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States May Be Looking to Balance Budgets on the Backs of Medicaid Health Plan Reserves

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As state governments look for ways to cover their budgetary shortfalls, Medicaid managed care organizations (MCOs) are an attractive target for cash-strapped states because many MCOs have accumulated "Medicaid savings" through years of efficient operation. These so called "clawback" amendments in states like North Carolina have targeted MCO reserves to address budget shortfalls and ultimately provide a budgetary gimmick to siphon off moneys dedicated to care but redirected toward other budgetary priorities.

At-risk MCOs receive capitation payments from the state and must provide all required covered services to plan members within their service areas. MCOs that cannot provide these services with the capitations received must use their Medicaid savings or risk reserves to fund their shortfalls, whereas MCOs that can find efficiencies and provide these services for less than the capitation amounts are entitled to keep the remainder. This remainder constitutes the MCOs' "Medicaid savings." Because some health plans' Medicaid savings are significant, state governments looking for money have begun eyeing these funds, especially as public opinion has (largely unjustifiably) swayed toward suspicion of profitable private health care operations.

Federal Law and Policy Protecting MCOs' Medicaid Savings

Importantly, Medicaid MCOs that find themselves targeted by state efforts to claw back their legitimately accrued Medicaid savings can take comfort in knowing that the law is on their side. These efforts could take a wide variety of forms, such as directing health plans to use their Medicaid savings to cover specific non-Medicaid services or requiring health plans to return some or all of their Medicaid savings to the state via intergovernmental transfers (IGTs). These efforts by states may come into conflict with a number of overarching federal laws, regulations, policies, and guidance.

As an initial matter, these state efforts may violate federal guidance on Medicaid savings, which prohibits states from directing or requiring MCOs to use their Medicaid savings in a particular way. For instance, the Centers for Medicare & Medicaid Services (CMS) has explicitly prohibited state Medicaid agencies from requiring MCOs via contractual provisions to use their Medicaid savings to provide health care services to non-Medicaid-eligible individuals. CMS

has also emphasized the wide latitude MCOs have in determining how to put their Medicaid savings to use and has directly prohibited state Medicaid agencies from seeking to influence or direct MCOs' use of these funds.

State attempts to claw back Medicaid MCO funds may also conflict with federal Medicaid regulations regarding the eligibility of state contributions for federal matching payments. Federal Medicaid regulations permit public funds to be used in a state's contribution for which it seeks federal financial participation (FFP) if the public funds are not federal funds or if they are federal funds authorized by federal law to be used for matching purposes. We are not aware of any federal law that authorizes Medicaid savings to be used for matching purposes, and so, based on the CMS guidance that explicitly prohibits state Medicaid agencies from requiring MCOs to use their Medicaid savings in a particular fashion, any state law or policy seeking to accomplish this would seem to contradict established federal guidance. Moreover, even though the CMS guidance leaves open the possibility of MCOs choosing to use their Medicaid savings to cover non-Medicaid-related services, federal Medicaid regulations would appear to prohibit MCOs from voluntarily using Medicaid savings—which, while the property of the MCO, are derived from federal funding—as part of an IGT to the state that the state would, in turn, use to seek federal matching dollars. This conclusion is reinforced by guidance issued by CMS, the Office of the Inspector General (OIG), and the Government Accountability Office (GAO).

The recycling policy

First, such state initiatives may run afoul of CMS's "recycling" policy, which prohibits states from using previously received federal Medicaid dollars as part of the state's nonfederal share of Medicaid expenditures, intended to draw down additional federal matching payments, in the absence of a corresponding increase in state funding. Since 2003, CMS has carefully reviewed states' uses of IGTs and has required states to terminate any IGTs that the agency views as "recycling" federal funds. As CMS has explained, "When a State chooses to recycle FFP..., the Federal taxpayers in other States disproportionately finance the Medicaid program in the State that is recycling FFP." While IGTs may properly be used as sources of state Medicaid financing in some instances, IGTs are not acceptable funding sources where the unit of government has "attempt[ed] to finance Medicaid payments using revenue from impermissible sources (such as, 'recycled' Medicaid payments, Federal grants precluded from use as State match, impermissible taxes, non-bona fide provider-related donations)."

The retention policy

Second, such state policies may contravene CMS's "retention" policy, which prohibits states from directly or indirectly preventing providers or any entity that receives Medicaid funding, including MCOs, from retaining the full amount of their Medicaid payments. CMS views such practices as enabling recycling and has sought to curb them. For instance, CMS has identified situations where a state or local government used funds returned by health care providers either to cover non-Medicaid-related costs or to seek additional FFP for other Medicaid-related costs, underscoring the inconsistency of such practices with Medicaid financing requirements. CMS has been scrutinizing these kinds of arrangements for over a decade. While the retention policy is not currently codified in federal regulations, there is ample evidence in CMS's formal and informal interactions with states that the agency will intervene when it perceives noncompliance with its retention policy.

OIG and GAO guidance

Finally, such state efforts may warrant scrutiny under OIG and GAO guidance on state Medicaid financing mechanisms, which has called into question arrangements that have the effect of increasing the federal share of contributions to a state's Medicaid program operations and decreasing the state's relative share of its Medicaid expenditures. The

OIG has scrutinized state Medicaid financing arrangements that appear to involve state efforts to maximize federal matching funds while simultaneously avoiding the state's obligation to contribute its required portion. These financing arrangements can take various forms, such as enhanced payments to providers based on federal Medicaid upper payment limit rules, IGTs from localities to states that include commingled federal funds, or other means of requiring public entities to return federal dollars to the state.

Regardless of the form, where the effect is the state benefiting at the federal government's expense, the OIG has scrutinized the arrangement closely and recommended CMS action. Similar to the OIG, the GAO has called attention to state financing mechanisms that effectively enable the state to avoid its requisite contribution for federal matching funds. CMS has expressed an overarching agreement with the basic policy goals discussed by the OIG and GAO, as well as a corresponding sensitivity to the types of potentially problematic state Medicaid financing mechanisms under review by the OIG and GAO.

Call for Caution

In the current climate of ever-constricting state budgets, it is reasonable to expect state legislatures and executive branches to continue seeking creative ways of financing their health care programs. However, state efforts to retroactively claw back risk-based savings from health plans that are effectively managing and caring for some of the most vulnerable and high-risk patient populations threaten the very foundation of risk-based managed care. Nearly 75% of all Medicaid beneficiaries are enrolled in MCOs today. Risk-based managed care is the payment methodology the federal government and most states are depending on to preserve essential patient services while also making the most efficient and effective use of taxpayer dollars.

For risk-based managed care to meet these goals, a delicate balance is required.

Medicaid's risk-based rate-setting methodology has been developed over an extended period. It combines the requirement that payments to plans be actuarially sound with the protection of an 85% medical loss ratio (MLR). The MLR is intended to ensure that rates are adjusted to accurately reflect the cost of efficient covered health services to the enrolled population while also providing adequate resources to health plans to cover a range of reasonable expenses. Those expenses include plan administration; taxes, licensing, and regulatory fees; contribution to reserves; risk margin; cost of capital; and other operational costs associated with providing covered services.

For all these reasons, the current Medicaid risk-based managed care payment methodology must be permitted to function effectively, as intended in federal law and regulations, to protect the integrity of the program and the ability to provide services to the most vulnerable patient populations while providing sufficient incentives to health plans to continue to assume the risk of serving these populations. Medicaid health plans should remain vigilant of improper state efforts to impinge on their Medicaid savings and be prepared to seek federal assistance in curbing these unlawful and ultimately self-defeating state practices.

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