HEALTH MANAGEMENT ASSOCIATES

MEDICAID MANAGED CARE PAYMENT POLICY

Moving Beyond COVID-19 Public Health Emergency Risk Corridors

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Executive Summary

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.[1] 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."[2]

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.

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.

Introduction

The announcement of the COVID-19 public health emergency (PHE) in March 2020 prompted the federal government and states to rapidly implement many policy and program changes.[i] To address the resulting impacts of the PHE on healthcare, state Medicaid agencies acted quickly to modify Medicaid eligibility and enrollment requirements, ensure access to services and benefits (including expanded coverage and access to COVID-19 testing and telehealth services from home origination sites), reduce cost-sharing requirements, and adjust provider payment rates.[3] Moreover, the Families First Coronavirus Response Act (FFCRA) authorized a 6.2 percentage point increase in the federal Medicaid match rate retroactive to January 1, 2020. Federal and state health agencies also sought to conserve health care resources and reduce transmission of the virus by advising people to limit the use of non-emergent, elective, and preventive medical services.[4] At the time, the initial impact of the PHE on healthcare use was not clear. Aggregate healthcare use could have spiked, due to new cases and hospitalizations. As it turned out, the nation's overall healthcare utilization and spending dropped precipitously, even as COVID-19 infection rates and hospitalizations continued to increase.[5] According to the Centers for Disease Control and Prevention (CDC), by June 2020, approximately 40 percent of adults delayed or avoided medical care.[6]

Adoption of COVID-19 Risk Corridors

Early in the pandemic, the Centers for Medicare & Medicaid Services (CMS) issued guidance to state Medicaid agencies to modify managed care organization (MCO) contracts and payment rates.[7] CMS allowed states to retroactively amend rate setting agreements with MCOs, including the implementation of managed care risk mitigation strategies to respond to COVID-19 PHE impacts. CMS extended the use of risk corridors to 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."[8]

CMS's decision to allow retroactive rate setting actions, including risk corridors, was not a small policy change. Managed care plays a large role in the delivery of healthcare to Medicaid enrollees. In 2019 for example, payments to MCOs accounted for about 46 percent ($278 billion) of state and federal spending on Medicaid services.[9] Prompted by the CMS guidance, many of the 40 states contracting with MCOs implemented COVID-19 risk mitigation strategies such as risk corridors in FY 2020. In a fall 2020 survey of state Medicaid agencies, 16 states reported they plan to make FY 2021 payment adjustments to MCO contracts or rates in response to COVID-19-related declines in utilization.[3]As time has progressed, healthcare utilization and spending has rebounded[5][10]

Policy Questions

The COVID-19 PHE affected states in ways beyond Medicaid. Many businesses closed as in-person services declined. Unemployment rates surged. State general revenues declined due to the loss of

[i] The official date of the Public Health Emergency (PHE) was established retroactive to January 1, 2020.

economic activity.[11] As state policymakers and Medicaid agencies grappled with their comprehensive budget challenges due to the COVID-19-induced downturn in the economy, some states opted to continue the use of risk corridors as part of managed care payment policy.

Policymakers must now consider how to design managed care payment policy through the end of the COVID-19 PHE and beyond. They must determine the role of risk corridors. This white paper helps policymakers to revisit the use of risk corridors by taking up the following policy questions:

- **When are risk corridors considered an effective state practice to mitigate risk and related financial uncertainty around Medicaid managed care capitation payments?**
- **How do risk corridors support or diminish states' ability to achieve state Medicaid managed care program goals?**
- **What alternative payment options and risk mitigation strategies can states use beyond the COVID-19 PHE to address any continued financial uncertainties around MCO capitation rates?**

To assist readers, this white paper provides background and analysis on Medicaid managed care and its goals, explains how managed care payment policy supports these goals, describes effective practices for states to use to address financial uncertainty in the development of capitation rates, and presents a description and evaluation of payment options to replace risk corridors.

Methodology

The information and analysis in this paper is informed by a review of published articles and research on Medicaid managed care and payment policy, publicly available federal and state policy documents, and Medicaid managed care contracts. 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 interested stakeholders.

Medicaid Managed Care

Historically, states paid Medicaid providers directly based on service volume. Over the last 30 years, however, states have increasingly shifted toward managed care delivery models. Under managed care, states pay a capitation rate payment, or per capita amount, to MCOs in exchange for providing services to enrollees.

Many states began turning to Medicaid managed care in the 1990s to address increasing concerns around care delivery. State concerns included uncoordinated care delivery, uneven quality, inefficient and potentially wasteful delivery of services, insufficient emphasis on prevention, and escalating healthcare costs. The federal government and some states were also interested in increasing access to care through Medicaid eligibility expansions. In 1989, the federal government required states to cover pregnant women and children below age 6 in families with income below 133 percent of the federal poverty level (FPL). In 1990, the federal government required states to phase in coverage of all children up to age 18 in families with income below 100 percent of the FPL.[12] The Affordable Care Act (ACA) further accelerated the use of managed care, as many states expanded Medicaid eligibility by covering

the newly eligible population with managed care.[13] State reliance on managed care models has increased in tandem with Medicaid eligibility expansions to new populations and geographic regions.

Today, many states use managed care to cover all or most Medicaid enrollees.[ii] Nearly 70 percent of the nation's Medicaid enrollees were enrolled in a comprehensive MCO across 40 states in FY 2019. **Error! Bookmark not defined.**

Key State Goals of Medicaid Managed Care

State Medicaid policymakers and managed care proponents offer many reasons for establishing Medicaid managed care programs and full-risk capitation arrangements with MCOs. Several policy and program goals emerge from the research.

- **Improve Budget Predictability.** Capitation payments give state budget officials a more predictable way to forecast Medicaid spending. MCO payment rates are calculated prospectively and paid, by contract, on a per member per month (PMPM) amount.
- **Limit Spending Growth, While Improving Access and Quality**. Managed care capitated models and other alternative payment models incentivize value over volume, a shift away from traditional fee-for-service (FFS) models. As Medicaid spending consumed a larger share of state budgets in the 1990s, Medicaid agencies increasingly turned to capitated payment models to incentivize MCO efficiency and effectiveness and improve access and quality. Many efforts showed great promise in reducing costs among commercially-insured populations. Studies on the effects of Medicaid managed care on costs, access, and quality have been numerous. An April 2020 review of 32 such studies on Medicaid managed care effects from 2011-2019 found state-specific cost savings and instances of increased access or quality with implementation or redesign of Medicaid managed-care programs.[14]
- **Enhance Program Integrity.** States also require MCOs to be accountable for program integrity. This means MCOs are at financial risk for provider fraud, waste, and abuse. MCOs conduct many traditional program integrity activities such as preventing false or improper claims submissions. These program integrity efforts performed by MCOs are central to providing healthcare to managed care populations effectively and efficiently.[15]
- **Foster Innovation.** Through managed care's capitated financing arrangement, MCOs gain the flexibility needed to pursue value-based payment models to be innovative and drive quality improvements.[16] MCOs can provide enrollees with additional, enhanced, and flexible support services, which are often not covered under traditional Medicaid FFS models. MCOs can focus on activities to improve healthcare quality with value add services, personal financial assistance

[ii] State Medicaid managed care programs vary extensively in how they design their managed care arrangements under capitated managed care models. Some states include a limited set of Medicaid services in the contract, while other states cover the full scope of Medicaid services.

grants, health and wellness products, housing assistance, and eligibility to participate in innovative programs, such as the use of peer support workers to help address enrollees' needs and social determinants of health. These supports can provide innovative interventions and alternatives to more costly care.

Medicaid Managed Care Capitation Rate Development

States invest considerable time to establish actuarially-sound Medicaid MCO capitation payment rates in accordance with federal law. Actuarially-sound rates require states to pay MCOs an adequate payment to reflect the set of services and populations for which MCOs assume risk. As the federal partner to state Medicaid programs, CMS is responsible for reviewing and approving state capitation rates. This process helps in part to ensure states do not underfund MCOs because of state budget pressure. CMS will only approve state Medicaid capitation rates if they are actuarially sound.[17] Capitation rates must be reasonable to support the managed care program. Capitation rates must meet the federal requirements of 42 CFR part 438 and generally accepted actuarial principles and practices. To meet these requirements, state Medicaid programs enlist help from actuaries. States and their actuaries are responsible for developing capitation rates and certifying all capitation rates as actuarially sound.

Credible and historical data are critical to developing actuarially-sound capitation rates for Medicaid managed care programs.[18] [19] State Medicaid programs typically rely on two key sources to create a historical data set: state Medicaid FFS data and MCO encounter data. Historical base data offers the benefit of providing a comprehensive account of the demographic characteristics, acuity level, diagnostic conditions, and healthcare utilization and costs for populations eligible and/or enrolled in Medicaid MCOs and for MCO-covered services.

State actuaries adhere to a technical and methodical process to give consideration to all adjustments to the historical base data. Many adjustments are made to improve the accuracy of the data for capitation rate development for the managed care program. The overall process is focused on capturing any changes to the historical base data due to the risk of the populations and services covered by the MCOs and managed care savings impacts on costs. This process must also capture any payments excluded from the base data such as payment settlements due to risk-corridors, which could increase or decrease historical trends. As the final step in the rate development process, a state's actuary certifies the actuarially-soundness of the rate for CMS review and approval.

Understanding the Role of MCO Incentives to Achieve State Goals

State Medicaid programs use many payment mechanisms to incentivize MCOs to achieve state goals. However, capitation rates are the primary payment mechanism. States are required to establish actuarially-sound capitation rates and to pay accurately. Payment adequacy and accuracy are key to incentivizing MCOs to achieve goals important to state Medicaid programs.[20] Payment accuracy is also critical to the financial sustainability of MCOs, without which they cannot establish, meet, and maintain adequate reserves to avoid financial instability. When capitation payment rates are neither actuarially sound nor accurate, state Medicaid programs and contracted MCOs will face financial uncertainties. Financial uncertainties have the potential to erode MCO incentives and hinder state goals. If capitation rates are set too low, MCOs may choose not to participate in the program, leading to tremendous disruption and risks for Medicaid members. Other MCOs may reduce value-added benefits that improve the quality of care. The positive incentives of capitation payments can turn to negative ones. These can also be called perverse incentives. Alternatively, if capitation rates are set too high, MCOs may have less incentive to deploy new interventions, care management programs, and negotiate against excessive provider rate increase requests.

Medicaid Risk Corridors for Managed Care

State Medicaid programs use risk corridors when there is significant financial uncertainty around the accuracy of the capitation rates. In these instances, risk corridors are used on a temporary basis for a targeted purpose and on a prospective basis. Risk corridors serve a purpose to limit MCO financial gains and losses if actual spending on healthcare services is materially different from what was expected when the states' actuaries developed the value of prospective capitation payments. States limit MCO gains and losses through a risk-sharing agreement around the capitation rates. This agreement specifies how the state and its MCOs will share gains and bear risks. Risk corridors are generally expressed as upper and lower financial thresholds set relative to a target total annual capitation rate revenue.

State Experience in Using Medicaid Risk Corridors

State Medicaid programs vary in how they design and administer risk corridors. States may choose different attachment points (i.e., the amount of gain or loss at which the corridors begin) and different arrangements for sharing gains or losses with MCOs, based on actual spending above or below the attachment point. States can also design risk corridor arrangements with one threshold or many thresholds. A simple (symmetrical) example of how risk corridors work can be found in Appendix A. Risk sharing of gains and assumption of risk can be also asymmetrical, however.

Some states establish risk corridors around spending based on a definition of MCO incurred medical costs, which typically includes care management services. Risk corridor financial calculations are based on MCO medical costs relative to a target claims cost component, (typically tied to the existing capitation rate). Other states establish risk corridors around a Medical Loss Ratio (MLR) target. An MLR

measures the ratio of MCO spending on medical and related benefits such as care management, compared to total MCO capitation revenue. Finally, some states exclude spending on quality improvements from their calculation of medical expenditures.

Effective Uses of Medicaid Risk Corridors

Risk corridors are typically considered an effective state practice when states do not have credible and historic data to develop accurate capitation rates. This typically happens for states and their actuaries when trying to predict the value of covering new populations, new drug treatments, or launching new care delivery demonstration programs. Most states also adopt other effective practices in designing risk corridors. First, they use risk corridors on a temporary basis. Second, they apply risk corridors prospectively to the contract. Three effective state uses are summarized below, followed by a more detailed description.

- **ACA Medicaid Expansion Population.** With the implementation of Medicaid expansion, state Medicaid programs faced difficulty in predicting the medical costs for the new population due to many unknowns about the underlying acuity of the population and concerns about pent-up demand for medical services. States established risk corridors to prevent the risk of over- or under-payments to MCOs.
- **Blockbuster Pharmacy Treatment.** With new blockbuster specialty pharmacy treatments for hepatitis C, Medicaid programs faced difficulty in predicting the growth in costs due to limited data. States established risk corridors to address the increase in healthcare use and MCO-variation in use.
- **Capitated Financial Alignment Initiative Demonstration.** With the implementation of new integrated care programs important to many individuals with disabilities and older adults, state Medicaid programs established risk corridors to support the capitated Financial Alignment Initiative (FAI) demonstration.

Risk Corridors for Unknown Populations: ACA Expansion Population

In 2010, the Affordable Care Act expanded Medicaid coverage to all adults under the age of 65 with incomes up to 138 percent of the FPL. In 2012, state Medicaid programs received the option to expand coverage. As of March 2021, 39 state Medicaid programs have expanded coverage to more than 15 million people enrolled in the ACA Medicaid expansion group. Most ACA expansion adults are enrolled in managed care.[21] In January 2014, many state Medicaid programs went live with expansion. Most of the newly eligible adult population enrolled in MCOs.

For the ACA expansion population, state Medicaid programs did not have the historical base data needed to establish accurate capitation rates. The ACO expansion population represented many unknowns. The state and its actuaries had concerns about the impacts of higher than average utilization and pent-up demand on capitation rates. As a result, many state Medicaid programs adopted risk corridors. Some states established risk corridors around the medical costs incurred by the MCO including care management services, relative to the claims cost component of the capitation rate. Other states adopted risk corridors based upon an MLR.

State Example: Michigan

Michigan implemented its Medicaid expansion in 2014. From 2014 until December 2015, the state established temporary risk corridors with its MCOs. As shown in the table, Michigan's risk corridor used five thresholds. Within 3 percent of the capitation rate (the first threshold) and beyond the 15 percent threshold (the fifth threshold), the MCO kept the gains or faced the risk of losses. This effectively meant that the state shared in the risk of losses up to 15 percent of the cost component.

State Example: Michigan Risk Corridor for ACA Medicaid Expansion Population	
Targeted Purpose	To limit MCO gains and losses during the early years of expanding to a new population, given the lack of historical base data on which to establish actuarially-sound capitation rates.
Effective Date	2014 through December 2015 (18 months), applied prospectively.
Risk Corridor	MI established its risk corridors as a percentage of MCO medical costs incurred including care management services, (as defined by the National Association of Insurance Commissioners (NAIC) MLR calculation). • +/- 3% of the claim cost component will be the full risk of the MCO • +/- 3%-8% of the claim cost component will be 75% to the MCO and 25% to the state • +/- 8%-12% of the claim cost component will be 50% to the MCO and 50% to the state • +/- 12%-15% of the claim cost component will be 25% to the MCO and 75% to the state • +/- 15% of the claim cost component will be the full risk of the MCO

Risk Corridors for Unpredictable Use of Blockbuster Drugs: Hepatitis C Treatment

In 2013 and 2014, two new medications were introduced to the market to treat and cure many types of hepatitis C. In late 2013, Sovaldi was introduced; in late 2014, Harvoni was introduced. Sovaldi and Harvoni are high cost drugs, priced around $100,000 for a 12-week regimen. These new drugs are often called blockbuster drugs due to their annual sales of at least $1 billion. By 2015, "before accounting for rebates, Medicaid programs nationwide spent more than $2.8 billion in 2015 on Sovaldi and Harvoni, almost 5 percent of total drug spending."[22]

Medicaid programs cover high cost and specialty drugs. This means they are included in the historical base data. However, the introduction of these two new blockbuster drugs in the market was a game changer. The historical base data did not capture the impact on trends. As a result, many state Medicaid programs adopted risk corridors to mitigate the risks facing MCOs. According to the Society of Actuaries: "While state actuaries generally anticipated an increase in specialty drug trend in calculating capitation rates, they did not anticipate the significant magnitude of utilization of certain new specialty drugs. Utilization of new medications such as those used to treat hepatitis C has grown very quickly and unpredictably."[23]

State Example: Ohio

Ohio's Medicaid program established a risk pool for treating members with hepatitis C in 2015. This risk pool worked like a risk corridor to limit MCO losses.

State Example: Ohio Statewide Risk Corridor for Hepatitis C Drugs via Targeted Risk Pool	
Targeted Purpose	To address the high cost of hepatitis C treatment and the potential variation in prevalence of treated hepatitis C members among MCOs.
Effective Date	2016, and removed when the base data reflected sufficient healthcare costs.
Risk Corridor	Ohio established a cost-neutral hepatitis C risk-sharing pool for its MCO program. The risk pool was based on the hepatitis C drug benefit expense per member per month (PMPM) in the capitation rates multiplied by actual membership for each rate cell and region. Additional payment (or recoupments) for each MCO is based on applying the distribution of actual hepatitis C costs across MCOs to estimated costs.

Risk Corridors for New Programs: Capitated FAI Demonstrations

In 2013 and 2014, several state Medicaid programs implemented capitated Financial Alignment Initiative (FAI) demonstrations to advance integrated care delivery for dually eligible individuals covered under Medicare and Medicaid. The population is diverse in age, race, and ethnicity. They often have multiple chronic conditions and disabilities and have needs spanning medical, behavioral health, long-term services and supports (LTSS).

State Example: Massachusetts

Massachusetts established the One Care program in 2013. Risk corridors were a key component of the financial arrangement between the state Medicaid program and One Care plans.[24] The following table provides information on the initial framework for the risk corridors. The state has since modified the original design of these risk corridors.

State Example: Massachusetts Risk Corridor for Capitated FAI Demonstration	
Targeted Purpose	To mitigate the financial risk assumed by One Care plans providing integrated services to dually eligible individuals. The state applied the risk corridors to Medicaid and Medicare Part A and Part B costs.
Effective Date	2013-Present
Risk Corridor	Several state Medicaid programs participated in the capitated FAI demonstrations. Risk corridors varied across the states.[25] The Year 1 risk corridor for the One Care program in Massachusetts was initially designed as follows: • +/- 1% of the claim cost component will be the full risk of the plan • +/-1.1-3% of the claims cost component will be 10% to the plan and 90% to Medicaid and CMS • +/-3.1-20% of the claims cost component will be 50% to the plan and 50% to Medicaid and CMS • +/- 20% of the claim cost component will be the full risk of the plan

State Examples in Using COVID-19 PHE Risk Corridors

In 2020, state Medicaid MCOs reported a marked drop in spending as compared to prior year spending during the pandemic's shutdown. In response, many state Medicaid programs established two-sided risk corridors with MCOs. These risk corridors served as the mechanism for state Medicaid programs to

recoup perceived windfalls to MCOs due to the COVID-19 PHE impact on MCO spending. These state actions were consistent with guidance issued by CMS in 2020.[26] In this guidance, CMS allowed states to use risk corridors for this purpose. Overall, about 50 percent of the states in our sample adopted risk corridors. Each state's Medicaid program varied in risk corridor design and implementation.

- **Effective Date.** Some states established risk corridors from January to June 2020. Other states applied risk corridors retroactive to the start of the contract year period, pre pandemic. Some state Medicaid programs have decided to continue risk corridors in 2021, due to continued uncertainties about COVID-19's impact on spending.
- **Risk Corridor.** Some states established risk corridors with thresholds around MCO incurred medical costs including care management services. In these cases, the state then compared MCO medical costs to the claims cost component of the capitation rate to determine the relative share of loss and gains between the state and each MCO. Other states established risk corridors around a simple MLR target.
- **Treatment of Spending for Quality Improvement.** Some states allowed quality improvement activities to be included in medical costs, while other states did not. Unfortunately, the exclusion of quality improvements from MCO medical costs can unfairly reward MCOs that do not invest in these activities.
- **Limits on Gain.** Some states set risk sharing around the first threshold very narrow; others make risk sharing broader. Some states set limits on gains at 1 percent around the capitation rates; other states set limits on gains at eight percent.

Example: California

California has the largest Medicaid managed care program in the country, providing coverage to 81 percent of its total Medicaid membership. Managed care is responsible for 10.6 million lives.[27] Due to COVID-19 PHE, the state's Medicaid program established a risk corridor around medical costs with allowance for MCO spending on quality activities in 2020. The state applied the risk corridors retroactively to July 2019 or pre-COVID-19. The state's Medicaid programs did not extend this risk corridor in 2021.

State Example: California Risk Corridor for COVID-19	
Targeted Purpose	To limit MCO gains and losses due to the impact of COVID-19 on spending; base data available to establish actuarially-sound capitation rates.
Effective Date	The risk corridor was introduced in November 2020. The state applied the risk corridor retroactively to July 2019. The risk corridor ended December 31, 2020.
Risk Corridor	CA established a risk corridor with more risk on MCOs. CA defined risk as a percentage of medical costs incurred. • +/-2% of 102% of the claim cost component the MCO will be 100% to the MCO • +/- 2%-6% of 102% of the claim cost component will be 50% to the MCO and 50% to the state

	• +/- 6%-10% of 102% of the claim cost component will be 25% to the MCO and 75% to the state • +/- 10% of 102% of the claim cost component will be the full risk of the state

Summary of Risk Corridors

The following table highlights four key points about how risk corridors for the COVID-19 PHE differ from historical, effective state practices. First, states established COVID-19 risk corridors to recoup excess capitation rate revenue. Second, many states applied risk corridors retroactively. Third, some states continued risk corridors. Fourth, some states narrowed the spending definition, excluding MCO spending on quality improvements.

Summary of the Risk Corridors				
	Appropriate: California ACA Expansion	**Appropriate: Ohio Hepatitis C**	**Appropriate: Massachusetts Capitated FAI Demonstration**	**Uncertain: COVID-19**
Available, Credible, Historical Data for Rate Setting	None. Unknown risk, acuity level, and healthcare use for this new population.	None. Unknown prevalence or utilizers of this expensive blockbuster drug among MCOs.	None. No historic data on healthcare use.	Yes. Historic data is available data on MCO-covered populations including risk, acuity level, health care use and variation across MCOs.
Targeted Purpose	To account for the unknowns and pent-up demand of a new population.	To account for the high costs of this new treatment and adverse selection.	To account for the unmet needs of a high-cost population.	To recoup excess capitation rate payments due to COVID-19.
Effective Date	Effective for 2-3 years; applied prospectively.	Effective for defined period (length varies by state); applied prospectively.	Effective for several years; applied prospectively.	Effective in 2020. Some states applied risk corridors retrospectively. Some states may continue in 2021.
Spending	Medical spending, with no exclusions.	Pharmacy spending on certain class of drugs	Medical spending, with no exclusions.	Medical spending. Some states excluded spending on quality improvement activities.

Key Challenges and Implications of Risk Corridors

Risk corridors are an important tool to mitigate the financial risks for states and MCOs when credible and historical data and information is lacking to support the development of actuarially-sound capitation rates and accurate payments.

State Medicaid programs are typically judicious in using risk corridors because they:

- **Weaken MCO Incentives to Achieve State Goals.** Risk corridors weaken MCO incentives under capitation. As previously described, state Medicaid programs have many goals for Medicaid managed care. Inappropriate use of risk corridors or prolonged use of risk corridors can undermine key state goals.

    - **Budget Predictability.** Risk corridors do not add to budget predictability, consistent with the way in which risk corridors work and the risk assumed by the state Medicaid program.
    - **Spending Growth and Access and Quality.** Risk corridors can weaken MCO incentives to control costs. Less attention to cost control initiatives under risk corridors can also lead to inflationary increases on Medicaid spending as additional costs are added to the historical base data.[28] Risk corridors can also weaken MCO incentives to improve access to preventive services, which can lead to greater healthcare use of more expensive care and lower quality care for the individual.
    - **Program integrity**. Risk corridors can weaken MCO incentives to strengthen program integrity efforts. In turn, this can lead to lower care quality for members should provider network quality suffer.
    - **Innovation**. Risk corridors can lead to reduced MCO investment in innovations to address the social determinants of health (SDOH) to avoid penalties under state reconciliations. In turn, less SDOH spending may contribute to poor member health outcomes due to unmet transportation, food, or housing needs.

- **Increase Administrative Burden for States and MCOs.** Risk corridors are designed around a retrospective process, which takes place many months after contract periods end. Reconciliations per the risk corridors are based upon medical claims incurred by MCOs. In general, state Medicaid programs wait to reconcile the risk corridor until long after the claims run-out period to make a full account of actual spending. This long administrative process can also lead to some financial uncertainties for states and MCOs.

Alternative Payment Options to Risk Corridors

In 2020 and 2021, state Medicaid programs acted to address far more than financial uncertainty. They pushed forward with myriad changes and innovations to respond to the pandemic emergency. They also moved quickly to protect Medicaid members from infection and illness and to prevent fatalities. They suspended eligibility redeterminations to ensure coverage. They rushed to help providers move to telehealth. State Medicaid managed care programs and their MCOs assisted in these efforts on behalf of their members and the community. MCOs introduced new value-added services in response to the COVID-19 PHE such as food assistance and home delivered meals. MCOs also offered enhanced MCO care management and outreach efforts often targeting persons at high risk for COVID-19 infection or complications or persons testing positive for COVID-19.[29]

State Actions to Recoup Capitation Revenue Windfalls

Over the last year, state Medicaid programs also established risk corridors in 2020 and 2021. This was done to recoup surplus capitation rate revenue states paid to MCOs. Since MCOs are paid on a prospective basis, state Medicaid programs continued paying monthly capitation rates to MCOs – capitation rates developed using the underlying assumptions internalized in the historical base data. Naturally, the historical base data does not account for a pandemic shutdown and its impact on healthcare spending.

At the same time, state Medicaid programs might have considered other ways to recoup MCO revenue windfalls. States might have used options to maintain MCO incentives, while also reducing the administrative burden of risk corridors on states and MCOs. Several organizations including CMS and the Kaiser Family Foundation have made many contributions over the last year in detailing the range of mechanisms to support this important partnership between state Medicaid programs and Medicaid MCOs. [30] [31]

Moving Beyond Risk Corridors: Payment Options for Consideration

States have many payment options to use to move beyond risk corridors. States could adjust the capitation rate; enforce the MLR minimum established by CMS guidance; use statewide risk corridors; and/or commit to ending risk corridors when the COVID-19 PHE ended.

Medicaid managed care programs are well established. Capitation rates are developed using a rich source of historical base data, with few financial uncertainties. States must consider the decision to use risk corridors by weighing the tradeoffs created by weakening managed care capitation rate's incentives.

There is no way to know how COVID-19 will change the underlying assumptions internalized in historical base data for managed care programs. In the coming months, healthcare payers including Medicaid will learn more about the long-term consequences of the pandemic on healthcare costs. Until such time, state Medicaid MCOs must be ready to address anticipated and unanticipated needs for healthcare and social services and supports, supported by strong incentives.

Adjust the Capitation Rate

Prospectively adjusting the capitation rates in the existing contract is one option state Medicaid programs could use to ensure payment accuracy. A capitation rate adjustment offers the benefit of capturing excess revenue due to large unexpected events such as COVID-19 PHE. State Medicaid programs can update capitation rates mid-year due to changes in the underlying data and assumptions used in capitation rate setting. It is important to note changes in the underlying assumptions could occur from the start of the contract year to a later point in the contact year due to a change in the overall population risk, provider payment rates, service coverage, or other factors. This option provides a streamlined way for state Medicaid programs to ensure payment accuracy.

This option maintains the full-risk capitation model for MCOs, incentivizing MCOs to operate effectively and efficiently. An upward adjustment in the capitation rates to account for changes in the population's risk would encourage MCOs to address the needs of populations with high needs. As compared to risk

corridors, this option has three advantages. First, it maintains the incentives under a full-risk capitated model. Second, it represents a fair approach for accounting for COVID-19's impact on MCO spending. All MCOs participate equally in risk mitigation. Under risk corridors, MCOs operating inefficiently prior to COVID-19 would be unlikely to return revenue to the state under risk corridors. These MCOs might even receive additional revenue via the risk corridor. Finally, capitation rate adjustments are easier to implement.

Any adjustment to the capitation rate will need to meet the actuarial soundness standard and continue to provide adequate and accurate payment to MCOs to address the services and populations the MCO insures. A capitation rate adjustment cannot be driven simply to address state budget challenges.

Medical Loss Ratio

According to the Society of Actuaries in 2017, "an MLR is the portion of premium spent on medical costs, as opposed to administrative or overhead costs. In general terms, an 85 percent MLR requirement, for example, means at least 85 cents of every premium dollar must be spent on direct medical costs. Many states already have some form of an MLR requirement, but the new federal rule requires all states to use historical program MLRs as a comparison point in setting rates to avoid excessive rates or underfunding. MLRs below 85 percent may indicate excessive margins (or higher levels of non-benefit costs), and high MLRs may indicate underfunded programs; either may indicate a lack of actuarial soundness in the rates. There is no penalty or payback required in the federal rule, but states may require MCOs rebate premium dollars to the state until an 85 percent or higher ratio is met."[33]

Enforce the Medical Loss Ratio

Enforcing the MLR is a second option state Medicaid programs could use to limit MCO losses and gains due to changes in the assumptions used in capitation rate setting. State Medicaid programs could enforce the MLR requirement.[32] Many states with COVID-19 risk corridors had MLR "floors" in place to limit MCO profits.

Changes in the underlying assumptions used in the capitation rate development process can occur during the contract year for many reasons. These changes could occur resulting from changes in covered populations, covered services, and payment rates for providers.

This option maintains the full-risk capitation model for MCOs, incentivizing MCOs to operate effectively and efficiently. As compared to risk corridors, this option has two advantages. First, it maintains the incentives under a full-risk capitated model. Second, it is easier to implement.

Adopt Statewide Risk Corridors

Adopting statewide risk corridors is a third option state Medicaid programs could use to limit MCO losses and gains. Statewide risk corridors offer the benefit of capturing excess revenue due to large unexpected events such as COVID-19 PHE. It is very similar to the capitation rate adjustment approach. This payment option could be implemented on a temporary basis.

This option supports states and MCOs in sharing risk around medical costs or an MLR based upon a comparison of total MCO medical expenditure to a statewide benchmark. The state calculates MCO gains and losses in proportion to each MCO's capitation rate revenue. This approach aligns with the way

in which state Medicaid programs develop capitation rates, which is by aggregating all MCO experience data and establishing a single capitation rate over MCO-specific capitation rates.

This option maintains the principles of the full-risk capitation model for MCOs, As compared to more permanent, traditional and MCO-specific risk corridors, this option has two advantages. First, it maintains the incentives of capitation. Second, it represents a fair approach to accounting for COVID-19's impact on MCO spending. This option neither punishes efficient MCOs nor rewards inefficient MCOs.

Summary of Payment Options

Due to the PHE and pandemic shut down, healthcare spending declined. States adopted COVID-19 risk corridors to recoup MCO excess revenues. At the same time, states also reduced MCO incentives around efficiency and effectiveness by using risk corridors. The following table provides a summary of the alternative payment options with a more positive impact on MCO incentives.

The Impact of Payment Options on MCO Incentives		
Adjust Capitation Rate	**Enforce MLR**	**Adopt Statewide Risk Corridors**
Maintains capitation rates' incentives by making an adjustment, preferably prospectively, to the capitation rate.	Maintains capitation rates' incentives by enforcing the MLR.	Maintains capitation rates' incentives by applying a rate reduction to total MCO spending based upon a statewide benchmark.

Conclusion

In response to the COVID-19 PHE, many state Medicaid programs adopted COVID-19 risk corridors in 2020 to recoup capitation revenue windfalls from MCOs. States' risk corridors varied extensively in their design and use. Some states made risk corridors retroactive to pre-COVID-19. Other states excluded MCO spending on important quality improvement activities. Still, other states decided to maintain risk corridors in 2021.

As the healthcare system moves beyond the immediate effects of the COVID-19 PH, state Medicaid programs may turn to several payment models to restore MCO incentives to achieve state goals and to drive greater value though innovation.

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. Dedicated to serving vulnerable populations, HMA assists policymakers, providers, health plans and communities in navigating the ever-changing healthcare environment with a focus on making programs like Medicaid and Medicare operate more effectively. HMA can be found online at healthmanagement.com and on Twitter **@HMAConsultants** and on LinkedIn at https://www.linkedin.com/company/health-management-associates/.

Appendix A. Simple Risk Corridors

Risk Corridor (Symmetrical) Provisions

1. In this simple example, the state Medicaid program established an MCO Medicaid risk corridor.
2. If the MCO actual claims are within 3% of expected claims, MCO keep the profits or bear the risks; and,
3. If claims are at least or > 4% more (or less) than expected, MCO pays Medicaid (or is reimbursed by Medicaid) 50% of the gains (losses) and keeps (or bears the risk of) the other 50%.

Key Assumptions

1. Based upon the state's component of the total capitation rate, the state expected claims to be $10.0 million.
2. Assuming the MCO spent 4% of the amount the state expected, the MCO would share in savings with the Medicaid program.
3. Assuming the opposite, the MCO would share in losses with the Medicaid program.

Savings: Actual spending < Expected spending		**Losses: Actual spending > Expected spending**	
MCO keeps 50% of gains	MCO keeps all gains	MCO bears all losses	MCO bears 50% of losses
MCO pays Medicaid 50% of gains			Medicaid reimburses 50% of losses
< -3%	**-3%**	**3%**	**> 3%**
Difference between actual spending and expected spending as a % of expected spending			

Endnotes

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