Medicaid Managed Care Regulations:
Minimum MLRs and Rate Setting Implications of Proposed Rules

Speakers:
Eileen Ellis, Managing Principal, Health Management Associates
Steve Schramm, Founder and Managing Director, Optumas

June 16, 2015
HMA Information Services Webinar
Topics for Today

- Increased CMS oversight of Medicaid managed care
- MLR calculations under the new rules
- Alignment of the proposed 85% MLR rules with existing state and NAIC regulations
- Impact on financial flexibility of Medicaid MCOs
- Impact of the shift to actuarial certification of specific rate cells on the competitive environment for Medicaid managed care plans
- Medicaid managed care plan opportunities for additional risk-sharing
- Additional documentation requirements: state and managed care organizations’ perspectives
CMS Goal: “Program and Fiscal Integrity Improvement and Alignment”

• Transparency in rate setting
• Establishing a medical loss ratio (MLR) for Medicaid and CHIP
• Minimum standards for provider screening and enrollment
• Expanding health plans’ responsibilities in program integrity efforts
• Encounter data submission

Also a goal of alignment with Medicare and marketplace health plans
MLR Rules

Text of the core provision at 42 CFR 438.8(a):

The State must ensure, through its contracts starting on or after January 1, 2017, that each MCO, PIHP, and PAHP calculate and report a MLR in accordance with this section. For multi-year contracts that do not start in 2017, the State must require the MCO, PIHP, or PAHP to calculate and report a MLR for the rating period that begins in 2017.

*(Page 506)*
MLR Numerator

Text of plain language summary:

“The total amount of the numerator is ... equal to the sum of the incurred claims, expenditures on activities that improve health care quality, and, ... activities related to proposed standards in §438.608(a)(1) through (5), (7), (8) and (b) of this proposed rule.”

Numerator has broad definition - specified to include:

- Incurred claims
- Expenditures on activities that improve health care quality
- Expenditures related to fraud prevention activities which recover incurred claims payment

*(page 46)*
Expenditures on Activities that Improve Health Care Quality

• Improving health care quality:
  – Service coordination
  – Care management
  – Activities supporting community integration for the LTSS population
  – Outreach and engagement

• External Quality Review Organization activity

• HIT and meaningful use
Issues with MLR Numerator

• Intentionally vague to allow broad interpretation
• Alignment with ACA not clear.
  – ACA includes, e.g.:
    • Activities to improve health outcomes
    • Wellness and health promotion activities
    • Activities to prevent hospital readmissions
  – ACA has a significant list of exclusions
How Will the MLR be Calculated?

• Plain language text define the **denominator** as:
  – Premium revenue
  – Less federal and state taxes and licensing or regulatory fees
  – Similar to private market and Medicare Advantage Differences for Medicaid are inclusion of:
    • One time payments – such as maternity “kick payments)
    • Special “pass through” payments such as GME

*(Pages 50 & 51)*
## Impact of Excluding Taxes

<table>
<thead>
<tr>
<th></th>
<th>If Taxes &amp; Fees Included</th>
<th>Taxes &amp; Fees Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Monthly Premium</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>B. Medical &amp; Health Improvement</td>
<td>$81</td>
<td>$81</td>
</tr>
<tr>
<td>C. Taxes &amp; Fees</td>
<td>$6</td>
<td>$6</td>
</tr>
<tr>
<td>D. Administration &amp; Profit</td>
<td>$13</td>
<td>$13</td>
</tr>
<tr>
<td>MLR</td>
<td>=B/A</td>
<td>=B/(A-C)</td>
</tr>
<tr>
<td>Calculated MLR</td>
<td>81%</td>
<td>86.2%</td>
</tr>
</tbody>
</table>
Timing & “Enforcement”

• Rate/reporting periods on or after 1/1/2017
• Reporting period must be aligned with the rate setting period
• State option to require remittance
• Reported data must be used for future rate setting
• Actuarially sound rates must be based on an MLR of 85% or higher
Alignment with Current State Practices

• State calculations vary significantly
• Per Kaiser Commission’s 2014 survey:
  – More than half of states have a minimum MLR
  – Generally 85% or greater (some as high as 90%)
  – A few states already recover excess “administrative expenses and profit”
  – Risk corridors might be adjusted if MLR not met
  – MLR target might be reduced if plan participates in certain quality initiatives
Alignment with NAIC & ACA

• Stated intent to align with NAIC
• Different reporting periods in many states
  – NAIC = calendar year; state may be fiscal year
• ACA definitions for numerator are more prescriptive with list of exclusions
• However ACA specifically includes:
  – Activities to improve health outcomes
  – Wellness and health promotion activities
  – Activities to prevent hospital readmissions
Impact on MCO Flexibility

- Ability to provide supportive services dependent on flexibility of definitions for numerator. For example:
  - Air conditioning for an asthmatic
  - Incentives for prenatal care:
    - Car seats
    - Gift cards
    - Cell phones
  - Outreach calls to new members
Possible Reasons for High or Low MLR

• In addition to differences in services provided, the MLR of an individual plan might be high or low because of:
  – Plan efficiency
  – Rate setting errors
  – Variation among plans (i.e. risk adjustment not robust enough)
Topics for Today

• Increased CMS oversight
• MLR calculations under the new rules
• Alignment of the proposed 85% MLR rules with existing state and NAIC regulations
• Impact on financial flexibility of Medicaid MCOs
• Impact of the shift to actuarial certification of specific rate cells on the competitive environment for Medicaid managed care plans
• Medicaid managed care plan opportunities for additional risk-sharing
• Additional documentation requirements: state and managed care organizations’ perspectives
Plain Language – Certification of Rate Cells*

Text of the plain language summary:

• Each individual rate paid to each MCO, PIHP, or PAHP be certified as actuarially sound with enough detail to understand the specific data, assumptions, and methodologies behind that rate

• States may still use rate ranges to gauge an appropriate range of payments on which to base negotiations but states will have to ultimately provide certification to CMS of a specific rate for each rate cell, rather than a rate range

* (Page 85)
Certification at the Rate Cell Level:

Concept – What is the problem?
• CMS cannot justify current variation in rates paid at the rate cell level or for MCOs
• CMS not certain current rates paid incentivize MCOs to increase access and innovate

Bottom line – to be good fiscal stewards and ensure appropriate beneficiary access, CMS needs more from the certifications…question is – more of “what”???
Certification at the Rate Cell Level:

Reality – Conflict with ASOP 49?

• Plain Language references Actuarial Standard of Practice No. 49 (ASOP 49)*

• Section 3.1 ASOP 49 says

  “…However, the actuary is not certifying that the underlying assumptions are appropriate for an individual MCO.”

* (Page 80)
Rate Cell Level Certification:

Reality – Now certifying to???

• **Reimbursement?** Each MCO’s underlying contracting strength/discounts available???
• **Utilization?** Each MCO’s underlying care management capabilities???
• **Appropriate costs?** Sophistication of each MCO’s network???
Rate Cell Level Certification:

Reality – Will competitive bidding be allowed?
• **Timing?** Bid and *THEN* develop certification???
• **New plans/populations?** No history, so knowledge of???
• **Market share/pressures?** Business decisions to enter/retain/grow/exit market???
Plain Language – Risk-Sharing Opportunities*

Text of the Plain Language summary:

We propose a definition for “risk corridor” with a slight modification from the existing definition at §438.6(c)(1)(v). The current definition specifies that the state and the contractor share in both profits and losses outside a predetermined threshold amount. Experience has shown that states employ risk corridors that may apply to only profits or losses. We therefore propose to revise the definition to provide flexibility that reflects that practice.

* (Page 93)
Risk-Sharing Opportunities

• What does it mean to MCO?
  – Potential MCO Example #1: Concerned that MLR limits your upside? Create a one-sided risk corridor…Use additional flexibility to create one-sided risk corridor arrangements? Only share in losses from -1 to -3%???
  – Potential MCO Example #2: With MLR requirements, are profits and losses equally likely?? Additional flexibility to create asymmetrical risk corridors? Share in 1-3% profits but increase to -1 to -5% losses???
Plain Language – Additional Documentation*

Text of the Plain Language Summary

In new §438.7, we propose the content of the rate certification that is submitted by the state for CMS review and approval...and

Proposed §438.7(b) would set forth the content that must be in the rate certification to initiate the CMS review process.

*(Page 102 and 103)
Additional Documentation: “Nothing **NEW** to see here folks, let’s move on”

- CMS and OACT have been consistently moving down this path for the last several years…
  - Draft 2016 Medicaid Managed Care Rate Development Guide. The document builds on the previous Consultation Guide released by CMS on September, 2014
  - Goal is to layout CMS’ expectations regarding the information required in the actuarial rate certification letter.
Additional Documentation:

• Rate Cell Certification
  1. **Reimbursement:** Contracted fee schedule and/or capitation rates for EVERY service and EVERY provider? Trade secret???
  2. **Utilization:** Care management capabilities? Proprietary programs???
  3. **Network:** Practice patterns? Who determines “appropriate”??
Additional Documentation:

• Incorporating MLR

1. What does it mean to incorporate MLR?
   – Additional financial reporting required of State and MCOs
   – Establish a process for intake, review/audit, and use of MLR results
Additional Documentation:

“Nothing NEW to see here folks, let’s move on”

**Bottom line** – while most States and MCOs can agree that a more comprehensive, consistent, and transparent process is a good thing, there is significant concern that CMS is underestimating the time, resources, and ultimately the expenses to the State and the MCO to meet this new process.

…Transparency is resource-intensive
Appendices: Text of Core Provisions

• Certification of rate cells
• Risk-sharing opportunities
• Additional documentation
Proposed Rules – Certification of Rate Cells*

Text of the core provision at 42 CFR 438.7(a) and (c):

Rate certification submission.

(a) CMS review and approval of the rate certification. States must submit to CMS for review and approval, all MCO, PIHP, and PAHP rate certifications concurrent with the review and approval process for contracts as specified in §438.3(a)…

(c) Rates paid under risk contracts. The State, through its actuary, must certify the final rate paid under each risk contract and document the underlying data, assumptions and methodologies supporting that specific rate

*(Pages 503 and 506)
Proposed Rules – Risk-Sharing Opportunities*

Text of the core provision at 42 CFR 438.6(a) and (b)(1)**:

Risk corridor means a risk sharing mechanism in which States and contractors may share in profits or losses under the contract outside of a predetermined threshold amount.

(b) Basic requirements (1) If used in the payment arrangement between the State and the MCO, PIHP, or PAHP, all applicable risk-sharing mechanisms, such as reinsurance, risk corridors, or stop-loss limits, must be described in the contract.

*(Page 500)

** Plain Language references 438.6(c)(1)(v)
Proposed Rules – Additional Documentation*

Text of the core provision at 42 CFR 438.7(a) and (c):

Rate certification submission
(a) CMS review and approval of the rate certification. States must submit to CMS for review and approval, all MCO, PIHP, and PAHP rate certifications concurrent with the review and approval process for contracts as specified in §438.3(a)...

(c) Rates paid under risk contracts. The State, through its actuary, must certify the final rate paid under each risk contract and document the underlying data, assumptions and methodologies supporting that specific rate

*(Pages 503 and 506)
Medicaid Managed Care Regulations:
Minimum MLRs and Rate Setting Implications of Proposed Rules

Eileen Ellis, HMA: EEllis@healthmanagement.com
Steve Schramm, Optumas: steve.schramm@optumas.com

June 16, 2015

HMA Information Services Webinar