

New CMS guidance for Medicaid managed care medical loss ratio calculations

Reporting requirements for pharmacy benefit managers and other third-party vendors

Paul Houchens, FSA, MAAA

Ian McCulla, FSA, MAAA

Amber Kerstiens



On May 15, 2019, the Centers for Medicare and Medicaid Services (CMS) released an Informational Bulletin¹ clarifying how payments to subcontracted vendors should be accounted for in the medical loss ratio (MLR) calculation required by 42 CFR §438.8 as established by the Medicaid and Children's Health Insurance Program (CHIP) managed care final rule published on May 6, 2016.² In the bulletin of May 15, 2019, CMS focuses on the responsibilities of a subcontractor in providing data and the proper accounting of subcontractor payments for purposes of MLR reporting. While the provisions outlined in the May 15, 2019, bulletin apply to all subcontractor relationships, CMS specifically highlights pharmacy benefit manager (PBM) arrangements that may include "spread pricing" and rebate retention.

The bulletin indicates CMS will conduct financial audits of Medicaid managed care plans' MLR calculations, with a specific focus on proper reporting of subcontractor expenditures.

The final rule requires states to complete MLR reporting for the first contract period beginning on or after July 1, 2017.³ It is anticipated that many state Medicaid programs will be providing MLR data to CMS for the first reporting period during calendar year 2019. Therefore, states should clearly articulate this guidance to contracted managed care plans and modify data collection processes and vehicles to collect the necessary detail to meet CMS requirements. Please note that, per CMS definitions, this analysis concerns "managed care plans," including managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management (PCCM) entities.

¹ CMS (May 15, 2019). Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors. Informational Bulletin. Retrieved May 31, 2019, from <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf>.

² The full text of the final rule is 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>.

³ For background information on Medicaid MLR reporting requirements, please see <http://www.milliman.com/uploadedFiles/insight/2016/medical-loss-ratio-in-mega-reg.pdf>.

How does CMS define a subcontractor and what are its general responsibilities under a managed care contract?

The final rule defines a subcontractor as:⁴

Subcontractor means an individual or entity that has a contract with a MCO, PIHP, PAHP, or PCCM entity that relates directly or indirectly to the performance of the MCO's, PIHP's, PAHP's, or PCCM entity's obligations under its contract with the State. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP.

The final rule further stipulates in 42 CFR §438.230(b)(1) that a managed care plan must ensure that its subcontractors fully comply with all terms and conditions of its contract with a state and must comply with all applicable Medicaid laws and regulations (including sub-regulatory guidance).⁵ These provisions in the final rule eliminate the possibility that a managed care plan could circumvent its state and federal obligations by delegating its services to a subcontractor. Note that the above requirements do not differ between sub-capitated and non-risk-based subcontracted vendors.

One area in which managed care plans commonly use subcontractors is in the delivery of pharmacy benefits. A managed care plan generally contracts with a pharmacy benefit manager (PBM) to provide state plan-covered pharmacy services to the managed care plan's covered Medicaid beneficiaries. While the PBM does not actually dispense prescription drugs to beneficiaries (and therefore is not considered a network provider), it maintains and develops the pharmacy network, negotiates rebates with drug manufacturers, and performs other activities that support the managed care plan's obligations under its contract with the state.

⁴ §438.8: Medical loss ratio (MLR) standards. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=f8e57d29f9326a1fdab3a10e3df95a1d&mc=true&node=se42.4.438_18&rgn=div8

⁵ §438.230: Subcontractual relationships and delegation. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=f8e57d29f9326a1fdab3a10e3df95a1d&mc=true&node=se42.4.438_1230&rgn=div8

When contracting with PBMs, managed care plans are often offered two pricing structures: pass-through and traditional. A pass-through pricing structure generally includes a specified administrative fee, such as a per member per month (PMPM) amount, and the benefit costs are “passed through” directly to the managed care plan. Conversely, a traditional pricing structure typically contains contractually defined aggregate discount guarantees between the managed care plan and the PBM. These guarantees mean that the managed care plan is contractually obligated to pay the PBM (in aggregate) a negotiated discount price for medications regardless of what the PBM pays the pharmacy. Under a traditional (or spread pricing) arrangement, this may result in a difference between what the managed care plan pays the PBM for individual drugs and what the pharmacies receive as payment for those same drugs.

Accounting for subcontractor payments within MLR reporting

The CMS bulletin clarifies that a managed care plan’s MLR calculation “may only include in incurred claims for Medicaid covered services the amount that the subcontractor actually pays the medical provider or supplier for providing Medicaid covered services to enrollees.”⁶ Subcontractors (such as PBMs) performing administrative functions in addition to providing Medicaid-covered services are required to appropriately classify and report the payments from the managed care plans into expenditures for incurred claims and activities that improve healthcare quality so that they may be included in the numerator of the MLR calculation. States should also collect non-benefit administrative cost or other non-benefit costs from the managed care plan’s subcontractors to ensure complete reporting of total expenditures as required by the medical loss ratio standards.

Exceptions to this guidance do exist. A subcontractor who provides Medicaid-covered services directly to Medicaid enrollees is an exception to the general rule noted above. An example of this type of arrangement would be a managed care plan contracting with a physician clinic at a set per member per month amount (a sub-capitated arrangement with a medical provider). The entire sub-capitated payment, including administrative expenses that are attributable to the direct provision of Medicaid services, would be allowable in the MLR calculation as long as the functions are performed by the subcontractor’s own employees and not through a contracted network of providers.

In cases where a subcontractor supplies delegated managed care services as well as acting as a healthcare provider that provides direct covered services to enrollees, 42 CFR 438.230(c)(1)⁷ requires that the managed care plan subcontractor agreement must clearly define the subcontractor’s delegated activities or obligations, as well as the related reporting requirements. Because the costs of the delegated managed care activities cannot be included in the managed care plan’s medical loss ratio calculation (with the exception of quality improvement activities), they should not be classified as incurred claims by the subcontractor/provider. States should monitor managed care plans and subcontractors for this distinction, given the intention of CMS financial audits to be specifically focused on subcontractor expenditures.

Implications on PBM spread pricing

As noted above, PBMs often contract with managed care plans using pricing structures commonly referred to as “spread pricing.” The spread pricing structure allows a PBM to charge set fees to the managed care plan, regardless of what is paid to the pharmacies providing the retail drugs. The “spread” is the difference between the amount paid to the pharmacy and the fee the managed care plan pays to the PBM. The spread amount is used by the PBM to support administrative functions the managed care plan has delegated to the PBM such as claim processing, utilization management, reporting, and network development. However, the final rule’s MLR provision specifically excludes amounts paid to third-party vendors for network development, administrative fees, claim processing, and utilization management from incurred claims included in the numerator of the MLR calculation.⁸

Without detailed reporting requirements for managed care plans and their subcontractors, this type of arrangement does not allow the managed care plan to easily distinguish incurred claim costs and non-benefit administrative costs implicitly paid to the PBM. For example, it is frequently observed that pharmacy paid amounts included in reported encounter files submitted to a state reflect the amounts paid by the managed care plan to the PBM (rather than the amount paid by the PBM directly to the pharmacy). This overstates the pharmacy benefit cost reported to a state because the reported paid amount also includes the spread (which funds non-benefit expenses related to the PBM’s administration of the pharmacy benefit).

⁶ CMS Informational Bulletin, op cit.

⁷ §438.230, op cit.

⁸ §438.8, op cit.

The CMS bulletin clarifies that managed care plans and their subcontractors continue to be subject to MLR reporting requirements when they enter into sub-capitated or spread pricing agreements. In reporting, it says, "the PBM must calculate incurred claims as the amounts paid to the retail or mail-order pharmacy (e.g., drug ingredient costs and dispensing fees) minus any prescription drug rebates."⁹

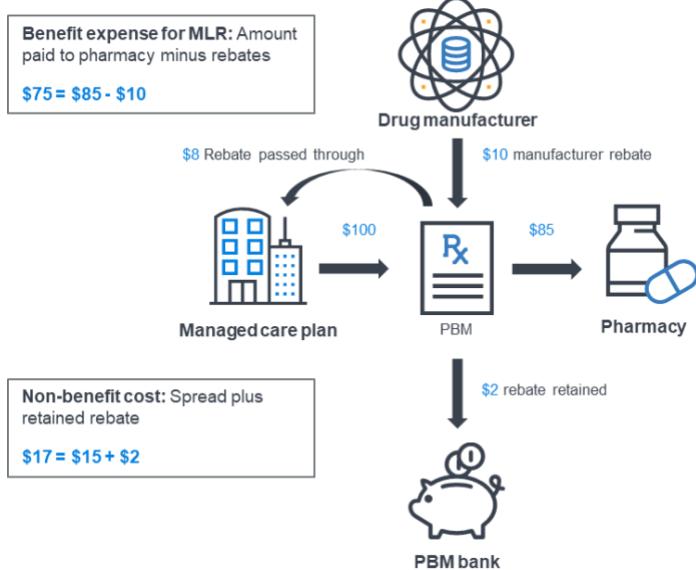
Prescription drug rebates

Manufacturers offer rebates for competitive high-cost drugs (rebates are rarely offered for generics) to incentivize PBMs and managed care plans to include the manufacturer's products in a preferred "tier" placement.¹⁰ PBMs may also have contractual arrangements with managed care plans that allow for the retention of all or a portion of pharmacy rebates. The CMS bulletin clarifies that prescription drug rebates received and accrued must be deducted from incurred claims regardless of the source of the rebate (manufacturer, retail pharmacy, incentive payments, or other items of value) and regardless of whether the managed care plan received the rebate or the rebate was retained by a third-party vendor. Therefore, if a PBM is retaining pharmacy rebates or other items of value in lieu of charging a separate administrative fee, then the amount of the rebates retained would need to be treated as a reduction to incurred expenses for MLR reporting purposes. The retained rebates or other items of value should be considered non-benefit administrative costs of the managed care plan (assuming the PBM would assess explicit charges to the managed care plan in the absence of the retention of rebates or other items).

Figure 1 illustrates a sample flow of funds for a PBM and how those expenditures should be reported in the MLR calculation. It shows that the benefit cost plus non-benefit cost (\$75 plus \$17 equals \$92) is equal to the net amount paid by the managed care plan (\$100 to PBM minus \$8 rebate passed through to the managed care plan). This example is for illustrative purposes only and does not reflect an estimate of aggregate market experience.¹¹ Actual rebates and discounts paid to the pharmacy

will vary by drug within the contract between the managed care plan and the PBM. As noted, the benefit expense that should be reported in the MLR calculation is the amount paid to the pharmacy less the total of the rebates (both those retained by the managed care plan and the PBM). The pharmacy spread amount and PBM-retained rebates should be considered non-benefit expenses.

FIGURE 1: FLOW OF FUNDS



Note: This example is for illustrative purposes only and does not reflect an estimate of aggregate market experience.

Summary

The clarifications in the CMS bulletin are effective for Medicaid MLR reporting in contracts beginning on or after July 1, 2017. The first round of MLR reporting will soon be necessary and states need to ensure that contracted managed care plans are fully meeting reporting requirements, including the accurate reporting of costs incurred by subcontractors.

CONTACT

Paul Houchens

paul.houchens@milliman.com

Ian McCulla

ian.mcculla@milliman.com

Amber Kerstiens

amber.kerstiens@milliman.com

⁹ CMS Informational Bulletin, op cit.

¹⁰ Dieguez, G., Alston, M., & Tomicki, S. (May 21, 2018). A Primer on Prescription Drug Rebates: Insights Into Why Rebates Are a Target for Reducing Prices. Milliman White Paper. Retrieved May 31, 2019, from <http://www.milliman.com/insight/2018/A-primer-on-prescription-drug-rebates-Insights-into-why-rebates-are-a-target-for-reducing-prices/>.

¹¹ For reference, while experience in each state Medicaid program is likely to differ, the presentation available at <https://apps.legislature.ky.gov/CommitteeDocuments/309/11792/Feb%202019%20Medicaid%20Prescription%20Drug%20Expenditures%20Steckel%20PowerPoint.pdf> documents spread pricing percentages in the Commonwealth of Kentucky's Medicaid program during calendar year 2018. Among the four managed care entities reporting experience, spread percentages ranged from approximately 10% to 15% of the managed care plan's pharmacy costs.