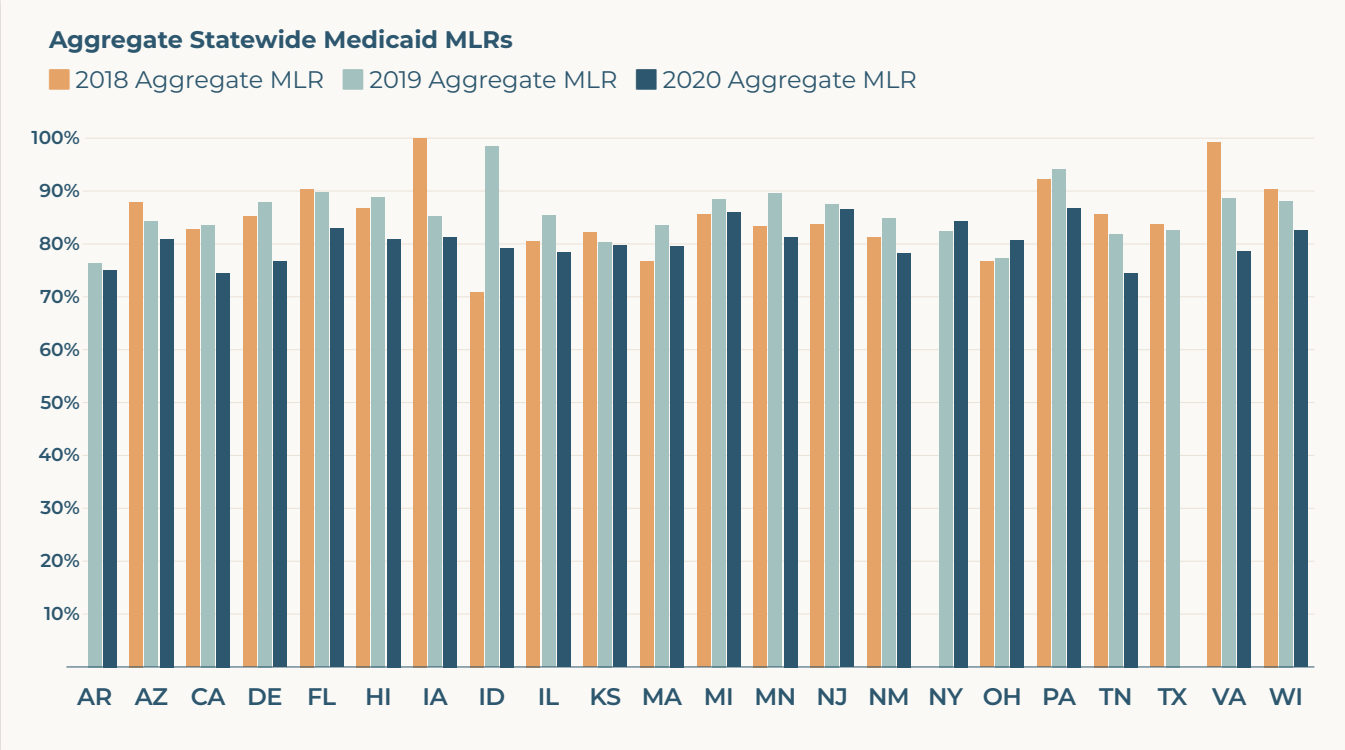
MLR-MLTSS Analysis

National Alliance for Care at Home

On Friday, November 1st CMS released public information on medical loss ratio (MLR) data for Medicaid managed care programs. MLR is a calculation used to measure revenue received by a health plan that was used to pay for services and for quality improvement activities. Medicaid law and statute do not require states to establish a mandatory minimum MLR for managed care organizations; however, guidance on setting the payment rates (i.e. "capitation" amounts) directs actuaries to target no less than 85%, provided that the rates account for reasonable non-benefit related costs. The November data includes MLR information from plan years 2018, 2019, and 2020.

The Alliance analyzed the MLR information to better understand health plan payment policy around the country. As part of the analysis, the Alliance filtered data to include only those plans that include long-term services and supports (LTSS), as these are the services most important to our members. Overall, the national average MLRs for managed LTSS plans (MLTSS) were 93.70% in 2018; 93.54% in 2019 and 91.85% in 2020.

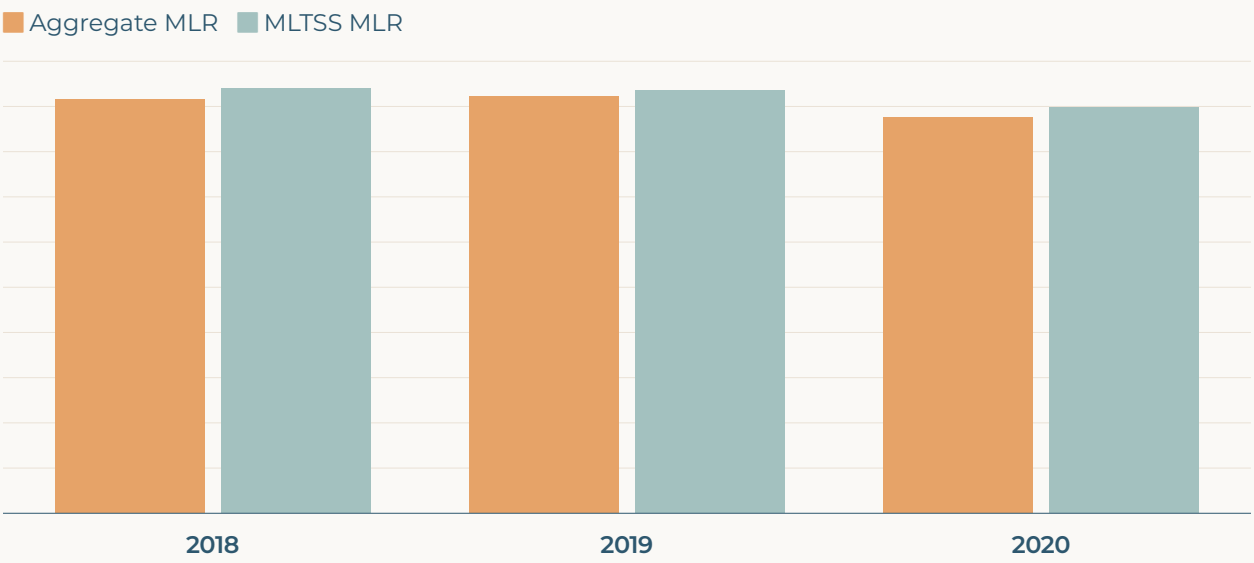
To develop statewide MLR estimates, we aggregated the reported MLR expenditure data for each plan in every state during a specific plan year. Then, we performed standard MLR calculation on the CMS-reported numerator and denominators to develop statewide MLR figures for MLTSS plans. The resulting state-specific MLRs varied across the country and within each plan year. Idaho (2018) had the overall minimum statewide MLR at 85.31% whereas Iowa (2018) had the highest overall statewide MLTSS MLR at 102.87%. Figure 1 shows the average statewide MLTSS MLRs for all state and plan years included in the CMS data:



CMS' data also includes health plan-specific MLR information. The highest reported MLR during the time period was Blue Cross of Idaho's Medicare/Medicaid Dual Eligible plan in 2019, with a reported 180%. In contrast, the lowest reported MLR was in 2018, when New York's Prime Health Choice, LLC MLTSS plan experienced a 78% MLR.

In comparison, aggregate Medicaid MLRs for all health plans were also high and above 90% but, on average, were slightly lower than the MLTSS-specific MLRs for the same plan year. In 2018, overall Medicaid MLR was 92.61; in 2019 it was 92.90%; and in 2020 it was 90.99%. As figure 2 demonstrates, these MLRs ranged from 1.09% to 0.64% lower than the MLTSS MLRs.

Aggregate Statewide Medicaid MLRs



The MLRs in Medicaid are relatively high – and exceed the 85% standard established by the Affordable Care Act for large group plans – which could lead to future rate challenges for providers as plans may be less likely to negotiate inflationary update. However, it is important to remember that the actuarial soundness requirements in Medicaid mandate that state rate-setting account for all health care service and non-service components, especially if the MLR exceeds 85%. As data from subsequent years becomes available, it is likely that it will remain consistent due to higher provider payments reflected via higher capitation rates.

As CMS seeks to expand transparency regarding MLRs, payments, access to care, and other core components of Medicaid program information, we anticipate that there will be additional information available that will help providers understand the financial dynamics within the various states and health plans around the country. This information can hopefully be useful with legislative advocacy as well as rate negotiations with state agencies and health plans. The Alliance has established a database of MLTSS MLR information that we will continue to build upon as more becomes available. Any requests for additional analysis or specific information can be sent to dterzaghi@nahc.org.