contract with or intends to contract with a capitated health care organization and makes a capitation payment\(^9\) to the organization for providing MediGrant services, including at least inpatient hospital services and physician services, the state’s MediGrant plan must include a description of the use of actuarial science in projecting expenditures, utilization for enrollees, and setting capitation payment rates. States are also required to describe the qualifications that participating plans must meet, including whether it must obtain a state license, or be accredited or certified in order to participate as a capitated health organization in the MediGrant plan. In addition, states must develop a process for disseminating to contractors the information on capitation rates and historical fee-for-service cost and utilization data.

Unlike the traditional Medicaid program, the MediGrant bill does not specifically prohibit significant cost-sharing\(^9\) requirements. It does require that states provide a public cost-sharing schedule listing of any charges which may be imposed. Limitations are placed on cost-sharing arrangements which may be applied to services for children and pregnant women.

The benefits derived from increased flexibility and less onerous administrative burdens is accompanied by the challenges most states will face as they take on this additional responsibility with a gradually lowering in the level of funding that they will receive from the federal government over the coming years. Block grants may further encourage state implementation of managed care programs for medical assistance beneficiaries to facilitate cost control efforts.

The ultimate outcome of the national debate on how the federal government will finance medical assistance will be determined over the coming weeks through negotiations between Congress and the Clinton Administration. Whether a state is operating under the traditional Medicaid program, a block grant program, or an alternative structure, the basic building blocks to a strong managed care program for medical assistance beneficiaries, previously mentioned in this document, remain the same. The development of any successful managed care plan which facilitates access for a range of medical assistance beneficiaries to quality health care services requires strong financial oversight by the state agencies responsible for managed care programs, sound actuarially determined payment rates which reflect the costs of providing care and the savings derived from managed care initiatives, and sufficient monitoring of plan marketing and other strategies to enroll participants. Particularly important in a new system will be an adequate time period for transitioning. Proper time to phase-in to a managed care plan will enable state agencies to develop the infrastructure necessary to accommodate changes and give providers, enrollees, and other members of the community time to provide input into the process and to adjust to a new managed care system. Appropriate staff expertise familiar with operational, financial and contractual structures of managed care arrangements will be critical to this endeavor.

\(^9\) A capitation payment is defined as “payment on a prepaid capitation basis or any other risk basis to an entity for the entity’s provision (or arranging for the provision) of a group of items and services, including at least inpatient hospital services and physician services.” Sec. 2114(c)(2).

\(^{10}\) Cost-sharing is defined to include “copayments, deductibles, coinsurance, and other charges for the provision of health care services.” Sec. 2113(d).

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Conclusion

Over the past decade, managed care arrangements have become a viable alternative to states seeking innovative strategies to provide medical assistance beneficiaries with quality health care in a cost-effective manner. Designing and implementing a Medicaid managed care program involves a plethora of issues which the states, providers and citizens must address. Many of the basic components for the development of a sound Medicaid managed care program remains the same irrespective of whether the public Medicaid assistance plan is a federal-state matching program or a block grant. Among the range of significant concerns, ensuring the financial solvency of Medicaid managed care plans is prominent. Ensuring financial solvency involves not only setting meaningful capital and reserve requirements but establishing standards and monitoring adequately the business practices of plans. Regulators in state insurance departments, Medicaid agencies, or other applicable agencies may have areas of expertise the contribution of which will facilitate state efforts to design an effective program. By working with providers and citizens within the state, states regulators will maximize their ability to balance the goals of protecting consumers, disseminating information to all concerned parties about the new managed care system, and facilitating the ability of managed care plans to perform their contractual obligations effectively.
Appendix A

State Activiti*:

Many states have acquired significant experience in the design and implementation of Medicaid managed care programs. As states evaluate or develop their own programs, it may be useful to consider how other states have addressed certain issues. State experience in the areas of risk adjustment, reinsurance, and transition periods have been highlighted below.

Risk Adjustment:

According to a study prepared by the Project HOPE Center for Health Affairs, Medicaid Managed Care Program Access Requirement: Final Report to the Prospective Payment Assessment Commission, several states, including Arizona, Florida, Massachusetts and Oregon, provide separate capitation rates for enrollees in different Medicaid eligibility categories.

Reinsurance:

Some Medicaid managed care programs developed by states with Section 1115 waivers, including Arizona, Delaware, Massachusetts, and Minnesota, have reinsurance provisions.

Transition Periods:

Some states have implemented their Medicaid managed care programs on a phased-in basis. For example, Oregon enrolled AFDC recipients in 1994 and phased in enrollment of elderly and disabled populations, individuals needing mental health and chemical dependency services, and foster children during 1995.

Vermont’s Medicaid managed care program is designed to include a three-year phase-in period. As planned, the program will enroll AFDC recipients and persons with incomes at or below the poverty line in 1996. Beginning in 1997, Supplemental Security Income (SSI) recipients and persons with incomes between 100 percent and 125 percent of poverty are to be enrolled. In 1998, state residents with incomes between 126 percent and 150 percent of poverty may enroll.

Unlike Oregon and Vermont, Connecticut enrollees are being phased-in on the basis of geographic area instead of by eligibility category.

*Source: Group Health Association of America