Issues in Medicaid Managed Care Rate Setting

Medicaid and CHIP Payment and Access Commission
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Overview

• During this session we will:
  – Provide an overview of current rules regarding Medicaid managed care payment
  – Describe payment-related areas that may be addressed in the forthcoming proposed rule
  – Identify areas for the Commission to consider once the proposed rule is published
Current Rules

• All payments and risk-sharing mechanisms in risk contracts must be actuarially sound
• Contracts must specify the payment rates and any risk-sharing mechanisms and their actuarial basis
• States must provide documentation to CMS
  – Actuarial certification of the capitation rates
  – Assurances regarding the data and assumptions
• States must ensure that no other payment is made to a provider for services under the contract
  – DSH and GME are excepted
Minimum Medical Loss Ratio

- Medical loss ratio (MLR) is a ratio of how much health plan revenue is spent on patient care vs. administration and profit
- MLRs are currently allowed but not required; many states use an MLR for at least some plans
- CMS could establish a national Medicaid MLR or require states to impose an MLR
- Medicaid managed care programs are heterogeneous, complicating efforts to determine an appropriate level for a national MLR
Supplemental Payments and Actuarial Soundness

- States may make supplemental payments to some providers up to the upper payment limit (UPL).
- Current rules do not allow states to include UPL payments in capitation rates or require MCOs to pass them through to providers.
- States have developed a variety of approaches to mitigate the potential loss of targeted supplemental payments (e.g., demonstration waivers).
- CMS could change actuarial soundness rules to let states preserve existing funding mechanisms while expanding the use of managed care.
Mid-year Changes

- Capitation rates are set prospectively and must be approved by CMS before going into effect.
- Recent federal policy changes and market actions have had significant mid-year effects on rates.
- Currently no standard guidelines requiring rate recertification for significant mid-year changes or an abbreviated process for federal re-approval.
- CMS could require states to resubmit actuarial certifications or allow states to prospectively certify a rate range.
Risk Mitigation

• Current rules allow states to implement risk corridors, stop-loss, or reinsurance
  – Allow plan and state to share in costs or savings beyond a certain threshold or protect plans from excessive losses

• CMS has encouraged states to implement risk mitigation in rate-setting for the new adult group

• CMS could require states to establish risk mitigation for new populations or benefits where there is significant risk or enhanced match
Transparency

• State practices for developing capitation rates vary significantly
• Current rules do not require states to share rate-setting documentation with plans or others before rates are submitted to CMS for approval
• Health plans and providers have raised concerns about the lack of transparency
• CMS could require states to share information regarding data and assumptions, allow plans to comment during federal review
Baseline/Encounter Data

- Current rules require states to use appropriate data to set rates and to document the types of quality of data used.
- Fee-for-service and encounter data can be used to support rate-setting; each data set has limitations as described in prior Commission work.
- CMS could impose additional requirements on states regarding the quality and timeliness of data used for rate-setting.
Next Steps

• CMS is expected to publish the notice of proposed rulemaking later this year
• Staff will prepare a detailed analysis of changes and new provisions
• Commissioners can determine whether to submit formal comments
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