

The Future of Medicaid Managed Care


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Agenda

- Medical loss ratio
- Development of capitation rates
- State direction of plan payments to providers
- IMD/Alternative services

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Medical Loss Ratio

- Proposed requirements for plans to report their medical loss ratio (MLR) starting with rate years that begin in 2017
- $MLR = (\text{Incurred claims} + \text{activities that improve health care quality} + \text{program integrity efforts}) \div (\text{Adjusted premium revenues})$
- Plans to report the calculated MLR each year, along with claims data, expenditures, and other data

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Medical Loss Ratio (cont'd)

- States are not required to impose a minimum MLR on plans or require remittance if the MLR is not met
 - If the state does impose a minimum MLR, must be at least 85%
- Capitation rates must be developed such that the plan would “reasonably achieve” an MLR standard of at least 85%

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Medical Loss Ratio (cont'd)

- Is an 85% MLR appropriate for Medicaid?
- CMS oversight of plan expenditures
- How will the MLR impact capitation rates?
- How will the MLR impact plan-provider negotiations?
- Collateral implications of other NPRM provisions (network adequacy, etc)

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Rate Development 7

- Significant update to the requirements related to actuarial soundness and the development of plan capitation rates
- Key changes:
 - Certification of actual final capitation rate for each plan (not hypothetical rates or ranges)
 - Rates to be based on encounter data no older than the most recent 3 years (time-limited exceptions available)
 - Asymmetrical risk corridors – risk sharing can be for profit or loss
 - State must receive approval of rate certification, similar to authority for contract approval

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Rate Development (cont'd) 8

- Are the rate development process changes feasible?
- How will they affect the timing of the rate development process?
- What state policies will have to change if the NPRM is finalized?
- CMS partial deferral/disallowance authority

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State Direction of Plan Expenditures ⁹

- NPRM would codify a requirement prohibiting states from directing a plan's expenditures under its risk contract without prior CMS approval

- What is the legal basis for this policy?

- Is this an expansion of current CMS policy?

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State Direction of Plan Expenditures (cont'd) ¹⁰

- CMS approval authority is narrowly circumscribed:
 - Value-based purchasing models for provider reimbursement
 - Plan participation in a multi-payer delivery system reform or performance improvement initiative
 - Minimum fee schedules or a uniform dollar increases for all providers of a service

- Arrangements must also meet additional criteria

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State Direction of Plan Expenditures (cont'd)

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- Are the proposed exceptions broad enough to allow states flexibility?
- Impact on state replacements for UPL revenue

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IMD/Alternative Services

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- NPRM proposes for plans to have express authority to receive capitation rates for individuals who are admitted for a short term (< 15 days during the month) stays in an IMD
- By statute, Medicaid does not cover services for adults age 21-64 who are in an IMD
- What is the legal basis for allowing capitation rates for short term IMD residents?

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IMD/Alternative Services (cont'd)

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- The preamble to the NPRM includes a discussion affirming plan ability to cover alternative services “in lieu of” covered Medicaid services
- What is the extent of a plan’s authority to offer alternative services “in lieu of” Medicaid services?
- How are IMD services/alternative services recognized in the capitation rates and in the MLR?

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Closing Thoughts/Questions

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- Comments on the NPRM are due July 27, 2015.

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