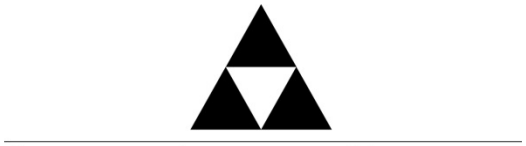

July 17, 2019

Calder Lynch
Acting Deputy Administrator and Director
Center for Medicaid and CHIP Services (CMCS)

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

Dear Acting Deputy Administrator and Director Lynch:

We appreciate the additional guidance offered in the May 15, 2019 CMCS Informational Bulletin (CIB) titled *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors.* On behalf of the Medicaid Subcommittee of the American Academy of Actuaries,[1] we would appreciate additional clarification of sections 42 CFR 438.8(c) and 42 CFR 438.8(j) MLR Standards, which are referenced in the recent CIB and are quoted below for reference:

> **(c)** ***MLR requirement.*** If a State elects to mandate a minimum MLR for its MCOs, PIHPs, or PAHPs, that minimum MLR must be equal to or higher than 85 percent (the standard used for projecting actuarial soundness under § 438.4(b)) and the MLR must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP, consistent with this section.
>
> **(j)** ***Remittance to the State if specific MLR is not met.*** If required by the State, a MCO, PIHP, or PAHP must provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent or higher if set by the State as described in paragraph (c) of this section.

The Centers for Medicare & Medicaid Services (CMS) has previously clarified the state's authority to determine the remittance on Page 27532 of the Federal Register (Vol. 81, No. 88) of the Medicaid Managed Care Regulations:

> "…Response: This final rule does not set the methodology for calculating remittances.

[1] The American Academy of Actuaries is a 19,500-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

> This rule requires the use of the MLR calculation and reporting standards set forth in §§ 438.8 and 438.74, requires that actuarially sound capitation rates be developed so that a managed care plan may achieve an MLR of at least 85 percent as described in § 438.4(b)(8) (redesignated in the final at § 438.4(b)(9)), and requires the return to CMS of the federal government's share of any remittance a state collects. Because remittances under this final rule will be imposed under state authority, we believe the state is best suited to determine the methodology for remittances."

In addition, at least one state has provided clarification(s) that it has received from CMS indicating that it is up to the state to determine if an MLR remittance will be required and the specific formula for calculating the remittance. Despite the above information, there does appear to be confusion/uncertainty on the topic. Therefore, confirmation that states with MLR remittances have the authority to determine the MLR methodology, including the definitions of the remittance MLR numerator and denominator would be appreciated.

Based on a review of the above, and in light of the recent CIB, we have also prepared the following questions and statements to request additional clarification for actuaries practicing in Medicaid managed care programs, such as those representing health plans or states.

To better understand the specifics of our questions below, we developed two MLR definitions for use in this letter:

- **Reporting MLR**: The MLR that all states must report to CMS for all MCOs, PIHPs and PAHPs using the requirements described in 42 CFR 438.8.
- **Remittance MLR**: A contractual risk sharing arrangement that requires MCOs, PIHPs, or PAHPs to refund revenue to a state if the MCO's, PIHP's, or PAHP's MLR falls below a pre-determined MLR percentage.

1) Please confirm that it is up to each state to determine whether or not to impose a minimum Remittance MLR or other risk sharing arrangement. Please clarify the role CMS plays in this decision and approval of the risk sharing arrangements.
2) Please confirm in states that have a Remittance MLR requirement, the states have the authority to define the numerator and denominator used in calculating the Remittance MLR differently than how the numerator and denominator are defined in 42 CFR 438.8(e) and 42 CFR 438.8(f)?
3) Please confirm that the clarifications in the May 15, 2019 CIB only apply to the Reporting MLR.
4) If a state does not use a Remittance MLR that is based on a minimum MLR guarantee but instead uses another risk sharing mechanism, such as a risk corridor or maximum net income, that requires MCOs, PIHPs or PAHPs to return funds to the state if certain conditions are met, is there any part of the 42 CFR 438.8 clarification that would apply to the remittance methodology? In other words, may the state create its own formulas and definitions for risk

sharing arrangements with MCOs, PIHPs or PAHPs when the risk sharing arrangement is not a minimum MLR (e.g., a risk corridor)?

5) Which of the following sub-bullets best describes the CMS interpretation of 42 CFR 438.8(c):
    a) "*MLR Requirement*. If a State elects to mandate a minimum Remittance MLR for its MCOs, PIHPs, or PAHPs, that Remittance MLR must be equal to or higher than 85 percent … and the Reporting MLR must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP, consistent with this section."
    b) "*MLR Requirement*. If a State elects to mandate a minimum Remittance MLR for its MCOs, PIHPs, or PAHPs, that Remittance MLR must be equal to or higher than 85 percent … and the Remittance MLR must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP, consistent with this section."
    c) *"MLR Requirement*. If a State elects to mandate a minimum Remittance MLR for its MCOs, PIHPs, or PAHPs, that Remittance MLR must be equal to or higher than 85 percent … and the Reporting MLR (after adjusting for the remittance) must be calculated and reported for each MLR reporting year by the MCO, PIHP, or PAHP, consistent with this section."
        - If this is the interpretation, what actions must the state take if the resulting Reporting MLR is lower than 85 percent?

6) When the Reporting MLR is calculated, does CMS desire to see the Reporting MLR pre, post (or both) any Remittance MLR?

* * * * * * *

We would welcome the opportunity to speak with you in more detail and answer any questions you have regarding these comments and questions. Please contact David Linn, the Academy's senior health policy analyst, at 202-223-8196 or linn@actuary.org to facilitate further discussions.

Sincerely,

Michael E. Nordstrom, MAAA, ASA
Chairperson, Medicaid Subcommittee
American Academy of Actuaries