

## V. VALUE AND PREDICTABILITY

This section of the evaluation assesses the HealthChoice program's success in achieving its underlying financing goals. These goals include improving the value of the health care services purchased for Medicaid beneficiaries while at the same time improving the predictability of the State's budget outlays for the Medicaid program.

The determination of purchaser value is not simply a comparison of current costs with the costs of the prior fee for service program. Rather, consistent with the other components of this evaluation, the measure of value should be based on whether or not the program's overall goals of improving access to and quality of Medicaid services were achieved at an appropriate price. The judgment of value also must be based on how successfully the program has been able to adjust to changes outside of its control, such as the enormous growth in program enrollment since the start of HealthChoice. A number of separate questions will be addressed, including:

- *Has HealthChoice complied with federal regulations?* This section will assess the HealthChoice program's compliance with federal financing regulations, which apply to both 1115 waivers and Medicaid managed care programs.
- *Has the HealthChoice program been adequately funded?* This section will consider whether the State's payments to MCOs have been adequate to achieve the State's goals of improving access and ensuring quality of care.
- *Has the program provided a stable financial platform?* This section will assess whether the State's payments to MCOs have fostered a stable financial platform for the MCOs.
- *Has the HealthChoice program led to greater budget predictability?* This section will address whether the HealthChoice program has contributed to more predictability for the State's budgeting of Medicaid expenditures.
- *What has been the effect of risk adjustment on purchaser value?* This section will discuss the unique risk-adjustment capitation rates used in Maryland and assess whether they have improved purchaser value.
- *Have the administrative costs of the HealthChoice program been reasonable?* This section will review the administrative costs of both the State and the MCOs in relation to the demands of the program and other states.

- Have the State's overall goals for value and predictability been met? This section will briefly summarize whether, taken together, the financial components of HealthChoice have led to improved value and predictability.

## **COMPLIANCE WITH FEDERAL REGULATIONS**

### **Overview**

Federal regulations impose two separate but related financing tests for the HealthChoice program, the upper payment limit (UPL) and the budget neutrality standard. These are presented first because the HealthChoice program must conform to these federally established funding parameters. If the HealthChoice program failed to meet these requirements, the Federal government could withdraw its authorization for the waiver and/or shift more financial responsibility for funding the program on to the State.

- **Upper Payment Limit Test.** Federal regulations specify that capitation rates paid to MCOs *cannot exceed* amounts that would have been paid in the fee-for-service program for the same services for an equivalent population. These regulations apply regardless of whether a State is operating a managed care program under a §1115 waiver (as is the case for HealthChoice), another type of waiver, or through the State's regular Medicaid program.

The UPL test is conducted annually by comparing MCO payment rates to the fee-for-service equivalency amount for that particular year. In Maryland, the fee-for-service equivalency amount for CY 2001 and CY 2002 is derived based on data from the State's 1997 fiscal year, which is trended forward to the year under review.

The State has established capitation rates for HealthChoice that have passed the federal upper payment limit test in each year of the program. For the two most recent years, capitation rates have been set at about 98 percent of the calculated upper payment limit.

- **Budget Neutrality.** Section 1115 waivers, such as HealthChoice, have an additional financial requirement that states must meet. Specifically, as part of the terms and conditions of the waiver, the State and federal government agree to a five-year spending cap for the program. The spending cap is derived from a base year period and inflated each year in accordance with previously established trend factors. In Maryland, the State used its 1996 Medicaid expenditures for the base period and agreed to an annual trend rate of a 5.5 percent increase in total costs per person through June 30, 2002.

Because the cap is based on a per person amount, the State's dramatic increase in HealthChoice enrollment over the last several years has not affected the State's ability to comply with the cap. The budget neutrality test is different from the Upper Payment Limit test in that it includes services that are not part of the MCO capitation rate. The most significant

of these 'wrap-around' services are mental health services, care delivered under the Rare and Expensive Case Management (REM) program, and special education services provided through schools.

The determination of whether the State meets its budget neutrality test is based on the cumulative spending for the entire five-year period of the waiver. Thus overspending in one year is permissible if lower spending levels in other years offset the overspending.

### **Findings**

Based on data submitted to the Federal Centers for Medicare and Medicaid Services, the State is complying with the Budget Neutrality requirements of the HealthChoice waiver. While the State exceeded the cap in the first two years of the demonstration, waiver spending has been under the cap since that time. By the end of the third year, spending was about two percent below the cap. Preliminary data indicate the State is likely to be further below the cap by the end of the fourth year.

Given the rise in health care costs, the State petitioned the Centers for Medicare and Medicaid Services (CMS) for an adjustment to its 5.5 percent annual inflation rate. CMS recently approved the State's request, increasing the trend rate to eight percent for the three-year waiver extension period from July 2002 to June 2005.

## **ADEQUACY OF PROGRAM FUNDING**

### **Overview**

This section focuses on the adequacy of payment to the MCOs. Funding adequacy needs to be measured in combination with access and quality standards. If capitation rates are not sufficient for even a mature, efficient managed care plan to provide high quality contracted services, the State will not fulfill its goal of adequate funding for the program. At the same time, if the rates paid to MCOs promote inefficient business models, then the State will be paying more than is necessary to achieve its goals.

The test for measuring funding adequacy is whether a sufficient number of MCOs have succeeded in providing contracted services while still generating a reasonable return on investment. Because Maryland's payments to MCOs take into account the health status of each plan's enrollees, an MCO's financial performance is more likely determined by the successful execution of managed care business practices than its ability to enroll individuals with better health status and lower costs.

### **Findings**

The funding analysis examined the financial results of all the MCOs that participate or have participated in the HealthChoice program since the program's inception in July 1997. The financial results through October 2001 show that the MCOs that cover approximately 70 percent of the 2001 HealthChoice enrollment have successfully provided the contracted benefits and are profitable. In aggregate, these profitable MCOs have averaged a 3.5 percent profit during the 1997-2000 period.

**Figure V-1: Financial Experience of Consistently Profitable MCOs  
1997 - 2000 Cumulative Results as of December 31, 2000**

<b>Consistently Profitable MCOs</b>		<b>1997 - 2000</b>
<b>Calendar Year (Reported) Basis</b>		
<b>PREMIUM REVENUE (\$ Mil)</b>		\$ 1,117.9
<b>MEDICAL LOSS RATIO</b>		83.5%
<b>ADMINISTRATIVE EXP. RATIO</b>		13.0%
<b>UNDERWRITING GAIN/(LOSS) (\$Mil)</b>		\$ 39.5
<b>PREMIUM SURPLUS RATIO</b>		3.5%
<b>OTHER REVENUE (\$ Mil)</b>		\$ 17.8
<b>INCOME/ (LOSS) **</b>		\$ 57.3
<b>MEMBER MONTHS (Millions)</b>		5.4
* Ratios based on Premium Revenue only, excludes investment income.		
** Excludes any adjustment for Federal Income Tax.		

The financial analysis also documented that some plans have consistently reported poor financial performance. As a result, a number of these MCOs no longer participate in the HealthChoice program. In reviewing the financial results reported by the MCOs, it is important to recognize that the full extent of the HealthChoice program's funding is affected by sub-capitated arrangements with downstream providers. Thus, if a sub-capitated provider incurred losses, those amounts would not be recorded on the MCO financial statements. MCOs made wide use of sub-capitated provider arrangements in the first two years of the HealthChoice program. Since then, the number of sub-capitated providers has been reduced dramatically at present only two of the six plans do any risk contracting, and those at only a minimal level. The reduction is due to concerns by the MCOs about these arrangements and to losses incurred by some of the providers that chose to enter into these sub-capitated arrangements.

### **Conclusions**

The contrast between financially successful and financially unsuccessful plans does not suggest that the capitation rates have been inadequate. As the earlier discussion of plan transitions showed (Chapter One), the HealthChoice MCO experience is consistent with other Medicaid managed care programs around the country. In addition and more importantly, the HealthChoice experience is consistent with the commercial managed care industry in Maryland, which saw a significant decrease in the number of plans from 1996 to 2000 (dropping from 23 to 14).

A review of one plan that exited the market due to financial losses demonstrates the different capabilities among the MCOs. A Medicaid plan was owned by a major commercial insurer and was sold to a new Medicaid insurer in Maryland. The acquiring plan successfully managed the transition and was able to generate a positive return on its investment within the first year of the acquisition. This strongly suggests that a managed care plan's execution of its business fundamentals is an essential determinant of financial success. When considered in the context of the other findings that cite improved access and consumer satisfaction, the State received value for the services purchased on behalf of Medicaid beneficiaries.

## **STABILITY OF FINANCIAL PLATFORM**

### **Overview**

As business entities, MCOs can more effectively implement the program's objectives if funding is both adequate and reasonably predictable. While the previous analysis demonstrated that funding has been adequate, controversy and uncertainty over capitation rates marked the first two years of the HealthChoice program. Specifically, amounts paid in 1998 were controversial due to the way that enrollees were assigned to the new risk-adjusted rate cells. An independent review of the rates identified this problem and other issues and concluded that, overall, the State paid close to the correct amount in the first year. It also concluded that the MCOs were paid more in the second year than they should have been. Equally important was the fact that payment rates were implemented with limited MCO involvement in the process. Furthermore, the rate-setting time periods provided only minimal notice to MCOs when rates were changed. These destabilizing outcomes eroded the financial platform for the MCOs.

Beginning with recommendations proposed by a special legislative committee on the administration of HealthChoice in September 1999, the State implemented a series of changes to promote a more stable and predictable payment process for the MCOs, including:

- Changing the capitation rate year from a State fiscal year to a calendar year. This allows more time for developing the rates and longer periods for the MCOs to react and consider the rates prior to implementation. In addition, this allows for the budget to include the appropriate amount of increase for at least one-half of the year.
- Completely revising the rate-setting process beginning with the CY 2001 rates, based on the following key attributes:
  - Open and data driven;
  - Collaborative with MCOs;
  - Provides sufficient time for MCO review and reaction prior to finalizing rates; and,
  - Provides regular feedback to MCOs to allow them to address internal MCO issues (e.g. missing encounter data submissions).
- Developing and implementing ongoing financial performance tools to enhance the State's understanding of the impact of the rates throughout the year. The primary tool is the HealthChoice Financial Monitoring Report (HFMR), which provides insight into the financial performance of individual MCOs as well as the overall program. Also, during the rate-setting process each MCO prepares templates presenting its current and

projected financial picture, enabling the MCO to show its operational activities and the impact of the rates on its financial position. Finally, the Department will be scheduling operational and financial audits of each plan by an independent CPA firm to verify the information reported in the HFMR.

Taken together, these changes have resulted in a more predictable and understandable rate-setting process for MCOs that participate in the HealthChoice program. The Department continues to try to improve the process each year. The ability to improve the process, however, is constrained by certain federal rules, particularly relating to the budget neutrality cap which incorporates the low Medicaid physician fees into the base. The upper payment limit also is based on what Medicaid would be spending fee-for-service in the absence of the waiver, a portion of which is based on the physician fee schedule, however, new Federal regulations may soon be issued to allow states to use different approaches.

## **BUDGET PREDICTABILITY**

### **Overview**

The health care industry in general, and Medicaid in particular, operates in an environment affected by many variables that limit its ability to forecast budgets accurately. Federal legislation, demographic trends, private sector health benefit trends, and the deployment of new medical technologies and pharmaceuticals all work together to affect the Medicaid program both in the short and long term. The recent slowing of the national and State economies, not foreseen when budget forecasts were prepared last year, further demonstrates how a change in market assumptions can upset enrollment projections and budget calculations.

The analysis of budget predictability, therefore, focuses only on the State's ability to budget appropriately with current market assumptions. The accuracy of enrollment projections is not addressed, as excess enrollment would shape the Medicaid budget regardless of the HealthChoice program.

### **Findings**

As described above, in the initial years of HealthChoice (1998 and 1999) there was considerable volatility in State budget costs stemming from the capitation rate process and outcomes. Uncertainty over the actual level of the rates, difficulties in projecting HealthChoice enrollment mix among the rate cells, and the relatively short time period between final rate development (May) and implementation of the rates (July) resulted in a lack of predictability for the State.

Beginning with the recommendations of the Special Committee on the Administration of HealthChoice and subsequent State actions, the development and implementation of HealthChoice rates are now partially integrated into the State's budget process. After the rates are developed through the collaborative process discussed earlier, the State is able to determine the impact on the budget for the second half of the current fiscal year, and the first half of the upcoming budget year. In this way, the State budget can incorporate the MCO rate increases that will be in place for the first six months of the new fiscal year. The budget does not include a projected increase for the second half of the new budget year because the State does not want to undermine the integrity of the rate-setting process. Therefore, there is built into the budget system an anticipated deficit for the second half of the fiscal year.

## **RISK ADJUSTMENT'S CONTRIBUTION TO VALUE**

### **Overview**

The most innovative financial aspect of the Maryland HealthChoice program is its use of health-based risk adjustment as the basis of paying the MCOs. The risk-adjusted payment method is statistically valid and ties an MCO's capitation rates to the health status of its enrollees. MCOs that attract a sicker population will be paid more than the average capitation rate. The risk-adjusted payment method substantially reduces the incentive for MCOs to try to enroll only relatively healthy individuals--a major criticism of managed care systems. At the same time, the risk adjustment system removes the implicit penalty for plans with networks that attract a substantially sicker case mix.

### **Findings**

The following tables demonstrate that risk adjustment has led to significant variance in the payments to participating MCOs. For enrollees in the families and children eligibility category, average MCO payments ranged from a low of 88 percent of the statewide average to a high of 106 percent of the statewide average, depending upon the case mix of the members. For the higher cost disabled population, the effect of risk adjustment on the comparative payments to the MCOs is even more dramatic, demonstrating that risk adjustment leads to payments that are more plan specific. Average MCO payments for the disabled range from a low of 77 percent of the statewide average to a high of 108 percent of the statewide average. When the entire case mix of enrollees is considered, average payments by MCO range from a low of 92 percent of the statewide average to a high of 157 percent.

**Figure V-2: Effect of Risk Adjustment on Comparative Payments to MCOs**

MCO	CY 2000
Plan A	0.92
Plan B	1.18
Plan C	0.99
Plan D	1.57
Plan E	1.02
Plan F	1.09
Plan G	0.93
All	1.00

**Figure V-3: Effect of Risk Adjustment on Comparative Payments to Select MCOs: Family & Children Enrollees**

MCO	CY 2000
Plan A	0.95
Plan B	1.04
Plan C	0.88
Plan D	1.06
All	1.00

**Figure V-4: Effect of Risk Adjustment on Comparative Payments to Select MCOs: Disabled Enrollees**

MCO	CY 2000
Plan A	0.92
Plan B	1.08
Plan C	0.77
Plan D	1.09
All	1.00

## **Conclusions**

Risk adjustment significantly contributes to the State's goal of enhancing purchaser value by more appropriately distributing the HealthChoice funds among plans according to the health status of their enrollees. As a result, this system provides MCOs with the right incentives to manage the care of its population effectively by providing outreach and case management services to avoid costly hospitalization, rather than seeking ways to avoid adverse selection.

The use of risk adjustment also has contributed significantly to the ability of provider-sponsored MCOs to participate in the HealthChoice program. Provider-sponsored MCOs tend to have provider networks with large Medicaid patient bases and higher risks and costs. When the actual case mix differences among Maryland MCOs is examined using the risk-adjusted payment method, the provider-sponsored plans have a higher cost case-mix. Under the risk adjustment system, these plans are paid more to care for their patients. In contrast, a traditional age-sex rate methodology would have generated lower payments to those provider-sponsored plans. It is fair to conclude, therefore, that

the risk-adjusted payment system has been essential to the continued participation of provider-sponsored MCOs in the HealthChoice program.

## **ADMINISTRATIVE COSTS**

### **Overview**

States planning to implement §1115 Medicaid managed care waivers may anticipate that their administrative costs will be reduced since some administrative activities are shifted over to the MCOs. In reality, states with managed care programs are required to perform a number of additional activities not required under a fee-for-service system. These new functions include: monitoring the enrollment broker and external quality review organization (EQRO) activities; responding to complaints and grievances; ensuring prompt payments to providers; providing outreach, care coordination and ombudsmen services through local health departments; collecting, analyzing, and reporting encounter data; overseeing the MCO capitation rate-setting process; and overall monitoring of the MCOs to ensure that the State's access and quality standards are ultimately being met. The State has a financial contract with MCOs and needs to monitor those contracts to ensure that state dollars are being used appropriately and predictably.

In addition to these new functions, states must continue to operate both fee-for-service and managed care components of Medicaid. In Maryland, despite the fact that the overwhelming majority of enrollees are in MCOs, well over 60 percent of the Medicaid budget expended via the Department's fee-for-service payments. HealthChoice created many new administrative activities, but the only significant administrative activities that were transferred to the MCOs were those involving some claims payments, which is a relatively low-cost activity, and contracting with and maintaining the provider network.

It is common for administrative spending to increase for states with §1115 Medicaid managed care waivers due to managed care oversight responsibilities. A Mathematica Policy Research report, dated April 2001, stated: "All states should expect to spend more, not less, to administer a managed care program. If they do not provide additional administrative resources, their programs may not be able to operate adequately." Since Maryland's managed care program is considered a highly regulated managed care program, it is even more likely that additional funds would be required for the oversight requirements of the program.

### **Findings**

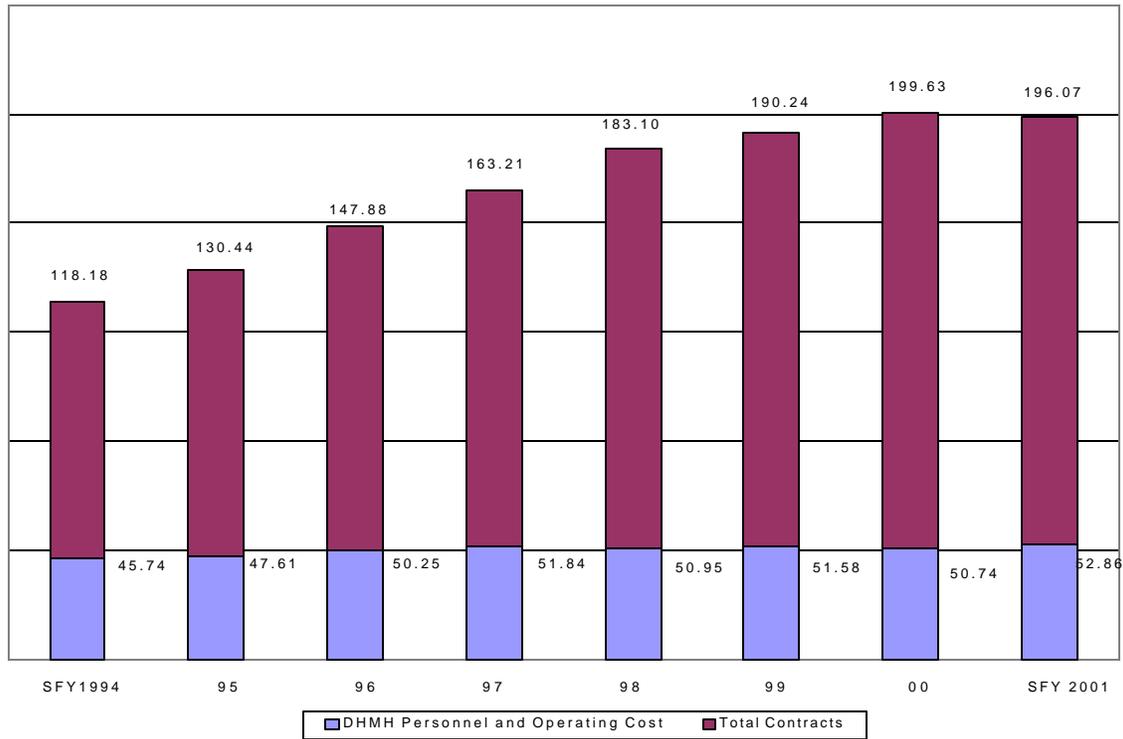
#### **Department of Health and Mental Hygiene**

Based on Medical Care Programs' expenditure data from fiscal year 1994 through 2001, the State's administrative costs have increased. The data summarize all Medicaid administrative costs and include both Department and contractor administrative costs. It is not possible to separate out "HealthChoice" administrative costs because many staff work on both Medicaid fee-for-service

and HealthChoice activities (see Chapter 2 for a discussion of Department operations).

The Department's administrative costs grew from \$83 million in FY 1997 (3.5 percent of Medicaid expenditures) to \$121 million in FY 2001 (4.4 percent of Medicaid expenditures). The administrative costs per person grew from \$163.21 in FY 1997 to \$196.01 in FY 2001, a 20 percent increase. Therefore, there are no administrative savings to the State that can be passed on to the MCOs as a component of the capitation rates.

**Figure V-4: Total DHMH Administrative Cost per Program Recipient**



Most of the growth in costs was due to Medicaid contracts for functions such as the enrollment broker, EQRO, and rate-setting. In addition to these new contractual costs, the Department took on a number of new administrative functions. It is important to note that many of the new responsibilities were absorbed within the Department's existing administrative budget.

The Mathematica study indicated that State administrative costs ranged from 3 to 8 percent of total program costs in the five states examined (including Maryland) because of their mandatory managed care and eligibility expansions. Based on this information, Maryland's administrative expenditures appear to be similar to those in other comparable states and are considered reasonable.

## **Providers**

In the provider forums, most providers reported new administrative costs, but they were unable to quantify these additional costs. The provider costs are attributed to pre-authorization, billing multiple entities, differing MCO formularies, medical record audits, encounter data reporting, and identifying an enrollee's PCP. In particular, providers who used to contract with one entity - the State - now contract with multiple MCOs each with own set of procedures and rules. In some cases, providers have stated that the need to add additional staff to handle the additional workload.

## **MCOs**

Direct comparisons between MCO administrative costs and those incurred by the State for operating a fee-for-service program are not appropriate. Essential elements of the managed care model require a highly developed management infrastructure. For example, MCOs must contract with and credential a provider network and operate information systems that go far beyond routine claims processing if they are to manage effectively and coordinate care. Successful managed care plans often make substantial investments in their administrative system so that care can be delivered in the most appropriate and cost effective setting.

MCOs reported \$111 million in administrative costs in calendar year 2000 and projected \$118 million for calendar year 2001. These estimates are problematic, however, because MCOs have not used a uniform definition of "administrative costs". For example, services such as case management and outreach may be included in administrative or medical costs. The Department is in the process of better defining how administrative costs are to be reported in its revisions of the HFMR reporting requirements.

It is important to keep in mind that when employers or State Medicaid programs contract with managed care organizations to provide services to their members, a major part of what they are purchasing is the MCOs' management expertise. With effective management MCOs are able to provide all necessary and appropriate services to their members at a lower cost than in a fee-for-service system, even taking into account their administrative costs. In the Maryland Medicaid program, total State capitation payments to the MCOs, which cover all services, case management and administrative costs and any operating margins the MCOs may generate, are about 2 percent less than what the same services would have cost if they had been in a fee-for-service system. In addition, the MCOs generally have been able to provide higher payments to physicians than the Medicaid program pays on a fee-for-service basis. This is possible because of effective management of resources.

Because of the relatively extensive quality and access standards included in Maryland's HealthChoice program, it is likely that MCO administrative costs are higher than in most other Medicaid or commercial programs. Indeed, some of the MCOs that operate plans in other states have reported higher administrative costs in Maryland. MCOs cite some administrative burdens as barriers to efficiently managing resources.

### **Discussion**

The administrative costs incurred by the Department and the MCOs are consistent with what would be expected under a managed care system. Managed care systems, as the name implies, require an investment in administrative systems if they are to succeed in achieving their goals. An important caveat to the need for administrative controls to manage patient care appropriately is the need to avoid overburdening the provider system with arduous tasks that do not yield returns, either in quality of care or efficiency.

## **OVERALL CONCLUSIONS**

This section of the evaluation addresses a series of questions about whether the State's goals of improving value and predictability have been achieved. The analyses show that:

- The State has passed the two federal financing tests under HealthChoice;
- MCO funding levels appear to have been adequate to achieve the program's goals;
- Although the program initially fell short of its goals for predictability, important procedural changes implemented in late 1999 have promoted greater budget predictability for the State and participating MCOs;
- The risk-adjusted payment method contributes significantly to achieving purchaser value by more efficiently allocating funds among the MCOs; and
- Administrative costs associated with the operation of the HealthChoice program are reasonable given the rigorous quality and access requirements of the program, but should be reviewed to identify opportunities to reduce unnecessary burdens.

All of these successes were achieved against a backdrop of an unprecedented expansion in program enrollment. In spite of real challenges and difficulties, the HealthChoice program's financing structure has proved durable and has helped to advance overall program goals.