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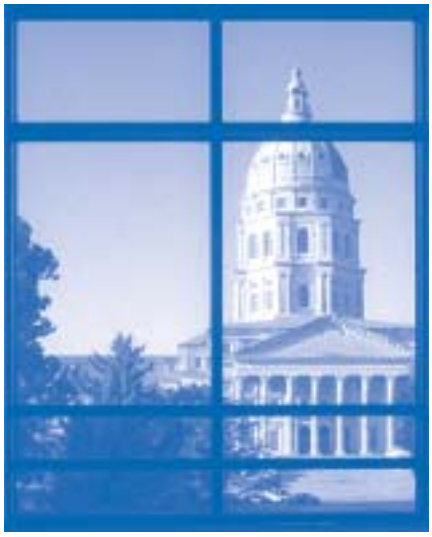

# Issue Brief

KANSAS HEALTH INSTITUTE

## Medicaid Capitation Rates: Implications and Options

*By Susan W. Kannarr, J.D.*

**Policy Implications for Kansas**

*• Managed care organizations (MCOs) may be unwilling to bid on Medicaid business if capitation rates are seen as inadequate.*

*• Lack of interest among MCOs in bidding can reduce the state's options for purchasing services and can put the state in a weaker bargaining position with MCOs.*

*• Low payment rates to health care providers may limit the number willing to participate in Medicaid and the number of Medicaid patients participating providers are willing to see.*

*• Fewer participating providers may negatively affect access to services for Medicaid beneficiaries.*

### Introduction

The rates paid to *managed care organizations*[1] (MCOs) and *providers* affect the ability of the Medicaid program to ensure beneficiaries have access to quality health care. MCOs and individual providers may choose not to participate in the Kansas Medicaid program if payment rates are set too low. The state, on the other hand, must set rates within boundaries determined by fiscal considerations and regulatory limits.

In November 2000, the Kansas Health Institute convened a group of legislators, provider representatives, state agency officials and other policymakers to discuss issues around Medicaid managed care payment rates in Kansas. As a followup, this issue brief will expand on that discussion. Specifically, the brief will provide background information on the Kansas Medicaid managed care program; a discussion of Kansas rates and their potential impacts; an overview of how rates are established; a summary of financial issues; and a glossary of terms.

### Medicaid Managed Care in Kansas

During the 1990s, a large number of states began implementing *managed care* within their Medicaid programs. Reasons for implementing Medicaid managed care included the need to control costs due to overprovision of services in the fee-for-service environment and to improve beneficiary access and continuity of care.[2] Joining a growing national trend, Kansas passed legislation in 1993 and 1994 requiring the Department of Social and Rehabilitation Services (SRS) to implement managed care in the Medicaid program. In Kansas, Medicaid managed care takes two different forms, *capitated managed care* and *primary care case management*. Certain Medicaid participants, largely low-income women and children, are required to participate in managed care.

In the capitated managed care system, SRS pays an MCO a fixed sum per enrollee — a *capitation rate* — for a required set of services to be delivered to each Medicaid beneficiary enrolled in the MCO. This form of payment is intended to transfer to MCOs the financial risk for beneficiaries who require services that are more costly than the

## Key Questions for Policymakers

**1.** Given the potential effect of low Medicaid payment rates on provider participation and beneficiary access, how can Kansas balance the desire to improve or maintain access and the need to be fiscally responsible?

**2.** The state's ability to increase capitation rates currently is dependent on fee-for-service rates. If federal constraints on capitation rates are reduced or eliminated in 2002, how will Kansas respond given the potential costs involved?

**3.** In light of the challenges encountered thus far, what is the level of commitment Kansas has to Medicaid capitated managed care?

*The contents of this report are solely the responsibility of the author and do not necessarily represent the views of the Kansas Health Institute.*

fixed sum they received from the state. In addition, the MCOs, and not the state, are primarily responsible for recruiting sufficient providers to maintain access for the beneficiaries. However, SRS, by federal law, still maintains ultimate responsibility for assuring beneficiaries have access to services. The MCOs negotiate a fee schedule with providers which may or may not mirror the *Medicaid fee-for-service* schedule. Kansas' capitated program (formerly known as PrimeCare Kansas) has recently been blended with the State Children's Health Insurance Program and is now part of the HealthWave program. Mental health and dental care are *carved-out* of the benefit package MCOs are required to provide. These services are provided through a separate system of care. Medicaid capitated managed care is available in 63 counties.

The Primary Care Case Manager (PCCM) model is a more limited form of managed care. Under this system, SRS contracts with physicians who, as PCCMs, take responsibility for coordinating beneficiaries' care in exchange for a monthly fee of two dollars per beneficiary. Individual services provided by the PCCM or through referral are paid on a fee-for-service basis. Kansas' PCCM program is called HealthConnect Kansas and is available statewide. This issue brief will focus only on the capitated form of managed care.

## Capitation Rates and Their Potential Impacts

MCOs typically consider the capitation rates paid by SRS for Medicaid patients to be too low. Health care providers in Kansas also believe that the payment rates they accept from Medicaid MCOs are too low. Research indicates that reimbursement rates can affect both access to health care services and health outcomes for Medicaid beneficiaries.[3] The adequacy of the established rates can be examined from several perspectives. These include comparisons between Kansas rates and rates paid by other states and assessments of beneficiaries' access to health care services.

## Comparisons to Other States

Assessing rate adequacy by comparing Kansas to other states is helpful, but comparison studies should be used with caution. Inter-state comparisons are complicated by many factors including variations in how states set rates, the use of different age categories, the use of rate adjustments by some states for special services and differences in the services included in the capitation rate. Also, rates considered adequate in one state may not be in another, so comparisons by themselves do not indicate the relative adequacy of a state's reimbursement rates. With these points in mind, consider the following studies:

- Preliminary information obtained from the Maternal and Child Health Research Center in Washington, D.C., shows that 1999 Medicaid ***capitation rates for children*** in Kansas were the lowest of 42 states included in a comparison study.[4] Kansas capitation rates ranged from 25-33 percent of the national average. Kansas rates remained low when compared to other states that also carve-out services such as mental health and dental care from the capitated benefit package. In this second comparison, Kansas rates were 40 percent of the national average.
- Another study comparing Medicaid rates across states for ***all low-income families and pregnant women*** in capitated managed care provides similar information. This study based on 1998 rates ranks Kansas near the bottom with only California, Florida, Georgia and

Tennessee ranking below Kansas. Kansas rates were 82 percent of the national average.[5]

- A 1997 study of the ***Medicaid physician fee schedule*** found that Kansas rates were approximately 84 percent of a four-state average.[6]
- Information from the American Academy of Pediatrics' Medicaid Reimbursement Survey for 1998/1999 that examined selected fee-for-service rates suggested that although the ***selected Medicaid fee-for-service rates*** in Kansas compared more favorably to other states than capitation rates, they were also below the national average.[7]

## Access to Health Care Services

Improving access to services was one of the original goals in implementing managed care and continues to be an important issue for states. The degree to which beneficiaries have adequate access to health care services can be difficult to measure. One method of measuring access is by examining the availability of health plans and providers in the Medicaid program.

### Health Plan Participation

After an early influx of commercial MCOs into Medicaid in the early 1990s, a growing number of MCOs are exiting the program or are hesitant to take on Medicaid business due in part to inadequate capitation rates.[8] The issue of low capitation rates in Kansas became apparent when two of the state's three Medicaid health plans dropped out of the program at the end of 1998 largely due to low rates. The only remaining MCO, Horizon Health Plan, went out of business in the spring of 1999. Its Medicaid business was assumed by First Guard Kansas, which is now the only Medicaid health plan in the state.

In 2001, for the first time, Kansas requested bids from health plans to serve participants in both the Medicaid and State Children's Health Insurance Program (HealthWave). The blended program began operation in October 2001 under the name HealthWave. During the bidding process, it became more clear that low Medicaid capitation rates affect the state's ability to contract with MCOs. Only one health plan, First Guard Kansas, bid on the blended program and was awarded the contract. According to information from SRS, a second MCO that had been involved with HealthWave since its implementation declined to bid on the blended program citing low Medicaid reimbursement rates as a financial risk it was unwilling to accept.

A number of hypotheses have been put forward to help explain why MCOs are making the decision to exit or refuse to enter Medicaid. Some of the factors cited are listed in the box on this page.[9] Another factor may be the level of provider capacity in the state. Proposed federal regulations to implement portions of the Balanced Budget Act of 1997 may also negatively affect the willingness of MCOs to participate in Medicaid in the future, because the regulations would impose significant administrative responsibilities on states and MCOs.

### Provider Participation

Research indicates that provider decisions on whether to participate in Medicaid or the number of Medicaid clients existing providers are willing to see are affected by payment levels.[10] However, as with health plans, reasons for participation or non-participation in Medicaid are more complex than payment amounts alone. The bigger question is whether participation rates are adequate to serve Medicaid beneficiaries. This question can be difficult to answer because it is not only the number of providers but also the number of beneficiaries they are willing to see and the amount of capacity open in their practices that determine adequacy.

Limited information is available regarding provider participation rates in Medicaid. However, results from a pre-

**Factors Affecting Health Plan Decisions to Leave or Refuse to Participate in Medicaid**

- Adequacy of capitation rates
- Ability to negotiate discounted fees and utilization controls with providers (e.g. MCOs are likely to accept lower capitation rates if there is greater competition among providers, because MCOs can more easily negotiate with providers.)
- Administrative burdens
- Anticipated enrollment volume
- Attractiveness of other lines of business in the state
- Provider capacity in the state
- State's experience with commercial managed care plans (A state with many commercial managed care plans is likely to have more plans participate in Medicaid.)
- Other social or philosophic factors

Source: Kaiser Commission on Medicaid and the Uninsured, *Commercial Health Plan Participation in Medicaid Managed Care: An Examination of Six Markets*, November 2000.

### Selected Results of Pediatrician Survey

| | Kansas | Region* | U.S. |
|---|---|---|---|
| Currently participate in Medicaid | 89.1% | 93.5% | 89.5% |
| Medicaid payments do not cover overhead | 68.4 % | 56.3% | 61.2% |
| "Low Reimbursement" cited as very important reason for limiting Medicaid participation | 62.5% | 57.5% | 58.4% |
| Percentage of their usual charge for well-child visit pediatricians say they need to receive to: | | | |
| Accept more or any Medicaid patients | 86.3% | 84.0% | 82.0% |
| Accept all Medicaid patients | 90.2% | 89.1% | 86.5% |

*Region includes: IA, KS, MN, MO, ND, NE & SD American Academy of Pediatrics, September 2000

liminary analysis of Kansas primary care providers in state fiscal year 2000 for managed care and fee-for-service populations indicates that 95 Kansas counties are underserved by Medicaid participating physicians.[11] The analysis also estimates that of 1,510 primary care physician FTEs (see definition in endnote 11) in the state, approximately 177 are available to Medicaid beneficiaries. There are a number of limitations to this analysis, and the results should be used with some caution.[12]

According to a recent national survey of pediatricians regarding participation in Medicaid and the State Children's Health Insurance Program (SCHIP), participation by Kansas pediatricians is similar to national and regional participation.[13] The box above illustrates some results from the survey. The study also found that pediatricians are more likely to accept all private patients than all Medicaid/SCHIP patients. Note that this survey looks at participation in Medicaid as a whole and not just the capitated managed care program. Also, pediatricians are only one of the provider types that serve Medicaid beneficiaries.

The same survey indicated that approximately one in four Kansas pediatricians would be willing to see more Medicaid patients if reimbursement was increased.[14] The box on this page also shows the level of the pediatricians' customary fees for a well-child visit they say they would need to receive from Medicaid to increase Medicaid participation. Limited information is available concerning the amount of increase in fees needed to induce significantly higher provider participation across all types of providers and services. Some studies conclude that raising primary care rates has limited effects on overall Medicaid participation.[15] Other research has estimated that substantial rate increases (e.g. to rates higher than those paid by Medicare) are required to increase access beyond a trivial amount.[16] Medicaid participation levels may be more attributable to practice capacities, distribution and availability of the provider type to the general population than to payment levels, especially in medical specialties and dentistry.

## Establishing Capitation Rates

Kansas and other states have struggled with establishing capitation rates within regulatory and fiscal limits while trying to attract MCOs into contracts to serve Medicaid beneficiaries. Medicaid capitation amounts are calculated based on fee-for-service rates. Because fee-for-service rates in Kansas are generally low when measured against other states, the resulting capitation rates are also comparably low.[17]

Within general federal guidelines, states have a great deal of flexibility in establishing the payment rates to individual providers (fee-for-service rates). However, there are significant federal restrictions on the establishment of capitation rates. Under federal law, capitated rates may not exceed fee-for-service costs in an equivalent population. This is referred to as the Upper Payment Limit (UPL). A state's total managed care program (both capitated and non-capitated models) must be cost effective. In the simplest terms, this means that the costs for operating a managed care program must be less than or equal to costs for operating a fee-for-service system. Therefore, without an increase in the fee-for-service base, there is a limit to the amount Kansas can adjust capitation rates paid to MCOs.

The federal government is in the process of proposing changes that will eliminate the UPL and create a new system for calculating capitation rates that grants states more flexibility. Specifically, the newest proposed regulations remove UPL requirements and insert specific requirements for state rate setting methods that are intended to ensure actuarially sound capitation rates and risk-sharing mechanisms.[18] Regulations containing these changes as well as a number of other managed care provisions are part of the Balanced Budget Act of 1997 and have been delayed in the regulatory process. The latest publication of the proposed regulations sets an effective date of August 2002. Assuming these regulations become effective, Kansas will need to evaluate its priorities, determine its commitment to Medicaid managed care and decide how or whether capitation rates should be adjusted.

Increasing capitation rates to MCOs

**The rates paid to managed care organizations (MCOs) and providers affect the ability of the Medicaid program to ensure beneficiaries have access to quality health care.**

will not necessarily result in comparable increases to individual providers. MCOs negotiate reimbursement rates with individual providers and are not required to follow the Medicaid reimbursement schedule, although they often do. Also, many beneficiaries, the aged and disabled, do not participate in capitated managed care. If only capitation rates are increased without adjusting the underlying fee schedule, Kansas may create a two-tier system where providers receive higher reimbursement rates for serving capitated managed care clients than for serving fee-for-service or PCCM enrolled populations.

The process of developing Medicaid capitation rates and attracting health plans is very complex. Medicaid programs must consider a variety of factors in determining what rates will properly compensate MCOs and ensure public dollars are spent appropriately. These factors include MCO medical costs (the cost of health services), administrative costs, the level of risk the health plan is accepting, the opportunity for third-party payment sources such as auto insurance or other insurance policies to share in the cost of providing services to beneficiaries, and allowances for MCO profits. Benefit packages in Medicaid programs tend to be much more specialized than standard commercial packages, adding additional complexity for states seeking to contract with commercial MCOs. States must also balance their "purchaser" role with the traditional responsibilities Medicaid has assumed over the years including the protection of safety-net providers, serving other populations that do not participate in managed care, financing other types of services such as those for mentally ill and developmentally disabled persons and funding medical education in academic health centers.

## Financial Issues

Like many other states, Kansas has not made systematic adjustments to the Medicaid fee-for-service reimbursement rate schedule over the last 35 years. Instead, rate increases have been sporadic and have often been made in response to federal mandates or local crises. States must continually evaluate their priorities and consider the availability of financial resources to sustain Medicaid programs in the long term.

A combination of additional funding from the Legislature and administrative changes has increased capitation rate revenues to MCOs between fiscal year (FY) 1998 and FY 2002. Kansas rate setting methodology considers geographic region, gender, age, and eligibility category. Taking these factors into account and applying several assumptions about numbers of beneficiaries,[19] revenues to the Medicaid MCO for FY 2002 are expected to exceed FY 2001 revenues by 17.1 percent. Increases in rates from July 1, 1998 to July 1, 2000 ranged between 16.3 percent and 57.5 percent depending on the age and sex of the beneficiaries. Until mid-2001, Kansas capitated rates were based on 1995 fee-for-service rates trended forward using a variety of factors. In 2000 and 2001, the Kansas Medicaid program recalculated capitation rates based on 1998 data. This "rebasing" was utilized in the calculation of capitation rates effective July 1, 2001.

States have struggled to balance their desire to support the growing Medicaid program with very real budget constraints since Medicaid was enacted in 1965. Budget challenges have often been dealt with by either lowering payments to providers or by not increasing payment levels and hoping providers would continue serving Medicaid clients. Medicaid is a federal entitlement program, meaning that if persons are eligible, they must be served regardless of state financial constraints. A potentially more important pressure on Medicaid spending is the political will to help the needy and to not take away benefits. As a result of these realities, states have a limited ability to control Medicaid budgets. States feel the pressure to increase Medicaid rates even as many of them deal with tight overall budgets. According to a survey by the National Conference of State Legislatures (NCSL) in October 2001, nineteen states reported state budget shortfalls, with Medicaid overruns reported in eleven of those states.[20]

Overarching budget constraints after years of prosperity may force states like Kansas to set priorities among expenditures. The size of the Medicaid program means that even small increases can have significant fiscal impacts. A 1997 study of Kansas Medicaid physician fees estimated that the total (state and federal) cost of increasing the fee schedule to equal the average of rates paid by a 4-state region would be $11 million. Increases to rates equal to those paid by Medicare would cost $40 million and increases equal to private managed care rates would cost $60-70 million.[21] These estimates are somewhat outdated at this time due to changes in rates and the number of beneficiaries but still provide a point of reference for policymakers.

## Conclusion

Medicaid payment rates, whether as reimbursements for individual services or as capitation payments, affect the decisions of providers and health plans (MCOs) to participate in the Medicaid program. Lack of MCO or individual provider participation, in turn, affects beneficiary choice of health plan and access to health care services. Lack of MCO interest in participating in Medicaid managed care can also negatively affect the state's ability to negotiate for the best services at the right price. Kansas has clearly struggled to maintain participation of MCOs in its capitated managed care program, and it appears that payment rates have played a role. In the past, the ability of the state to increase capitation payments has been limited not only by budgetary considerations but also by federal restrictions. If the federal limits are removed, the state will have an opportunity to address the issue in a new way. Even without the changes, the state has the power to increase capitation rates through the fee-for-service schedule. Either way, Kansas has important decisions to make regarding the Medicaid program and its commitment to capitated managed care.

## Glossary of Terms

***Capitation*** *(capitated managed care)*
A prospective payment method that pays the provider of a service a uniform amount for each person served, usually on a monthly basis. Capitation is used in managed care alternatives such as health maintenance organizations (HMOs).

***Carved-out services***
Medicaid-covered services, usually mental health/substance abuse and dental, that are not included in (carved-out of) contracts with managed care organizations. These services are then provided through separate delivery systems and usually paid on a fee-for-service basis.

***Fee-for-Service Reimbursement***
The traditional health care payment system, under which physicians and other providers receive a payment for each unit of service they provide.

***Health Maintenance Organization*** *(HMO) or* ***Managed Care Organization*** *(MCO)*
An organization that delivers and manages health services under risk-based arrangements. The HMO or MCO usually receives a monthly premium or capitation payment for each person enrolled, which is based on a projection of the cost of a typical patient. If enrollees, in the aggregate, cost more, the HMO or MCO may suffer losses. If the enrollees cost less, the HMO or MCO profits.

***Managed Care***
A system in which the overall care of a patient is overseen by a single provider or organization.

***Medicaid***
A joint federal-state entitlement program that pays for medical care on behalf of certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

***Primary Care Case Management (PCCM)***
Managed care option in which each participant is assigned to or selects a single primary care provider who must authorize most other services, such as specialty physician care, before they can be reimbursed by Medicaid.

***Provider***
A person, group or agency who provides a covered Medicaid service to a Medicaid client. Providers could include hospitals, physicians, clinics, dentists, psychologists or other types of professionals.

***Risk Contract***
An agreement with a managed care organization (MCO) to furnish services for enrollees for a determined, fixed payment. The MCO is then liable for services regardless of their extent, expense or degree.

***Upper Payment Limit (UPL)***
Currently, the maximum amount a state can pay an MCO in capitation payments. The cost of the capitation payments cannot exceed the cost to the state of covering the same population under the fee-for-service reimbursement system.

Source: National Conference of State Legislatures, Forum for State Health Policy Leadership, Frequently Asked Questions...Medicaid, www.ncsl.org.

# Endnotes

[1] Italicized terms are defined in the glossary on page six of this brief.

[2] Urban Institute, *Questions for States As They Turn to Medicaid Managed Care*, Series A, No. A-11, August 1997.

[3] Urban Institute, *Recent trends in Medicaid Physicians Fees, 1993-1998*, September 1999.

[4] Information provided by Margaret McManus of the Maternal and Child Health Research Center based on telephone interviews with state Medicaid officials as of December 1999. A final report on this issue is being prepared with more recent data included and is expected to be released in 2002.

[5] Holahan, J., Rangarajan, S., Schirmer, M., "Medicaid Managed Care Payment Rates in 1998," *Health Affairs*, May/June 1999.

[6] Mathematica Policy Research, Inc., letter to the Kansas Medicaid Director dated January 8, 1998, referenced in Kansas Department of Health and Environment, Center for Health and Environmental Statistics, Office of Health Care Information and the Kansas Insurance Department, *Kansas Health Insurance Information System: Progress Report*, September 2000. Four state average includes rates paid by Missouri, Iowa, Nebraska and Indiana.

[7] American Academy of Pediatrics, *Medicaid Reimbursement Survey: 1998/1999*, May 1999.

[8] Kaiser Commission on Medicaid and the Uninsured, *Commercial Health Plan Participation in Medicaid Managed Care: An Examination of Six Markets*, November 2000.

[9] See endnote 8. Also see Holahan, J., Rangarajan, S., Schirmer, M., "Medicaid Managed Care Payment Rates in 1998," *Health Affairs*, May/June 1999.

[10] See endnote 3.

[11] Information obtained from Kansas Department of Health and Environment, Office of Health Care Information, *Medicaid Primary Care Physician Providers: Preliminary Analysis*, February 2001. For the purposes of this analysis, "underserved" is defined to mean that the ratio of population below 200% of the federal poverty level to provider FTE is greater than 3,000 to 1. One FTE is equal to 5,000 Medicaid claims submitted. This is based on the recommended federal methodology for Health Care Provider Shortage Area applications and is equal to 20 visits per day for 250 days per year.

[12] Cautions to using the data are included in the document cited in endnote 11.

[13] American Academy of Pediatrics, *Pediatrician Participation in Medicaid/SCHIP: Survey of Fellows of the American Academy of Pediatrics, 2000*, September 2000.

[14] See endnote 13.

[15] Fanning, T., de Alteris, M., "The Limits of Marginal Economic Incentives in the Medicaid Program: Concerns and Caution," *Journal of Health Politics, Policy and Law*, 1993, 18 (Spring): 27-42. Also, Fox, M.L., Weiner, J.P., Phua, K. "Effect of Medicaid Payment Levels on Access to Obstetrical Care," *Health Affairs* 11 (Winter): 150-61.

[16] Perloff, J., Kletke, P., and Fossett, J., "Which Physicians Limit Their Medicaid Participation and Why," *Health Services Research* 30:1 (April 1995, Part 1). Access can be increased by either attracting new providers or increasing the number of Medicaid patients a provider will see.

[17] In a recent study by the Maternal and Child Health Policy Research Center, Kansas's capitated rates for children ranked 42nd out of 42 states in the study.

[18] Notice of Proposed Rulemaking: Medicaid Managed Care; 42 CFR Part 400, et.al. August 20, 2001, found at http://www.hcfa.gov/medicaid/omchmpg.htm.

[19] In the matrix used to establish rates, there are 90 rate cells covering 6 rate regions and 15 age/gender/eligibility groups. Each cell has a unique number of beneficiaries in it with the largest populations being children under 21 years of age. Without weighting rate cells to account for these population differentials, a simple average of the rate table does not provide an accurate picture of the changes in the rates paid to MCOs in Kansas. Between SFY 2001 and SFY 2002, some cells increased and some cells decreased. However, holding the MCO-assigned population constant to that of January 2001 and changing only the rates applied to those populations results in an expected increase in revenue to the MCO of 17.1 percent for SFY 2002 over the amount which would have been received in FY 2001.

[20] National Conference of State Legislatures, *State Fiscal Outlook for 2002: October Update*, October 31, 2001.

[21] See endnote 6.

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