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Moving Beyond COVID-19 Public Health Emergency Risk Corridors

The purpose of this white paper is to identify appropriate – and inappropriate – uses of risk corridors in the context of Medicaid managed care capitation rate setting. This paper offers a timely examination of this topic given the widespread use of risk corridors by states during the COVID-19 public health emergency (PHE) and the potential continuation of those risk corridors after the PHE ends.

More than 30 years ago, state Medicaid programs established managed care programs and capitated payment models to provide managed care organizations (MCOs) with strong incentives to drive improvements in the healthcare system. States typically put MCOs at full risk, avoiding misuse of risk corridors. Risk corridors can weaken managed care's incentives and jeopardize state goals. As a result, policymakers must carefully examine the potential continuation of risk corridors past the PHE.

Several themes are raised in this paper to help policymakers consider the implications of this topic:

Managed care payment policy is critically important to appropriately incentivize Medicaid MCOs to achieve state Medicaid program goals. Key goals include improving budget predictability, limiting spending growth, improving access and quality, investing in preventive care, enhancing program integrity to address fraud, waste and abuse, and fostering innovation to address social determinants of health (SDOH) and advance health equity and wellness.

The COVID-19 PHE introduced temporary financial uncertainty for state Medicaid programs and managed care payment policy. In the early stages of the COVID-19 PHE, the net impact on healthcare utilization was not clear. Policymakers anticipated increased use as cases and hospitalizations multiplied as well as decreased use as individuals avoided care and deferring elective procedures. In response, the Centers for Medicare & Medicaid Services (CMS) issued guidance encouraging state Medicaid agencies to modify MCO contracts. CMS promoted the adoption of risk corridors to address the potentially dramatic spike or decline in healthcare use with upside and downside risk arrangements between states and MCOs. CMS asserted risk corridors would provide "prudent protections and limit financial risk to both state and federal governments and managed care plans during this period of uncertainty caused by the public health emergency."

States responded to the federal encouragement – many of the 40 states contracting with MCOs implemented risk corridors in 2020. States' risk corridors often were designed to recoup perceived MCO windfalls for reductions in healthcare use below pre-pandemic assumptions internalized in capitation rates. Some states also implemented risk corridors retroactive to periods prior to the pandemic, a unique allowance by CMS. Many states have maintained their COVID-19 risk corridors into 2021.

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There are appropriate times to use risk corridors. A risk corridor is a risk mitigation mechanism in which states and MCOs share upside and downside risk. Under a risk corridor arrangement, if an MCO experiences a significant loss, the state will share losses with the MCO. Conversely, if an MCO experiences a significant gain, the MCO will share savings with the state. States use of Medicaid risk corridors is appropriate when they do not have access to credible, historic data to develop MCO capitation rates. This circumstance occurs when a state adds a new population, such as the Medicaid expansion to adults covered under the Affordable Care Act (ACA). In this case, states did not have the data to establish a capitation rate and answer unknowns about the population. Will this new adult population have high healthcare use due to pent-up demand? Or will they have low healthcare use? When the population's needs and costs are unknown, capitation rates are based on assumptions. This is when risk corridors are appropriate. Even in this case, states should only use risk corridors on a temporary basis, and only prospectively, and remove risk corridors when healthcare use data are available.

However, prolonged or inappropriate risk corridor use weakens managed care's fundamental incentives to achieve state policy and program goals. Routine use of risk corridors is not appropriate. Risk corridors diminish MCO incentives to limit spending growth and other goals such as improving access and quality, enhancing program integrity, and fostering innovation. Prolonged and inappropriate use of risk corridors may also remove MCO flexibility around care management spending, depending upon the state's spending definition used in executing the risk corridor.

State Medicaid programs could have used other payment models to capture MCO windfalls from COVID-19. State Medicaid programs could have used other payment options to appropriately incentivize MCOs around state goals and to avoid and/or recoup windfalls. States could enforce existing Medical Loss Ratio (MLR) minimums established by CMS guidance; use statewide (program-wide) risk corridors; and/or commit to terminating risk corridors when the COVID-19 PHE ends.

Capitation rates are the best mechanism to use to ensure Medicaid populations receive care when they need it, where they need it, and how they need it. In exchange for payment, state Medicaid programs expect MCOs to achieve state policy goals. MCOs invest in prevention and wellness, innovations, and community-based organizations (CBOs) to address social determinants of health (SDOH) and advance health equity. MCOs also make myriad other care delivery investments such as hiring community health workers (CHWs), implementing respite housing programs, establishing remote patient monitoring, or contracting with emergency medical technicians. And finally, MCOs use value-based models to drive outcomes.