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Medicaid Managed Care Payment Policy

Restoring Capitation's Incentives to Advance State Goals Post-Public Health Emergency (PHE)

White Paper – August 2023

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EXECUTIVE SUMMARY

The purpose of this white paper is to examine the use of risk mitigation strategies among state Medicaid programs, assess their limiting impact on capitation's incentives for managed care organizations (MCOs), and seek to assist policymakers in designing future Medicaid program payment policies that advance state financial and programmatic goals.

State Medicaid programs use risk mitigation strategies by building on the capitation model. Across the nation, states vary greatly in how they design MCO risk mitigation strategies, with varying effects on capitation's incentives. Some states use risk mitigation mechanisms in targeted ways to address capitation rate uncertainties in providing certain services or covering certain populations; one example is the use of risk corridors. Others use profit caps or minimum medical loss ratios (MMLRs) to limit the total amount MCOs can spend on administrative costs and earn in profit or use risk corridors to provide financial protection for both the state and its MCOs. Finally, some states use a combination of these mechanisms; for example, risk corridors in tandem with MMLRs.

For more than 30 years, state Medicaid programs have partnered with MCOs to advance their goals. States have paid MCOs a fixed, capitated amount to provide care focused on specific quality and access measures and outcomes for their Medicaid members. This arrangement has provided fiscal stability for states by having MCOs assume the financial risk of administering high-quality, cost-effective Medicaid services for members. If MCOs are inefficient in providing these services—and costs exceed the Medicaid cap—they must then absorb the excess costs. If, however, they are efficient and successful in keeping costs lower than their capitation payments, they earn a modest profit. When MCOs succeed in earning profits, state Medicaid programs also succeed, as lower expenditures underpinning those profits are reflected in future capitation rates, which then helps states better manage the overall growth rate of Medicaid spending. In this way, capitation works to align state goals with MCO incentives. Many states have developed reasonable risk mitigation strategies to balance the capitation payment system's inherent risks and opportunities for gains. Other states, however, have nearly eliminated MCO incentives by adopting restrictive strategies. Hence, state Medicaid programs must consider ways to restore capitation's incentives to support MCO performance.

This paper offers a timely examination of this topic as state Medicaid programs emerge from the COVID-19 public health emergency (PHE) and navigate the unwinding of Medicaid continuous coverage. This paper also builds upon the Health Management Associates May 2021 white paper, Moving Beyond COVID-19 Public Health Emergency Risk Corridors, which more narrowly focused on appropriate and inappropriate use of risk corridors.

Key Takeaways

Key Takeaway #1: State Medicaid programs have built a strong partnership with MCOs to improve lives and ensure the program's financial sustainability.

State Medicaid programs contract with MCOs to provide care to more than 70 percent of Medicaid-covered individuals under a capitation model to incentivize MCO performance. To support the goals of this collaboration, state Medicaid programs pay MCOs approximately $400 billion annually, which accounts for more than 50 percent of total Medicaid spending nationally. MCOs spend nearly all of these dollars on member services and care delivery. States began partnering with MCOs more than 30 years ago, when they decided to move away from a poorly incentivized and inefficient fee-for-service (FFS) provider-based payment system. Today, state Medicaid programs partner with MCOs to achieve many important state goals that extend beyond traditional managed care roles and functions. State Medicaid programs leverage managed care contracts to advance health equity, invest in communities where Medicaid-covered individuals live, provide whole-person care and value-added benefits (VABs), engage in quality improvement activities (QIAs) and adoption of value-based payment (VBP) models, and support the state's long-term financial sustainability. Managed care's many successes include improving quality and access while lowering costs.

Key Takeaway #2: Full-risk capitation arrangements work best to incentivize MCO performance and advance key state goals.

More than 40 states have managed care contracting partnerships with MCOs operating under a capitation model. Capitation rates incentivize MCOs to be efficient through the use of a fixed, prospective payment to the MCOs. The MCOs can generate profit by providing quality care at lower cost under prospective capitation rates. MCOs create profit through their ability to lower Medicaid program costs. Lower program costs, in turn, directly support Medicaid's long-term financial sustainability, as MCO savings lower the growth of future capitation rates. MCO profits enable them to remain in business and make investments that support state goals.

Medicaid's capitation rate development process includes "an explicit provision for margin."[i] The margins provided for in capitation rates vary from state to state but generally are modest, ranging from 1 percent to 3 percent. It is important to note that these margins are not pure profits. Margins represent the amount included in the capitation rate to cover an MCO's insurance risk, contributions to risk-based capital, income taxes, investment expenses, and retained earnings or profit. Of note, MCOs are not guaranteed to earn margins. MCOs earn margins by lowering medical spending through improved care coordination and reductions in unnecessary admissions and emergency department visits. Under a full-risk capitation arrangement, a state allows MCOs to retain all margins and assume all risks. MCOs can then use any resulting profits to invest in member care and communities. California is an example of a state that operates under a full-risk capitation rate. Under this arrangement, the state recognizes that the margins MCOs earn can also translate into future capitation rate reductions.

Key Takeaway #3: In response to the PHE, many state Medicaid programs implemented restrictive risk mitigation strategies.

Restrictive risk mitigation strategies reduce capitation's incentives for efficiency by providing MCOs with less opportunity for margins and less spending flexibility. Restrictive strategies also can reward poor performance by limiting MCO financial losses from inefficiencies in care delivery. Today's capitation incentives typically are weaker than in 2019. States can design any risk mitigation mechanism to be restrictive by lowering profit caps, increasing MMLRs, and using risk corridors inappropriately. As we emerge from the PHE, most states already have ended their restrictive risk mitigation strategies, but others have not. These restrictive strategies reduce MCO incentives and flexibilities and jeopardize states' goals. Washington's 2023 risk corridors are even more restrictive than its 2019 corridors. The 2023 corridors limit MCO margins to 1.5 percent and require MCOs to assume unlimited risk. This strategy provides MCOs with limited incentive to advance and invest in state goals for QIAs and benefit coverage through VABs and runs the risk of driving up future state capitation payments.

Key Takeaway #4: As state Medicaid programs emerge from the PHE, state Medicaid programs must consider removing incentive-limiting risk mitigation strategies to restore capitation's incentives.

State Medicaid programs must consider ways to restore capitation's incentives to support the continued evolution of managed care programs in keeping with new and emerging goals. Restoring capitation's incentives will advance Medicaid's long-term financial sustainability by lowering medical costs and incentivizing reinvestment in member services and communities. To move beyond the PHE, states must review current risk mitigation strategies to identify restrictions that compromise efficiencies and jeopardize state goals. State Medicaid programs must continue to optimize the value of managed care.

To learn more about Medicaid managed care payment policy, including the capitation rate development process, the components of MCO margins, and risk mitigation, readers may turn to several organizations and sources, including but not limited to the *American Academy of Actuaries*, the *Society of Actuaries (SOA)*, the *Actuarial Standards Board*, and the *Centers for Medicare & Medicaid Services (CMS)*.

INTRODUCTION

Medicaid managed care is the primary payment and healthcare delivery system for more than 70 percent of Medicaid-covered individuals in the United States. From 1995 to 2023, managed care enrollment increased from 15 percent to more than 70 percent. For children, the managed care enrollment rate is 80 percent. In 2021, total Medicaid payments to comprehensive managed care organizations (MCOs) were estimated at $364 billion. That amount is more than 50 percent of total national Medicaid spending, now at $728 billion.[ii] Medicaid MCO spending is likely closer to $400 billion today. State Medicaid programs rely on capitation's incentives, and the managed care contracting process, to provide MCOs with positive incentives for high performance. Given managed care's sheer size and share of the Medicaid program, state Medicaid programs succeed when MCOs succeed. The opposite also may be true. If MCOs perform poorly, so might the states. The future of Medicaid is inextricably linked to MCO performance. States and MCOs have a mutual interest in designing financial arrangements that incentivize MCO investments to improve care quality and members' outcomes and produce cost savings for state Medicaid programs.

Policy Questions

In the context of Medicaid managed care payment policy, risk mitigation is a critical component, with significant impacts on capitation's incentives. Risk mitigation affects capitation's incentives by adjusting the financial risks and opportunities facing MCOs.

States implement risk mitigation mechanisms to avoid the risk of over- or underpayment to MCOs. Mechanisms are, therefore, used to limit MCO profits and administrative costs or to provide states and MCOs with protection. Many states design strategies that are reasonable and maintain capitation's positive incentives. These strategies provide MCOs with a reasonable opportunity to earn margins needed to remain in business and reinvest in member services, care delivery, and communities.

During the PHE, however, state Medicaid policymakers responded to reductions in healthcare use (below pre-pandemic assumptions used to develop the capitation rates) by implementing new risk mitigation strategies. CMS encouraged and supported these state actions too. Many state Medicaid programs implemented restrictive risk mitigation mechanisms such as low profit caps, high minimum medical loss ratios (MMLRs), and tight risk corridors that limited MCO profits and losses to a narrow range of possible outcomes. These more restrictive designs required MCOs, in some cases, to assume more downside risk than upside opportunity for margins. They also weakened capitation's incentives.

As states emerge from the PHE, state Medicaid policymakers must lean into their important partnership with regional and national MCOs to restore capitation's incentives. Strong incentives are needed to drive important state goals. Strong incentives are needed to tackle the many simultaneous crises in our nation from our maternal mortality crisis to our mental health crisis to our opioid crisis to our workforce crisis. State policymakers must provide MCOs with a reasonable opportunity to earn margins that they can reinvest to support state goals.

This white paper helps policymakers to review and revise Medicaid risk mitigation policy strategies and mechanisms by considering the following policy questions:

- Why are capitation's incentives important to state Medicaid programs' goals?
- How do state risk mitigation policies affect capitation's incentives?
- Why should states focus on restoring capitation's incentives?

This report addresses risk mitigation, an important Medicaid payment policy matter affecting Medicaid's long-term financial sustainability. MMLRs are the most common form of risk mitigation based on national survey data. Most states require MCOs to pay a remittance to the state if they fail to meet the MMLR standard. To assist readers, this paper provides important background on state Medicaid managed care programs, explains how incentives support state goals, presents an analysis of the impacts of risk mitigation mechanisms on capitation's incentives in 15 states, and provides a pathway for restoring capitation's incentives.

Methodology

Informing this paper is a review of published articles and research on Medicaid managed care and payment policy, publicly available federal and state policy documents, Medicaid managed care contracts, and rate certification letters for 15 states from 2019 to 2023.

To track shifts in state Medicaid risk mitigation strategies, HMA reviewed rate certification letters for the 15 state Medicaid programs, tracking state strategies across three time periods: 1) before the PHE (2019), 2) during the PHE (2020−2022), and 3) emergence from the PHE (2023). HMA interpreted state risk mitigation strategies based on these documents. Taken together, the 15 states—Arizona, California, Florida, Louisiana, Maryland, Mississippi, Nevada, New York, Ohio, Oregon, South Carolina, Texas, Virginia, Washington, and Wisconsin—represent 64 percent of all Medicaid managed care enrollees and 56 percent of total Medicaid enrollees in the nation. For more information on managed care enrollment, see Appendix A-1.

HMA brings professional experience, expertise, and analysis to the topic. In so doing, HMA endeavors to provide an objective analysis of key public policy issues for the benefit of policymakers and other stakeholders.

CAPITATION'S INCENTIVES

Why are capitation's incentives important to state Medicaid programs' goals?

For more than 40 state Medicaid programs that operate a comprehensive managed care program under a capitation model, capitation's incentives are key to encouraging MCOs to achieve state goals. States benefit most from capitation rates when incentives are strong, and they are strongest in a full-risk capitation model, under which states prospectively pay MCOs a fixed amount per enrollee.

The fixed nature of this payment model creates strong incentives for MCOs to operate efficiently, because MCOs assume full risk for gains and losses. Under this arrangement, they are incentivized to spend less than 100 percent of the capitation rate and provide for members' needs, meet quality targets, and generate margins that they can use to make further investments in care quality and state goals, while continuing to operate as viable businesses that serve the state's Medicaid population. The capitation model also provides states with the

flexibility to provide care efficiently and effectively. Conversely, some states apply restrictive risk mitigation mechanisms to the capitation model. Restrictive mechanisms limit the already modest margins that MCOs can earn in this model and undermine alignment between MCO incentives and state goals.

A capitation rate is a fixed per capita amount made on a prospective basis. For a quick refresher on why states moved away from an inefficient fee-for-service (FFS) reimbursement and provider-based delivery system to a capitated payment and care delivery model, see Appendix A-2.

Capitation's Incentives Advance State Goals

State Medicaid programs leverage managed care's capitation model to achieve broad state goals. They maintain Medicaid members are better served in a comprehensive managed care program than through the FFS system. States benefit from the budget predictability that fixed capitation rates provide. Capitation provides MCOs with incentives and flexibility to transform payment and care delivery, create new care models, and implement value-based payment (VBP) models. As policymakers appreciate, state Medicaid programs differ in how they design managed care programs, but their goals are similar. Table 1 provides a list of some common goals that states advance through managed care programs.

Table 1. State Goals for Managed Care Programs

State Goals for Managed Care Programs	
• Advance health equity	• Provide in-lieu-of-services (ILOS)
• Invest in communities	• Provide value-added benefits (VABs)
• Provide whole-person care	• Measure and reduce health disparities
• Improve members' outcomes	• Collect and share data to drive outcomes
• Advance financial sustainability	• Use value-based payment models
• Implement a population health program	• Engage in quality improvement activities
• Stratify members based on need	• Reduce preventable service use
• Provide person-centered care	• Design a robust provider network
• Increase access to preventive care	• Partner with community organizations

State Goals for Managed Care Programs	
• Integrate care across service continuum	• Enhance program integrity
• Address social determinants of health	• Improve budget predictability
• Address health-related social needs	• Achieve efficiencies and lower cost trends

Capitation's Incentives Create Key Opportunities

All state Medicaid programs want to do more than they were able to accomplish in a poorly incentivized and inflexible FFS system. In more than 40 states, MCOs are integral to achieving states' ideals. State Medicaid programs seek to build managed care programs that can advance health equity, provide Medicaid-covered individuals with access to an integrated care delivery program, and address whole-person needs in a person-centered manner. Capitation's incentives are critical to operationalizing these opportunities and driving MCO performance.

In recent years, state Medicaid programs have assessed their partnerships with MCOs in innovative ways. The COVID-19 pandemic demonstrated the flexibility to strengthen these collaborations. During the pandemic, for example, MCO performance was central to the "accessibility, timeliness, and quality of COVID-19 care"[iii] for Medicaid enrollees. State Medicaid programs and MCOs must continue to build upon managed care's successes to tackle new needs. To realize these opportunities, state Medicaid policymakers must lean into the capitation model to incentivize MCO performance.

HMA engaged three former state Medicaid directors in a structured Medicaid Managed Care Roundtable to discuss Medicaid managed care payment policy and risk mitigation tools. See Table 2, which summarizes their views on the key benefits of Medicaid managed care and the value of capitation incentives.

Table 2. Key Takeaways from Medicaid Managed Care Roundtable

Former Medicaid Directors Lean into the Capitation Model	
Key Takeaway #1: Medicaid managed care plans operating under capitation rates and their incentives benefit states and members in many ways.	Medicaid managed care offers many benefits to both states and members. HMA colleagues highlighted improved budget predictability for states. Both states and members benefit from MCO improvements in network adequacy and member service access, MCO flexibility to address populations' needs or individual cases, and MCO ability to provide services that are unavailable under FFS, including VABs.
Key Takeaway #2: Medicaid managed care programs provide great value and can "bend the cost curve."	Managed care has demonstrated value in many ways. HMA colleagues highlighted managed care's ability to achieve lower spending trends than other payers and to support the rebalancing of the long-term services and supports (LTSS) system.
Key Takeaway #3: Risk corridors are a blunt tool for managing risk because they are fundamentally at odds with the incentives that capitation rates are designed to create.	HMA colleagues discussed how risk corridors can mask or prop up weak and poor-performing plans. Hence, risk corridors do not directly address concerns about excessive gains, which could be better addressed through the rate-setting process. Risk corridors are appropriate to use in a targeted manner or under extraordinary circumstances, such as when data are lacking. In the case of the unwinding of Medicaid continuous coverage, state Medicaid programs could consider a more refined actuarial analysis of the data to improve the accuracy of the prospective capitation rate development process.

The following opportunities depend upon high-performing MCOs.

Support Medicaid's Long-Term Financial Sustainability. Medicaid's long-term financial sustainability is paramount to ensuring financial stability and maintaining program access and quality. MCOs have played a significant role in supporting Medicaid's sustainability. MCOs operating under capitation have reportedly generated considerable savings in comparison with what state Medicaid programs would have paid through an FFS system. According to a report that the Association for Community Affiliated Plans (ACAP) commissioned, The Menges Group estimated that "the MCO model delivered nationwide Medicaid savings of $7.1 billion in 2016, assuming that provider unit prices paid by Medicaid MCOs are equivalent in the aggregate to Medicaid fee-for-service (FFS) levels. The $7.1 billion figure represents an overall savings of 2.6 percent on all the funds paid via capitation."[iv] The Center for Evidence-Based Policy reported that Medicaid managed care has yielded savings in several states including Texas, Ohio, and Pennsylvania in the billions, when compared with FFS.[v] In another study that The Menges Group conducted on pharmacy benefit administration, the authors found that MCO benefit management is less costly than if the state were to manage the benefits, and carving pharmacy out of managed care would increase state costs significantly.[vi] Finally, MCOs are key to enhancing program integrity to address fraud, waste, and abuse.

Improve Quality. State Medicaid programs use a variety of strategies to improve the overall quality of care for individuals with Medicaid coverage. States monitor MCO performance and use value-based models to improve quality. States require MCOs to establish a quality strategy, with dedicated resources to assess and improve healthcare quality and services. States expect MCOs to implement performance improvement programs (PIPs) to improve quality. Many states also encourage MCOs to invest in healthcare quality improvement activities (QIAs) by allowing MCOs to include spending in MMLR calculations. According to industry experts, managed care has led to significant improvements in quality. Researchers at The Menges Group analyzed quality improvement in managed care and found that over the five years studied (2014−2018), "Managed care organizations improved performance across 87 percent of Healthcare Effectiveness Data Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures."[vii]

Invest in Community, Equity, and Whole-Person Care. State Medicaid programs have come to depend upon MCOs to invest in key priorities, such as community organizations, health equity initiatives, and models of care that support whole-person care. Capitation incentives are critical to achieving these state goals. Without the opportunity to earn margins, MCOs will be unable to make these investments.

- **Investment:** Many states direct or encourage MCOs to reinvest a portion of their profits into the communities they serve.[viii] Several states, such as Arizona, California, Hawaii, Nevada, Oregon, and Tennessee, include community investment provisions in their MCO contracts.
- **Health Equity.** Advancing health equity is one of the greatest opportunities managed care affords.[ix] Many states require MCOs to advance health equity in their contracts.[x] Some states require MCOs to develop a comprehensive approach to improve maternal and infant health, driven by the stark racial disparities in outcomes.[xi] Medicaid

financed more than 40 percent of all births in the United States in 2021. Managed care programs are incentivized to ensure that individuals optimize health before pregnancy and deliver high-quality care throughout pregnancy, birth, and an extended postpartum period.[xii]

- **Whole-Person Care.** Many states require MCOs to conduct comprehensive assessments to identify members' health-related social needs (HRSNs) processes, broaden networks to include community-based organizations (CBOs), and incentivize MCOs to provide value-added benefits by allowing MCOs to include spending on VABs in MLR calculations. California describes whole-person care as the "coordination of health, behavioral health, and social services, as applicable, in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources." Arizona "launched the Whole Person Care Initiative (WPCI) to enhance our existing efforts to identify and address the social risk factors which impact the health outcomes of our members."[xiii]

RISK MITIGATION STRATEGIES

How do state risk mitigation policies affect capitation's incentives?

State risk mitigation policies have varying effects on capitation's incentives. Risk mitigation can maintain, strengthen, or weaken incentives, depending on the state's strategies. State Medicaid programs have considerable latitude in designing risk mitigation strategies. States typically consider the need for risk mitigation as part of the capitation rate development process. See Appendix A-3 for an overview of the capitation rate development process. To assess the impact of state risk mitigation policies on capitation's incentives, HMA reviewed 75 rate certification letters for 15 states over a five-year period (2019−2023).

In recognition of the historical significance of the PHE, HMA reviewed risk mitigation strategies employed in the 15 states study, with consideration to the following three time periods: pre-PHE (2019), during the PHE (2020−2022), and emergence from the PHE (2023). Throughout the PHE, state Medicaid programs made important changes in MCO payment policies as a response to reduced healthcare use. For this reason, HMA determined that it would be best to examine five years of data to inform our findings and to treat the PHE years separately.

To structure and simplify our review, we sorted state strategies into three risk mitigation categories to capture the annual changes in state strategies. These methodologies and their impacts on capitation's incentives are defined in Table 3. For example, states may use targeted risk mitigation strategies, profit caps or MLRs, and risk corridors, regardless of an MLR provision.

Table 3. Risk Mitigation Categories

	Targeted	Gain Share Caps	Risk Corridors
Mechanism	Targeted use of any risk mitigation mechanism.	Profit caps or minimum MLRs.	Risk corridors of any type.
Description	States use risk mitigation mechanisms for a targeted or limited purpose to address uncertainty in the capitation rate-setting process. For example, states may design risk corridors around a new population or a new service, for which no prior experience data are available. In general, the state does not operate a program-wide risk mitigation strategy.	States use profit caps to limit MCO profits. States use MMLRs to limit MCO spending on non-benefits and MCO profits. These mechanisms maintain capitation's prospective payment approach.	States use risk corridors to protect states and MCOs, cap downside risks (losses) or upside gains. Most states use two-sided risk corridors, either symmetrical or asymmetrical in design. States also may use risk corridors in tandem with an MMLR requirement.
Impact on Incentives	Targeted use of risk mitigation mechanisms can maintain capitation's incentives, as they do not apply to MCO capitation rates broadly.	Profit caps and MMLRs can weaken capitation's incentives; for example, when states set restrictive limits on MCO gains or administrative costs.	Risk corridors can weaken capitation's incentives. This can occur when states set restrictive limits on MCO gains and when states ask MCOs to assume a disproportionate share of downside risk relative to upside gain.

Assessment Criteria

All state risk mitigation strategies affect capitation's incentives; however, some strategies bear down harder on capitation's incentives. The extent to which risk mitigation strategies affect

capitation's incentives is not necessarily tied to the mechanism. Rather, the state's strategy affects incentives. State Medicaid risk strategies vary along a continuum.

For this reason, HMA developed a working definition to distinguish reasonable from unreasonable (or restrictive) risk mitigation strategies and assess the impact of risk mitigation strategies on capitation's incentives. See Table 4 for clarification on reasonable versus restrictive strategies.

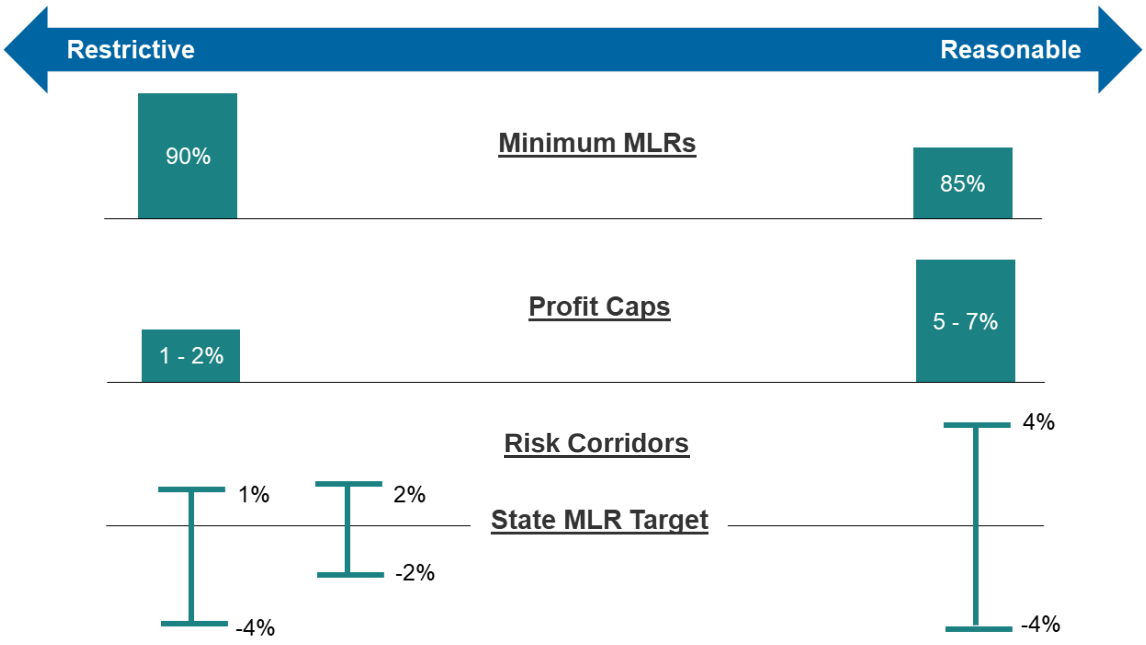
Table 4. Reasonable versus Restrictive Strategies

	Reasonable	Restrictive
Definition	Reasonable strategies maintain capitation's incentives or incentivize MCOs to be efficient and innovative.	Restrictive strategies weaken or erode capitation's incentives or disincentivize MCOs to be efficient and innovative.
Balance between Risks and Margins	Strategies provide MCOs with a reasonable opportunity to earn margins in balance with the risks that the MCO assumes.	Strategies provide MCOs with an unreasonable opportunity to earn margins out of balance with the risks that the MCO assumes.
Treatment of QIAs and VABs	Strategies include consideration of MCO spending on QIAs and VABs in calculating MCO spending on benefits.	Strategies exclude consideration of MCO spending on QIAs and VABs in calculating MCO spending on benefits.

State Examples

As Figure 1 demonstrates, state Medicaid programs use risk mitigation mechanisms that range along a continuum from restrictive to reasonable.

Figure 1. A Risk Mitigation Continuum for Defining Restrictive and Reasonable Mechanisms



As described in Table 5, state Medicaid programs use risk mitigation mechanisms that can be used in a reasonable or restrictive manner.

Table 5. State Risk Mitigation Examples

Mechanism	Targeted Use of Any Risk Mitigation Mechanism	Profit Caps or MMLRs	Risk Corridors of Any Type
Reasonable	**CA: Targeted Risk Corridors** California uses targeted risk mitigation by implementing risk corridors for directed payments for providers.[xiv] Directed payments are a means of linking	**OR: MMLR** Oregon maintained an MMLR of 85% across all contract periods in 2019−2023, with a rebate requirement for MCOs if their MMLR dropped below 85%.[xvi] **TX: Profit Caps**[xvii] Texas has maintained	**AZ: Risk Corridors**[xviii] Arizona uses risk corridors annually, applied broadly across its program. This extensive use of risk corridors can weaken capitation's incentives. However, MCOs may earn up to a 4%

Mechanism	Targeted Use of Any Risk Mitigation Mechanism	Profit Caps or MMLRs	Risk Corridors of Any Type
	payments to certain state goals.[xv]	a profit cap across its Medicaid program from the 2019 contract period through the 2023 contract period.	margin in alignment with a 4% risk they assume. **CA: Targeted Risk Corridors** California uses targeted risk mitigation by implementing risk corridors for directed payments for providers. Directed payments are a means of linking payments to certain state goals.
Restrictive	No examples.	**MS: MLR** Mississippi increased the MMLR from 85% to 87.5% in 2022 with a two-sided risk corridor. Similarly, Kentucky, which is not included in the 15-state review, established an MLR of 90% with an MCO retention of 75% between 86 and 90%. For example, in Kentucky, if the MCO achieved an MLR of 88%, then they would retain [75% * (90%−88%)] = 1.5%.	**WA: Risk Corridors** Washington implemented an asymmetrical risk corridor in the 2022 and 2023 contract periods with a strict limit which begins profit recoupment at 1 percent and has a maximum of 1.5 percent on total medical expense gains and loss sharing for half of medical expense losses greater than 3%. This strategy offered the state more protection than MCOs, which must assume 100% of all losses up to 3% and 50% of all losses beyond 3%, while having any gains capped at 1.5%.

Key Insights

HMA reviewed and analyzed risk mitigation strategies in the 15 states from 2019 to 2023 to determine the value of capitation incentives as the nation emerges from the PHE. These 15 states represent more than one-third of all states with managed care programs and more than 60 percent of all Medicaid managed care enrollees.

The following are key insights gleaned from our review.

Insight #1: State Medicaid program risk mitigation strategies vary extensively. State Medicaid programs vary extensively in how they design and use risk mitigation strategies, although several states use the same mechanisms. Florida and Texas consistently use profit caps, for example, whereas Ohio and Oregon use MMLRs. Some states, such as Nevada and Wisconsin, use MLRs in combination with risk corridors. HMA has prepared a comprehensive table to share our state-by-state results. Table 6 summarizes each state's risk mitigation policies, treatment of QIAs and VAB s in the MLR calculations, and impact on capitation incentives. Washington has the most restrictive risk mitigation strategy of all 15 states studied.

Insight #2: State Medicaid risk mitigation policies are more restrictive in 2023 than in 2019. Based on HMA's assessment criteria, the number of states with restrictive risk mitigation strategies increased to five states in 2023 from no states in 2019 (see Table 6). To be expected, many states established risk mitigation strategies such as risk corridors during the PHE to prevent MCO windfall profits. Most states repealed restrictive PHE policies by 2023; however, five states have maintained restrictive mechanisms.

Table 6. 15 States Sorted by Reasonable and Restrictive Strategies and Time Period

	Reasonable	Restrictive
Pre-PHE: 2019	Total States: 15/15	Total states = 0/15
	States: AZ, CA, FL, LA, MD, MS, NV, NY, OH, OR, SC, TX, VA, WA, WI	States: None
Emerging from the PHE: 2023	Total states: 10/15	Total states: 5/15
	States: AZ, CA, FL, LA, MD, OH, OR, SC, TX, VA	**States:** MS, NV, NY, WA, WI

Insight #3: Four states have MMRLs that are higher than the federal standard.

HMA found Ohio, South Carolina, Mississippi, and New York implemented MMLRs that are higher than the federal standard of 85 percent. In these four states, MMLRs ranged from 86 percent to 90 percent. High MLRs reduce MCOs' potential for gains and dampen capitation incentives for controlling costs and investing in care management.

Insight #4: Some states have lifted policies established during the PHE.

Many states implemented two-sided risk corridors to mitigate the uncertainty associated with the PHE. California and South Carolina, for example, implemented temporary risk corridors. They now have reverted to their pre-PHE strategies.

Insight #5: California is the only state with a targeted risk mitigation strategy.

In 2019, four states including California, Ohio, Virginia, and Wisconsin used risk mitigation only for targeted purposes. Today, California is the only state with a targeted risk mitigation strategy. California uses targeted risk mitigation by implementing risk corridors for directed payments for providers. Directed payments are a means of linking payments to certain state goals. The other three states moved to program-wide risk mitigation strategies during the PHE.

Insight #6: The majority of states include QIAs in MLR calculations.

HMA found that 11 of the 15 states allow MCOs to include spending on QIAs in the MLR calculation or risk corridors. One state (Wisconsin) did not allow MCOs to include spending on healthcare quality improvements in their MLR calculation. The exclusion of MCO spending on QIAs in implementing risk mitigation strategies weakens MCO incentives to invest in quality improvements. For three states, (Arizona, Florida, and New York), HMA did not have enough information to confirm.

Insight #7: Washington's risk mitigation policy is an outlier in its restrictive nature.

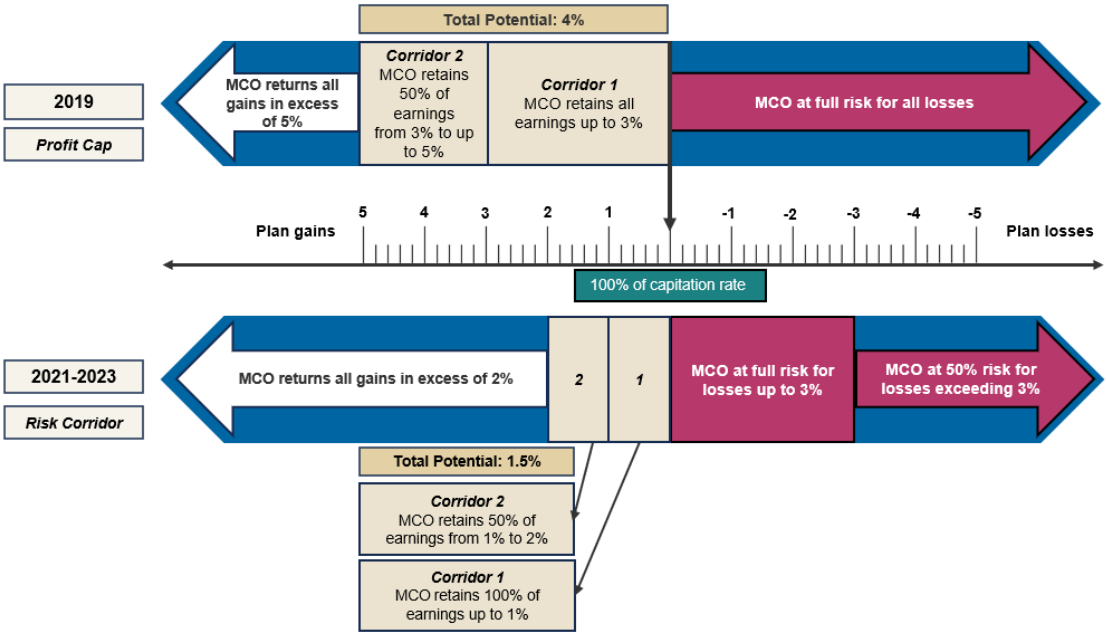
From 2019 to 2021−2023, Washington's risk mitigation policy grew more restrictive. As Figure 2 demonstrates, the state reduced MCOs' opportunity for margin from 4 percent in 2019 to 1.5 percent in 2021−2023, while requiring the plans to absorb all losses in the event costs exceeded capitation funding by 3 percent, and 50 percent of all losses in excess of losses beyond 3 percent. Figure 2 compares Washington's risk mitigation mechanisms for 2019 to its mechanisms for 2021−2023.

Figure 2. Washington's Risk Mitigation Mechanisms in 2019 and 2021−2023

2019: The state operated a one-sided MMLR-based risk corridor that allowed MCOs to retain all earnings of up to 3 percent; half of earnings from 3 percent to 5 percent; and returned all gains in excess of 5 percent. In 2020, this arrangement remained in place in addition to a MMLR of 85% requiring the MCO to submit a remittance for an MLR below 85 percent.

2021-2023: The state moved to a two-sided MMLR based risk corridor such that MCOs retained all earnings of up to 1 percent; half of earnings from 1 percent to 2 percent; and returned all gains in excess of 2 percent. In addition, MCOs were at risk for all losses up to 3 percent and shared equally with the state in losses exceeding 3 percent. The MMLR of 85 percent remained in place for 2021 through 2023.

Washington: Risk Corridors in 2019 and 2021-2023



A FIVE-YEAR REVIEW

Table 7 provides a state-by-state summary and analysis of risk mitigation strategies that the 15 states used over a five-year period (2019−2023) based on HMA's analysis of state Medicaid rate certification letters.

This summary includes:

- A five-year review of the state's risk mitigation strategies and notable changes in strategy
- A description of the state's treatment of MCO spending on healthcare QIAs
- An expert opinion on the impact of the state's risk mitigation strategies on capitation's incentives.

Table 7. A Five-Year Review (2019−2023) of Risk Mitigation Policies in 15 States

#	State	Summary Information
1	AZ	**Five-Year Review:** The state implemented annual program-wide risk corridors in 2019−2023. As noted in the state's certification letter, the continuous use of risk corridors is unrelated to the PHE, but rather reflects a state policy preference to use risk corridors to protect the state from excessive MCO profits. The parameters of the state's medical expense risk corridors, beginning with the 2020 contract period, generally offer MCOs the opportunity to earn up to a 4 percent profit while also limiting MCO losses to 2 percent. In addition, the state operates a risk corridor for a fixed administrative cost component reconciliation, based on the difference between assumed and actual member months. **Healthcare Quality Improvement:** HMA was unable to determine whether healthcare quality improvement costs were included in the medical expenses of the risk corridors, nor could HMA determine, based on the state's certification letter, whether these expenses are included in the non-benefit cost component of the capitation rates. **Impact on Incentives:** The state's use of risk corridors protects both the state and the MCOs without excessive limitations on potential MCO gains.
2	CA	**Five-Year Review:** The state implemented a program-wide risk corridor for the 2020 contract period in response to the PHE. The state did not have risk corridors in other years from 2019−2023. **Healthcare Quality Improvement**: HMA was unable to determine, based on the state's certification letter, whether these expenses are included in the non-benefit cost component of the capitation rates.

#	State	Summary Information
		Impact on Incentives: The state's one-time use of risk corridors during the PHE was common practice for many states. The state's reversion to a full-risk arrangement preserves capitation's incentives.
3	FL	**Five-Year Review:** State statute mandates an achieved savings rebate to the Medicaid program. This arrangement, which preceded the PHE, allows MCOs to retain 100% of the margin up to and including 5%; MCOs retain 50% of the margin above 5% and up to 10%; and MCOs do not retain any of the margin above 10%. Plans that exceed quality metrics established by the state may retain an additional 1% margin. **Healthcare Quality Improvement:** HMA could not determine whether healthcare quality improvement costs were included in the MLR calculation. **Impact on Incentives:** The state's use of a robust and tiered approach to a profit cap, plus an additional 1% margin for quality metrics, provides strong incentives.
4	LA	**Five-Year Review:** The program operated with an MMLR of 85% in 2019−2023, requiring a remittance from the MCO to the state if the MCO reports an MLR below the set threshold. In one contract period, 2020, the state implemented a retroactive two-sided risk corridor in response to the PHE. **Healthcare Quality Improvement**: Health QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state's risk mitigation strategy is consistent with the federal minimum MLR. The state's decision to include healthcare quality activities incentivizes MCOs to invest in these activities.
5	MD	**Five-Year Review:** The program has operated with an MMLR of 85% in 2019−2023, requiring a remittance from the MCO to the state if the MCO reports an MLR below the set threshold. During the 2021 and 2022 contract periods, the state implemented a two-sided risk corridor in response to the PHE. **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state's risk mitigation strategy is consistent with the federal MMLR. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities. The state's use of risk corridors was temporary.

#	State	Summary Information
6	MS	**Five-Year Review:** The program operated with an MMLR of 85% in 2019−2021, requiring a remittance from the MCO to the state if the MCO reports an MLR below the set threshold. During the 2022 and 2023 contract periods, the state increased the minimum MLR to 87.5% in addition to the implementation of a two-sided risk corridor in response to the PHE. The two-sided arrangement limits MCO gains and losses to +/− 2.0%, and the capitation rates allow for a 1.8% target margin. **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state's risk mitigation strategy limits incentives. The MLR is above the MMLR of 85% federal standard. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities.
7	NV	**Five-Year Review:** The program has operated with an MMLR of 85% in 2019−2023 requiring a remittance from the MCO to the state if the MCO reports an MLR below the threshold. During the 2021 and 2023 contract periods, the state implemented a two-sided risk corridor in response to the PHE. The risk corridors are centered on the target pricing MLR for the capitation rates and offer two-sided protection such that gains and losses are tiered with 100 percent MCO risk for the first 2.0 percent around the pricing MLR, 50/50 sharing for the next 2.0 percent around the pricing MLR, and 25/75 sharing beyond that. **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state's risk mitigation strategy is incentive-limiting with broad risk corridors; however, the arrangement offers both MCO and state protection. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities.
8	NY	**Five-Year Review:** New York has separate managed care programs serving different populations. Each program has operated with an MMLR of 85% in 2019−2023, with each program having a different established MMLR threshold. A retroactive MLR-based two-sided risk corridor was implemented for the 2020−2021 contract period across all programs with the target MLR generally set at 90%. **Healthcare Quality Improvement**: HMA was unable to determine whether healthcare QIA costs were included in the MLR calculation.

#	State	Summary Information
		Impact on Incentives: The state's risk mitigation strategy could limit incentives if the MLR continues to hover around 90%.
9	OH	**Five-Year Review:** The program did not operate a program-wide risk mitigation strategy in 2019. Beginning in 2020 and continuing through 2023, the state implemented an MMLR requirement of 86%, requiring a remittance if the MCO reports an MLR below the threshold. The state put temporary risk corridors in place for the 2021 and 2022 contract periods in response to the PHE. **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state risk mitigation strategy upholds capitation's incentives. The MLR is only 1 percentage point above the federal standard of 85 percent. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities.
10	OR	**Five-Year Review:** The program has operated with an MMLR of 85% in 2019−2023 requiring a remittance from the MCO to the state if the MLR falls below 85%. **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state's risk mitigation strategy is simple, straightforward, and upholds strong incentives. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities.
11	SC	**Five-Year Review:** The program has operated with an MMLR of 86% in 2019−2023 requiring a remittance from the MCO to the state if the MLR falls below 86%. During the 2021 contract period, a two-sided risk corridor was implemented in response to the PHE. **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state's risk mitigation strategy upholds strong incentives; the MLR is only 1 percentage point above the federal standard of 85%. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities. The state temporarily used risk corridors during the PHE.

#	State	Summary Information
12	TX	**Five-Year Review:** Texas state government code requires MCOs to share profits through an experience rebate. The state established a tiered rebate method such that for contract periods in 2019−2021, MCOs retained 100% of profits up to 3%, 80% between 3% and 5%, 60% between 5% and 7%, 40% between 7% and 9%, 20% between 9% and 12%, and 0% for profits greater than 12%. In 2022 and 2023, the tiers were adjusted such that MCOs retained 100% of profits up to 3%, 80 percent between 3% and 5%, and 0% for profits greater than 5%. This tiered approach for 2022−2023 provides MCOs with a calculated opportunity to generate 4.6% in margins, (compared to a 7.2% opportunity in 2019−2021). **Healthcare Quality Improvement:** Healthcare QIAs are factored into the calculation of profits. **Impact on Incentives:** The state's risk mitigation strategy upholds strong incentives. The state's decision to include healthcare QIAs provides incentivizes MCOs to invest in these activities.
13	VA	**Five-Year Review:** The program has operated a two-sided risk corridor for the Affordable Care Act (ACA) population in 2019−2023. No other program-wide risk mitigation strategies were in place in 2019−2021. Beginning in 2022 and continuing through 2023, the state implemented an MMLR of 85%, requiring a remittance from the MCO to the state if the MCO reports an MLR below the threshold. In addition, the state imposed a limit on underwriting gains for both the 2022 and 2023 contract periods such that half of gains earned between 3% percent and 10% must be returned to the state, and all gains above 10% must be returned to the state. This tiered approach for 2022−2023 limits gains to 6.5%, based on the opportunity to earn 3% percent plus another 3.5%. **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation. **Impact on Incentives:** The state has limited its use of incentive-weakening risk corridors to the ACA population. Overall, the state's current use of an MLR of 85% is consistent with the federal standard. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities.
14	WA	**Five-Year Review:** In 2019, the state operated a one-sided MLR-based risk corridor such that MCOs retained all earnings up to 3%, half of earnings from 3% to 5%, and returned all gains in excess of 5%. In 2020, this arrangement remained in place in addition to an MMLR of 85%, requiring the MCO to submit a remittance for an MLR below 85%. In 2021−2023, the arrangement moved to a two-sided MLR-based risk corridor, such that MCOs retained all

#	State	Summary Information
		earnings up to 1%, half of earnings from 1% to 2%, and returned all gains in excess of 2%. In addition, MCOs retained all losses of up to 3% and shared equally with the state in losses exceeding 3%. The MMLR of 85% remained in place for 2021−2023**.** **Healthcare Quality Improvement:** Healthcare QIAs are included in the numerator of the MLR calculation and the risk corridor calculations. **Impact on Incentives:** The state's use of an asymmetrical risk corridor transfers all risk to the plan, but with limited opportunity for gain. Consequently, MCOs would be correct in considering payment policy unfair. The state's decision to include healthcare QIAs incentivizes MCOs to invest in these activities. The state has continued to use an asymmetrical risk corridor, transferring a greater share of risk to the plan than allowed to be gained and lowering the overall potential gain for the MCO in comparison with 2019. It is possible that the state's use of risk corridors may reflect deeper challenges in setting accurate capitation rates, which would require state actuarial attention
15	WI	**Five-Year Review:** The program did not operate a program-wide risk mitigation strategy in 2019 and 2020. Beginning in 2021 and continuing through 2023, the state implemented a two-sided risk corridor. The risk corridor centers on the target pricing MLR for the capitation rates and offers two-sided protection such that gains and losses are tiered with 100% MCO risk for the first 2% around the pricing MLR, 50/50 sharing for the next 4% around the pricing MLR, and 0% sharing for the MCO beyond that point. The arrangement limits gains and losses to 4% without consideration of the underwriting margin built into the capitation rates. **Healthcare Quality Improvement:** Healthcare QIAs are excluded from the risk corridor calculation. **Impact on Incentives:** The state's use of risk corridors dampens the incentives of capitation. The state's decision to exclude healthcare QIAs further removes MCO incentives to invest in these activities.

LOOKING AHEAD

Why should states focus on restoring capitation's incentives?

As the nation emerges from the PHE, state Medicaid programs must carefully consider how they use risk mitigation strategies and their impact on capitation's incentives. Restrictive risk mitigation mechanisms undermine MCO incentives to be efficient and innovative, whereas reasonable mechanisms reinforce these incentives. State policymakers need MCOs to be efficient and innovative to support Medicaid's long-term financial sustainability. The use of reasonable strategies will advance incentives for MCOs and generate profits that lower the growth rate of future capitation rates.

States also must carefully consider the many future challenges that require a robust partnership between state Medicaid programs and MCOs. Reasonable risk mitigation strategies generate profits for efficient and innovative MCOs and provide the funding that MCOs need to make investments in state goals. As state Medicaid programs face the challenges of an aging population and people living with long COVID, they must partner with MCOs to create the next generation of care coordination strategies and community innovations. States must optimize the value inherent in the capitation payment model to execute this strategy.

States Must Account for the Unwinding in Restoring Capitation's Incentives.

As state Medicaid policymakers consider ways to restore capitation's incentives to support state goals, they must also account for the unwinding of Medicaid continuous coverage in the post-pandemic capitation rate development process. The unwinding of Medicaid continuous coverage will increase costs and acuity in the Medicaid population. Several actuarial experts in Medicaid capitation rate development explain that Medicaid costs per enrollee will increase as members with higher acuity retain Medicaid coverage and those individuals with lower acuity or who are healthier are disenrolled from the Medicaid program. Congressional Budget Office officials anticipate that the unwinding of continuous Medicaid coverage requirements will reduce Medicaid enrollment numbers by approximately 15 million low-income individuals.

Several nationally recognized experts, including leaders of the American Academy of Actuaries, have outlined options to address impending rate-setting uncertainties at the statewide and plan-specific levels. Consistent with prior guidance, CMS encourages state Medicaid programs to account for rate setting uncertainties and increased MCO financial risk introduced because of the PHE unwinding. States, in partnership with their actuarial experts, can restore capitation incentives while addressing higher per-enrollee Medicaid costs by adjusting the base data used to develop capitation rates. Some actuaries suggest that states can adjust the base data either by excluding members likely to lose Medicaid coverage or estimating the acuity impact of the future population on the base data. According to CMS, "acuity adjustments may be used prospectively or retrospectively." States that adjust the base data for capitation rate development also must commit to revisiting critical actuarial assumptions applied to the base data in future time periods to account for the actual difference in acuity states experience at intervals throughout the year.

APPENDIX

A-1: State Medicaid and Managed Care Enrollment Data for 15 States

#	State	Comprehensive Risk-Based Managed Care Enrollees (A)	Estimated Medicaid Enrollment (B)	Percent of State Medicaid Enrollment (A/B = C)	State as a % of Managed Care Included in the Review (D)
1	AZ	1,711,292	2,013,285	85%	5%
2	CA	10,639,267	13,022,359	82%	29%
3	FL	3,278,980	4,209,217	78%	9%
4	LA	1,468,380	1,731,580	85%	4%
5	MD	1,256,167	1,483,078	85%	3%
6	MS	450,665	705,266	64%	1%
7	NV	558,040	720,052	78%	2%
8	NY	4,760,049	6,458,682	74%	13%
9	OH	2,574,386	2,972,732	87%	7%
10	OR	968,101	1,159,402	84%	3%
11	SC	841,387	1,276,763	66%	2%
12	TX	4,006,196	4,221,492	95%	11%
13	VA	1,398,958	1,472,587	95%	4%
14	WA	1,607,696	1,831,089	88%	4%
15	WI	877,612	1,307,917	67%	2%
States (15 states)		**36,397,176**	**44,585,501**	**82%**	**100%**
United States		**57,039,632**	**79,553,183**	**72%**	
% of Total		**64%**	**56%**		

A-2: Key Differences between FFS and Capitation

FFS	Capitation
• Under FFS, Medicaid pays providers for each service delivered.	• Under capitation, Medicaid pays plans a fixed amount per enrollee, providing a comprehensive set of benefits.
• FFS disincentivizes efficiency and preventive care to reduce potentially avoidable ED visits and inpatient care.	• Capitation incentivizes efficiency and preventive care to reduce potentially preventable emergency department visits and inpatient care.
• FFS does not incentivize higher quality care, as providers are paid on the basis of the service delivered.	• Capitation incentivizes quality, as plans are paid to deliver high-quality care.
• FFS does not typically involve value-based payment models linking payment to outcomes.	• Capitation supports the use of value-based payment models linking payment to outcomes.
• FFS does not typically create any flexibility for Medicaid members to access services that will address their health-related social needs and social determinants of health.	• Capitation provides the flexibility for states to ensure that Medicaid members can access services that will address their health-related social needs and social determinants of health.
• FFS does not establish benefits such as in lieu of services or value-added benefits to increase members' benefits and decrease spending.	• Capitation can cover in lieu of services or value-added benefits to increase members' benefits and decrease spending.
• FFS does not create incentives to rebalance LTSS spending by shifting care from nursing homes to community-based settings.	• Capitation creates incentives to rebalance LTSS spending by shifting care from nursing homes to community-based settings.

A-3. The Capitation Rate Development Process

To realize managed care's potential, however, state Medicaid programs must establish capitation rates with strong incentives. The capitation rate development process provides states with a roadmap for establishing accurate and adequate capitation rates. All states must set capitation rates that meet federal standards of "actuarial soundness," meaning that capitation rates must provide for all reasonable, appropriate, and attainable costs required under the terms of the contract and to operate the managed care plan for the time period and the population covered under the terms of the contract. Such capitation rates are developed in accordance with 42 CFR § 438.4(b)."[xix] States must engage qualified actuaries in this process to certify that the capitation rates anticipate costs and appropriately balance risk and profit.

Capitation Rate Development Steps: The capitation rate development process includes several key steps, as shown in Table A. As the steps indicate, state Medicaid programs follow a detailed methodology to ensure that capitation rates are accurate and adequate. Readers should note two important steps. First, states benefit from managed care's efficiencies captured in the baseline data (Step 1). Second, states also account for non-benefit costs such as a risk margin (Step 4). A risk margin also is referred to as underwriting gain, which accounts for compensation for the risks an MCO assumes. Risk margin is not profit. It is "a necessary component of managed Medicaid capitation rates to ensure solvency, stabilize Medicaid financial results, and provide market-required rates of return invested in the Medicaid programs, and allows for choice among MCOs due to the uncertainty of competition."[xx]

According to the Society of Actuaries, "Actual performance over the past few years has varied widely among MCOs and states, but the average margin1 in 2015 was 1.8% for for-profits and 1.5% for nonprofits, according to financial database results described later in the report."[xxi]

State Consideration of Risk Mitigation: As the final step in the capitation rate development process, state Medicaid programs also can consider the need for and benefit of special contract provisions (Step 5). CMS allows state Medicaid programs to use risk mitigation tools to protect the state and the MCO from the risk that the assumptions used in the initial development of capitation rates differ from actuarial experience. State Medicaid programs can use risk mitigation strategies when uncertainty emerges in the capitation rate development process. Typically, this step provides states with an opportunity to review and revise the state's use of risk mitigation mechanisms, such as: profit caps, MMRLs, and/or risk-sharing arrangements to address risk and limit MCO profits and administrative costs. As part of the review process, states must carefully analyze the impacts of risk mitigation mechanisms on capitation's incentives, as mechanisms can undermine the value of capitation's incentives to states.

Table A-3. Key Steps in Developing the Capitation Rate Methodology

Steps	Capitation Rate Development Process
Step 1	Establish the baseline costs and service utilization for covered populations and adjust to reflect reasonable, appropriate, and attainable costs
Step 2	Develop rates for subgroups or rate cells based on the program design, availability of information, and state preferences
Step 3	Project the baseline costs to the future contract period, accounting for several factors including inflation, utilization changes, and program changes
Step 4	Calculate the non-benefit costs including expenses related to administration, taxes, and licensing and regulatory fees, contributions to reserves, risk margin, and capital costs, and other specific operational costs
Step 5	Consider the need for and benefit of special contract provisions such as risk sharing arrangements, incentives, withholds, state directed payments, and pass-through payments

ABOUT HEALTH MANAGEMENT ASSOCIATES

Founded in 1985, Health Management Associates (HMA) is a national consulting firm specializing in publicly funded healthcare, its stakeholders, and its beneficiaries. HMA can be found online at healthmanagement.com, on Twitter @HMAConsultants, and on LinkedIn at https://www.linkedin.com/company/health-managementassociates/.

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