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**MEMORANDUM**

DATE: January 30, 2015

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 18 DE Reg. 504 (DMMA Prop. Certification & Regulation of Medicaid MCOs Reg.)

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Medicaid and Medical Assistance's (DMMAs) proposal to adopt regulations for fiscal solvency of Medicaid managed care organizations (MCOs). The proposed regulation was published as 18 DE Reg. 504 in the January 1, 2015 issue of the Register of Regulations.

As background, DMMA contracts with MCOs to administer the Diamond State Health Plan and Diamond State Health Plan Plus programs. Federal regulation 42 C.F.R. §438.116 (attached) requires MCOs to either meet state solvency standards for private health maintenance organizations or be licensed or certified by the state as a risk-bearing entity. DMMA is adopting the second option, i.e., it will certify MCOs which meet certain standards contained in the proposed regulation. SCPD has the following observations.

First, on p. 504, the references to 42 C.F.R. §483.1 and 42 C.F.R. §483.116 are incorrect. The correct citations are 42 C.F.R. §438.1 and 42 C.F.R. §438.116 respectively.

Second, §3.1.2 requires an MCO to demonstrate "net equity in excess of $[10] million." At a minimum, the brackets should be deleted. On a substantive level, SCPD questions whether net equity of $10 million is sufficient. Delaware's Medicaid population has grown to approximately 230,000 individuals. See DHSS Secretary's FY16 budget presentation to OMB (November 20, 2014), available at http://www.dhss.delaware.gov/dhss/index.html. Most of Delaware's Medicaid population is served by two MCOs (Highmark; United Healthcare). Assuming equal enrollment, each MCO would serve 115,000 individuals and have approximately $86 in equity for each participant. Some of the $10 million in equity could be in fixed or non-liquid assets

out-of state or out of the country. SCPD recognizes that the managed care system is intended to not tap equity, i.e., monthly State capitation payments (§5.2) should ideally cover MCO outlays. Moreover, DMMA enjoys the protection of a performance bond equal to one month's capitation payment. In reality, an MCO could suffer huge losses if an epidemic or natural disaster resulted in unanticipated health costs. An MCO with only $10 million in net equity may be unable to absorb such costs.

Third, §5.0 may merit further review to ensure consistency. On the one hand, an MCO is required to submit a performance bond equal to the projected first month's capitation payment "up front". See §§5.1 and 5.2. On the other hand, §5.4 requires MCO supplementation of the bond "if the performance bond falls below 90% of the first month's capitation in any month". Literally, this could never occur since the performance bond based on 100% of the first month's capitation amount was already submitted to DMMA up front. If DMMA intends that the MCO increase the bond based on later increases in monthly capitation amounts, the regulation should be reworded.

Fourth, §9.1 contemplates MCO maintenance of a system for tracking incurred but unreported costs and unpaid claims by category (e.g. hospital; nursing facility). The MCO is expected to review its system annually and DHSS can prompt adjustments. DMMA may wish to consider requiring a 6-month report of data under this section. If a year passes, and the system/methodology has resulted in grossly inadequate reservation of funds, it may be too late to intervene in the face of huge unpaid bills.

Fifth, it's unclear when the performance bond required by §5.0 lapses. Obviously, an MCO which terminates its participation as an MCO will still have to cover bills incurred during the contract period. It is possible that the DMMA-MCO contract addresses the duration of the performance bond. If it does not, the regulation could be revised to include some standards.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations on the proposed regulation.

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

18reg504 dmma-mco certification 1-30-15

**§438.116 Solvency standards.**

(a) *Requirement for assurances* (1) Each MCO, PIHP, and PAHP that is not a Federally qualified HMO (as defined in section 1310 of the Public Health Service Act) must provide assurances satisfactory to the State showing that its provision against the risk of insolvency is adequate to ensure that its Medicaid enrollees will not be liable for the MCO's, PIHP's, or PAHP's debts if the entity becomes insolvent.

(2) Federally qualified HMOs, as defined in section 1310 of the Public Health Service Act, are exempt from this requirement.

(b) *Other requirements*—(1) *General rule.* Except as provided in paragraph (b)(2) of this section, an MCO or PIHP, must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity.

(2) *Exception.* Paragraph (b)(1) of this section does not apply to an MCO or PIHP, that meets any of the following conditions:

(i) Does not provide both inpatient hospital services and physician services.

(ii) Is a public entity.

(iii) Is (or is controlled by) one or more Federally qualified health centers and meets the solvency standards established by the State for those centers.

(iv) Has its solvency guaranteed by the State.

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]