CLIENT ALERT: MEDICAL LOSS RATIO STANDARDS

CMS Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (CMS-2439-F)

On April 22, 2024, the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality rule was finalized by the Centers for Medicare & Medicaid Services (CMS). The final rule was published in the Federal Register on May 10, 2024 and will become effective July 9, 2024. 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 finalized rule text, see https://www.federalregister.gov/public-inspection/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and

The final 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.

Finalized MLR regulatory revisions consist of the following primary topic areas:

- 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.

MYERS AND STAUFFER LC

CMS notes a current disassociation between meeting measurable clinical or quality improvement standards and receiving provider incentive payments. The final 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.

CMS recognized specific concerns for managed care plans that own or are owned by companies that also own networks of providers and other health care services with the opportunity and means to channel excessive dollars to its affiliated providers and increase profit for the managed care plan's parent company. CMS stated it understands these concerns regarding managed care plans that are integrated with health care providers and continues to encourage state oversight of the types of arrangement and payment models employed and consider any impact of vertical integration on the reporting and treatment of provider payment under the MLR framework codified in § 438.8.

Therefore, CMS clarifies 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 the original intentions for inclusion of these payments within the MLR numerator. This finalized change also aligns with the 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 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.
  - Clearly-defined, objectively measurable, and well-documented clinical standard the provider must meet to receive the incentive payment.
  - A specified dollar value or percentage of a verifiable dollar amount 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 clinical 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 managed care plan make the payment contracts and supporting documentation available to the state; and explicitly prohibit attestations from network provider(s) as suitable documentation.

Applicability date: § 438.8(e)(iii)(A); Effective date of the final rule.
Applicability date: § 438.3(i)(3) and (4); No later than the rating period beginning on or after one year following the effective date of the final rule.

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

CMS' finalized changes 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 managed care plans and lines of business. CMS addresses that managed care plans should continue to report its Medicare MLR consistent with the Medicare regulations.

As explained in the Marketplace and Medicaid 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 in the Marketplace rule that non-salary benefits (health coverage, retirement contributions, life insurance, or similar) of employees performing QIA functions would be considered direct QIA expenditures, but are limited to the actual percentage of time spent performing QIA duties. CMS noted within the Medicaid rule that in such cases, states should ensure the managed care plan provides documentation, such as time studies, showing how it determined the portion of time that staff expended on QIA programs versus non-QIA programs.

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 within the Marketplace rule, but declined to specify within the Medicaid rule, as these types of costs are numerous and providing such a list could lead to inappropriate inclusion of costs that were not specified in the regulation.

Nevertheless, CMS noted the Marketplace final rule preamble included: 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. If the managed care plan indicates it cannot separate indirect or overhead expense for QIA, CMS clarified the state should disallow the entirety of QIA claimed expenditures in the MLR.

Expenses supporting regular business or other functions would be considered non-claims costs. CMS further clarified when a software license or IT infrastructure is used to support QIA activities, but is not the primary function, this expense is not considered QIA. Other costs of IT that primarily support regular business functions, including billing, enrollment, claims processing, financial analysis, and cost containment do not constitute a direct expense related to QIA.

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.

CMS also addressed social determinants of health (SDOH), health-related social needs (HRSN), and value-added services (VAS) related to QIA. CMS references the State Health Official Letter dated January 1, 2021, to address SDOH and HRSN expenses in the MLR. Regarding VAS, the costs of these services may not be included in the capitation rate; however, they can be considered as incurred claims in the numerator for the MLR calculation if the services are activities that improve health care quality.

Applicability date: Effective date of the final rule.

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

CMS clarifies that 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).

Reference our Client Alert – State Directed Payments for information regarding the reporting requirements and applicability dates to support SDP oversight, as CMS is not electing to do so through the MLR reporting vehicle. However, within the MLR reporting, states may still want to consider calculations for how SDPs impact the MLR and remittances, if included.

CMS did not adopt the new reporting requirements for separate CHIP managed care plans as SDPs are not applicable.

Applicability date: 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 used to allocate expenditures for MLR reporting purposes that may apply across multiple lines of business or markets. However, CMS noted a lack of detailed information in the Medicaid managed care plans' MLR cost allocation reporting to states.

CMS requires that 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.

CMS did not specify preferred or required allocation expense methodologies nor did it address consistency in allocation factors between MLR reporting periods.

We recommend states consider language in the managed care plan contracts to mitigate any shifting of expenses between markets or lines of business. Additionally, many states must quickly implement revisions to their MLR templates to accommodate these detailed requirement changes.

Applicability date: Effective date of the final rule.

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

CMS requires a contract provision between the state and each managed care plan to report all overpayments identified or recovered within 30 calendar days to the state, specifically identifying which overpayments are due to potential fraud. Current regulations require managed care plans have procedures to provide for prompt reporting of overpayments; however, the term "prompt" was not previously defined.

Additionally, CMS requires the 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. 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.

CMS removed the reference to the applicability of the overpayment reporting requirements to non-emergent transportation health plans, as these are excluded from the regulatory provision under existing §§ 439.9 and 457.1206.

Applicability date: No later than the rating period beginning on or after one year following the effective date of the final rule.

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

CMS previously proposed to amend current regulatory text, which required managed care plans to only resubmit the MLR when the state makes a retroactive change to capitation rates. CMS clarified this proposed change would have been too restrictive, and the MLR may not be accurate as a result. Therefore, this change was not finalized.

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

CMS requires 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.

Applicability date: Effective date of the final rule.

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

CMS removed 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 used a statistical model applying the Central Limit Theorem (80 FR 31111) which produced factors not expected to change annually. CMS noted its commitment to review them on a regular basis and to publish updates if the factors change.

Applicability date: Effective date of the final rule.

Next Steps

The finalized rule has a significant impact on state requirements for MLR managed care plan reporting, as well as monitoring and contract provisions. States are required to review MLR reporting templates, MLR reporting instructions, managed care plan contracts, and their managed care plans' contracts with providers to determine the impact the that these changes 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 plans and compliance with CMS regulatory requirements, including all aspects of MLR reporting and auditing. With strengthened oversight required by CMS, states need assistance to ensure compliance with new regulations. Our MLR examination services not only ensure compliance with the required periodic audit requirement of financial data, but also address risks presented above through our testing procedures.

For More Information

Myers and Stauffer is available to discuss any issues in the finalized rule. If you have questions or need assistance in assessing the impact of these changes on your managed care program, or if you are in need of guidance in implementing required contractual or oversight changes, please contact the following members of our managed care engagement team.

Tami Bensky, CPA
Member
PH 800.505.1698
TBensky@mslc.com

Joanna Garnett, CPA
Member
PH 816.945.5316
JGarnett@mslc.com

Beverly Gehrich, CPA
Member
PH 800.877.6927
BGehrich@mslc.com

Judy Hatfield, CPA
Member
PH 800.374.6858
JHatfield@mslc.com

Janae Jensen, CPA
Member
PH 816.945.5327
JJensen@mslc.com

Mike Johnson, CPA
Member
PH 866.758.3586
MJohnson@mslc.com

Randy Rehn, CPA, CFE
Member
PH 404.524.9514
RRehn@mslc.com

Keith Sorensen, CPA
Member
PH 877.829.7306
KSorensen@mslc.com

MYERS AND STAUFFER LC