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CMS's Final Medicaid Rule Creates Medicaid MLR Framework but Leaves Room for State Variation

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Summary

This article is the first in a series that takes an in-depth look at the new federal Medicaid managed care final rule and its effect on Medicaid managed care organizations, health care providers and other industry stakeholders. This installment addresses new Medicaid medical loss ratio requirements. Future articles in this series will address new requirements for the Medicaid managed care program relating to program integrity, marketing, physician incentive plans and long-term care.

In Depth

The final Medicaid managed care rule issued by the ***Centers for Medicare & Medicaid Services (CMS)*** on April 25, 2016, (the Final Rule) establishes a new federal ***medical loss ratio (MLR) standard*** for ***Medicaid and Children's Health Insurance Program (CHIP)*** managed care contracts (the Medicaid MLR). The new Medicaid MLR standard will be applicable for state contracts beginning on or after July 1, 2017, (rather than January 1, 2017, as originally proposed).

Up until now, certain states imposed state-specific MLR requirements on ***Medicaid managed care organizations (MCOs),*** but there has been no federal mandate for states to do so. The Final Rule requires states to (1) set capitation rates so that MCOs' projected MLR is 85 percent or more and (2) establish an annual MLR reporting process. The Final Rule is also noteworthy for what it does not do; unlike the commercial market and Medicare MLR standards, the Final Rule does not require states to collect remittances from an MCO if its MLR is below the applicable MLR threshold.

CMS's professed goal in the Final Rule was to promote consistency among state Medicaid MLR requirements and the commercial and Medicare MLR standards. This, for example, led the agency to adopt the commercial market MLR definitions for incurred claims, quality improvement activity and

non-claims costs for purposes of the Medicaid MLR. Recognizing that states play a significant role in Medicaid administration, however, CMS carved out ample room for state-by-state variation in key aspects of Medicaid MLR implementation. This flexibility will likely be appreciated by state regulators but it has the potential to erode the sought-after benefits of consistent federal rules across multiple programs. MCOs that operate in multiple states may face operational challenges in accounting for different states' varying MLR standards. Because the Final Rule defers critical decisions to state regulators, issuers should consider turning their advocacy efforts towards the states in order to influence state-specific MLR standards.

There are several critical takeaways from the Medicaid MLR standards:

- **States must project at least an 85 percent MLR for rate-setting purposes.** When setting capitation rates, states must set capitation amounts so that MCOs "would reasonably achieve a medical loss ratio standard ... of at least 85 percent for the rate year" (42 C.F.R. § 438.5). CMS considered an upper MLR limit for purposes of rate setting (*e.g.*, rates must be sufficient so an MCO's projected MLR is less than 95 percent), but the agency determined that "appropriate higher MLR standards may depend on the particular managed care program." An upper MLR limit for rate-setting would have provided an important protection for MCOs from insufficient capitation rates, but CMS likely wanted to avoid creating budget difficulties for states by creating a mechanism that could require higher payments to MCOs.

- **States must require MLR reporting each year (and may require rebates).** States must require MCOs to report their MLR after each contract year, but the Final Rule does not require states to collect remittances from MCOs. If a state does collect remittances, then the minimum MLR threshold must be at least 85 percent. States must, however, pay CMS the portion of the remittance that reflects the applicable percentage federal financial participation. As a result, states would receive only a portion of any MLR remittances.

- **The Medicaid MLR reflects existing federal MLR standards (sort of).** CMS noted in the Final Rule that "the calculation of the MLR should be consistent so that there will be some level of meaningful comparison across states and [the calculation] should be as consistent as possible with other markets." Many Medicaid MCOs, particularly those participating in multiple states and markets, likely will find this consistency appealing compared to the current patchwork of state Medicaid MLR standards that are often vague and use different expense definitions than those that apply under the Federal commercial and Medicare MLR standards.

- Despite CMS's professed interest in moving towards uniformity, the Final Rule creates flexibility for state regulation in a number of key areas that could diminish any benefits CMS sought by imposing a uniform Medicaid MLR standard. For example:

    - *MLR threshold*. States may set their Medicaid MLR standard above 85 percent. This includes the MLR threshold for rate-setting purposes and for purposes of calculating remittances (if the state requires remittances).

    - *Quality improvement activities*. The general definition of "quality improvement activities" lines up with existing Federal MLR standards, but this definition defines general quality improvement categories and is not meant to be an exhaustive list of all quality improvement activities. When questions arise whether an activity qualifies as a quality improvement activity, CMS instructs MCOs to "discuss those services or

additional activities with the state to determine if they quality as quality improvement expenses, incurred claims, or administrative expenses." This requirement could lead to the same activity receiving different MLR treatment in various states and under the federal commercial and Medicare MLR standards.

- *MLR subregulatory guidance*. To help insurers implement the commercial market MLR standards, CMS has released a number of MLR subregulatory guidance documents, such as frequently asked questions (FAQs). Recognizing the importance of these guidance documents, CMS has explicitly adopted them for Medicare MLR reporting.

- Commenters to the Final Rule asked whether the four-part clinical risk-bearing entity test that the agency adopted for purposes of the commercial market MLR guidance applies to Medicaid reporting. The agency responded that "[s]tates have the discretion to apply the four-part test." This is significant for two reasons: (1) many issuers rely on the four-part clinical risk-bearing entity test to report subcontractor payments in the commercial and Medicare markets and (2) it suggests that states have the discretion to determine whether to adopt CMS's existing commercial MLR subregulatory guidance (even if states must adhere to the Federal MLR regulatory definitions). State policies on the application of Federal MLR guidance will be important for MCOs to follow because it creates the potential for expenses to be treated differently under the Medicaid MLR standard than under the commercial and Medicare MLR standards.

- *Population-specific or contract-wide application of MLR*. States will have the flexibility to calculate MCOs' MLRs on a population-specific basis, contract-specific basis or aggregated cross multiple contracts. MCOs would normally prefer MLR standards to be set at the highest level of aggregation so that low MLRs on certain population segments can be offset by high MLRs on other segments. As a result, a state's decision about the level of aggregation will be significant.

- **Implementation considerations.** MCOs should begin developing the operational capacity to implement the MLR reporting required by the Final Rule. For example:

  - *Provider payment cycles*. CMS guidance could suggest that provider incentive payments must be paid within 12 months of the contract year to be included in the MLR calculation. CMS was asked to clarify that provider incentive and bonus payments included in the numerator would include both amounts actually paid and amounts expected to be paid. CMS replied:

We agree that amounts expected to be paid should also be included in this calculation. *We encourage managed care plans and states to exercise caution and ensure that these payments are made within the 12 month period after the end of the MLR reporting year*. *We believe this should provide sufficient time for managed care plans to calculate incentive or bonus payments and issue such payments to network providers*.

CMS's reply appears to suggest that any incentive or bonus payments that are not paid within 12 months following the end of a contract year must be excluded from the numerator. If a state takes this position, MCOs may want to consider amending existing provider incentive arrangements to the extent the reconciliation is completed more than 12 months after the end of a contract year.

- *Claims adjudication vendors.* MCOs must require vendors providing claims adjudication services to provide MLR-related data to the MCO either within 180 days after the end of the reporting year or within 30 days after the MCO's request. The Final Rule applies this requirement regardless of the terms of the vendor's contract. As such, Medicaid MCOs must ensure their vendor contracts provide a basis to collect this data, and it may be necessary to amend current vendor contracts to allow for this.

You can find part 2 here.

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