Issues in Medicaid Managed Care Rate Setting

Medicaid and CHIP Payment and Access Commission
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May 15, 2015

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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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