MACPAC

Medicaid and CHIP Payment and Access Commission

Summary Report on Managed Care Payment Roundtable

Chris Park

April 10, 2014

Overview

- On March 13, 2014, MACPAC convened an expert roundtable on Medicaid managed care rate setting
- Attendees included representatives from actuarial firms, state Medicaid officials, managed care plans, CMS, and beneficiary advocacy groups
- Today's session provides a summary of the main issues and themes that arose from the roundtable discussion

Roundtable Topics

- Medicaid expansion population
- Managed long-term services and supports (LTSS)
- Risk sharing and risk mitigation
- Pay-for-performance and value
- Medical loss ratios
- Managed care and other delivery models
- Federal oversight and state interaction
- Areas for future work

Medicaid Expansion Population

- Lack of historical experience to develop baseline rates and adjustments
- Assumptions on pent-up demand and mix of enrollees have greater uncertainty
- Experience in other states hard to apply broadly due to differences in state eligibility rules and benefit design

Managed LTSS

- Blended rate versus separate nursing facility and community-based rate cells
- Assumptions may need to differ by region due to provider capacity
- Plan-specific targets based on actual enrollment mix can reduce risk
- Functional assessment data can improve rate setting

Risk Sharing and Risk Mitigation

- CMS encourages states to use two-sided risk corridors for expansion population
- Plans have some concerns with timing of cash flow when using risk corridors
- Targeted risk mitigation around certain assumptions
- High-risk pool for special high-cost populations

Pay-for-Performance and Value

- Quality measures should be consistent, transparent, and attainable
- For new programs or populations, use operational quality measures first, then clinical measures later
- Withhold amount should be considered in determining actuarially sound rate range

Medical Loss Ratio (MLR)

- National MLR requirement would be difficult for Medicaid due to differences across states
- MLR should consider profit and loss for more than one year
- A few states use profit-sharing instead of MLR

Managed Care and Other Delivery Models

- Managed care sometimes overlaps with other delivery models such as accountable care organizations (ACO)
- Challenges in calculating savings for these other models
- State should clearly define how profits and losses should be shared between plan and other entities such as ACOs

Federal Oversight and State Interaction

- CMS working on improving the review process by updating tools and protocols
- Actuaries and plans would like more guidance from CMS on complicated issues
- Both CMS and states are concerned about administrative capacity

Areas for Future Work

- Data and research to improve adjustments
  - Expansion population
  - MLTSS incentives
- Guidance or technical assistance
  - Structure of quality incentives
  - Core domains of functional assessment
- Training and education