



Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

**California Medicaid Managed Care Plans’
Medical Loss Ratio Calculations**

**Review Periods: January 1, 2014 to June 30, 2015,
and July 1, 2015 to June 30, 2016**

Medical Loss Ratio Examination

Final Report

June 2020

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Executive Summary

In June 2018, the Centers for Medicare & Medicaid Services (CMS) announced a Medicaid Program Integrity Strategy that includes initiatives designed to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools. A key component of the strategy is conducting targeted examinations of some states' Medicaid Managed Care Plans' (MCPs) financial reporting. States have adopted risk mitigation strategies, such as Medical Loss Ratio (MLR), as a standard for MCPs to meet, and CMS is reviewing MCP experiences to make sure claims experience matches the MLRs that MCPs reported. These MLR examinations will include a review of high-risk vulnerabilities.

CMS conducted this examination of the MLR reported by the 22 Medicaid MCPs that cover California for the January 1, 2014 to June 30, 2015 and July 1, 2015 through June 30, 2016 periods. In 2018, the California Department of Health Care Services (herein referred to as California) conducted a review of the same 22 MCPs to determine if the MLR was reasonably represented by the MCPs. As a result of that review, MCPs returned \$2.56 billion to California, which was ultimately returned to the Federal Government.

In California, pursuant to federally-approved state contractual requirements, a MCP is required to remit the difference to the state if the plan ultimately has an MLR under the 85 percent threshold for the Affordable Care Act (ACA) Medicaid adult expansion population, covering the contract periods of January 1, 2014 to June 30, 2015; July 1, 2015 through June 30, 2016; July 2016 through June 30, 2017; and July 2017 through June 30, 2018. The state is then required to pay back the Federal portion of those costs to the Federal Government. Conversely, if the MLR is over 95 percent, the state reimburses the MCP the portion of the medical expenses in excess of the 95 percent limit.

The primary objective of CMS' examination is to determine if California's review correctly identified findings and overpayments, and the documentation accepted by California was reasonable to support the amounts included in the MLR calculation. CMS evaluated whether the MLR was reasonably represented by the MCPs, specifically whether the numerator was accurately reported to California with appropriate documentation and consistent with generally accepted accounting principles (GAAP). Other objectives of the examination were to:

- Assess if the MCPs' provider incentive payments and payments to related-party entities were consistent with California's contractual requirements and documented appropriately.
- Determine what caused California to require multiple re-submissions of the MCP's MLR calculations, and if the root cause of the re-submissions had been corrected.
- Ensure that the MCPs had sufficient documentation to support the MLR calculations, in light of the large variations observed across MCPs in the components used to calculate the individual MLRs.

California provided technical comments in response to the draft report, which can be found in Appendix D. Several technical corrections were made to the final report as a result of these comments.

California's Review of 22 Medicaid MCPs Correctly Identified Findings and Overpayments Related to Reporting Accurate MLRs

Based on the results of this examination (examination period: January 2014 through June 2015 and July 2015 through June 2016), California's review correctly identified findings and overpayments related to reporting accurate MLRs. While CMS did not identify new findings or overpayments, several observations and recommendations for improvement were identified, below.

Results of the Examination

California's review correctly identified findings and overpayments related to reporting accurate MLRs, resulting in recoupments from MCPs amounting to \$2.56 billion. CMS did not identify any new findings as a result of this examination; however, CMS identified several areas for improvement when California calculates and reviews each MCP's MLR in the future:

Verification of MLR Calculations and Recoupments

1. California should consider reviewing historical paid claims data that can be used to detect anomalies in claim payments, and independently calculate medical experience, especially if the review date is closer to the end of the period under review.
2. California should initiate MLR reviews within 6-12 months of the end of the review period. The review should be completed and recoupments settled within 24 months of the end of the review period.
3. California should work closely with MCPs to prevent late disclosures of information after the completion of the analysis of the reported MLR calculations. In cases when this does arise, California should work to ensure this will be resolved in a timely manner.

Provider Incentive Payments

4. While California followed the applicable incentive payment contract regulation and guidance in place during the period of performance, going forward, California should ensure that incentive payment contracts between the MCPs and providers follow leading practices. Contract language should not be open-ended, and MCPs should be required to maintain adequate documentation to support the incentive payments.
5. Attestations should not be accepted as the sole source of provider contracting documentation. CMS has informed California that it will not consider approval of its SFY 2018 managed care plan contract actions until the state includes adequate MLR documentation requirements. This includes a MLR documentation standard that prohibits attestations as an acceptable form of documentation in most circumstances, including for provider incentive payments. On May 7, 2020, California submitted SFY 2018 contract actions with this required documentation. CMS also strongly recommends that California utilize this same documentation standard for the SFY 2017 MLR calculations.
6. California should further review the amount of overall incentive payments from the MCP to the providers as part of the rate approval process to ensure the payments align with program goals and program integrity.

Global Sub-Capitation

7. Pursuant to newly released guidance published on May 19, 2019, which was released after the completion of California's MLR calculation, California should require MCPs to collect data needed to calculate a MLR for the globally sub-capitated portion (i.e., the portion that is sub-contracted to third party MCPs) of the business to ensure an appropriate amount of capitation rates are spent on medical services.
8. California should maintain adequate documentation to memorialize guidance and direction given to MCPs to prevent the loss of knowledge in the event of significant staff turnover.

Medical Loss Ratio Examination: California Medicaid Managed Care Plans' Medical Loss Ratio Calculations

Background

In June 2018, the Centers for Medicare & Medicaid Services (CMS) announced a Medicaid Program Integrity Strategy that includes initiatives designed to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools. A key component of the strategy is conducting targeted examinations of some states' Medicaid managed care plans' (MCPs) financial reporting. States have adopted risk mitigation strategies, such as Medical Loss Ratio (MLR), as a standard for MCPs to meet, and CMS is reviewing to make sure claims experiences matches the MLRs that MCPs reported. These MLR examinations will include a review of high-risk vulnerabilities.

CMS conducted this examination of the MLR calculation for the Affordable Care Act (ACA) Medicaid adult expansion population in California, covering the contract periods of January 1, 2014 to June 30, 2015, and July 1, 2015 through June 30, 2016. The California Department of Health Care Services (herein referred to as California) developed a MLR risk corridor effective between 85 percent and 95 percent of capitation payments for the ACA Medicaid adult expansion population. In California, pursuant to federally-approved state contractual requirements, MLR experience below 85 percent resulted in a recoupment of funds from the MCPs; an MLR experience above 95 percent resulted in additional payments made to MCPs. This requirement was established in order to address uncertainty related to the cost of serving the Medicaid adult expansion population and applied to the contract periods of January 1, 2014 to June 30, 2015; July 1, 2015 through June 30, 2016; July 2016 through June 30, 2017; and July 2017 through June 30, 2018.

In 2018, California conducted a review of the 22 Medicaid MCPs that serve California for the January 1, 2014 to June 30, 2015 and July 1, 2015 through June 30, 2016 periods to determine if the MLR was reasonably represented by the MCPs. As a result of that review, which was finalized in November 2018, California returned \$2.56 billion to the Federal Government in order to meet the minimum 85 percent MLR imposed by California.

The primary objective of CMS' examination is to determine if California's review correctly identified findings and overpayments, and the documentation accepted by California was reasonable to support the amounts included in the MLR calculation. The following sections describe California's Medicaid expansion activities, MLR methodology and calculations, and findings and recoupments from California's own MLR review.

California's MLR Review

Section 2001 of the ACA established a new eligibility group and gave states the option of providing health care coverage to previously ineligible adults without dependent children. These changes were significant in that, for the first time since the establishment of the Medicaid program in 1965, states could receive Federal Medicaid funds, without a waiver, to provide coverage to low-income individuals without regard to disability, parental status, or most other categorical limitations. The ACA's changes to Medicaid eligibility criteria expanded coverage to nearly all non-elderly adults

without dependent children and incomes at or below 138 percent of the Federal Poverty Level (FPL).

Due to the limited historical data and experience for the newly-eligible adult expansion population prior to 2014, developing and reviewing managed care capitation rates was more challenging than for populations of individuals traditionally eligible for Medicaid. To address the uncertainty regarding this population, states employed risk mitigation strategies in setting managed care capitation rates. Specifically, California used a MLR to protect against rates that may have been higher than necessary due to the uncertainty with this population. For the expansion population, California required an 85 percent minimum MLR for the state's MCPs for the examination periods. These risk mitigation requirements, along with the contracts and capitation rates, were initially submitted by California to CMS after the beginning of the first examination period. The contracts and capitation rates were required to be submitted by California and approved by CMS for the following periods of January 1, 2014 to June 30, 2014, July 1, 2014 to June 30, 2015, and July 1, 2015 to June 30, 2016.

In October 2017, California sent the initial proposed methodology for the MLR calculation to CMS for review, and the methodology formed the basis of California's MLR review. California finalized its MLR methodology in December 2017. California then sent the data requests to the 22 MCPs in January 2018, requiring the MCPs to complete the MLR template for each of the two review periods (January 1, 2014 to June 30, 2015, and July 1, 2015 through June 30, 2016) by the end of March 2018. Prior to beginning their review, California provided clarifying guidance to the MCPs through a Frequently Asked Question (FAQ) document and hosted an All-MCP technical assistance webinar to assist the MCPs in responding to the data request.

California began their review in April 2018. The review lasted until the end of November 2018, when California sent the final determination letters to the MCPs. The determination letters showed the calculated MLR and subsequent recoupments due to the risk corridor imposed by California. The recoupments were settled in December 2018.¹

MLR Methodology

The MLR for the expansion population needed to be calculated according to a set methodology developed by California. The methodology was prescribed in detail within the Data Request Instructions and Methodology Letter that were sent to the MCPs by California.

The MLR is defined as "Outgo" divided by "Income." Outgo is defined as allowable medical expenses, and income is the net capitation revenue received by the MCPs. This formula is depicted below:

$$MLR = \frac{Outgo}{Income} = \frac{Allowable\ Medical\ Expenses}{Net\ Capitation\ Revenue}$$

¹ Molina sent a clarification letter to California Department of Health Care Services dated June 4th, 2019, disclosing additional information that would impact the MLR results.

The California Methodology Letter specified the exact components that were allowable within the numerator and denominator. Each component is defined below.

Allowable Medical Expenses, the numerator, is defined as the sum of direct paid claims (Fee-For-Service & Capitation), Global Sub-Capitation Payments, Settlements, Medi-Cal Incentive Pools and Bonuses, Direct Claim Liability and Reserve, Allowable Fraud Reduction Expenses, Health Care Quality Improvement Expenses and Utilization Management & Quality Assurance Expenses.

Net Capitation Revenue, the denominator is defined as gross capitation revenue less Hospital Quality Assurance Fee, Assembly Bill 85 seventy-fifth percentile rate range, and applicable taxes and fees. Applicable taxes and fees include Federal and state taxes and fees.

The MLR for each MCP was subject to the following ACA risk corridor requirements:

- If the MLR was below 85 percent for a specific county or region, then the MCP was required to return to California the difference between 85 percent of the total net capitation payments and the actual allowed medical expenses incurred for that county or region. California would then return the Federal funds associated with the difference to CMS. This requirement ensured that a minimum of 85 percent of the net capitation payments was spent on medical services for the ACA expansion population.
- If the MLR was between 85 percent and 95 percent for a specific county or region, there was no adjustment.
- If the MLR exceeded 95 percent for a specific county or region, then California was required to make an additional payment to the MCP equal to the difference between the MCP's allowed medical expenses and 95 percent of net capitation payments received for that county or region. The additional payment made by California was matched by CMS at the appropriate Federal Medical Assistance Percentage. This ensured that the MCP had additional financial protection should the MLR be greater than expected, which would otherwise cause the MCP to incur a financial loss and not be able to meet its obligations to the expansion population.

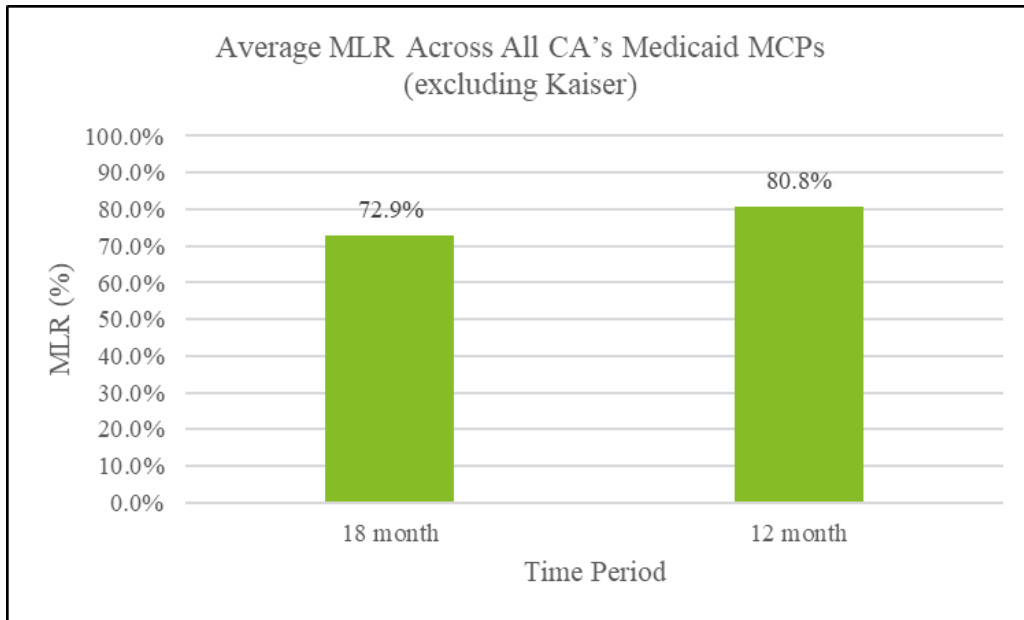
MLR Results

The MLR results for each of the 18-month and 12-month periods are included below. The MLR results were calculated by California based on data reported by each MCP in the MLR template. California reviewed the data and adjusted the data to ensure that the data was consistent and met the guidelines, and that all expenditures reported were allowable.

Average MLR Results

The graph below shows the average MLR results for the 18-month and 12-month time periods for

California's Medicaid MCPs (excluding Kaiser).²



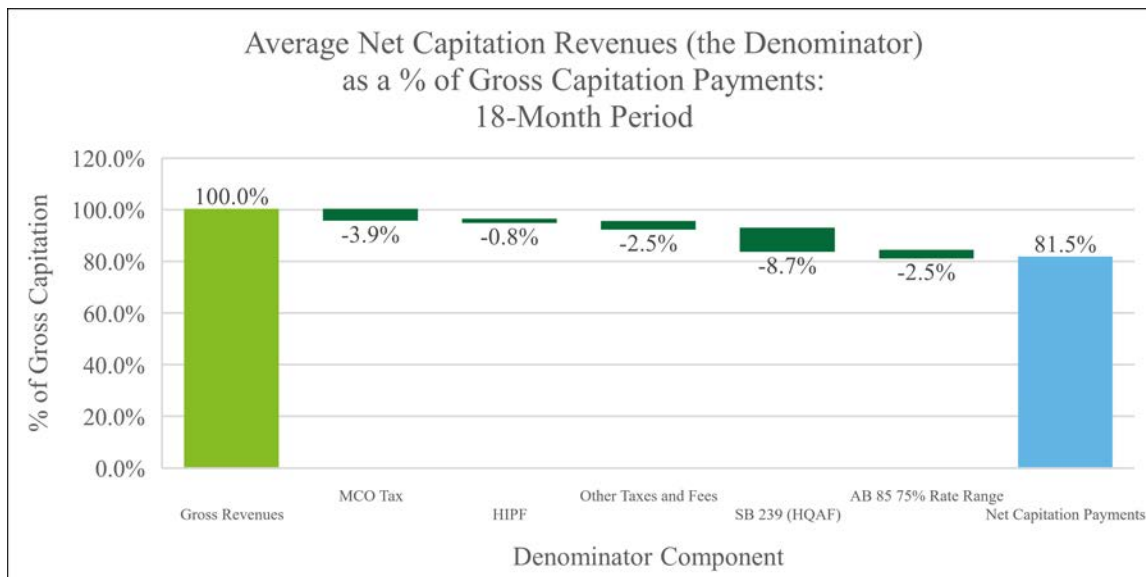
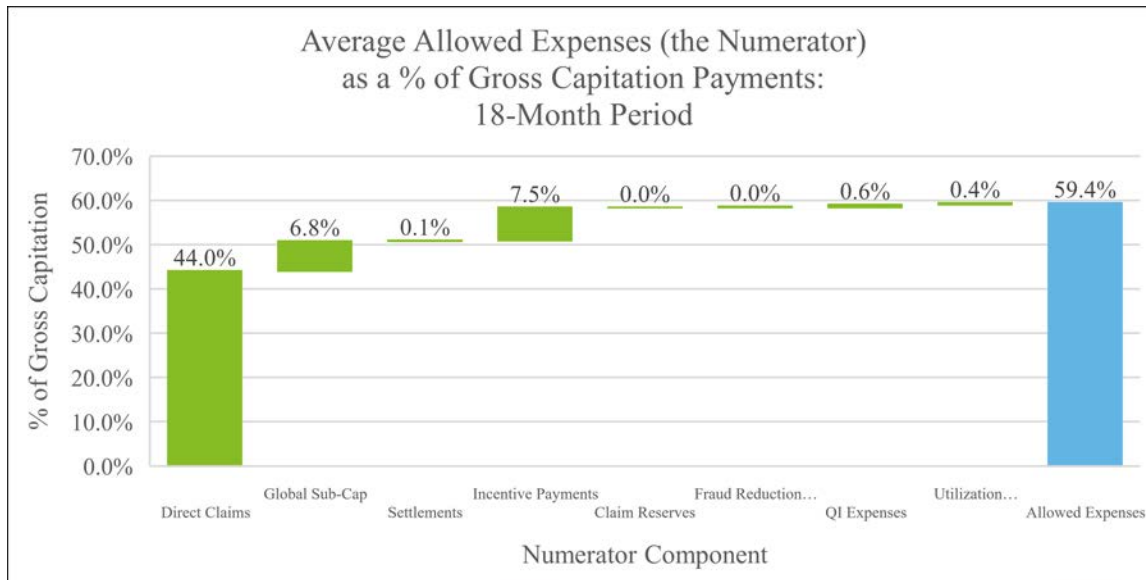
The average MLR was below the 85 percent minimum for both the 18-month and 12-month time periods. This resulted in MCPs that were below the minimum MLR returning \$2.56 billion to California and ultimately the Federal Government. These recoupments are quantified in the 'Recoupments' section, below.

The increase in the average MLR across MCPs was largely due to decreases in the gross capitation rates (the denominator) between the 18-month period and 12-month periods, but as will be discussed in more detail in the sections that follow, other MLR components also decreased between the 18-month and 12-month time periods.

MLR Components

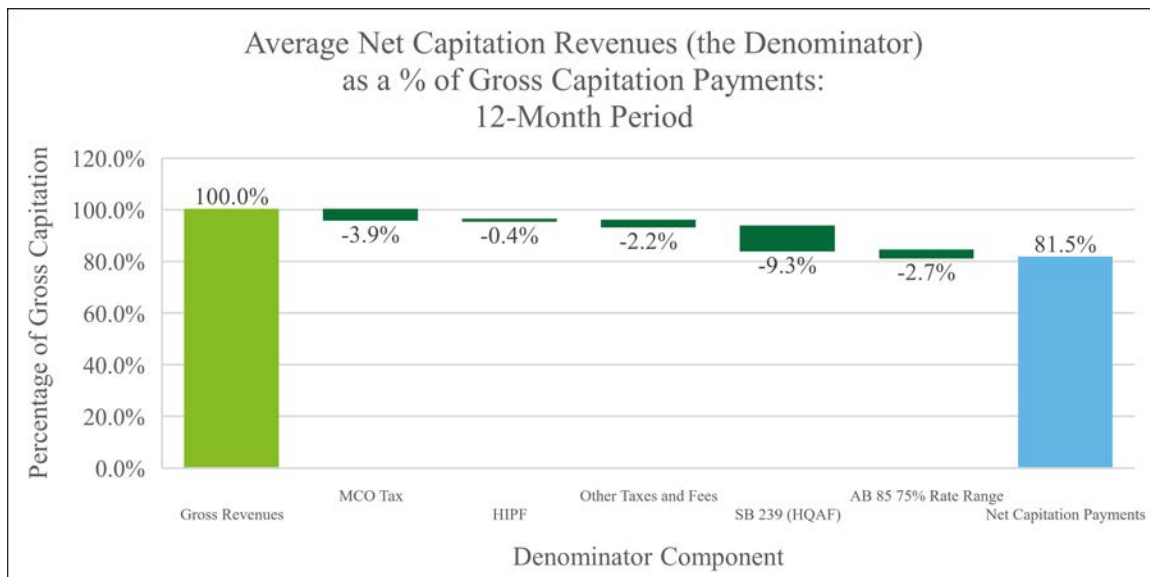
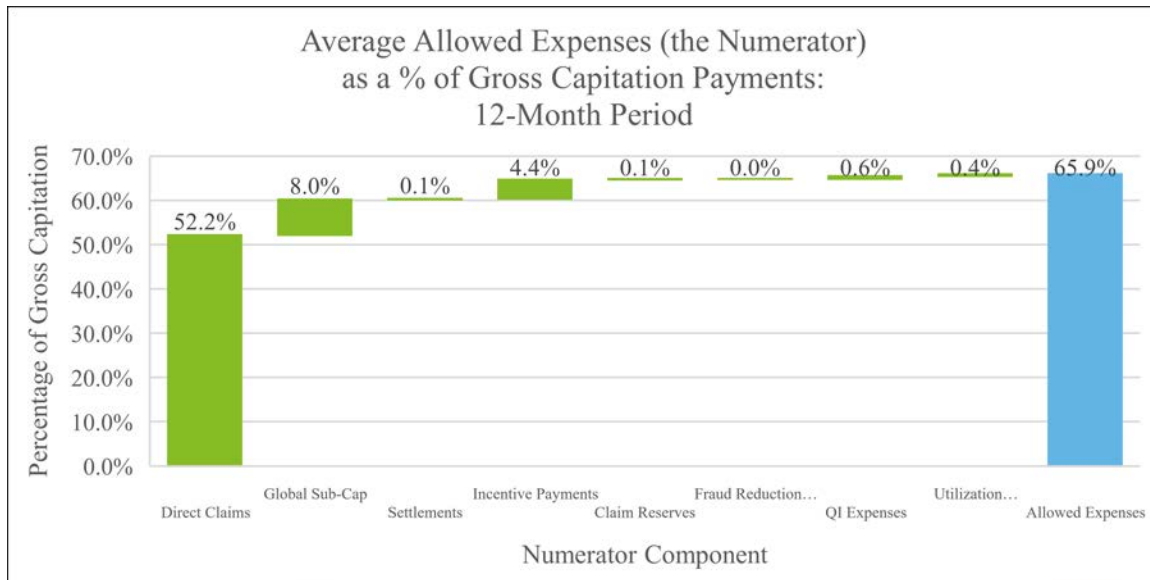
The following graphs show the average allowed expenses (the numerator) as a percentage of gross capitation payments, as well as the average net capitation revenues (the denominator) as a percentage of gross capitation payments across all MCPs for the 18-month period.

² The MLR calculated by California was calculated at a county or regional level for each MCP. The aggregated results shown here were aggregated first for each MCP in the region in which they operated and then across the 21 MCPs. Kaiser was excluded given that they follow the HMO model and own their provider network. As they were unable to report expenditure (numerator) items, per the methodology outlined by California, Kaiser's MLR was taken to be the average MLR across all MCPs operating in the applicable county or region.



The average MLR for the 18-month period was 72.9 percent, which was calculated by dividing the allowed medical expenses (59.4 percent) by the net capitation payments (81.5 percent). In the numerator, direct claims, global sub-capitation, and incentive payments comprised the largest percentage of the numerator, with the other five components only accounting for 1.1 percent of gross capitation payments. In the denominator, Hospital Quality Assurance Fee, Assembly Bill 85 seventy-fifth percentile rate range and taxes and fees accounted for 18.5 percent of the gross capitation payments, and these were subtracted from the gross capitation payments to determine the net capitation payments.

The results of the 12-month period are shown in the graphs below:



The average MLR for the 12-month period of 80.8% was calculated by dividing the allowed medical expense (65.9%) by the net capitation payments (81.5%). In the numerator, direct claims, global sub-capitation, and incentive payments comprised the largest percentage of the numerator, with the other five components only accounting for 1.2 percent of gross capitation payments. In the denominator, Hospital Quality Assurance Fee, Assembly Bill 85 seventy-fifth percentile rate range and taxes and fees accounted for 18.5 percent of the gross capitation payments, and these were subtracted from the gross capitation payments to determine the net capitation payments.

California Adjustments

California reviewed the MLR templates submitted by the MCPs and adjusted the data to ensure that the expenditure amounts reported represented allowable expenditures that were in line with all Federal and state regulations and guidelines. This involved comparing the expenditures reported in

the MLR template against another data source, the rate development template. Any variation between the two sources was questioned directly with the MCP.

In many cases California required the MCPs to resubmit the MLR template to ensure that all requirements were met. Some MCPs had to resubmit their MLR templates up to four times. Common reasons for resubmission included:

- Expenditures for enrollees with Medicare coverage were not reported (incomplete submission) or placed into an incorrect category
- Expenditures (e.g., incentive payments, global sub-capitation) and/or allocation of expenses were updated in response to California review questions
- Expenses for Managed Long-Term Services and Supports that are part of Coordinated Care Initiative risk corridor calculations, and thus should be excluded from the MLR, were erroneously included
- Supplemental payments to globally sub-capitated plans were erroneously not reported as expenses or underreported
- Technical corrections due to linking, data entry, and other errors

After California's review of the final MLR template that was submitted, California further made two types of general adjustments:

- A general or manual adjustment to a specific component in the MLR calculation. Examples included disallowing an incentive payment if the payment had not yet been made or limiting global sub-capitation payments if payments exceeded 95 percent of the net capitation payments (for non-Kaiser global sub-capitation arrangements) and 98 percent of net capitation payments (for Kaiser global sub-capitation arrangements).
- An enrollment adjustment that increased or decreased the MCPs reported expenditure based on the difference between the MCP reported enrollment numbers and internal California enrollment numbers. California believed that the internal sources were more accurate and any deviance in enrollment numbers also needed to be allowed by adjusting expenditure and revenue (numerator and denominator) amounts.

The average adjustment had an impact of reducing the MLR by approximately 0.5 percent for both the 18-month and 12-month periods.

Recoupments

Based on the data reported by the MCPs, along with the adjustments, 19 of the 22 MCPs in the 18-month period and 18 of the 22 MCPs in the 12-month period had to return funds due to not meeting the minimum MLR requirement. Funds were sent from the MCPs to California and then from California to CMS. One MCP in the 18-month period and 2 MCPs in the 12-month period received additional payments from California for exceeding the 95 percent MLR. These financial reconciliations represented the amount of net capitation payments needed to bring the MLR up to 85 percent if the calculated MLR was below 85 percent, and the amount of net capitation payments needed to bring the MLR down to 95 percent if the calculated MLR was above 95 percent, respectively. Additional funding to MCPs that experienced an MLR above 95 percent amounted to \$1.65 million, while the recoupments from MCPs amounted to \$2.56 billion.

Scope and Methodology of the Examination

CMS examined the MLR calculations and supporting documentation of the 22 MCPs in California participating in the Medicaid expansion. In the examination of the MCPs related to their compliance with the MLR requirements, reliance was placed on data previously collected by California as part of the state's review. California collected the data and information in their MLR Templates for the review periods of January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016 following their provided Data Request Instructions.

The review of the 22 MCPs participating in the program included the data submitted by the MCPs and the subsequent MLR calculations by California. For each MCP, CMS reviewed key components that make up the MLR calculation, which are further discussed in subsequent sections.

Appendix B contains the details of the examination scope and methodology.

Results of the Examination

The primary objective of CMS' examination is to determine if California's review correctly identified findings and overpayments, and the documentation accepted by California was reasonable to support the amounts included in the MLR calculation. CMS conducted an examination of the MLR reported by California's 22 MCPs. CMS focused on these objectives:

- Determine if the MLR was reasonably represented by MCPs, specifically whether the numerator was accurately reported to California with appropriate documentation and consistent with generally accepted accounting principles;
- Assess if the MCPs' provider incentive payments and payments to related party entities were consistent with California's contractual requirements and documented appropriately;
- Focus on MCPs that required multiple re-submissions of their MLR calculations to California to determine the cause of those re-submissions and if the causes of the re-submissions had been corrected; and
- Determine and understand what factors were responsible for large variations across MCPs in components of their MLR calculations to ensure that the MCPs had sufficient documentation related to the factors to support the MLR calculations.

Based on the results of this examination (the examination periods: January 1, 2014 to June 30, 2015, and July 1, 2015 to June 30, 2016), California's review correctly identified findings and overpayments related to reporting accurate MLRs, resulting in recoupments from MCPs amounting to \$2.56 billion. CMS did not identify any new findings as a result of this examination; however, CMS identified several areas for improvement when California calculates and reviews each MCP's MLR in the future. Results from each area of review are described in detail below.

Verification of MLR Calculations and Recoupments

CMS completed the following steps to verify that the MLR calculations and related recoupments were correct:

- Confirmed that the MLR was being calculated correctly. This was accomplished using the data provided by a few sample MCPs and the adjustments made by California.
- Confirmed that the type of adjustments made by California were done correctly.
- Verified that the recoupments listed in the MLR Dashboard matched the recoupments listed in the 22 determination letters that were sent to each MCP.
- Verified that the MLR results and recoupment amounts, per the determination letters, matched the California review file for each MCP.
- Verified that the California review file was structured correctly to calculate the MLR results and consistent with the applicable regulations and guidelines.

CMS did not perform the following:

- Independently recalculate the MLR results for each MCP.
- Review interim MLR templates submissions made by the MCP.
- Confirm that every adjustment made by California was reasonable and justifiable.

While CMS did not identify any errors in reporting of the MLR, CMS' examination identified several observations related to the steps taken to calculate and report the MLR. California should consider these observations in the future to ensure accurate reporting of the MLR.

A. Historical paid claims data

California did not collect historical paid claims data; rather California relied on summary reports from the MCPs. While this allowed California to conduct the MLR review years after the program began and the vast majority of claims had been reconciled and paid, in the future California should further analyze the paid claims experience to detect patterns of anomalies in payments .

Reviewing this information will allow for an independent calculation of the medical experience and highlight reporting inconsistencies for a given MCP earlier in the review process. One potential issue this can highlight is a one-time increase in provider payments when an MCP was experiencing a low MLR. Historical paid claims data will also allow California to independently calculate medical experience, which will be beneficial in understanding payment anomalies if the review date is closer to the end of the period under review.

B. Timely review process by California

CMS recommends that reviews by California be started within 6 to 12 months after the end of the review period. The review should be finalized and recoupments settled within 24 months after the end of the review period.

C. Additional disclosures by an MCP after the MLR review was completed

California received a letter from the MCP Molina on June 4, 2019, which provided additional disclosures within their MLR calculation and was almost three years after the completion of the MLR calculation period. This late disclosure, after all analysis and recoupments were complete, means the MLR calculation for Molina may be inaccurate and require revision. As of this report,

California has not yet determined what, if any, impact the additional disclosures may have on the MLR calculation. In future reviews, California should work to ensure this will be resolved in a timely manner.

Provider Incentive Payments

CMS regulations at 42 CFR 438.6(h) (42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015)³ requires Medicaid contracts to comply with the Medicare Advantage (MA) program requirements set forth in 42 CFR 422.208, which allows MCPs to enter into a physician incentive plan with a healthcare provider as long as the incentive plan does not act as an inducement to reduce or limit medically necessary services, and that if the incentive plan places the provider at substantial financial risk, the MCP must assure that all provider groups have appropriate reinsurance arrangements in place. California's MCPs often use these incentive plan as a way to increase and maintain their provider network.

As a result of the California MLR review, California made manual adjustments to some of the incentive payments. These manual adjustments were made for specific incentive payments being disallowed, as well as some incentive payments being shifted from the 18-month time period to the 12-month time period or vice versa. Certain incentive payments were adjusted downward by a set percentage. General reasons why an incentive payment would be disallowed or adjusted are:

- The incentive payment had not yet been paid;
- Administration fees were included in the incentive payments and needed to be removed;
- The incentive payment was related to more than one population (e.g., Medicaid expansion population and non-Medicaid expansion population)
- Incentive payments related to periods which were outside of the MLR review period
- Adjustments related to incentives paid to related parties. Payments to related parties were limited and defined in the methodology letter

In total, California disallowed \$17.4 million of incentives reported in the 18-month time period and \$3.1 million in the 12-month time period.

CMS identified observations where the incentive payment documentation did not always follow leading practices. Inconsistent documentation practices led to difficulties in confirming and verifying the appropriateness of some incentive payments. While these leading practices are not currently Federal or state requirements, and thus this observation does not represent an error to the state, following these leading practices could help California ensure that Medicaid dollars are appropriately paid to providers and included in the MLR calculation.

Under this examination, all MCP contracts were reviewed and assessed as to whether each contract followed leading practices. Overall, leading practices related to incentive payment contracting between an MCP and a healthcare provider for the ACA expansion population are as follows:

³ This Federal requirement is currently included in 42 CFR 438.3(i).

- The contract clearly states that the incentive contract applies to or includes the ACA expansion population
- The contract should have an effective period, with the effective period falling into one of the MLR review periods (either January 2014 to June 2015 or July 2015 to June 2016)
- The contract should be signed and dated by both parties before the commencement of the effective period
- The contract should have clear metrics that the provider needs to meet. These metrics could be related to:
 - The improvement in the quality of healthcare services/patient outcomes; or
 - Improving patient access to care, which may require provider network expansion offered by the MCP
- The contract should specify a dollar amount that can be clearly linked to successful completion of the metrics in the incentive contract, and when it will be paid

The above leading practices were condensed to the following three main issues:

1. If the contract effective period was within the MLR period
2. Some form of metrics were included within the contract
3. The contract was signed by both parties, with the signed date evaluated in comparison to the listed effective date

Below are examples identified by CMS of MCP's incentive contracts not meeting leading practices:

A. The contract effective period was not within the MLR period. Examples include:

1. HPSJ's contract with Dameron⁴ reported in the 18-month period. The contract had an effective date starting November 1, 2017
2. ABC's contract with CHCN reported in the 18-month period. The contract had an effective date starting July 1, 2015

B. The contract did not have any quantitative or qualitative metrics that providers were required to meet. Examples include:

1. Many of Molina's contracts with various providers did not include any details other than a specific dollar amount that would be paid. The contract did identify the lump sum is based on the number of ACA expansion members serviced by the provider. The contract did not include any metrics that the provider needed to meet.
2. Some of Kern's contracts provided a qualitative description of what the incentive payment will be paid for, but there were no goals or metrics linked to the payment of the incentives

⁴ Were other contracts between HPSJ and Dameron. However, the first contract that mentions incentive payments had an effective date of November 1, 2017.

C. The contract was not signed before the effective period.⁵ Examples include:

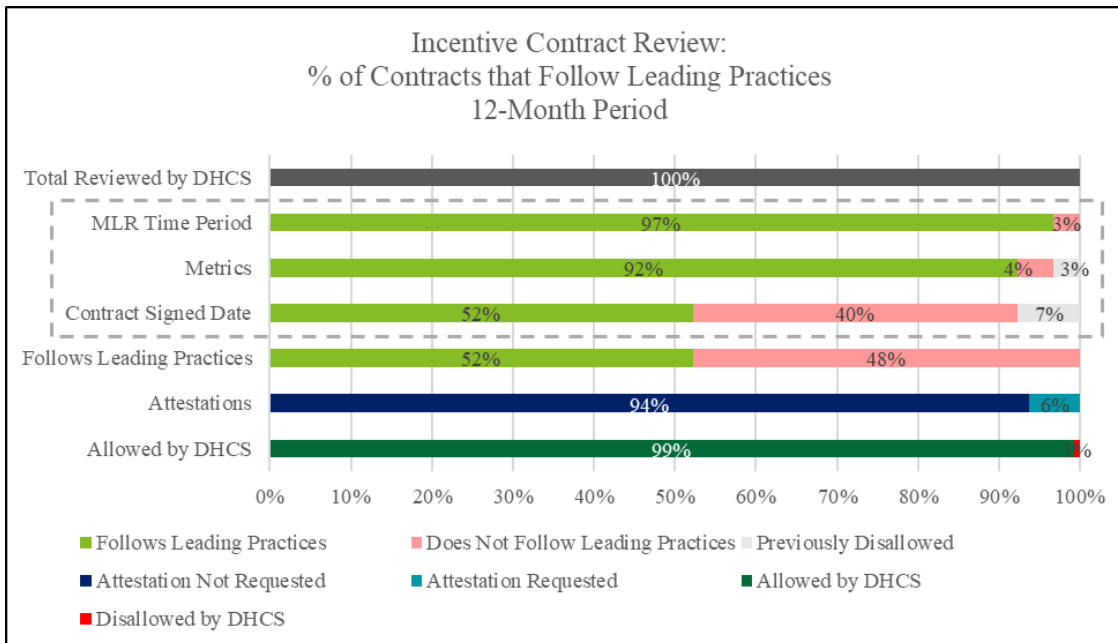
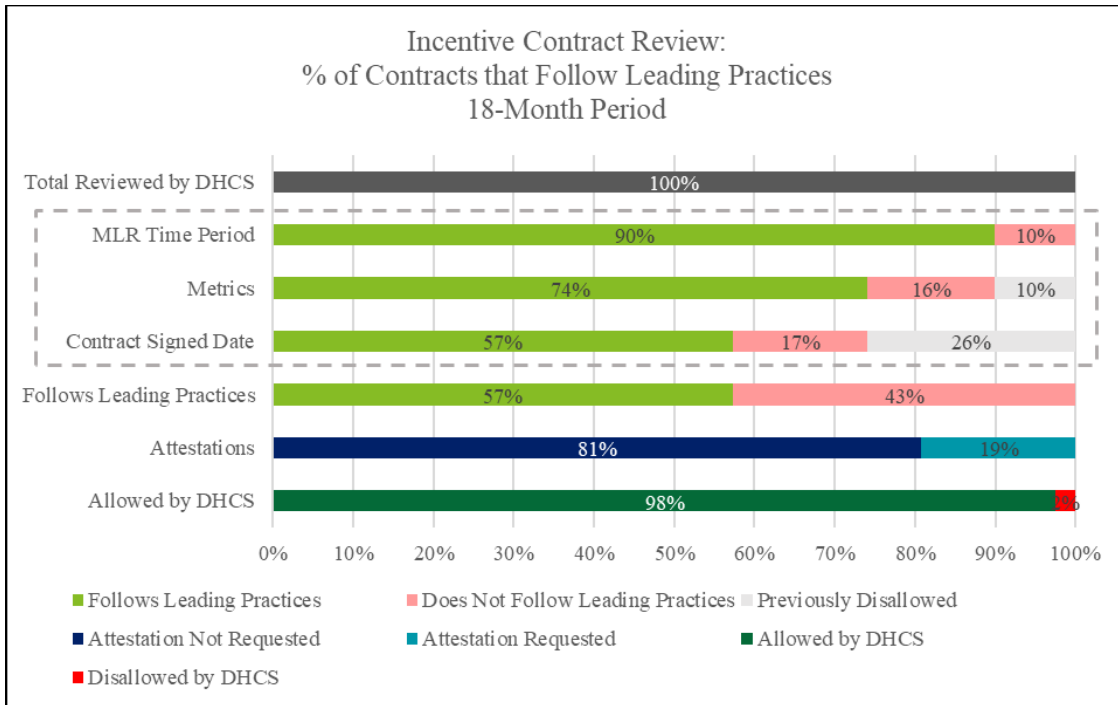
1. SCFHP's contract related to the 18-month period with PMG was signed in December 2015, six months after the end of the MLR review period.
2. LA Care's contract related to the 12-month period with Antelope Valley Health Centre was signed in March 2018, almost 21 months after the end of the MLR review period.

D. Attestations from senior MCP leadership were accepted in instances where documentation was incomplete. The following five MCPs were all requested to provide attestations:

1. Alameda Alliance for Health (AAH) attested that incentive payments during both the 18-month and 12-month periods were paid and that providers had prior knowledge of the incentive payment.
2. Anthem Blue Cross (ABC) attested that specific lump sum payments paid to specific providers in the 18-month period were for the ACA expansion population only and did indeed relate to the 18-month time period.
3. Care1st attested that incentive payments during both the 18-month and 12-month period were for those time periods and that the payments related only to the Adult Expansion Population.
4. Community Health Group attested that the incentive payments for the 18-month and 12-month periods were for the ACA expansion population and that providers had prior knowledge of these incentive payments.
5. Molina attested that the incentive payments related to services performed during the 18-month period and paid during the 12-month period were for the ACA expansion population. Furthermore, the attestation clarified that the incentive payments were discussed with the providers during the 18-month period, with providers having a reasonable expectation to receive the payments after the end of the 18-month period. Molina also provided attestations from the sampled providers stating something similar to the above.

The results of the incentive payment analysis shown as percentages related to each decision, are shown below.

⁵ The California review did confirm with the MCP that both parties, the MCP and the provider, were aware of the incentive arrangement before the commencement of the effective period, even though the contract had been signed after the effective period. This confirmation was in the form of an e-mail. Such confirmations do not follow leading practices.



Within the 18-month time period, 57 percent of the sampled incentive contracts followed the leading practices and the remaining 43 percent did not follow leading practices. Similarly, within the 12-month time period, 52 percent of the sampled incentive contracts followed leading practices and the remaining 48 percent did not follow leading practices.

CMS recommends the following be implemented as it relates to California’s oversight of incentive payment contracts between MCPs and providers:

- All incentive payments should follow leading practices discussed in this report, especially having incentive contracts targeting specific provider behaviors.
- Attestations should not be accepted as the sole source of provider contracting documentation. CMS has informed California that it will not consider approval of its SFY 2018 managed care plan contract actions until the state includes adequate MLR documentation requirements. This includes a MLR documentation standard that prohibits attestations as an acceptable form of documentation in most circumstances, including for provider incentive payments. On May 7, 2020, California submitted SFY 2018 contract actions with this required documentation. CMS also strongly recommends that California utilize this same documentation standard for the SFY 2017 MLR calculations.
- Further review the amount of overall incentive payments from the MCP to the providers as part of the rate approval process to ensure the payments align with program goals and program integrity.

Global Sub-Capitation

Global sub-capitation refers to payments made by MCP A to MCP B, and in return MCP B assumes full responsibility for all medical costs of the sub-capitated member. California requires that these payments made by MCP A (the “Direct” MCP) to MCP B (the “Sub-Capitated” MCP) do not exceed 95 percent of total net capitation payments for MCP A, unless an exception is granted. When globally sub-capitating members MCPs, California required the following guidelines be met: (1) the direct MCP was required to report the number of members globally sub-capitated, along with the associated expenditures to each sub-capitated MCP; (2) the expenditures were required to be split between related and unrelated parties; and (3) expenditures to related parties were limited to what would be considered allowable within the MLR calculation; and then California reviewed the global sub-capitation expenditure and disallowed any expenditure above 95 percent of net capitation payments, with the exception of Kaiser Health Plan (Kaiser), which was granted a 98 percent limit. There were no related party expenditures related to global sub-capitation during the two periods under review, and as such is not applicable for this review.

Expenditures in the context mentioned above refer to the dollar amounts paid from the direct MCP to the sub-capitated MCP; it does not refer to the medical expenditure of the sub-capitated MCP members. Any information on medical expenditures of the sub-capitated MCP members were not collected by California. This was in alignment with the MLR methodology and corresponding contract. It is not clear if the direct MCP collects this information; therefore, it is not possible to calculate an MLR for the globally sub-capitated business, although the full expenditure by the direct MCP on global sub-capitation is allowed in the MLR calculation by California. Once the funds are transferred from the direct MCP to the sub-capitated MCP, the ACA risk corridor provisions are no longer applicable. Over the 30-month period, globally sub-capitated expenditures totaled over \$2.5 billion, which were not subject to the minimum MLR requirement.

CMS’ examination found that California’s review appropriately focused on ensuring that the global sub-capitation payments did not exceed 95 percent of net capitation payment (or 98 percent in the case of Kaiser). As a result of its own review, California adjusted three direct MCPs global sub-capitation expenditures and disallowed \$30,833,215 worth of global sub-capitation expenditure. This

amount only included manual adjustments that California made to direct MCP's expenditure due to the 95 percent threshold and did not include adjustments due to enrollment changes.

At the time of this examination period there was no CMS requirement to collect data on the global sub-capitated portion of the business nor was this required in the MLR methodology and corresponding contract. As such, CMS identified an observation that the only data the MCPs reported to California was membership numbers and expenditure amounts from the direct MCP to the sub-capitated MCP. Once those funds transferred from the direct MCP to the sub-capitated MCP, the funds were no longer subject to the ACA risk corridor requirements. Because the average MCP MLR was below 85 percent over the 18 and 12-month contract periods, it is possible the MLR for global sub-capitation payments would have also been below 85 percent. However, due to the limited data that was required to be reported for the global sub-capitation, it was not possible to calculate the MLR for the globally sub-capitated portion of the business. Collecting this data would allow California to ensure that an appropriate portion of capitation rates are spent on medical services for the globally sub-capitated population and that MCP's are not making profits exceeding the MLR requirements. In the future, California could also request the contracts between the direct MCP and sub-capitated MCP to ensure that appropriate risk sharing arrangements are in place.

Since California's review, CMS has issued a CMCS Informational Bulletin (CIB) on May 15, 2019 clarifying the MLR reporting requirement established by the April 2016 final rule at 42 CFR 438.8 related to sub-contractual relationships and delegations described in 42 CFR 438.230. Specifically, the CIB reiterated the April 2016 final rule requirement that a sub-capitated MCP to report to the direct MCP all the underlying data needed to calculate an MLR. Going forward, this will allow the direct MCP to report the complete MLR to California. While this guidance was not in place for the review period, it is now in effect and should now be enforced by California.

CMS also identified that California granted an exception to Kaiser by allowing the direct MCPs to pay Kaiser at a rate higher than the 95 percent contractual requirement. While exceptions are allowed, it is unclear why this exception was granted due to lost knowledge as a result of significant staff turnover at California. It appears California did not maintain adequate documentation to memorialize why the exception was granted.

CMS recommends the following be implemented as it relates to California's oversight of global sub-capitation expenditures:

- California should incorporate all current CMS regulatory requirements and guidance, including the May 15, 2019 CIB, within their MCP contracts. California can then monitor the level of profits/losses that sub-capitated MCPs are experiencing and compare that to the regular profits/losses the MCP is making on their direct business.
- California should maintain adequate documentation to memorialize guidance and direction given to MCPs to prevent the loss of knowledge in the event of significant staff turnover.

Recommendations for Improvement

As noted above, while CMS did not identify any new findings as a result of this examination, CMS identified several areas for improvement when California calculates and reviews each MCP's MLR in the future:

Verification of MLR Calculations and Recoupments

1. California should consider reviewing historical paid claims data that can be used to detect anomalies in claim payments, and independently calculate medical experience, especially if the review date is closer to the end of the period under review.
2. California should initiate MLR reviews within 6-12 months of the end of the review period. The review should be completed and recoupments settled within 24 months of the end of the review period.
3. California should work closely with MCPs to prevent late disclosures of information after the completion of the analysis of the reported MLR calculations. In cases when this does arise, California should work to ensure this will be resolved in a timely manner.

Provider Incentive Payments

4. While California followed the applicable incentive payment contract regulation and guidance in place during the period of performance, going forward, California should ensure that incentive payment contracts between the MCPs and providers follow leading practices. Contract language should not be open-ended, and MCPs should be required to maintain adequate documentation to support the incentive payments.
5. Attestations should not be accepted as the sole source of provider contracting documentation. CMS has informed California that it will not consider approval of its SFY 2018 managed care plan contract actions until the state includes adequate MLR documentation requirements. This includes a MLR documentation standard that prohibits attestations as an acceptable form of documentation in most circumstances, including for provider incentive payments. On May 7, 2020, California submitted SFY 2018 contract actions with this required documentation. CMS also strongly recommends that California utilize this same documentation standard for the SFY 2017 MLR calculations.
6. California should further review the amount of overall incentive payments from the MCP to the providers as part of the rate approval process to ensure the payments align with program goals and program integrity.

Global Sub-Capitation

7. Pursuant to newly released guidance published on May 19, 2019, which was released after the completion of California's MLR calculation, California should require MCPs to collect data needed to calculate a MLR for the globally sub-capitated portion (i.e., the portion that is sub-contracted to third party MCPs) of the business to ensure an appropriate amount of capitation rates are spent on medical services.
8. California should maintain adequate documentation to memorialize guidance and direction given to MCPs to prevent the loss of knowledge in the event of significant staff turnover.

Federal Requirements on MLR for Medicaid and the Children's Health Insurance Program (CHIP)

Rulemaking has occurred since the time period of this examination to establish Federal requirements for MLR calculation and reporting by managed care plans and associated rate development standards. On April 25, 2016, CMS released the [Medicaid and CHIP Managed Care Final Rule](#), which aligns key rules with those of other health insurance coverage programs, including establishing a MLR for Medicaid and Children's Health Insurance Program (CHIP) to ensure a common national standard for calculating MLR allowing comparability across states, and facilitating more accurate rate setting moving forward.

- In accordance with 42 CFR 438.8 and 42 CFR 457.1203, Medicaid and CHIP managed care plans must calculate and report their MLR according to standards that are similar to Medicare Advantage and the private market, while accounting for unique characteristics of the Medicaid or CHIP programs. These Federal requirements are in effect for Medicaid managed care contracts effective on or after July 1, 2017.
- CMS also developed standards for state oversight of the MLR standards in 42 CFR 438.74. Standards for state oversight include required annual reporting to CMS and repayment and reporting of the Federal share of any remittances the state chooses to collect from its managed care plans.
- States will use MLR data from its managed care plans in the development of actuarially sound capitation rates. For contract rating periods beginning on or after July 1, 2019 for Medicaid managed care contracts, capitation rates must be developed in such a way that the managed care plan would reasonably achieve a medical loss ratio standard of at least 85 percent for the rate year, following the method laid out in 42 CFR 438.8. This is required as part of the actuarial soundness requirements under 42 CFR 438.4(b)(9). States must also take into account the managed care plan's past MLR, as calculated under 42 CFR 438.8, in the development of the capitation rates consistent with 42 CFR 438.5(b)(5).
- The MLR and MLR-related parallel requirements for CHIP were effective for CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018.

Appendix A: Definitions

18-Month Period: Refers to the period from January 1, 2014 to June 30, 2015, i.e. 18 months, and is the first period for which California completed an MLR calculation and review.

12-Month Period: Refers to the period from July 1, 2015 to June 30, 2016, i.e. 12 months, and is the second period for which California completed an MLR calculation and review.

ACA: Refers to the Patient Protection and Affordable Care Act, signed into law by President Obama on March 23, 2010.

ACA Expansion Population: Refers to the optional adult expansion population that was eligible for expansion Medicaid benefits after the passing of the ACA in 2010. The expansion program started in January 2014 for states that wished to expand Medicaid.

Boilerplate Contract: Refers to the standardized contract between each MCP and California.

Data Request Instructions: Refers to the Data Request Instructions that California sent to each MCP. The document name is [AE-MLR Data Request Instructions_2018-01-10.pdf].

Determination Letter: Refers to the letter sent by California to each MCP containing the results of the MCP's MLR calculation and final recoupment amount.

California Review Files: Refers to the excel file used by California for each MCP to calculate the final MLR and recoupment amounts. This file contains all the adjustments that California made to the MCP reported data.

Global Sub-Capitation: Refers to payments made by MCP A to MCP B, and in return MCP B assumed full responsibility for all medical costs of the sub-capitated members. Also referred to as a sub-contractor within the report.

Gross Capitation Rates: Refers to the per member per month (PMPM) rate that each MCP received per month for each enrollee. These rates were calculated prior to the review periods.

Gross Capitation Revenue: Refers to the total amount of revenue that the MCP received for the ACA expansion population.

Incentive Payments: In the context of the MLR Review, incentive payments refer to payments between an MCP and a healthcare provider to incentivize the provider to adopt a behavior when providing services to members of the ACA Adult Expansion Population.

MCP: Refers to one of the twenty-two (22) Managed Care Plans that were contracted with the State of California to provide expansion Medicaid benefits to eligible members. A list of the 22 MCP's can be found in Appendix C.

Methodology Letter: Refers to the CMS ACA Expansion Population MLR Methodology Letter sent by California to the MCPs. The document name is [CMS ACA OE Methodology Letter for CMS_2017-12-06.pdf].

MLR Dashboard: Refers to the dashboard containing the final recoupments as calculated by California. These results are contained in a document named [CA Optional Expansion MLR Dashboard_11-16-18.pdf].

MLR Template: Refers to the excel spreadsheet designed by California to collect data that each MCP was required populate for both the 18-month and 12-month periods.

Net capitation revenue: Refers to the denominator in the MLR calculation and is equal to the gross capitation revenue less Hospital Quality Assurance Fee, Assembly Bill 85 seventy-fifth percentile rate range and applicable taxes and fees.

P1: Refers to the first 6-month period of the MLR review, i.e. January 1, 2014 to June 30, 2014.

P2: Refers to the second 6-month period of the MLR review, i.e. July 1, 2014 to December 31, 2014.

P3: Refers to the third 6-month period of the MLR review, i.e. January 1, 2015 to June 30, 2015.

P4: Refers to the fourth 6-month period of the MLR review, i.e. July 1, 2015 to December 31, 2015.

P5: Refers to the fifth 6-month period of the MLR review, i.e. January 1, 2016 to June 30, 2016.

Recoupments: Refers to money that transferred to or from CMS because of the MLR calculation. If the MLR was below 85% the MCP was required to reimburse money back to CMS, while if the MLR was above 95%, CMS would further reimburse money back to the MCP.

Related parties: Refers to parties where the MCP had a financial interest in the party to which the payment is being made and was defined per GAAP (FASB Accounting Standards Codification 850-10).

Review period: Refers to the total 30-month period of the MLR review. This includes the 18-month period and 12-month period for which California calculated an MLR.

Appendix B: Examination Scope and Methodology

Scope

CMS' examination covered the MLR reported for California's 22 MCPs for the periods of January 1, 2014 to June 30, 2015 and July 1, 2015 to June 30, 2016. CMS performed examination work from January 2019 to December 2019.

Methodology

To accomplish the objectives, CMS:

- Reviewed relevant literature to understand the regulatory requirements and MLR calculation methodology. This includes: contracts between California and each MCP; methodology documents and instructions issued to MCPs by California; and the MLR template that needed to be submitted by each MCP for each time period.
- Reviewed applicable Federal and state laws, regulations, and other requirements related to MLR calculations and reporting.
- Held discussions with California to understand what data was collected, the MLR calculation methodology, and what review process was followed during the MLR calculation.
- Obtained the MLR templates for the 22 MCPs.
- Aggregated the experience from the MLR template to create a benchmark to identify components of the MLR calculation and MCPs that needed to be examined further.
- Collected and reviewed detailed data from California for two MCPs – Molina and Kern Health Systems. This included all data and correspondence between California and the MCP. During the California review, some MCPs required multiple resubmissions of the MLR template. Molina was identified as such a plan while Kern was identified as one that did not require any resubmissions.
- Requested detailed data for all 22 MCPs, but the scope of the data request was limited to the California review files containing the adjustments that California made to the expenditure figures reported by each MCP (the California review files) as well as the data related to incentive payments.
- Discussed examination results with California.

Appendix C: Managed Care Plans

The table below includes a list of the 22 MCP's that were contracted with the State of California to provide expansion Medicaid benefits to eligible members during the examination periods. The MCP's full name, profit status, Federal tax status and the number of counties/regions in which the MCP is contracted to provide ACA expansion benefits is also provided.

	MCP Abbreviation	MCP Full Name	Not-for-Profit	Exempt from Federal Taxes	Number of Counties/Regions Contracted to Provide Expansion Benefits
1	AAH	Alameda Alliance for Health	Yes	Yes	1
2	ABC	Anthem Blue Cross	No	No	11
3	CalOptima	CalOptima	Unanswered	Unanswered	1
4	CalViva	CalViva Health	Yes	Yes	3
5	Care1st	Care First Health Plan	No	No	1
6	CCAH	Central Coast Alliance for Health	Yes	Yes	3
7	CenCal	CenCal Health	Yes	Yes	2
8	CHG	Community Health Group	Yes	Yes	1
9	CHW	CA Health & Wellness	No	No	2
10	Contra Costa	Contra Costa Health Plan	Yes	Yes	1
11	GCH	Gold Coast Health Plan	No	Yes	1
12	Health Net	Health Net of California	No	No	7
13	HPSJ	Health Plan of San Joaquin	No	Yes	2
14	HPSM	Health Plan of San Mateo	Yes	Yes	1
15	IEHP	Inland Empire Health Plan	Yes	Yes	2
16	Kaiser	Kaiser Health Plan of California	Yes	Yes	3
17	Kern	Kern Health Systems	Yes	Yes	1
18	LA Care	LA Care Health Plan	Yes	Yes	1
19	Molina	Molina Healthcare of California	No	No	5
20	Partnership	Partnership Health Plan of California	Yes	Yes	7
21	SCFHP	Santa Clara Family Health Plan	Yes	Yes	1
22	SFHP	San Francisco Health Authority	Yes	Yes	1

Appendix D: California's Response

State of California-Health and Human Services Agency

Department of Health Care Services

April 15, 2020

Ms. Jennifer Dupee, Acting Director
Governance Management Group
Center for Program Integrity
Centers for Medicare & Medicaid
Services 7500 Security
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Baltimore, MD 21244-1850

Draft Report Response

Dear Ms. Dupee:

The California Department of Health Care Services (DHCS) is pleased to provide you with the response to the Centers for Medicare & Medicaid Services' (CMS) draft report titled, "California Medicaid Managed Care Plans' Medical Loss Ratio Calculations." The examination report resulted in zero findings, however, six areas of improvement were identified specific to the state's review of each Managed Care Plan's (MCP) Medical Loss Ratio (MLR) for the Affordable Care Act (ACA) Medicaid adult expansion population. The areas of improvement identified in the report are noted below.

- 1. DHCS should ensure that incentive payment contracts between the MCPs and providers follow leading practices. Contract language should not be open-ended, and MCPs should be required to maintain adequate documentation to support the incentive payments.**

DHCS partially agrees.

DHCS agrees MCPs should maintain adequate documentation to support incentive payments. However, due to MCP staff turnover compounded with the limited timeframe allowed to complete the final MLR reviews, DHCS allowed MCPs to provide attestations as one type of supporting documentation. Attestations were not solely relied upon to verify such expenditures. For example, DHCS verified the expenditures were related to the adult expansion population, collected and reviewed a variety of supporting documentation outside of attestations, and verified the expenses was incurred and paid to the applicable providers.

DHCS disagrees with applying all of the leading practices entirety as outlined in the report as the practices are not required within the federal Medicaid regulation, the federal ACA commercial MLR guidance, nor the CMS approved state contractual requirements and methodology. The retroactive imposition of such leading practice would be inappropriate as the practice was not part of the CMS approved contract and methodology and MCPs were unaware of the requirements prior to the start of the contract and rating period tied to the reviews. DHCS and our MCPs experienced a large influx of adult expansion Medicaid members, well above fiscal projections made by multiple state entities, during the time period MCPs were focused on ensuring the new adult expansion members had appropriate access to care. As a result, MCPs employed various financial practices including, but not limited to, a variety of incentive arrangements not necessarily solely tied to metrics. DHCS agrees with the concept of having a contract signed by the start of the rating period. However, in practice, the concept is not always realistic given MCP contract negotiations can take a significant amount of time leading to delays in finalizing the formal executed contract. DHCS does not see value in retroactively applying leading practices as MCPs were not aware of these requirements prior to the start of the rating period. DHCS will not be imposing the practices for state fiscal year (FY) 2017-18 and 2018-19 adult expansion MLR reviews as MCPs were not aware of the requirements prior to the start of the rating period. As indicated in the report for the FY 2018-19 adult expansion review, DHCS will be imposing the disallowance of attestation in most instances, the disallowance has to be incorporated in the contract for the time period.

2. DHCS should maintain adequate documentation to memorialize guidance and direction given to MCPs to prevent the loss of knowledge in the event of significant staff turnover.

DHCS agrees.

During the course of the audit, DHCS acknowledged the leadership staff turnover that occurred prior to the finalization of the adult expansion contract language, methodology, and final MLR calculations. DHCS has implemented new practices to prevent the loss of future knowledge including, but not limited to, documenting key dates, incorporating multiple levels of staff in current and future MLR reviews to prevent key person dependencies, and implementing a policy on the storing and preserving of MLR guidance and documentation.

3. DHCS should complete the MLR review in a timely manner.

DHCS agrees.

DHCS agrees the MLR review could have been completed in a timelier manner. However, we would like to note the development of the MLR contracts, process, templates, and methodology was a more lengthy process than initially intended in part due to key DHCS staff turnover, the technicality of the subject, and timeframe necessary to receive CMS review and approval of the final contract and methodology. While the reviews began later than expected, DHCS is pleased no report findings have been identified specific to the final MLR calculations for the time periods reviewed.

4. DHCS should work closely with MCPs to prevent late disclosures of information after the completion of the analysis of the reported MLR calculations.

DHCS disagrees.

DHCS provided appropriate supporting documentation during the course of the examination demonstrating a clear and defined closeout process. The supporting documentation included the CMS approved methodology letter, MCP MLR

Instruction Document, and the MCP MLR Determination Letters which included the following language:

"Upon conclusion of all reviews of Contractor's reported data, DHCS will calculate Contractor's Adult Expansion (AE) MLR for each county or region and AE-MLR reporting period. DHCS will issue a determination letter to Contractor which will include key findings, material adjustments by DHCS, and the AE-MLR calculated by DHCS. If Contractor does not respond in writing within 30 days to challenge the determination letter, the AE-MLR calculation will be considered final and complete by both Contractor and DHCS. If Contractor disagrees with the determination letter, Contractor will have the opportunity to appeal to the Deputy Director of Health Care Financing. To appeal, Contractor must respond in writing within 30 days of the date of the determination letter to the Deputy Director of Health Care Financing. Contractor's appeal must state the basis for the appeal and must include evidence supporting the findings, adjustments, and/or calculations being appealed. The Deputy Director of Health Care Financing will accept or deny the appeal within 30 days and notify Contractor of this decision.

If accepted, DHCS will reinitiate review of the Contractor's reported data to account for the additional evidence provided during the appeal. Once the review is completed, DHCS will issue its decision containing the final AE-MLR calculation in writing.

If denied, the AE-MLR provided in the original determination letter will be considered final and complete, subject to remedies otherwise available under the contract."

Further the MCP MLR Determination Letters included the following language under the Right of Appeal section.

"If the plan disagrees with the MLR calculations documented in this determination letter, the plan may appeal in writing to DHCS within 30 calendar days of the date of this letter. If no written appeal is received by that date, the MLR calculations documented herein will be considered final and complete."

The supporting documentation provided during the course of the examination clearly documents and outlines DHCS' closeout process. We would also like to note that our approved CMS methodology included the following language should a materially error or omission be identified subsequent to the MLR finalization.

"In addition, DHCS reserves the right to redetermine the MLR calculations stated in this letter if, subsequent to the date of this letter, an error or omission is identified that would materially, as determined by DHCS, change the final MLR calculations. Further, final MLR calculations may also be subject to change based on State or federal audit or similar review."

In the instance of Molina disclosing additional information after the finalization of the MLR, we do not see value in discouraging MCPs from notifying DHCS should a material error or omission be identified. Based upon the information above, we disagree with the area of improvement and recommend the item be removed from the final examination report.

5. DHCS should consider historical paid claims data to independently calculate the medical experience.

DHCS partially agrees.

DHCS collected summary reports from MCPs in place of paid claims given the appropriate claims had runout and the majority of MCP claims were paid. If the MLR review was able to be completed closer to the end of the rating period we would see value in this additional step. However, given the timeframe of the MLR reviews it was determined immaterial to review the MCP incurred but not the reported paid claims data which made up 0.0% and 0.1% of all claims for 18 month and 12 month periods. DHCS will evaluate the claims runout period to determine if the step is appropriate for future adult expansion MLR reviews.

6. DHCS should require MCPs to collect data needed to calculate a MLR for the globally sub-capitated portion (i.e., the portion that is sub-contracted to third party MCPs) of the business to ensure an appropriate amount of capitation rates are spent on medical services.

DHCS disagrees.

The CMS approved contract and methodology did not require the state to calculate a MLR for globally sub-contracted and sub-capitated MCPs. As discussed throughout the course of the examination DHCS was under significant time pressure to complete the MLR by a timeframe outlined by CMS. In the event DHCS was able to complete this step, DHCS would have had no contractual authority to recoup potential funds from the global sub-contractor. The application of rules retroactively cannot and should not be applied to MLR calculation and DHCS recommends this item be removed from the final report.

DHCS appreciates the work performed by CMS and the opportunity to respond to the draft report. If you have any questions, please contact Internal Audits at (916) 445-0759.

Sincerely,

A blue ink handwritten signature, appearing to read 'B. Gilbert', with a horizontal line extending to the right.

Bradley P. Gilbert, MD, MPP

Director

Enclosure

cc: Jacey Cooper
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