CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: December 13, 2024

ALL PLAN LETTER 24-018

TO: ALL MEDI-CAL MANAGED CARE PLANS

SUBJECT: MEDICAL LOSS RATIO REQUIREMENTS FOR SUBCONTRACTORS AND DOWNSTREAM SUBCONTRACTORS

PURPOSE:
The purpose of this All-Plan Letter (APL) is to provide guidance to Medi-Cal managed care plans (MCPs) on the Medical Loss Ratio (MLR) requirements set forth by the federal Centers for Medicare & Medicaid Services (CMS) in the California Advancing & Innovating Medi-Cal (CalAIM) Section 1915(b) waiver's Special Terms and Conditions (STCs)[1] and pursuant to the MCPs' contractual requirements in Exhibit A, Attachment III, Provision 3.1.5(B)(31).[2]

BACKGROUND:
Existing federal regulations obligate states to require MCPs to annually calculate and report an MLR in accordance with section 438.8 of Title 42 of the Code of Federal Regulations (CFR).[3] Title 42 CFR section 438.8(j) gives states the option to require MCPs to provide a remittance if the MCP does not achieve a minimum MLR standard, not less than 85 percent, established by the state. Additional guidance was provided in the May 15, 2019, and June 5, 2020, CMCS Information Bulletins (CIB) that included MLR requirements related to third-party vendors[4] and MLR frequently asked questions.[5]

Commencing July 1, 2019, Welfare and Institutions Code (W&I) section 14197.2 established a minimum MLR standard of 85 percent.[6] W&I section 14197.2(c) imposes a remittance requirement for MCPs, except Dental MCPs, that do not achieve this

[1] The STCs can be found at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-STCs.pdf.
[2] The boilerplate MCP Contract can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx
[3] The CFR is searchable at: https://www.ecfr.gov/search
[4] For more information see the May 15, 2019, CIB which is available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051519.pdf.
[5] For more information see the June 5, 2020, CIB which is available at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib060520_new.pdf.
[6] California State Law is searchable at: https://leginfo.legislature.ca.gov/faces/home.xhtml

standard for rating periods beginning on or after July 1, 2023—i.e., starting the Calendar Year (CY) 2024 rating period. The W&I section 14197.2 reporting and remittance requirements apply to all services covered by MCPs' Contracts with the Department of Health Care Services (DHCS), including the Secondary Operations (state-only) Contract.

In December 2021, CMS approved California's CalAIM Section 1915(b) waiver including new MLR reporting and remittance requirements in STC A11. The new requirements set forth in STC A11 increase DHCS' oversight of MLR reporting in the context of Subcontractor arrangements. Such arrangements exist throughout California, with MCPs delegating risk to other health plans, independent physician associations (IPAs), medical groups, hospital systems, and other healthcare entities. In certain circumstances, these Subcontractors sub-delegate further to Downstream Subcontractors. Pursuant to STC A11, DHCS must oversee the imposition of MLR reporting and remittance requirements on applicable downstream entities that are Subcontractors and Downstream Subcontractors of MCPs.

The reporting and remittance requirements set forth by STC A11 require the following:

Effective the CY 2022 MLR reporting year:

- DHCS must collect and submit to CMS the MCP-generated MLR reports, including but not limited to the information detailed in 42 CFR section 438.8(k) and documentation of DHCS' compliance review.

For MCPs that delegate risk to Subcontractors, DHCS must consider MLR requirements related to third-party vendors.[7]

Effective the CY 2023 MLR reporting year:

- DHCS must require MCPs that delegate risk to Subcontractors to impose MLR reporting requirements equivalent to the requirements in 42 CFR section 438.8(k) on their applicable Subcontractors and Downstream Subcontractors.

Effective no later than the CY 2025 MLR reporting year:

- DHCS must require MCPs that delegate risk to Subcontractors to impose MLR remittance requirements equivalent to 42 CFR section 438.8(j), (i.e., equivalent to DHCS' minimum standard for MCPs, as applicable) on their applicable Subcontractors and Downstream Subcontractors.

[7] For more information see the May 15, 2019, CIB.

POLICY:
Effective January 1, 2023, MCPs must impose MLR reporting requirements equivalent to the requirements in 42 CFR section 438.8(k) on their applicable Subcontractors and Downstream Subcontractors. No sooner than January 1, 2025, MCPs must impose MLR remittance requirements equivalent to the requirements in 42 CFR section 438.8(j) on their applicable Subcontractors and Downstream Subcontractors.

Scope
MCPs must use the following framework to identify the Subcontractors and Downstream Subcontractors that are subject to the MLR reporting and remittance requirements as outlined in STC A11:

> Applicable Subcontractors are Subcontractors or Downstream Subcontractors that enter into a Subcontractor agreement with, and consequently assume financial risk from, an MCP or its Subcontractors and Downstream Subcontractors and receive payment that relates directly or indirectly to the performance of the MCP's obligations under the Contract.

Table 1. Entities Subject to STC A11	
MCPs	Plans that are contracted directly with DHCS to provide Medi-Cal services in a Service Area.
Subcontractor Plans	Plans[8] that assume fully or partially delegated risk from an MCP, or its Subcontractor or Downstream Subcontractor, in a Service Area.
Other Applicable Subcontractors	Subcontractors, except Subcontractor Plans, that assume risk and receive payment from an MCP, or its Subcontractor or Downstream Subcontractor, for services provided beyond their own entity (i.e., services which they do not directly deliver to Members). This may include IPAs, medical groups, hospital systems, or other entities.
Non-Reporting Entities	Direct Providers or Provider groups, purely Administrative Subcontractors, and non-applicable Subcontractors that do not assume risk or assume risk only for services provided within their own entity.

The distinction between reporting and non-reporting entities outlined in Table 1 is based on the assumption of capitated risk for services that an entity does not directly provide. In accordance with STC A11, and subject to consideration of a materiality threshold, as discussed below, MCPs must require Subcontractor Plans and Other Applicable Subcontractors to satisfy MLR reporting and remittance requirements. Non-Reporting Entities are exempt from having to calculate and report MLR in accordance with STC

[8] Licensed health plans can be found at: https://wpso.dmhc.ca.gov/Dashboard/SearchHealthPlan.aspx.

A11. A single entity may be both a Non-Reporting Entity in some instances (e.g., for certain services or arrangements) and an Other Applicable Subcontractor in other instances.

Materiality Threshold
MCPs must utilize a materiality threshold established by DHCS for determining whether a Subcontractor or Downstream Subcontractor Agreement is subject to the STC A11 reporting and remittance requirements.

For the CY 2023 MLR reporting year, and until modified by DHCS, applicable Subcontractors that receive $30,000,000 or more in Medi-Cal capitation annually, from a single upstream entity, as payment for services rendered in a single county or rating region, for which they assume risk and are not directly providing will be subject to MLR reporting requirements. Subcontractors and Downstream Subcontractors that fall below the annual threshold dollar will not be subject to reporting for the given MLR reporting year, except as required by DHCS on a case-by-case basis.

For future MLR reporting years, DHCS will make use of the actual MLR data reported by MCPs and their Subcontractors and Downstream Subcontractors to evaluate the continued appropriateness of the established materiality threshold. DHCS reserves the right to change the thresholds as necessary at DHCS' sole discretion following consultation with MCPs and CMS. DHCS will communicate any changes to the materiality threshold amount or approach through an APL or other similar instruction.

Four-Part Test
As stated in the preamble to CMS' May 6, 2016, Managed Care Final Rule[9], states have the discretion to adopt the Four-Part Test established in the February 9, 2012, Center for Consumer Information and Insurance Oversight (CCIIO) and CMS Guidance (2012 CCIIO Guidance).[10] The Four-Part Test may be used to determine whether MCP payments to a Subcontractor, or a Subcontractor's payments to a Downstream Subcontractor, count as incurred claims under 42 CFR section 438.8(e)(2), or are excluded from incurred claims as an administrative cost under 42 CFR section 438.8(e)(3)(v)(A)(2). A state's decision to use or not use the Four-Part Test is consistent with the requirements for the calculation of the MLR in 42 CFR section 438.8 and the 2012 CCIIO Guidance.

DHCS will adopt the Four-Part Test for the CY 2023 and CY 2024 MLR reporting years for Other Applicable Subcontractors. MCPs may not view payments to Subcontractor Plans from the lens of the Four-Part Test because Subcontractor Plans are not clinical risk-bearing entities. Notwithstanding the use of the Four-Part Test, Other Applicable

[9] See page 27527 of the Preamble in CMS' May 6, 2016, Managed Care Final Rule, available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.
[10] See CCIIO Technical Guidance (CCIIO 2012-001): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule, available at: https://www.cms.gov/cciio/resources/files/downloads/employer_faq_bulletin_2_9_12_final.pdf.

Subcontractors are required to fully report payments to Providers for the CY 2023 and CY 2024 reporting years.

Under the Four-Part Test, payments to a clinical risk-bearing entity are considered incurred claims if the following four factors are met:

- The entity contracts with an issuer to deliver, provide, or arrange for the delivery and provision of clinical services to the issuer's enrollees but the entity is not the issuer with respect to those services;
- The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to enrollees;
- The entity delivers, provides, or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as Provider performance reviews, tracking clinical outcomes, communicating evidence-based guidelines to the entity's clinical Providers, and other, similar care delivery efforts; and
- Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incident to the clinical services, and must be performed on behalf of the entity or the entity's Providers.

Under the Four-Part Test, administrative functions that a Subcontractor or Downstream Subcontractor performs on behalf of its Providers would be included in incurred claims. Conversely, to the extent that administrative functions are performed on behalf of the issuer, such as processing claims in order to issue explanations of benefits (EOBs) to enrollees and handling enrollee appeals and grievances, that portion of the issuer's payment that is attributable to these administrative functions may not be included in incurred claims. Additional guidance is contained in the May 13, 2011[11] and July 18, 2011[12] CCIIO Technical Guidance Questions and Answers on the treatment of expenditures to third-party vendors. MCPs must remedy, or require their Subcontractors and Downstream Subcontractors to remedy, any misapplication of the Four-Part Test that is identified by the MCP or DHCS.

DHCS will not utilize the Four-Part Test starting with the CY 2025 MLR reporting year. Beginning with the CY 2025 MLR reporting year, DHCS will continue to follow the May 15, 2019, CIB entitled Medical Loss Ratio (MLR) Requirements Related to Third Party Vendors (2019 CIB) to determine whether a payment to a Subcontractor or Downstream

[11] See Question and Answer #12 in the May 13, 2011, CMS, CCIIO Insurance Standards Bulletin related to CCIIO Technical Guidance (CCIIO 2011—002): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule. The document is available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-guidance-20110513.pdf.
[12] See Question and Answer #19 in the July 18, 2011, CMS, CCIIO Insurance Standards Bulletin related to CCIIO Technical Guidance (CCIIO 2011—004): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule. The document is available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/20110718_mlr_guidance.pdf.

Subcontractor should be included as an incurred claim or excluded as an administrative cost.

Newer Experience
Consistent with 42 CFR section 438.8(l), MCPs may exempt a newly contracted Subcontractor or Downstream Subcontractor from the MLR reporting requirements in the Subcontractor's or Downstream Subcontractor's first year of operation. Exemptions may only apply to the first MLR reporting year that overlaps with the newly contracted Subcontractor's or Downstream Subcontractor's first year of operation regardless of whether the overlap is less than 12 months. Beginning with the CY 2023 MLR reporting year, MCPs must report any exempted Subcontractors and Downstream Subcontractors to DHCS by the end of the third quarter of each MLR reporting year utilizing DHCS' reporting form. DHCS reserves the right to reverse any exemption approved by an MCP based on information obtained during the initial review of MLR reporting or subsequent state or federal reviews or audits. MCPs, and their Subcontractors and Downstream Subcontractors, must comply with any such reversal and submit or amend MLR reporting as needed.

Beginning with the CY 2023 MLR reporting year, MCPs must identify all their respective Subcontractors and Downstream Subcontractors in their MLR submission whether or not the Subcontractors and Downstream Subcontractors are required to submit an MLR report.

Flow of Reporting and Remittance
MCPs must require their Subcontractors and Downstream Subcontractors to report an MLR at the Subcontractor Agreement and Downstream Subcontractor Agreement level, respectively, by county or rating region, to their upstream entity. DHCS will not accept submissions of MLR reports from Subcontractors and Downstream Subcontractors directly.

MCPs must ensure that Subcontractors and Downstream Subcontractors that report an MLR include within their MLR the revenues, expenses, and membership specific to the services for which they are at risk and which are not directly provided by them. Consistent with 42 CFR section 438.8(k)(3), MCPs must require Subcontractors and Downstream Subcontractors providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCPs within 180 days of the end of the MLR reporting year or within 30 days of being requested by the MCP, whichever comes sooner. For each MLR reporting year pursuant to this APL, DHCS will set the paid-through dates for all levels of delegation to ensure consistency of the data received by the upstream entities.

Commencing with the CY 2025 MLR reporting year, MCPs must impose remittance requirements equivalent to 42 CFR section 438.8(j) on their Subcontractors and Downstream Subcontractors. If the MLR for a Subcontractor Agreement or Downstream Subcontractor Agreement, by county or rating region, does not meet the established minimum standard of 85 percent or higher for the respective MLR reporting year, then

the MCP must require the Subcontractor or Downstream Subcontractor to pay a remittance to their upstream entity. The upstream entity must account for this remittance in their own MLR report as a reduction to expenditures.

Credibility Adjustment
Consistent with 42 CFR sections 438.8(h) and (k)(1)(viii), and the July 31, 2017, CIB entitled Medical Loss Ratio (MLR) Credibility Adjustments,[13] Subcontractors and Downstream Subcontractors may apply credibility adjustment factors within their MLR reporting. MCPs must require Subcontractors and Downstream Subcontractors that are non-credible but meet the materiality threshold to submit an MLR report. DHCS will communicate any changes to the credibility adjustment factors through an APL or other similar instruction.

MCP Review and Oversight
MCPs must impose requirements on Subcontractors to ensure that Subcontractors and Downstream Subcontractors perform delegated activities or obligations, and related reporting responsibilities, relating to Members, in accordance with 42 CFR section 438.230(c)(1). Subcontractors must comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions, in accordance with 42 CFR section 438.230(c)(2).

MCPs must ensure MLR reports submitted by Subcontractors and Downstream Subcontractors are consistent with the information required in 42 CFR section 438.8(k). MCPs are expected to review and provide oversight of their downstream entity MLR submissions and must attest to performing this review as part of the MCP's MLR submission. Specific expectations may include, but are not limited to:

- Review each Subcontractor's and Downstream Subcontractor's MLR and reported medical cost per Member per month to identify and investigate outliers.
- Review reported expenses to ensure medical and non-medical expenses are appropriately accounted for in the MLR calculation.
- Review that reported expenses align with service volume reported in encounters.
- Review that the Subcontractor's or Downstream Subcontractor's reported revenues align with the payments reported by the upstream entity.
- For Subcontractor Agreements or Downstream Subcontractor Agreements covering multiple lines of business, review the methodologies for allocation of expenditures to ensure reasonableness.
- Reviewing Incurred But Not Reported for reasonableness.

State Directed Payment Programs and Recalculation
There are multiple State Directed Payment (SDP) programs that are based on utilization during the program year and are calculated or paid after the closing of the applicable MLR reporting year. In accordance with 42 CFR section 438.8(k)(2), MCPs

[13] For more information see the July 31, 2017, CIB which is available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/cib073117_105.pdf.

must submit their MLR reports to DHCS within 12 months of the end of the MLR reporting year, which is before the timeframe for these SDPs to be calculated and paid. Therefore, these SDPs will not be included in the initial MLR report submitted by Subcontractors and Downstream Subcontractors. When the remittance requirement is imposed beginning with the CY 2025 MLR period, a proxy remittance amount will be calculated, which will exclude these SDPs. The remittance of payments from Subcontractors and Downstream Subcontractors to their upstream entities, and from MCPs to DHCS, will be delayed until these SDPs have been finalized and paid. After these SDPs are calculated and paid, the MLR will be recalculated and resubmitted, in accordance with 42 CFR section 438.8(m) (see example timeline below). Subcontractors and Downstream Subcontractors may only need to re-report their MLR if those SDP amounts flow to them from their upstream entity. The final remittance amounts will be calculated and collected following receipt of the restated MLRs. DHCS will limit standard re-reporting of the MLR to no more than one instance but may require re-reporting on an ad hoc basis if material discrepancies, errors, or omissions are identified.

Date	Activity
No later than 12/31/2025	**Receipt of CY 2024 MLRs –** MCPs submit their CY 2024 MLR report to DHCS accounting for their applicable Subcontractors' MLRs.
1/1/2026 – 9/30/2026	**DHCS' MLR Review –** DHCS reviews compliance with CY 2024 MLR reporting requirements, including consideration of Subcontractor reporting, and calculates, but does not collect, draft remittance in accordance with State law.
No later than 3/31/2027	**Receipt of Restated CY 2024 MLRs –** MCPs submit their restated CY 2024 MLR reports including their final SDP revenues and expenditures.
4/1/2027 – 9/30/2027	**DHCS' MLR Review –** DHCS calculates CY 2024 MCP remittances in accordance with State law.
No later than 12/31/2027	**Remittance Collection –** MCPs remit any owed amounts for CY 2024.

MCPs must review their contractually required policies and procedures (P&Ps) to determine if amendments are needed to comply with this APL. If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's contractually required P&Ps, the MCP must submit its updated

P&Ps to its Managed Care Operations Division (MCOD)-MCP Submission Portal[14] within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must attach an attestation to the Portal within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The attestation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, Contract requirements, and other DHCS guidance, including APLs and Policy Letters. MCPs must ensure their Subcontractors have reviewed and updated their P&Ps. MCPs must submit an attestation validating that Subcontractors subject to this APL have compliant P&Ps within 120 days of the release of this APL. These requirements must be communicated by each MCP to all Subcontractors and Network Providers. MCPs should review their Provider and/or Subcontractor Agreements, including Division of Financial Responsibility provisions as appropriate to ensure compliance with this APL. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions, for non-compliance. For additional information regarding administrative and monetary sanctions, see APL 23-012, and any subsequent iterations on this topic. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions.[15]

If you have any questions regarding this APL, please contact your MCOD Contract Manager and Capitated Rates Development Division Rate Liaison.

Sincerely,

Original Signed by Bambi Cisneros

Bambi Cisneros
Acting Division Chief, Managed Care Quality and Monitoring Division
Assistant Deputy Director, Health Care Delivery Systems

[14] The MCOD Contract Oversight SharePoint Portal is located at: dhcs.sharepoint.com/sites/MCOD-MCPSubmissionPortal/SitePages/Contract%20Oversight.aspx. .
[15] W&I section 14197.7.