CLIENT ALERT: MEDICAL LOSS RATIO STANDARDS

CMS Proposed Rule: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P) in the Federal Register

On May 3, 2023, the Centers for Medicare & Medicaid Services (CMS) published a proposed rule titled: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-P) in the Federal Register. Myers and Stauffer is providing this client alert to ensure states are aware of several notable provisions specific to the medical loss ratio (MLR) standards. For the full proposed rule text, see https://www.federalregister.gov/documents/2023/05/03/2023-08961/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

The proposed MLR rule revisions primarily focus on achieving the following CMS goals:

- Align Medicaid and CHIP MLR regulations with Marketplace regulations.
- Provide clarifications and definitions to promote consistency, enhance transparency, and provide comparability of MLR reporting state to state and among commercial, Medicare, Medicaid, and CHIP managed care plans.
- Promote strengthened contractual requirements.

Proposed MLR regulatory revisions consist of eight primary topic areas identified by CMS.

- Provider Bonuses and Incentives Payments
- Prohibited Costs in Quality Initiatives Activities (QIA)
- Reporting of State Directed Payments (SDP) and Associated Expenses
- Expense Allocation Methodology
- Prompt Reporting of Overpayments and Recoveries
- MLR Resubmission Requirements
- Level of MLR Data Aggregation
- Credibility Factor Adjustment Update Frequency

Provider Bonuses and Incentives Payments

Since the implementation of the 2016 Medicaid managed care rule, CMS states it has identified inconsistencies, financial and reporting risks, and missing contractual documentation standards related to the reporting of provider bonuses and incentive payments in the MLR. CMS notes a current disassociation between meeting measurable clinical or quality improvement standards and receiving provider incentive payments. The proposed

rule outlines how this can create a potential risk for artificial inflation of qualifying costs, rate period shifting of reported costs, and ultimately manipulated MLR percentages by managed care plans to avoid paying remittances (if applicable) for non-compliance with state's minimum MLR requirements. Additionally, this could further result in inflated rate setting calculations for both current and future managed care capitation rates. Therefore, CMS proposes to provide clarity to both the Medicaid and CHIP MLR regulations to require additional contractual provisions to be explicitly included within the state – managed care plan contracts and subsequently the managed care plan – provider incentive contracts to align with original intentions for inclusion of these payments within the MLR numerator. This proposed change also aligns with the recently updated Marketplace regulations.

MLR Regulation Update (§§ 438.8(e)(2)(iii)(A); 457.1203)

- To be includable as incurred claims within the MLR numerator, provider bonuses and incentive arrangement payments would be required to be tied to clearly defined, objectively measurable, and well documented clinical or quality improvement standards.

Contractual Language Requirement Updates (§§ 438.3(i)(3) and (4); 457.1201)

- State managed care plan contracts would require each provider incentive contract between the managed care plan and network provider(s) include the following provisions:
  - Defined performance period tied to the MLR reporting period(s).
  - Requirements that contracts must be signed and dated by all parties prior to the beginning of the performance period.
  - Well-defined quality improvement or performance metrics the provider must meet to receive the incentive payment.
  - A specified dollar value tied to the successful completion of the established metrics, as well as an established payment date.
- The managed care plan would continue to determine the appropriate quality improvement or quantitative metrics to include within provider incentive contracts, but the state managed care plan contract would need to outline the documentation required to be maintained by the managed care plan; require that the health plan make the payment contracts and supporting documentation available to the state; and explicitly prohibit attestations from network provider(s) as suitable documentation.

Proposed applicability date: § 438.8(e)(2)(iii)(A); 60 days following the effective date of the final rule.
Proposed applicability date: § 438.3(i)(3) and (4); No later than the rating period beginning on or after 60 days following the effective date of the final rule.

Compliance with the § 438.8(e)(2)(iii)(A) 60 days following the effective date of the rule, which requires provider incentives to be linked to quality measures for inclusion in the MLR calculation, could be problematic given the contractual updates required in § 438.3(i)(3) and (4) would not be required until the rating period beginning on or after 60 days following the effective date of the final rule. Provider incentives not linked to quality measures would be excluded from the MLR calculation prior to the requirement for managed care plans to include the performance objectives in provider contracts.

Prohibited Costs in QIA (§§ 438.8(e)(3)(i) and 457.1203(c))

CMS' proposed change to prohibit the inclusion of indirect or overhead expenses not directly improving health care quality for reporting of QIA costs in the numerator of the MLR further supports alignment with Marketplace guidance. In addition, it improves MLR reporting consistency for better comparison across health plans and lines of business.

As explained in the Marketplace rule's comments and responses, the previous lack of clarity in regulation resulted in wide discrepancies regarding the types of expenses reported as QIA, creating an unequal playing field among issuers. CMS clarified the non-salary benefits (health coverage, retirement contributions, life insurance, or similar benefits) of employees performing QIA functions would be considered direct QIA expenditures but are limited to the actual percentage of time spent performing QIA duties. However, many other indirect expenses would be incurred regardless of whether the issuer was engaged in QIA or not and thus are non-includable as QIA. CMS provided a list of non-exhaustive examples of indirect expenses to be excluded from QIA reported costs, which includes: office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, and wall art), human resources, salaries of counsel and executives, computer and telephone usage, travel and entertainment, company parties and retreats, IT systems, and marketing of issuers' products. CMS further stated as a general guideline, there must be a quantifiable and reasonable relationship that exclusively or primarily supports health care quality to be considered as a direct QIA expense. Expenses supporting regular business or other functions would be considered non-claims costs. CMS further clarified when a software license or IT infrastructure is utilized to support QIA activities, but is not the primary function, this expense is not considered QIA. Finally, CMS clarified when QIA is outsourced versus provided in-house, the same principles for determination of QIA costs is necessary, which means the vendor's indirect costs and any profits cannot be includable as QIA within the MLR calculation.

Proposed applicability date: 60 days following the effective date of the final rule.

States may have remaining questions related to CMS' definition of overhead or indirect expenses directly improving health care quality, which would be an includable QIA expense for the MLR. In addition, the Marketplace rule outlined executive salaries as an example of overhead that would be considered indirect and therefore not considered a QIA cost. However, it did not clearly define who would be considered an executive.

Reporting of SDPs and Associated Expenses (§§ 438.8(f)(2)(vii) and (e)(2)(iii)(C); §438.74; §457.1203(e) and (f))

Due to the increasing volume in SDPs over the last several years, CMS is proposing to broaden the visibility of SDPs specifically as it relates to MLR reporting. This proposed change aligns with reporting required for Medicaid FFS supplemental payments.

CMS proposes to require SDPs, developed under 438.6(c), be included within premium revenue of the MLR calculation (denominator) and amounts managed care plans distributed to providers as the associated expense of SDPs be included within incurred claims of the MLR calculation (numerator).

Submission of MLR summaries for each managed care plan to CMS is currently required of the state. CMS proposes to require managed care plans to report SDPs and associated expenses separately within MLR reporting to states. Furthermore, states would be required to include and separately identify this information within the MLR summaries to CMS.

CMS does not propose adopting the new reporting requirements for separate CHIP managed care plans as SDPs are not applicable.

Proposed applicability date: Managed care plan to state reporting — 60 days following the effective date of the final rule; State to CMS reporting — The first rating period that starts on or after the effective date of the final rule.

Expense Allocation Methodology (§§ 438.8(k)(1)(vii) and 457.1203(f))

Currently managed care plans provide a report regarding the methodologies utilized to allocate expenditures for MLR reporting purposes. However, CMS noted a lack of detailed information in the Medicaid managed care plans' MLR cost allocation reporting to states.

CMS proposes managed care plans must include information to reflect the same information required under the Marketplace requirements in the MLR report submitted to the state to offer more oversight and transparency into cost allocations and to reduce administrative burden for managed care plans. This change expands the existing text to clarify that the managed care plans' expense allocation methodology(ies) provided must contain detailed descriptions outlining the methods used to allocate the following expense types:

- Incurred claims.
- QIA.
- Federal and state taxes and licensing or regulatory fees.
- Other non-claims costs.

Proposed applicability date: 60 days following the effective date of the final rule.

CMS does not propose specifying preferred or required allocation expense methodologies nor does it address consistency in allocation factors between MLR reporting periods.

Prompt Reporting of Overpayments and Recoveries (§§ 438.608(a)(2) and(d)(3); and 457.1285)

CMS proposes requiring a contract provision between the state and each managed care plan to report all overpayments identified or recovered within 10 business days to the state, specifically identifying which overpayments are due to potential fraud. (Note: The fraud distinction is relevant to the MLR calculation as this recovery amount, not to exceed the amount of fraud reduction expenses, may be added back/included as incurred claims as prescribed in § 438.8(2)(iii)(B).) Current regulations require managed care plans have procedures to provide for prompt reporting of overpayments; however the term "prompt" is not defined.

Additionally, CMS proposes to revise the required annual overpayment reporting each managed care plan must submit to the state to include both identified and recovered overpayments. Current regulations only

require overpayment recoveries be reported to the state. All identified overpayment/ recovery amounts must be excluded (reduction) from capitation rates and MLR numerator, prior to special consideration of fraud overpayments noted above. This ensures a complete reporting of all overpayment amounts (i.e., not partial settlements) and in the correct reporting period for inclusion within the correct rating period. Some managed care plans were applying recovery amounts against future incurred claims which may be reported in a subsequent rating period.

Proposed applicability date: 60 days following the effective date of the final rule.

MLR Reporting Resubmission Requirements (§§ 438.8(m) and 457.1203(f))

CMS proposes to amend current regulatory text which requires managed care plans to resubmit MLR calculations when a retroactive change in capitation payments occurs to only require resubmission when the state makes a retroactive change to capitation rates. This assists with any confusion regarding resubmissions not being required solely based on retroactive eligibility membership reviews that change the amount of capitation payments to the managed care plan, but do not change capitation rates. CMS notes the proposed regulatory change would require resubmission of the MLR by the managed care plan when a state modifies a state directed payment paid under a separate payment term.

Proposed applicability date: 60 days following the effective date of the final rule.

It may be advantageous for states with MLR rebate requirements or similar risk corridor settlements contingent on MLR calculations to continue to require MLR resubmissions even if CMS does not require this practice. Retroactive changes due to eligibility reviews many times result in increases in capitation payments, which if significant, could trigger or increase rebates due to states by the managed care plans.

Level of MLR Data Aggregation (§§ 438.74(a) and 457.1203(e))

CMS proposes to require states submit a summary description of each MLR report received from the managed care plans under contract with the state, rather than a summary aggregating MLR data over the entire state. CMS notes its original intention was for the summary description to include MLR data at a managed care plan-level basis. However, based on submissions it received from several states, this was not stated explicitly enough.

Proposed applicability date: 60 days following the effective date of the final rule.

Credibility Factor Adjustment Publication Frequency (§§ 438.8(h) (4) and 457.1203(c))

CMS proposes to remove the reference to the "annual" frequency basis for the credibility factor adjustment, as the factors and model have not changed since the original publication in 2017. The model utilized a statistical model applying the Central Limit Theorem (80 FR 31111) which produced factors not expected to change annually.

Proposed applicability date: 60 days following the effective date of the final rule.

Next Steps

The proposed rule will have a significant impact on state requirements for MLR managed care plan reporting as well as monitoring and contract provisions. States will need to review MLR reporting templates, MLR reporting instructions, managed care plan contracts, and their managed care plans' contracts with providers to determine the potential impact the proposal may have on their current managed care program. Myers and Stauffer partners with more than 20 states and CMS in ensuring proper oversight of managed care health plans and compliance with CMS regulatory requirements, including all aspects of MLR reporting and auditing.

The proposed rule is open for comments until July 3, 2023. Formal comments can be submitted here.

For More Information

Myers and Stauffer is available to discuss any issues in the proposed rule. If you have questions or would like help drafting formal comments, please contact the following members of our managed care engagement team.

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