

# Proposed Rule's Medicaid Managed Care Medical Loss Ratio Requirement Will Likely Impact Plans, Providers and Patients in New York

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## Medicaid Managed Care Proposed Rule

On June 1, 2015, the Department of Health and Human Services Center for Medicaid and Medicare Services (CMS) published a proposed rule at 80 Fed. Reg. 31097 (Proposed Rule) that will fundamentally change state Medicaid Managed Care programs. Since CMS last issued Medicaid Managed Care regulations in 2002, states have substantially expanded the use of Medicaid Managed Care with over 40 million individuals currently enrolled in Medicaid Managed Care plans. In response to this exponential growth, CMS has proposed sweeping changes to the Medicaid Managed Care regulations to improve Medicaid beneficiaries' access to care, support states' efforts to deliver high-quality cost-effective care, strengthen the health care delivery system's ability to serve diverse populations, and promote greater alignment of Medicaid Managed Care policies with those of other payers. CMS believes these lofty goals can be met by implementing the changes set out in the 653-page Proposed Rule. These changes include, among others:

- new medical loss ratio requirements;
- new quality measure requirements, including the establishment of a Medicaid Managed Care quality rating system that would include performance information on all health plans;
- enhanced network adequacy standards and access to providers requirements, including state certification that Medicaid Managed Care beneficiaries have access to doctors and hospitals;
- enhanced public reporting and transparency requirements for Managed Care plans and states;

- enhanced beneficiary protections to improve experience and ensure continuity of care;
- strengthened fiscal and program integrity, including clarification on actuarial soundness and rate setting; and
- streamlined Medicaid Managed Care requirements to align with Medicare Advantage and commercial insurance requirements.

While many of the provisions proposed in the Proposed Rule are significant, the new medical loss ratio requirements are garnering notable attention and are discussed in more detail below.

### **Medical Loss Ratio Requirement**

The Proposed Rule sets a minimum for any state-required medical loss ratio (MLR) at 85% for Medicaid Managed Care plans. MLR is the share of premium revenues that a plan spends on patient care and quality improvement activities as opposed to amounts retained for administration and profit. Requiring Medicaid Managed Care plans to spend their premium revenues on health care delivery, rather than on administrative services or for retained profit, is intended to ensure that health care providers are receiving adequate compensation for providing care services and that plans are not retaining an excessive proportion of health care funding for overhead and profit.

While the MLR concept has been around for some time, it became a more visible system after the Affordable Care Act (ACA) imposed MLR standards on most commercial health insurance plans and Medicare Advantage plans. Although the ACA did not impose MLR standards on Medicaid health plans, a number of states (e.g., Florida, New Jersey, Maryland) have nevertheless incorporated MLR requirements into their Medicaid Managed Care contracts.

CMS notes that including MLR requirements for Medicaid Managed Care plans is valuable, as such requirements align with commercial and Medicare Advantage standards and provide "administrative simplicity for states and health plans to manage health care delivery across different product lines, as well as to enhance beneficiary protections." Additionally, CMS emphasizes that the MLR requirements are meant to help CMS and states monitor and evaluate whether capitation rates are actuarially sound "by generally illustrating how [] funds are spent on claims and quality improvement activities as compared to administrative expenses."

- MLR MINIMUM STANDARD

The Proposed Rule provides that a state need not set a minimum required MLR. However, if states choose to, their minimum MLR must be at least 85% and must be calculated as set forth in a new section 42 C.F.R. § 438.8 and as described below. The Proposed Rule acknowledges that some states may already impose an MLR requirement on Medicaid Managed Care plans, and notes that states may maintain their current MLR requirements so long as the minimum standard is higher than 85% and the MLR is calculated according to the method set forth in § 438.8.

By comparison, the Proposed Rule does not set a maximum MLR. CMS does point out that a MLR that is "too high" could imply capitation rates are too low, which could have a negative effect on enrollees' access to services and provider participation. Although the Proposed Rule does not set a maximum MLR, CMS encourages states to establish a "maximum MLR threshold, which accounts for the type of services being delivered, the state's administrative requirements, the maturity of the program and the Managed Care plans."

- CALCULATING THE MLR

The MLR is calculated by dividing eligible medical costs ("Medical Costs") by premium revenue (less federal and state taxes and licensing and regulatory fees, excluding fines and penalties) ("Adjusted Premium Revenue").

"Medical Costs"

MLR = "Adjusted Premium Revenue"

The Proposed Rule defines "Medical Costs" to be the sum of the following:

1. Incurred claims, including any payments made by Managed Care plans into Medicaid-specific solvency funds, and certain payments that Managed Care plans make to the states, including risk-corridor or risk adjustment payments, but excluding amounts paid to third-party vendors for secondary network savings, network development, administrative fees, claims processing, amounts paid for professional services, and utilization management, as well as certain payments that Managed Care plans receive from states, including stop-loss payments, risk-corridor payments, or retrospective risk adjustment payments;
2. Expenditures for activities that improve health care quality, including expenditures for activities listed in the commercial MLR rules, health informational technology and meaningful use of electronic health records, and external quality-of-care activities; and
3. Expenditures for fraud/abuse prevention activities, although such expenditures would be capped at 0.5% of a Managed Care plan's premium revenues.

The impact of the MLR requirements will turn on what activities and expenditures are ultimately included in the definition of medical costs. CMS notes that it intends for service coordination, case management, and activities supporting state goals for community integration of individuals with complex needs to fall within the purview of "expenditures on activities that improve health care quality" and is seeking comment on whether the language of the Proposed Rule is broad enough to reasonably include these activities. Moreover, unlike the Medicare Advantage and commercial insurer MLR requirements, the Proposed Rule includes a limited amount of fraud/abuse prevention expenditures in the definition of medical costs. Stakeholders must ensure that CMS' definition of medical costs does not include activities primarily aimed at controlling a plan's costs, but exclusively includes activities focused on improving quality of care.

- REPORTING REQUIREMENT

The Proposed Rule provides that, starting in 2017, states must require Managed Care plans to submit detailed reports on their MLR calculations to the state each year. The state, in turn, is required to annually submit to CMS an actuarial certification and summary description of the plan's MLR reports. Though Managed Care plans' reports must meet specific content standards defined in §438.8(k) to ensure the state has enough information to monitor and confirm compliance with the standards for calculation of the MLR, the timing and manner of reporting is left up to the states. CMS is soliciting comments on the appropriateness of the reporting requirements, and hopes to establish a national outline of minimum components to each state's plan monitoring system and oversight responsibilities for MLR reporting.

- RATE-SETTING

The Proposed Rule notes that CMS believes that "considering the MLR as part of the rate-setting process would be an effective mechanism to ensure that program dollars are being spent on health care services, covered benefits, and quality improvement efforts rather than on potentially unnecessary administrative activities." The Proposed Rule requires that states develop capitation rates that "would reasonably achieve" an MLR of 85% while providing all covered services. If a state does not impose a minimum MLR of 85% or higher, and they use the calculations required by the Proposed Rule to discover their Managed Care plans are operating at an MLR below 85%, they are required to use this information to set a future rate such that, using the projected revenues and costs for the rate year, the plan would achieve an MLR of at least 85%. In setting the rates, states also would need to "take into account" the entity's past and projected MLR.

- ENFORCEMENT

The Proposed Rule has left many administrative and oversight requirements to the state Medicaid agencies to develop. This grants states flexibility, but also adds administrative and oversight burdens. It will be a heavy burden for some, as a recent review of CMS data found that out of 167 Managed Care plans in 35 states, one in ten had MLRs below 79% and one in four had MLRs below 83%.[\[1\]](#)

If the Proposed Rule is enacted as drafted and a Managed Care plan does not meet the 85% MLR (or a higher MLR minimum set by the state), the state may choose to require the entity to provide a remittance. Unlike the ACA's MLR standards, which require insurers and Medicare Advantage plans to provide consumers rebates if they do not meet the MLR standard, the Proposed Rule does not require such remittance. Instead, states may require plans to pay remittances for not meeting the minimum MLR required by the state. However, if states impose such a requirement, they must reimburse CMS for an amount equal to the Federal share of the remittance.

### **Implications of the MLR Requirement for New York Medicaid Managed Care**

New York State currently does not impose MLR requirements on Medicaid Managed Care plans. However, the State subjects Medicaid Managed Care plans to an administrative per member-per month cost cap, which is likely below the 15% MLR threshold under the Proposed Rule. However, this is very different than an MLR. It is a factor in rate-setting; it is not a standard against which plans are evaluated and plans may spend more or less on administration without penalty. According to a New York State Department of Health Office of Quality and Patient Safety All Plan Summary Report (Published May 2014) (the "New York Report"), New York Medicaid Managed Care plans averaged an MLR of 89.3% in 2012 with the highest MLR being 100.4% and the lowest being 75.3%. While the New York Report defines medical loss ratio to be the percentage of premium dollars spent on medical costs divided by total premium revenue, the New York Report does not specify what is included in medical costs. Nor does a high or low MLR trigger review by the State.

As noted, New York currently does not impose an MLR requirement on Medicaid Managed Care plans, and pursuant to the Proposed Rule would not be required to impose such an MLR. That said, if New York does decide to require plans to meet an MLR requirement, under the Proposed Rule the minimum MLR must be at least 85% and calculated according to the methodology set forth in the Proposed Rule. In this event, the definition of "medical costs" will be critical in the final rule. Although the New York Report noted that New York's Medicaid Managed Care plans averaged an MLR of 89.3%, it is unclear what services were or were not included in the medical costs numerator, and thus that average may not be indicative of New York's Medicaid Managed Care plans' MLRs, as calculated pursuant to the methodology set forth in the Proposed Rule.

Even though New York would not be required to mandate that plans meet a minimum MLR requirement, under the Proposed Rule, New York plans would still be required to submit annual MLR reports to the State, using the calculation method set forth in the Proposed Rule. Additionally, New York would be required to take into account a plan's MLR in setting capitation rates and strive to set rates that "would reasonably achieve" an MLR of 85%.

In sum, whether or not New York imposes an MLR standard on Medicaid Managed Care plans, the Proposed Rule would impose MLR reporting and rate-setting requirements with implications for plans, providers and patients and require states and plans to focus greater attention on the relative proportion of Medicaid premiums used for medical services, care management and other plan purposes.

Comments to the Proposed Rule are due by July 27, 2015.

[\[1\]](#) *CMS Unveils Proposed Rule for Medicaid Managed Care Plans*, California Healthline (May 27, 2015).