Policy Title: Rates: Require a Medical Loss Ratio of at least 85% that does not include case management

Primary Contact and Names of Members Who Worked on the Proposal: Beth Swedeen, John Sauer, Margie Steinhoff, Ted Behnke, Bill Crowley, Lisa Pugh, Todd Costello

Brief Description

Include in the Family Care contract (FC, FCP, Pace) a requirement for an 85% medical loss ratio. Direct that care management service expenses cannot be included in the service cost component of the calculation.

Analysis

A medical loss ratio (MLR) in managed long-term services and supports (MLTSS – programs like Family Care and Family Care Partnership) is the percentage of capitation rate dollars a managed care organization spends to provide medical services and health care quality improvement activities for its members. "Health plans that spend a higher proportion of the premium on medical services are viewed as providing better value for the payer and consumer than plans that spend a higher proportion of the premium on administrative expenses and profit margins." (Dominiak and Libersky 2012).

The Center for Medicare and Medicaid Services (CMS) published a final rule on May 6, 2016, that requires Medicaid MCOs (like those in Badgercare) to calculate, report and use an MLR to develop capitation rates. The final rule requires that the capitation rates for MCOs be set for a minimum MLR of at least 85 percent. States can also apply MLR standards in managed care within long-term services and supports, but there is no requirement to do so.

In its 2016 report on MLTSS, the National Council on Disability, which visited Wisconsin during the investigation for its report, states that "Advocates should provide details on the kinds of activities that should be included as a community integration activity for purposes of the MLR numerator."

The Family Care contract https://www.dhs.wisconsin.gov/familycare/mcos/2018-generic-final.pdf - includes no MLR percentage requirement, only a reporting requirement. Also, all care management expenses are included in the service cost component and are not delineated from direct services to participants.

- "The MLR calculation for the FC, FCP and PACE programs includes care management service expenses in the service cost component of the calculation."

The federal Health and Human Services (HHS) Office of Inspector General (OIG) conducted an analysis of Wisconsin MLR in 2017. Two Family Care MCOs were included, and their MLR was above 90%, however, including care management costs in the calculation may not provide a clear picture of expenditure on direct services.
https://oig.hhs.gov/oas/reports/region5/51500040.pdf

In 2020, in part to address the direct care workforce crisis, DHS directed the actuaries who develop capitation rates for Family Care, to include in the 2020 MCO capitation rates, "a rate adjustment to increase average provider reimbursement rates by1% for waiver services provided in mature GSRs (i.e., all GSRs other that GSR 12) above the unit cost trend included in the rate development. With this rate adjustment is the expectation that certain Family Care MCOs will implement corresponding provider rate increases effective CY 2002." See: https://www.dhs.wisconsin.gov/non-dhs/dms/fc-2020capitationrates.pdf, page 16.

Despite this specific rate adjustment, not all Managed Care Organizations passed along rate increase to providers, nor was there required reporting to identify whether this had occurred.

Wisconsin DHS posts the MCO quarterly financial summaries at: https://www.dhs.wisconsin.gov/familycare/mcos/financialsummaries.htm. The most recent posting for the 3rd quarter of 2019 is pasted here, identifying the proportion of capitation rate spent by each MCO on care management (ranging from 9.5% to 13.4%) and member service expense (ranging from 80.4% to 88.5%)

	Inclusa	LCI	MCFCI	CCI	CWF	Total
Key Ratios (as % of Revenue)						
Member Service Expense, Net	80.4%	82.0%	85.3%	83.9%	88.5%	83.7%
Care Management Service Expense	13.4%	11.9%	12.5%	9.5%	10.3%	11.6%
Total Member Service Expense	**93.8%**	**93.9%**	**97.8%**	**93.4%**	**98.8%**	**95.3%**
Administrative Expense	4.2%	3.7%	3.2%	2.3%	3.9%	3.5%
Total Operating Expense	98.0%	97.6%	101.0%	95.7%	102.7%	98.8%
Income (Loss) from Operations, CY	**2.0%**	**2.4%**	**-1.0%**	**4.3%**	**-2.7%**	**1.2%**
Net Income/(Loss)	2.5%	2.5%	0.4%	4.2%	2.9%	2.6%

Potential funding options/cost savings/benefits

Requiring an MLR in the Family Care contract and removing care management expenses from the calculation should offer transparency into the rates paid to providers who offer direct services and ensure that funding is prioritized to care and HCBS supports to individuals. More attention to efficiency in care management expenditures could save funds over time. Any directed increase in the capitated rate for a specific service component, including direct care, should be reflected in the member service portion of expenditures.

What state agency or other entity would be responsible for implementing the proposal, if it were approved?

Department of Health Services (DHS)

Cost estimates: Include any known information on what types of costs there would be, including staffing needs, and whether they would be one-time or ongoing. As possible, include as close an approximation of the likely costs as is available (e.g. several million dollars annually; $500,000 on a one-time basis; $100 to $200 million annually)

This recommendation should not increase costs.