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***CMCS Informational Bulletin***

**DATE:** May 15, 2019

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Center for Medicaid and CHIP Services

**SUBJECT: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors**

The Centers for Medicare & Medicaid Services' (CMS) Medicaid and Children's Health Insurance Program (CHIP) managed care final rule<sup>1</sup> adopted standards for the calculation and reporting of a medical loss ratio (MLR) applicable to Medicaid and CHIP managed care contracts, including contracts with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). In Medicaid managed care contracts that started on or after July 1, 2017, states were required to include requirements for managed care plans to calculate and report an MLR, including related underlying data as described in 42 CFR 438.8. CHIP also adopted the Medicaid requirements for calculating and reporting MLRs in 42 CFR 438.8 for CHIP managed care contracts at 42 CFR 457.1203(c) through (f); however, the CHIP requirements were effective for CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. Although we refer to the MLR requirements as part of the Medicaid program in this CIB, this guidance is equally applicable to CHIP managed care entities for contracts and rating periods that begin on or after July 1, 2018, pursuant to § 457.1203.

As provided by 42 CFR 438.8(d), the MLR experienced for each managed care plan in an MLR reporting year is the ratio of the numerator to the denominator. Under 42 CFR 438.8(e), the numerator of a managed care plan's MLR for an MLR reporting year is the sum of the managed care plan's incurred claims, the managed care plan's expenditures for activities that improve health care quality, and fraud prevention activities.

Under 42 CFR 438.8(f), the denominator of a managed care plan's MLR for an MLR reporting year must equal the adjusted premium revenue. The adjusted premium revenue is the managed care plan's premium revenue minus the managed care plan's federal, state, and local taxes and licensing and regulatory fees and is aggregated for all Medicaid eligibility groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific populations.

In calculating and reporting the MLR, states are responsible for ensuring that managed care plans are complying with these MLR requirements and should be routinely auditing reported data and

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<sup>1</sup> Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016); 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>.

MLR calculations to ensure that revenues, expenditures, and other amounts are appropriately identified and classified within each managed care plan's MLR; that is, distinguishing which amounts were actually paid for benefits, or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities.

To assist states in ensuring that revenues, expenditures, and amounts are appropriately identified and classified for each managed care plan, this guidance clarifies and provides an example to illustrate some requirements in 42 CFR 438.8(e)(2) for determining the amounts that can be included and must be excluded from incurred claims, particularly when a managed care plan uses a third-party vendor in a subcontracted arrangement. Specifically, this CIB highlights and clarifies the provisions in 42 CFR 438.8(e)(2)(ii)(B), 438.8(e)(2)(v)(A), 438.8(k)(3), and 438.230(c)(1).

**42 CFR 438.8(e)(2)(ii)(B)**

Under 42 CFR 438.8(e)(2)(ii)(B), prescription drug rebates received and accrued must be deducted from incurred claims.

**42 CFR 438.8(e)(2)(v)(A)**

Under 42 CFR 438.8(e)(2)(v)(A), incurred claims must exclude non-claims costs, which include the following:

- (1) Amounts paid to third-party vendors for secondary network savings;
- (2) Amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management;
- (3) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State Plan services or services meeting the definition for in-lieu-of services in 42 CFR 438.3(e) and provided to an enrollee; and
- (4) Fines and penalties assessed by regulatory authorities.

**42 CFR 438.8(k)(3)**

Under 42 CFR 438.8(k)(3), managed care plans must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the managed care plan to calculate and validate the accuracy of MLR reporting.

**42 CFR 438.230(c)(1)**

Under 42 CFR 438.230(c)(1), if a managed care plan delegates any of its activities or obligations under its contract with the State to a subcontractor, then:

- (1) The delegated activities or obligations, and related reporting responsibilities, must be specified in a contract or written agreement;
- (2) The subcontractor must agree to perform the delegated activities and reporting responsibilities specified in compliance with the managed care plan's contract obligations; and
- (3) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the State or the

managed care plan determine that the subcontractor has not performed satisfactorily.

We highlight these requirements to remind states and managed care plans that when a managed care plan subcontracts with a third-party vendor to administer, and potentially provide, a portion of Medicaid covered services to enrollees, the subcontractor must report to the managed care plan all of the underlying data needed for the Medicaid managed care plan to calculate and report the managed care plan's MLR.

### **General Responsibilities of Subcontractors for Reporting MLR Data**

The Medicaid managed care regulation at 42 CFR 438.230(c)(1) requires, through contractual requirements in the managed care contract between the managed care plan and the state, certain agreements to be in subcontracts: subcontractors agree to perform the delegated activities and reporting responsibilities in compliance with the managed care plan's contract obligations. Additionally, the regulations at 42 CFR 438.8(k) also require states, through their contracts with managed care plans, to require each managed care plan to submit an annual MLR report. These reporting standards specify that managed care plans must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR calculation and reporting.

Consequently, all subcontractors that administer claims for the managed care plan must report the incurred claims, expenditures for activities that improve health care quality, information about mandatory deductions or exclusions from incurred claims (overpayment recoveries, rebates, other non-claims costs, etc.) to the managed care plan. The reporting must be in sufficient detail to allow a managed care plan to accurately incorporate the expenditures associated with the subcontractor's activities into the managed care plan's overall MLR calculation. The level of detail must be no less than the reporting requirements in 42 CFR 438.8(k), but may need to be more if necessary to accurately calculate an overall MLR or to comply with any additional reporting requirements imposed by the state in its contract with the managed care plan.

### **Accounting for Subcontractors**

In general, Medicaid requirements for managed care plans to account for expenditures by third-party vendors under subcontract follow the approach used to account for third-party vendors' expenditures in the MLR calculations for health insurance issuers subject to the requirements in 45 CFR Part 158<sup>2</sup>. In general, a Medicaid managed care plan 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. Where the subcontractor is performing an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and

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<sup>2</sup> 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>

See also 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](https://www.cms.gov/CCIIO/Resources/Files/Downloads/20110718_mlr_guidance.pdf)

profits on these functions would be considered a non-claims administrative expense as described in 42 CFR 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations.

An exception to the general approach applies when a subcontractor, through its own employees, provides Medicaid covered services directly to enrollees. In this circumstance, the entire portion of the amount the Medicaid managed care plan pays to the third-party vendor that is attributable to the third-party vendor's *direct provision of Medicaid covered services* should be included in incurred claims, even if such amount includes reimbursement for the third party vendor's own administrative costs related to the direct provision of Medicaid covered services<sup>3</sup>. The phrase "through its own employees" does not include a subcontractor's contracted network of providers because such network providers are not considered employees of the third-party vendor. Additionally, when the subcontractor is also performing an administrative function not attributable to its direct provision of Medicaid covered services, such as eligibility and coverage verification, claims processing, utilization review, or network development, payment by the managed care plan to the subcontractor for such functions are a non-claims administrative expense as described in 42 CFR 438.8(e)(2)(v)(A), and should not be counted as an incurred claim for the purposes of MLR calculations.

#### **Accounting for Prescription Drug Rebates Received and Accrued**

The Medicaid managed care regulations at 42 CFR 438.8(e)(2)(ii)(B) require that prescription drug rebates received and accrued must be deducted from incurred claims. CMS interprets this regulation to require that any time a managed care plan receives something of value for the provision of a Medicaid covered outpatient drug (e.g., manufacturer rebates, incentive payments, direct or indirect remuneration, goods in kind, etc.), regardless from whom the item of value is received (e.g., pharmaceutical manufacturer, wholesaler, retail pharmacy, etc.), the value of that rebate must be deducted from the amount of incurred claims used for calculating and reporting the MLR. CMS also interprets this requirement to apply equally regardless of whether the prescription drug rebate is received by the managed care plan (i.e., directly) or by a subcontractor (i.e., indirectly) administering the covered outpatient drug benefit on behalf of the managed care plan. This interpretation is consistent with the general requirements in 42 CFR 438.230, which require subcontractors to comply with the standards in the managed care plan's contract that govern the managed care plan's performance. Where the managed care plan is required to treat these additional items of value as deductions or exclusions from incurred claims under § 438.8(e)(2), receipt by a subcontractor rather than the plan itself does not change that requirement.

We are clarifying the treatment and accounting required for prescription drug rebates to ensure that there is no confusion related to the calculation of an MLR under Medicaid managed care. The regulation at 42 CFR 438.8(e)(2)(ii)(B) requires that prescription drug rebates received and accrued must be deducted from incurred claims in calculating and reporting the applicable managed care plan's MLR. The regulation does not require that the Medicaid managed care plan itself receive the prescription drug rebate directly. We believe that requiring the managed care plan to account for the prescription drug rebate (as we interpret that term) regardless of whether

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<sup>3</sup> In the circumstance where the third-party vendor provides Medicaid covered services directly to enrollees through its own employees, the expenditures are treated in the same manner as a payment to a network provider for the same services.

the value of the rebate is received directly, or indirectly through a subcontractor, ensures that the MLR calculation does not include artificially inflated totals for incurred claims because a subcontractor has been used by the managed care plan.

### **Example**

We illustrate the application of these requirements in the situation where a Medicaid managed care plan subcontracts with a pharmacy benefit manager (PBM) for the administration of the Medicaid covered outpatient drug benefit. The PBM administers the covered outpatient drug benefit through a contracted network of pharmacies and does not provide any of the Medicaid covered outpatient drugs directly to enrollees through its own employees. In this circumstance, the PBM is required to report to the managed care plan all of the information necessary for the managed care plan to meet its MLR obligations under 42 CFR 438.8. The PBM is required to classify and report revenues and expenditures associated with the administration of the Medicaid covered outpatient drug benefit to the managed care plan in the same manner that the managed care plan would be required itself to classify and report this information if the managed care plan had administered the covered outpatient drug benefit directly.

Even if the managed care plan pays the PBM a capitated amount in a risk-based arrangement, the managed care plan and PBM must classify and report revenues and expenditures associated with the administration of the Medicaid covered outpatient drug benefit consistent with 42 CFR 438.8. That is, the managed care plan may not use the entire capitated payment to the PBM as incurred claims. Rather, 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 (as we interpret that term) and accounting for any other applicable requirements in 42 CFR 438.8(e)(2). Other expenditures by the PBM under subcontract with the managed care plan (e.g., activities that improve health care quality, non-claims costs for administrative services, taxes and fees, etc.) would also need to be classified appropriately and reported to the managed care plan to facilitate the managed care plan's MLR calculations and reporting.

In this example, the managed care plan only contracted with the PBM for the provision and administration of the Medicaid covered outpatient drug benefit. If the managed care plan contracted with the PBM to provide and administer other Medicaid covered services (e.g., medication therapy management), the PBM would also need to classify and report revenues and expenditures for those additional Medicaid covered services in a manner consistent with the regulations and this clarifying guidance.

### **Technical Assistance and Audits**

CMS intends to begin working with states to conduct financial audits of Medicaid managed care plans' MLR calculations. We are planning for these audits to specifically focus on ensuring that subcontractors' expenditures (such as PBM costs) are properly incorporated into the MLR calculations. If you have questions or would like to request technical assistance related to this guidance or with respect to the MLR standards applicable to Medicaid and CHIP managed care contracts, please send an email to [ManagedCareRule@cms.hhs.gov](mailto:ManagedCareRule@cms.hhs.gov).