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Medicaid Managed Care Organizations and Providers Caught in Crossfire as States Cut Medicaid Budgets

By James Hutchison

Medicaid MCOs typically receive a per capita payment from the state Medicaid agency, i.e., a per member, per month fee for each individual covered by the MCO's Medicaid program. By contrast, MCOs often contract to pay their network providers for Medicaid covered services based on rates for services provided, using a percentage of billed charges or Medicaid fee tables. The MCO's profit is based on the difference between the aggregate payment received from Medicaid and the total amount paid to providers, and this is generally seen as an acceptable trade for the MCO's ability to cut administrative costs and negotiate rates with their Medicaid providers, many of whom also participate in the MCO's private-pay programs.

What happens, however, when a budget crisis forces the state to cut funding for Medicaid services, and thus reduce the per capita payment to its Medicaid MCOs? The contract between the state and the MCO may prohibit midterm reductions, but as a practical matter, if the funding is not there the MCO must accept lower payments or opt out of the Medicaid program, which may not be a viable option. So, the MCO often accepts the reduced per capita payment from the state and then seeks to reduce reimbursement rates to its providers. Is this legal? Fair? Unfortunately, the answer is often unclear, and this scenario can throw the state Medicaid agency, MCOs, and providers into a complex debate which involves considerations of economics, politics, and law that are not easily reconciled.

Just as the contract between the MCO and the state agency provides per capita payments that are fixed for a term, so too does the contract between the MCO and its providers generally suggest fixed reimbursement rates for a year or longer. It may therefore be understandable for hospitals and other Medicaid providers to cry fowl when MCOs seek to adjust reimbursement rates mid-term. On the other hand, some Medicaid provider contracts contain economic "force majeure" provisions, which recognize the close financial relationship between the MCO, the provider, and the state Medicaid agency. These clauses may suggest that the MCO and provider will re-negotiate their rates if a change in state law or regulation alters payments to the MCO such that the provider contract should be changed accordingly. Such provisions, however, may not state how much of a change in the state's payment to the MCO is required to trigger re-negotiation, and they may not provide concrete parameters for the negotiations.

To further complicate matters, federal regulations require that state Medicaid programs be actuarially sound, meaning the state must certify that the funding for the program is sufficient to cover the projected costs of covered services. If a reduction in the per capita payment from the state to the MCO is not accompanied by a reduction in reimbursement rates from the MCO to its providers, a concern arises concerning the actuarial soundness of the program—because the projected costs may then outstrip the funding. Some would argue that a shortfall of this type should be covered, at least temporarily, by the MCO, either from reserves or by shaving profits. This only goes so far, however, since Medicaid MCOs typically have rather low state-mandated profit margins and annual surpluses must be returned to the state. Accordingly, it may be incorrect to think of the MCO as a repository of extra cash that can be used to cover a Medicaid budget crisis. And, as if the situation wasn't complicated enough, state Medicaid agencies have different means of communicating reductions in Medicaid funding. Some may constitute a change in "law or regulation" sufficient to trigger re-negotiation between the MCO and its provider

under economic "force majeure" provisions of the type described above, such as where the change is published in the state Medicaid manual. Others, however, may take the form of communications directed solely from the state agency to the MCOs, inevitably raising a debate over whether the re-negotiation clause should apply, and whether the state intended for the per capita reduction to be "passed on" by MCOs to providers in the form of lower reimbursement rates.

It is no surprise that these complexities result in substantial uncertainty for Medicaid providers and MCOs attempting to operate in a fiscally sound, predictable, and even profitable way. So, what's the answer? It may lie in better contracting.

The provider contract should be clear about what occurs in the event of a reduction in payments from the state Medicaid agency to the MCO. These provisions can take many forms. The parties may agree that the MCO shall absorb reductions up to a point (keeping in mind actuarial soundness concerns), and thereafter make reductions in reimbursement rates to providers to offset the per capita reductions. The parties may adopt a formula that creates a direct mathematical relationship between the per capita payments from the state and provider reimbursement rates, with assumptions concerning utilization based on recent experience.

Any number of solutions can be imagined. But, in an era when state budgetary crises are the norm, Medicaid MCOs and providers are advised to negotiate the allocation of Medicaid payment cuts at the time of contracting. As challenging as those negotiations may be, they are far easier in the relative peace and quiet of contract drafting and execution than they are after a state payment reduction has occurred. In the latter context, negotiations are often forced and combative as the parties gear up for litigation or arbitration and scramble for arguments as to why the other party should bear the brunt of the reduction.

The move to pricing based on the use of Ambulatory Payment Classifications and Enhanced Ambulatory Patient Groups may address some of the problems resulting from reductions in state Medicaid funding, but in the meantime, consider revising your Medicaid managed care contract to address potential cuts in state funding before they occur.
