State of California—Health and Human Services Agency
Department of Health Care Services

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DIRECTOR

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GOVERNOR

DATE: March 26, 2020

ALL PLAN LETTER 20-005

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EXTENSION OF THE ADULT EXPANSION RISK CORRIDOR FOR STATE FISCAL YEAR 2017-18

PURPOSE:
The purpose of this All Plan Letter (APL) is to notify Medi-Cal managed care health plans (MCPs) that the Adult Expansion Risk Corridor (AE Risk Corridor) is being extended to cover State Fiscal Year (SFY) 2017-18.

POLICY:
At the direction of the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) is extending the AE Risk Corridor to cover SFY 2017-18. As part of this extension, CMS is also requiring certain changes to the contract language instituting the AE Risk Corridor. Specifically:

1. Attestations documenting MCPs' data or assumptions may only be used in limited circumstances for SFY 2017-18 AE Risk Corridor calculation; and
2. The treatment of revenues and expenses related to Directed Payment Initiatives under Title 42 of the Code of Federal Regulations (CFR) section 438.6(c) and Pass-Through payments under Title 42 of the CFR section 438.6(d) is clarified.[1]

Attachment A to this APL includes the updated AE Risk Corridor language reflecting these changes. These updated terms are made effective immediately through this APL, and this language will be added to MCP contracts through the formal amendment process as soon as possible.

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=9a6ca82b62335f91daacca12e91a0c5c&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_16.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

Attachment A

Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

14. Adult Expansion ~~Medical Loss Ratio and~~ Risk Corridor

A. Establishment of an Adult Expansion ~~Medical Loss Ratio~~ **Risk Corridor (AE Risk Corridor), based on an Adult Expansion Medical Loss Ratio (AE**-MLR)**.**

For Adult Expansion Members, DHCS shall make additional assumptions to the benefit of both the State and Contractor for this ~~risk mitigation~~ **AE-Risk Corridor** provision using **an** AE-MLR. DHCS shall perform AE-MLR calculations for the incurred periods stated below. Incurred dates align with the Net Capitation Payments and service dates of the Allowed Medical Expenses.

1) DHCS shall perform AE-MLR calculations for the incurred periods ~~(incurred dates align with the Net Capitation Payments and service dates of the Allowed Medical Expenses)~~ of January 1, 2014 to June 30, 2015, the first period, July 1, 2015 to June 30, 2016, the second period, July 1, 2016 to June 30, 2017, the third period**, and July 1, 2017 to June 30, 2018, the fourth period**.

2) For the first and second period**s**, DHCS or its designee will initiate the AE-MLR calculation **no sooner than** 12 months after the end of each incurred period. For the third period, DHCS or its designee will initiate the AE calculation no sooner than January 1, 2019. **For the fourth period, DHCS or its designee will initiate the AE-MLR calculation on April 1, 2020.**

3) DHCS will give consideration to paid claims data at least through June 30, 2016, for services incurred during the first period, at least through June 30, 2017, for the second period, ~~and~~ at least through December 31, 2018, for the third period**, and at least through March 31, 2020, for the fourth period**.

4) Contractor shall provide and certify the ~~AE-MLR~~ **AE Risk Corridor** data and shall be subject to review or audit by DHCS or its designee**.**

a) For the fourth period, attestations will not be considered acceptable forms of documentation except when determined appropriate by DHCS in the following limited instances: attestations specific to the methodology used to calculate Excluded Federal Taxes and Assessments and Excluded State Taxes and Assessments, and attestations specific to the classification of related and non-related party expenses. All other attestations will be disallowed for this period. This documentation expectation does not impact the requirement for the managed care plan's Chief Executive Officer or Chief Financial Officer to certify data, documentation and information submitted for the AE Risk Corridor data is accurate, complete and truthful for the MLR period.

5) The ~~AE-MLR~~ **AE Risk Corridor** provision applies to this Contract only and will end with capitation and incurred dates as of June 30, ~~2017~~ **2018**.

B. ~~AE-MLR Risk Corridor~~ Adult Expansion Medical Loss Ratio (AE-MLR)

This Contract shall provide a**n AE-Risk Corridor** pertaining to AE-MLR for Adult Expansion Members.

1) Contractor shall be required to expend at least 85 percent of Net Capitation Payments received on Allowed Medical Expenses for Adult Expansion Members, for each ~~county~~ **rating region**. If Contractor does not meet the minimum 85 percent AE-MLR threshold for a given ~~county~~ **rating region**, then Contractor shall return to the State the difference between 85 percent of total Net Capitation Payments and actual Allowed Medical Expenses incurred for each ~~county~~ **rating region** as directed by DHCS.

2) After completion of the AE-MLR calculation, if it is determined that Contractor's AE-MLR is less than 85 percent for a given ~~county~~ **rating region**, then DHCS will notify Contractor of the Capitation Payments to be returned to the State.

3) Contractor shall remit to **the** State the full amount due within 90 calendar days of the date DHCS provides notice to Contractor of that amount.

4) Contractor protection is included for Allowed Medical Expenses above 95 percent of the total Net Capitation Payments received by Contractor for Adult Expansion Members, for each ~~county~~ **rating region**.

a) If Contractor's AE-MLR exceeds 95 percent ~~of total Net Capitation Payments under this Contract~~ for a given ~~county~~ **rating region**, then DHCS shall make additional payment to Contractor.

b) This additional payment from DHCS to Contractor will be the difference between ~~the~~ Contractor's Allowed Medical Expenses and 95 percent of Net Capitation Payments received for that ~~county~~ **rating region**.

c) DHCS shall remit this payment to Contractor within 90 days of completion of this calculation**, or within 90 days of approval to claim the additional federal funds, whichever is later**.

5) If the AE-MLR is between 85 percent and 95 percent ~~of total Net Capitation Payments under this Contract~~, then there will not be a**n** ~~MLR~~ **AE Risk Corridor** adjustment from Contractor to DHCS or from DHCS to Contractor.

C. Final Rates of Payment

For Adult Expansion Members, the actual payment rate for providing Covered Services under this Contract may differ from the rates initially included in this Contract, or the negotiated rate.

1) Actual payments may be adjusted if an adjustment is required subject to the provisions of this AE ~~MLR~~ **Risk Corridor** methodology. Both Contractor and DHCS agree to accept the final payment levels that result from the AE ~~MLR~~ **Risk Corridor** methodology calculation.

2) As a payment corridor, it is explicitly provided that this payment provision may result in payment by Contractor to DHCS or by DHCS to Contractor.

3) In the event of a change in capitation rate for Adult Expansion Members, for each period provided in this Provision, an AE ~~MLR~~ **Risk Corridor** calculation in accordance with the requirements of this Provision shall be re-determined.

4) Subsequent to this re-determination, adjustments to payments in accordance with this Provision may result in changes in payment by Contractor to DHCS or by DHCS to Contractor.

D. AE ~~MLR~~ **Risk Corridor** Disputes

Contractor shall have the opportunity to appeal a determination, through an appeal process defined by DHCS, that the 85 percent AE-MLR threshold has not been met and provide evidence that the required minimum has been met.

Exhibit E, Attachment 1, DEFINITIONS
[Relevant DEFINED TERMS]

Adult Expansion Medical Loss Ratio (**AE-**MLR) means the Allowed Medical Expenses for the Covered Services provided to **Adult Expansion** Members under this Contract divided by the amount of Medi-Cal managed care Net Capitation Payments ~~or revenues~~ recorded by Contractor, by ~~county~~ **rating region**. The **AE-**MLR will be measured by the same ~~county~~ **rating region** that was used in the development of the capitation rates paid to ~~the~~ Contractor, under this Contract.

A. **For the first, second, and third periods, t**~~T~~he calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments.

B. For the fourth period, the calculation excludes both the portion of Contractor's capitation revenues and associated expenses for items such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d).

If a Staff Model Contractor does not account for Allowed Medical Expenses specifically by line of business and uses an allocation methodology, the AE-MLR shall be the average AEMLR of all other Medi-Cal **M**~~m~~anaged **C**~~c~~are **Health Plans** ~~contractors~~ operating within the ~~county~~ **rating region** in which Contractor operates. In such cases, **the** Staff Model Contractor's AE-MLR shall be excluded from the average AE-MLR.

Adult Expansion Member means a Member enrolled in aid codes L1, M1, and 7U as newly eligible and who meets the eligibility requirements in Title XIX of the federal Social Security Act, Section 1902(a)(10)(A)(i)(VIII), and the conditions as described in the federal Social Security Act, Section 1905(y). Expenditures for services provided to Adult Expansion Members qualify for the enhanced federal medical assistance percentage described in that section.

Allowed Medical Expenses means Contractor's expenses incurred and accounted for in accordance with Generally Accepted Accounting Principles (GAAP) for Covered Services delivered to Members during each period, including expenses incurred for utilization management and quality assurance activities, shared risk pools, incentive payments to Providers, **payments required by Directed Payment Initiatives,** and excluding administrative costs as defined in Title 28 CCR Section 1300.78.

A. For the ~~AE-MLR calculation~~ **first, second, and third periods**, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as intergovernmental transfers ~~and~~**,** ~~H~~Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, Health Insurance Providers Fee (HIPF), Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments, are excluded.

B. For the fourth period, designated medical expense amounts included in the capitation rates that Contractor is required to pay Providers such as Medi-Cal Managed Care Plan Taxes, Health Insurance Providers Fee (HIPF), Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d), are excluded.

C. Global sub-~~C~~**c**apitation ~~P~~**p**ayment**s** made by Contractor, where entire Allowed Medical Expenses are shifted to another entity, gross or net of utilization management or quality assurance, shall not exceed 95 percent, unless otherwise agreed by DHCS, of the Net Capitation Payment for consideration within Allowed Medical Expenses.

C. Payments by Contractor to related party Providers shall not exceed the rate paid by Contractor for the same services to unrelated ~~parties~~ party Providers within the same ~~county~~ **rating region**. Related parties are defined by GAAP.

Directed Payment Initiative means a CMS-approved payment arrangement described in 42 C~~.~~F~~.~~R~~.~~ §438.6(c) that directs certain expenditures made by ~~the~~ Contractor under this Contract.

Excluded Federal Taxes and Assessments means all federal taxes and assessments allocated to health insurance coverage, including but not limited to federal income taxes and the Patient Centered Outcomes Research Institute (PCORI) Fee.

Excluded State Taxes and Assessments means:

A. Any industry-wide or subset assessments, other than surcharges on specific claims, paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State as applicable under this Contract;

B. Guaranty fund assessments;

C. Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by the State;

D. State income, excise, and business taxes other than premium taxes;

E. State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes; and

F. Payments made by a Federal income tax exempt issuer for community benefit expenditures, to the extent allowed pursuant to 45 CFR 158.162(b)(1)(vii).

Health Insurance Providers Fee (HIPF) means an annual fee starting in 2014 and paid by covered entities that provide health insurance for United States health risks during each year as described under Section 9010 of the Patient Protection and Affordable Care Act (Public Law 111-148), and as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Medi-Cal Managed Care Plan Taxes mean the extension of the State sales tax to sellers of Medi-Cal Managed Care plans for the privilege of selling Medi-Cal related health care services at retail in California as described under Revenue and Taxation Code Sections 6174 through 6189, and any successor State managed care organization provider tax applicable to Contractor.

Net Capitation Payments means**, for the first, second, and third periods,** Contractor's capitation revenues less designated amounts included in capitation rates that Contractor is required to pay to Providers such as intergovernmental transfers, Hospital Quality Assurance Fees, Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, and Excluded State Taxes and Assessments. **For the fourth period, Net Capitation Payments means Contractor's capitation revenues, including amounts related to Directed Payment Initiatives, less designated amounts included in capitation rates that Contractor is required to pay to Providers such as Medi-Cal Managed Care Plan Taxes, HIPF, Excluded Federal Taxes and Assessments, Excluded State Taxes and Assessments, and amounts paid under 42 CFR 438.6(d). For all periods,** Net Capitation Payments shall exclude retroactive adjustments relating to the prior service period(s) and shall include amounts accrued/recognized for the service period in accordance with GAAP.