CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: October 10, 2024

TO: ALL MEDI-CAL DENTAL MANAGED CARE PLANS

SUBJECT: **APL 24-003 Medical Loss Ratio Requirements for Subcontractors and Downstream Subcontractors**

PURPOSE:

The purpose of this Dental All-Plan Letter (APL) is for the Department of Health Care Services (DHCS) to inform Medi-Cal Dental Managed Care (DMC) plans on the Medical Loss Ratio (MLR) requirements set forth by the Centers for Medicare and 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 DMC plans' contractual requirements in Exhibit A, Attachment 3, Provision 2, Minimum Loss Ratio, and APL 13-002 Minimum Loss Ratio Clarification.

BACKGROUND:

Existing federal regulations obligate states to require DMC plans to annually calculate and report a MLR in accordance with Part 438.8 of Title 42 of the Code of Federal Regulations (42 CFR section 438.8). 42 CFR section 438.8(j) gives states the option to require DMC plans to provide a remittance if the DMC plan 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 Bulletin (CIB) that included MLR requirements related to Third-Party Vendors[2] and MLR frequently asked questions[3].

Commencing July 1, 2019, Welfare and Institutions Code (W&I), section 14197.2 established a minimum MLR standard of 85 percent. DMC plans that do not achieve this standard are subject to a DHCS contractually imposed remittance requirement for rating periods beginning on or after July 1, 2019. No later than January 1, 2025, DHCS must require DMC plans that delegate risk to subcontractors to impose MLR remittance requirements on their applicable direct and indirect subcontractors equivalent to 42 CFR § 438.8(j), i.e., equivalent to DHCS' minimum standard for DMC plans, as applicable.

[1] The STCs can be found at https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM-1915b-STCs.pdf.
[2] Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors
[3] Medicaid Managed Care Frequently Asked Questions (FAQs) - Medical Loss Ratio

The W&I section 14197.2 reporting and remittance requirements apply to all services covered by DMC plans contracts with DHCS, including the 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. 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 DMCs.

The newly adopted 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 DMC-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 DMC plans that delegate risk to Subcontractors, DHCS must consider MLR requirements related to third-party vendors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf.

Effective the CY 2023 MLR reporting year:

- DHCS must require DMC plans 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 DMC plans 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 DMC plans, as applicable, on their applicable Subcontractors and Downstream Subcontractors.

POLICY:

Effective January 1, 2023, DMC plans 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, DMC plans must impose MLR remittance requirements equivalent to the requirements

in 42 CFR section 438.8(j) on their applicable Subcontractors and Downstream Subcontractors.

SCOPE:

DMC plans 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, a DMC plan or its Subcontractors and Downstream Subcontractors and receive payment that relates directly or indirectly to the performance of the DMC plans obligations under its contract with DHCS.

Table 1. Entities Subject to STC A11	
DMC Plans	Plans that are contracted directly with DHCS to provide Medi-Cal services in a service area.
Subcontractor Plans	Plans[4] that assume fully or partially delegated risk from a DMC plan, or its Subcontractor or Downstream Subcontractor, in a Service Area.
Other Applicable Subcontractors	Subcontractors, except Subcontractor Plans, that assume risk and receive payment from a DMC plan, or its Subcontractor or Downstream Subcontractor, for services provided beyond their own entity, i.e., services which they do not directly deliver to Members.
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, DMC plans must require Subcontractor Plans and Other Applicable Subcontractors to satisfy applicable MLR reporting and remittance requirements. Non-Reporting Entities are exempt from having to calculate and report MLR in accordance with STC 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.

[4] Licensed health and dental plans can be found here: Choose Health Plan (ca.gov).

Materiality Threshold

DMC plans 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 $2,000,000 or more in capitation annually as payment for services for which they assume risk and are not directly providing will be subject to MLR reporting requirements. The materiality threshold will be applied independently to each separate Subcontractor Agreement or Downstream Subcontractor Agreement. Subcontractor Agreements and Downstream Subcontractor Agreements 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 DMC plans 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 the department's sole discretion following consultation with DMC plans 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 the CMS' May 6, 2016, Managed Care Final Rule[5], 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).[6] The Four-Part Test may be used to determine whether DMC plan's 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 the Four-part test, or not to 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 CY 2023 and the CY 2024 MLR reporting year for Other Applicable Subcontractors. DMC plans 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 Subcontractors are

[5] 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.
[6] 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

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 the administrative functions may not be included in incurred claims. Additional guidance is contained in the May 13, 2011[7] and July 18, 2011[8] CCIIO Technical Guidance Questions and Answers on the treatment of expenditures to third party vendors. DMC plans must remedy, or require their Subcontractors and Downstream Subcontractors to remedy, any misapplication of the Four-Part Test that is identified by the DMC plan 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

[7] 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

[8] 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

In congruence with 42 CFR section 438.8(l), DMC plans may exempt 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 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 reporting year, DMC plans must report any exempted Subcontractors or 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 a DMC plan based on information obtained during the initial review of MLR reporting or subsequent state or federal reviews or audits. DMC plans 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 reporting year, DMC plans must identify all their respective Subcontractors and Downstream Subcontractors in their MLR submission whether or not the Subcontractors and Downstream Subcontractor will be required to submit an MLR report.

Flow of Reporting and Remittance

DMC plans 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 submission of MLR reports from Subcontractors and Downstream Subcontractors directly.

DMC plans must ensure that reporting Subcontractors and Downstream Subcontractors that report an MLR the revenue, expenses, and membership specific to the services for which they are at risk and are not directly provided by them. Consistent with 42 CFR section 438.8(k)(3), DMC plans must require Subcontractors and Downstream Subcontractors providing claims adjudication activities to provide all underlying data associated with MLR reporting to the DMC plans within 180 days of the end of the MLR reporting year or within 30 days of being requested by the DMC plan, 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, DMC plans must impose remittance requirements equivalent to 42 CFR section 438.8(j) on their Subcontractor 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 DMC plan 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 section 438.8(h) and (k)(1)(viii), and the July 31, 2017, CIB entitled Medical Loss Ratio (MLR) Credibility Adjustments,[9] Subcontractors and Downstream Subcontractors may apply credibility adjustment factors within their MLR reporting. DMC plans 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.

DMC Plan Review and Oversight

DMC plans 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).

DMC plans must ensure MLR reports submitted by Subcontractors and Downstream Subcontractors are consistent with the information required in 42 CFR section 438.8(k). DMC plans are expected to review and provide oversight of their downstream entity MLR submissions and must attest to performing this review as part of the DMC plans MLR submission. Specific expectations may include, but are not to be 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 (IBNR) for reasonableness.

[9] Medical Loss Ratio (MLR) Credibility Adjustments

REQUIREMENTS:

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in a DMC plan's contractually required policies and procedures (P&Ps), the DMC plan must submit its updated P&Ps with and without Track Changes to DHCS' Medi-Cal Dental Services Division (MDSD) at dmcdeliverables@dhcs.ca.gov within 90 days of the release of this APL. If a DMC plan determines that no P&P changes are necessary, the DMC plan must submit an email confirmation to dmcdeliverables@dhcs.ca.gov within 10 days of the release of this APL, stating that the DMC plan's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

DMC Plans 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. These requirements must be communicated by each DMC Plan to all Subcontractors and Network Providers.

If you have any questions regarding this APL, please contact the Medi-Cal Dental Services Division, at dmcdeliverables@dhcs.ca.gov and Capitated Rates Development Division, at CRDDFIN@dhcs.ca.gov.

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 22-009 and APL 13-004. Any failure to meet the requirements of this APL may result in a CAP and subsequent sanctions (W&I 14197.7).

Sincerely,

Original Signed by

Adrianna Alcala-Beshara, JD, MBA
Chief, Medi-Cal Dental Services Division
Department of Health Care Services