Department of Health and Human Services
Centers for Medicare & Medicaid Services
Center for Program Integrity

Oregon Medicaid Managed Care Medical Loss Ratio Audit

Audit Period: Calendar Year 2019 Reporting Period

Final Report

March 2023

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) conducted an audit of the Medical Loss Ratio (MLRs) reported by the 15 Medicaid Coordinated Care Organizations (CCOs) contracted with the Oregon Health Authority (Oregon) during calendar year (CY) 2019. The primary objectives of the MLR audit were to determine if the (1) CCOs submitted annual MLR reports to Oregon pursuant to federal requirements, and (2) annual MLR reporting and minimum MLR remittance calculations for the CCOs were supported by the underlying data and supporting documentation received by Oregon.

To meet the objectives of this MLR audit, CMS reviewed the CY 2019 minimum MLR remittance submissions and additional supporting documentation provided by Oregon. CMS also requested additional detail from CCOs to substantiate reported MLR amounts and understand Oregon's oversight procedures. CMS reviewed applicable data from CYs 2018 and 2019 due to Oregon's "two-year rolling average" MLR remittance methodology. All Medicaid data collected for this audit were aggregated on a program-wide basis.

This report includes CMS' findings, recommendations, and observations, that were identified during the MLR audit.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified 37 instances across all CCOs requiring correction to the MLR remittance calculations reported by CCOs. Because none of these corrections resulted in a recalculated MLR that fell below the 85 percent remittance threshold, CMS did not identify any remittances that should have been paid. In response to these findings, CMS identified 9 recommendations that will enable the state to come into compliance with federal and/or state Medicaid MLR requirements. These recommendations include the following:

Special Payments and State Directed Payments (SDPs)

1. In accordance with 42 CFR § 438.6(c)(2)(ii)(A) and 42 CFR § 438.8(e)(2)(i)(A), Oregon should closely monitor receipt of qualified directed payment (QDP) and passthrough payments, including Oregon's hospital reimbursement adjustments (HRAs), and reconcile all amounts with CCOs' MLR reporting.

Third-Party Vendor Data and Contracts

2. In accordance with 42 CFR § 438.8(e)(2)(v)(A), Oregon should update its instructions and augment its oversight activities to disallow the inclusion of non-medical costs of any third-party vendor, including sub-capitated entities. Oregon should also include in its

instructions to CCOs guidance on the treatment of medical and non-medical costs from pharmacy benefit managers (PBMs).

3. In accordance with 42 CFR § 438.8(k)(3), Oregon should ensure CCOs collect all underlying data associated with MLR reporting from third-party vendors providing claims adjudicating activities so that the CCO can reliably calculate and validate the accuracy of the reported MLR.
4. In accordance with 42 CFR § 438.230(c)(1), Oregon should ensure that CCOs are establishing and maintaining contracts with their subcontractors to reinforce compliance with third-party reporting responsibilities.

Allocation of Expenses Methodology

5. Oregon should update future Medicaid MLR reporting instructions to clearly state that any non-Medicaid line of business (LOB) expenses, including Cover All Kids (CAK) expenses, should not be included within the Medicaid MLR reporting and remittance calculations in accordance with 42 CFR § 438.8(g).
6. Oregon should request information on how allocation percentages were determined across LOBs in accordance with 42 CFR § 438.8(k)(1)(vii). For example, Oregon should request specific information on how certain types of non-claims expenditures (e.g., salaries, human resource) are allocated across LOBs, as well as request information on how QIA program expenditures that affect multiple LOBs were allocated across LOBs.

Health Care Quality Improvement Activity (QIA) Expenditures

7. Oregon should remove health-related service (HRS) costs, including community benefit initiatives (CBIs) from the description of items to include as non-encounterable service costs. HRS costs should be included within QIA expenditures if the services qualify as QIA as defined by 45 CFR § 158.150 or 45 CFR § 158.151.
8. Oregon should update the MLR template and instructions to require CCOs to report CBI expenditures as community benefit expenditures (CBEs) as specified in 42 CFR § 438.8(f)(3)(v). Because Oregon's CBIs meet the definition of CBEs, they should be included as an offset to premium revenue in the denominator, rather than in the numerator of the MLR calculation. (Since this audit was conducted, Oregon has implemented this recommendation; however, this recommendation will remain for purposes of this report, as it was accurate at the time of this audit).

Additional MLR and Remittance Calculation Findings

9. In accordance with 42 CFR § 438.8(f)(2)(vi), Oregon should update its reporting instructions and rebate template to remove state-mandated private reinsurance reconciliations from the numerator of the MLR calculation.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified 8 observations related to Oregon's oversight of CCO's MLR reporting. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this audit include the following:

State Oversight of CCO MLR Reporting

1. CMS recommends that Oregon consider using predefined, quantifiable tolerance levels, both on a line-item and aggregated basis, to indicate when Oregon should further request CCO substantiation of information reported.
2. CMS recommends that Oregon consider sufficiently reviewing CCO-provided information to ensure MLR line items are appropriately reconciled with line items from corresponding financial statements.
3. CMS recommends that Oregon consider updating its tools provided to CCOs for MLR reporting by updating MLR reporting instructions to ensure they reflect federal requirements, correcting errors in MLR submission templates, adding instructions to ensure that CCOs sufficiently provide and archive documentation, and implementing measures to ensure expenses and revenues are reported in appropriate categories.

Provider Incentives Payments and Contracts

4. CMS recommends that Oregon consider ensuring that incentive payment contracts between the CCOs and providers follow leading practices to strengthen consistency and accuracy of incentives reporting and benchmarking among CCOs.
5. CMS recommends that Oregon consider collecting additional data to substantiate evidence of timely payments to providers to ensure incentive payments are made to providers in a timely manner.

Special Payments and State Directed Payments

6. As indicated by the August 4, 2021 technical assistance correspondence, QDPs should be included in both the numerator and denominator of the MLR calculation as part of state oversight of CCOs' payments to providers. SDPs to CCO providers should be included in the numerator and SDP revenue from the state to the CCOs should be reflected in the denominator – both as line items.

Allocation of Expenses Methodology

7. CMS recommends that Oregon consider increasing oversight activities and updating future MLR reporting instructions to provide a clear and detailed description of the information required, to ensure that CCOs provide a detailed, targeted methodology as part of their MLR submission.

Additional MLR and Remittance Calculation Observations

8. CMS recommends that Oregon consider excluding fraud prevention activities from the MLR numerator of the reporting template until fraud prevention activities are defined in federal regulation.

Oregon's Medicaid Managed Care MLR Audit

Background

The Comprehensive Medicaid Integrity Plan for FYs 2019-2023 describes CMS' 5-year Medicaid program integrity strategy that aims to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools.[1] A key component of this strategy includes conducting targeted audits of states' Medicaid managed care plan (MCP) MLR financial reporting. Under federal regulations, all Medicaid managed care contracts, including managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans are required to calculate and report an MLR to their respective states to ensure that a sufficient percentage of the premium payments are spent on medical services and quality improvements rather than health plan administration expenses, reserves, and profit.

The primary objectives of the MLR audits are to determine if (1) MCPs submitted annual MLR reports to the state pursuant to federal requirements, and (2) the annual MLR reporting and minimum MLR remittance calculations are supported by the underlying data and related documentation received by the state. Through these audits, CMS also provides states with feedback and promising practices that may be used to enhance program integrity in Medicaid.

Overview of CMS' Medicaid Managed Care MLR Requirements

Federal regulations require that capitation payments made by states to MCPs be actuarially sound.[2] The MLR is a component of rate setting that aims to ensure that a sufficient percentage of the total capitation is spent on services and quality improvements rather than health plan administration expenses, reserves, and profit. Federal regulations do not require states to implement a minimum MLR or a remittance arrangement with MCPs. Under 42 CFR § 438.8(b), if a state elects to mandate a minimum MLR for its plans, that minimum MLR must be equal to or higher than 85 percent, and the MLR must be calculated and reported for each MLR reporting year by the MCP. States that implement a minimum MLR for its MCPs can also determine whether to require their MCPs to pay remittances if they fail to meet their state's minimum MLR requirement. If a state requires a remittance arrangement, it can decide the methodology for calculating or collecting remittances, but it must specify any differences from the MLR methodology under 42 CFR § 438.8 in its contracts with its MCPs and develop separate MLR reports for rate setting and compliance reporting to CMS.

Pursuant to 42 CFR § 438.8(k), MCPs are required to submit a report to the state that includes at least 13 data elements for the MLR reporting year. This report, which must be submitted for each reporting year and within 12 months after the end of the reporting year, must follow the MLR

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf
[2] Section 1903(m)(2)(A) of the Social Security Act

methodology outlined in 42 CFR § 438.8. While the MLR formula methodology for rate setting and annual reporting purposes must follow the formula outlined in 42 CFR § 438.8, states have flexibility in setting the calculation methods for remittance arrangements. In other words, minimum MLR remittance calculations can differ methodologically from the MLR regulations in 42 CFR § 438.8.

Overview of Oregon's Medicaid Managed Care Program and the MLR Audit

Oregon provides health care coverage for the Medicaid managed care population through the Oregon Health Plan (OHP). CCOs, which are risk-bearing, locally governed provider networks, receive annual capitated payments from Oregon to provide services to enrollees covered under the OHP and as described by the OHP section 1115 demonstration waiver.[3]

CMS conducted an audit of the MLR calculation for the Medicaid managed care population in Oregon, covering the 2019 contract period.[4] To assess compliance with Federal and state MLR requirements, CMS reviewed MLR calculations and supporting documentation of Oregon's 15 Medicaid CCOs. Oregon utilizes a two-year rolling average minimum MLR remittance methodology that also required review of applicable information from both CY 2018 and CY 2019. CMS utilized the submitted CY 2019 minimum MLR remittance submissions and additional supporting documentation provided by Oregon. CMS also requested additional detail from CCOs to substantiate reported MLR amounts and understand Oregon's oversight procedures.

During this audit, CMS identified a total of 9 recommendations and 8 observations. Appendix A contains additional detail on this audit's scope and methodology. CMS also included CCO-specific information in Appendix B. The state's response to CMS' draft report can be found in Appendix C, and the final report reflects changes CMS made based on the state's response.

This audit encompasses the six following areas:

A. **State Oversight of CCO MLR Reporting** – CMS regulations at 42 CFR § 438.74 established requirements for state oversight of MLR reporting. The requirements at 42 CFR § 438.74(a) require states to submit an annual summary description of the MLR reports received from MCOs. The summary description is required to include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each MCP for the MLR reporting year.

B. **Provider Incentive Payments and Contracts** – CMS regulations at 42 CFR § 438.3(i) requires Medicaid contracts to comply with the Medicare Advantage (MA) program

[3] See the Supporting Documents for OHP's 1115 Demonstration.
[4] All Medicaid data collected for this audit were aggregated on a program-wide basis.

requirements set forth in 42 CFR § 422.208, which allows MCPs to enter into a physician incentive plan with a healthcare provider as long as the incentive plan does not act as an inducement to reduce or limit medically necessary services, and that if the incentive plan places the provider at substantial financial risk, the MCP must assure that all provider groups have appropriate reinsurance arrangements in place.

C. Special Payments and State Directed Payments (SDPs) –Under 42 CFR § 438.6(c), SDPs are payments directed by a state that must reconcile to the utilization of services, advance at least one of the state's goals in quality strategy in a way that is regularly measured and evaluated, be directed equally and under the same performance terms among providers covered under contract, do not require provider participation in intergovernmental transfer agreements, and are not automatically renewed.

D. Third-Party Vendor Data and Contracts – Medicaid managed care regulations at 42 CFR § 438.230(c)(1) require certain agreements between MCPs and the state to be in subcontracts. Those third-party vendors providing claims adjudication activities for MCPs must comply with federal regulations at 42 CFR § 438.8(k), meaning incurred claims, expenditures for activities that improve health care quality, and information on mandatory deductions or exclusions from incurred claims must be reported to the MCPs in sufficient detail to allow the MCP to incorporate the subcontractors' expenditures into the MCPs overall MLR calculation.

E. Allocation of Expenses Methodology – To accurately report the annual MLR to the state, CCOs must allocate expenses using an appropriate method as instructed by Federal regulations at 42 CFR § 438.8(g). If CCOs fail to provide sufficient documentation on the methodology used for expense apportionment, certain reported expense amounts in the MLR report cannot be verified. In addition, improper allocation of expenditures may require adjustment.

F. Quality Improvement Activity (QIA) Expenditures and Contracts – To qualify as a QIA expenditure, expenditures must be directly related to quality improvement activities. QIAs are designed to improve health quality; increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results; be directed toward enrollees, specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities; and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized organizations.

G. Other High-Risk Expenditures – Unlike Medicare and private insurance, states may allow plans to report the results of state-mandated reinsurance arrangements as an

adjustment to premium in accordance with 42 CFR § 438.8(f)(2)(vi). Fraud prevention expenditures cannot be included in the Medicaid MLR calculation until the expenditures are defined in regulation; 42 CFR § 438.8(e)(4) serves as a placeholder for fraud prevention expenditures until that time. CCOs report an estimate of unpaid claims reserve on the MLR rebate template. Federal regulations at 42 CFR § 438.8(e)(2) outline the components to be reported as incurred claims and unpaid claims liabilities.

CMS also recalculated the CY 2019 MLR remittance calculations to determine if the recalculated data results in a MLR lower than 85 percent, which would require remittances be made to the state and CMS. None of these corrections resulted in a recalculated MLR that fell below the 85 percent remittance threshold.

Oregon's MLR Methodology and Policies

Under § 438.8(d), the MLR formula is defined as the ratio of the "Numerator" to the "Denominator", which is increased by a credibility adjustment when applicable. This formula is depicted below:

$$MLR = \frac{Numerator}{Denominator} + Credibility\ Adjustment$$

See Appendix E for a detailed list of expenditures included in the numerator in accordance with 42 CFR § 438.8(e) and the denominator in accordance with 42 CFR § 438.8(f). The Oregon 2019 MLR reporting instructions[5] specified the exact components that were allowable within the numerator and denominator. Each component is defined below.

The numerator is defined as the following components: paid claims, reinsurance/stop loss recoveries net of premiums paid, unpaid claim reserve, non-encounterable service costs, sub-capitated payments (excluding non-medical component of sub-capitated payments), incurred medical incentive pools and bonuses, other incurred medical costs, QIA activities, and fraud prevention activities.

The denominator is defined as net premiums plus other health care related revenues. Net premiums are defined as gross premiums less the sum of HRA payments, risk corridor rebates, Federal & state taxes and licensing or regulatory fees, and QDPs.

[5] See Oregon's 2019 MLR Instructions.

The credibility adjustment[6] is added to a MCP's calculated MLR if the MCP is partially credible[7] to account for the likelihood that the actual and target MLRs differ from a lack of fully sufficient claims experience (measured in member months).[8]

In Oregon, a CCO is required to remit the difference to the state if the MCP reports an MLR under the 85 percent threshold for the Medicaid population. For its 2019 MLR methodology, Oregon applied a two-year rolling average MLR in its remittance calculations, as well as 2019 Quality Pool-aligned provider incentive payments to be paid in 2020.

Initial MLR Remittance Results

Results of the original CY 2019 MLR remittance calculations are included below. The MLR remittance results were calculated by Oregon based on data reported by each CCO in their MLR template. Oregon reviewed the data to determine that the data was consistent and met the guidelines, and that all expenditures reported were allowable.

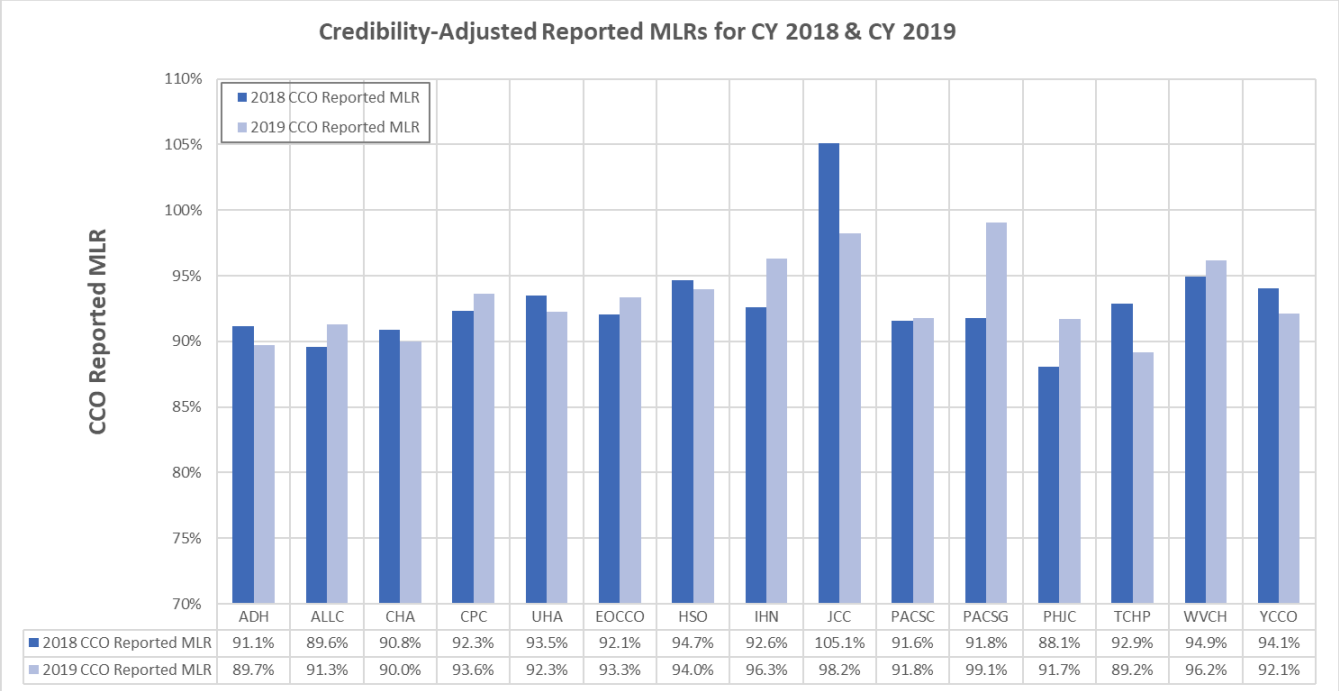
Figure 1 depicts the credibility-adjusted annual MLR for CY 2018 and CY 2019 based on the reports submitted by CCOs to Oregon for minimum MLR remittance calculations. For this figure, CY 2019 includes Quality Pool payments incurred in 2019 and paid by CCOs to providers in the first half-year of 2020.

[6] § 438.8(h)

[7] § 438.8(b)

[8] See the CMCS Information Bulletin from July 31, 2017, which defines non-credibility, partial credibility, full credibility, and the credibility adjustment calculation methodology required by MCPs. Oregon utilizes the credibility adjustment calculation methodology delineated in this bulletin for its remittance calculation.

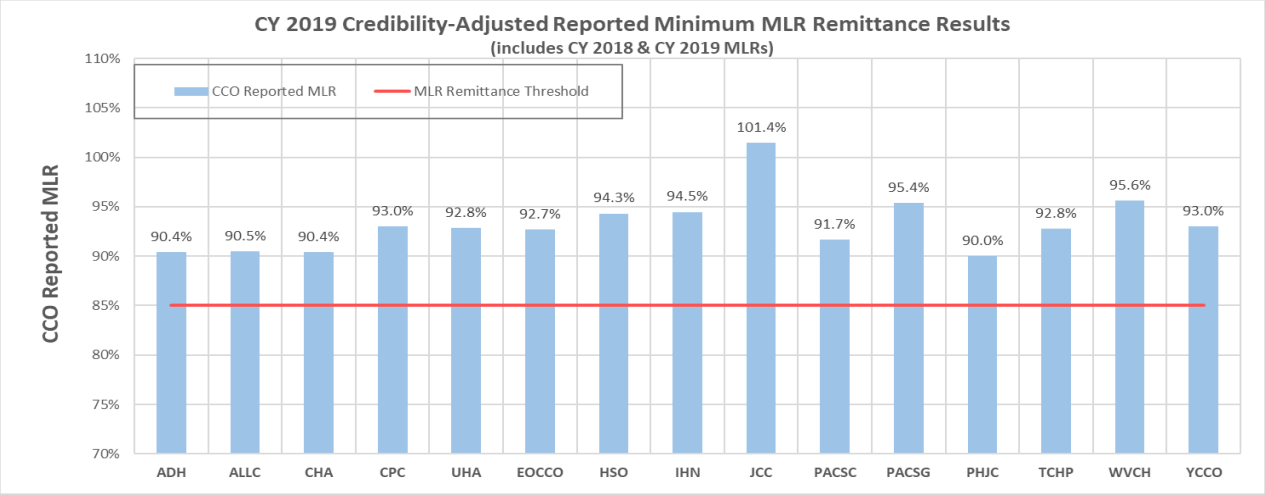
Figure 1



	ADH	ALLC	CHA	CPC	UHA	EOCCO	HSO	IHN	JCC	PACSC	PACSG	PHJC	TCHP	WVCH	YCCO
2018 CCO Reported MLR	91.1%	89.6%	90.8%	92.3%	93.5%	92.1%	94.7%	92.6%	105.1%	91.6%	91.8%	88.1%	92.9%	94.9%	94.1%
2019 CCO Reported MLR	89.7%	91.3%	90.0%	93.6%	92.3%	93.3%	94.0%	96.3%	98.2%	91.8%	99.1%	91.7%	89.2%	96.2%	92.1%

Figure 2 depicts the credibility-adjusted minimum MLR remittance calculations reported by CCOs for the reporting period CY 2019. These MLRs were used to determine whether CCOs owed remittances to Oregon and combines the CYs 2018 and 2019 MLRs in Figure 1 with only one credibility adjustment (based on the average member months between the two CYs).

Figure 2



MLR Components

Figures 3 and 4 show the average incurred medical related costs (numerator) and average medical related revenues (denominator) as a percentage of gross premiums reported in the CY 2019 minimum MLR remittance calculations by all 15 CCOs.[9]

Figure 3

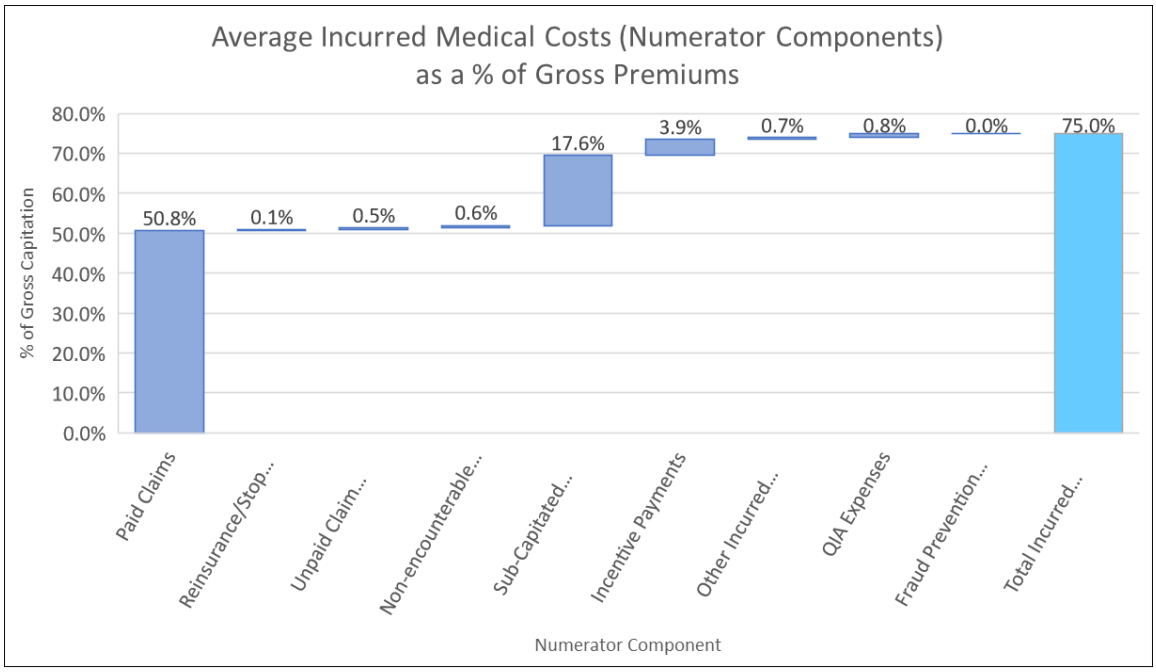
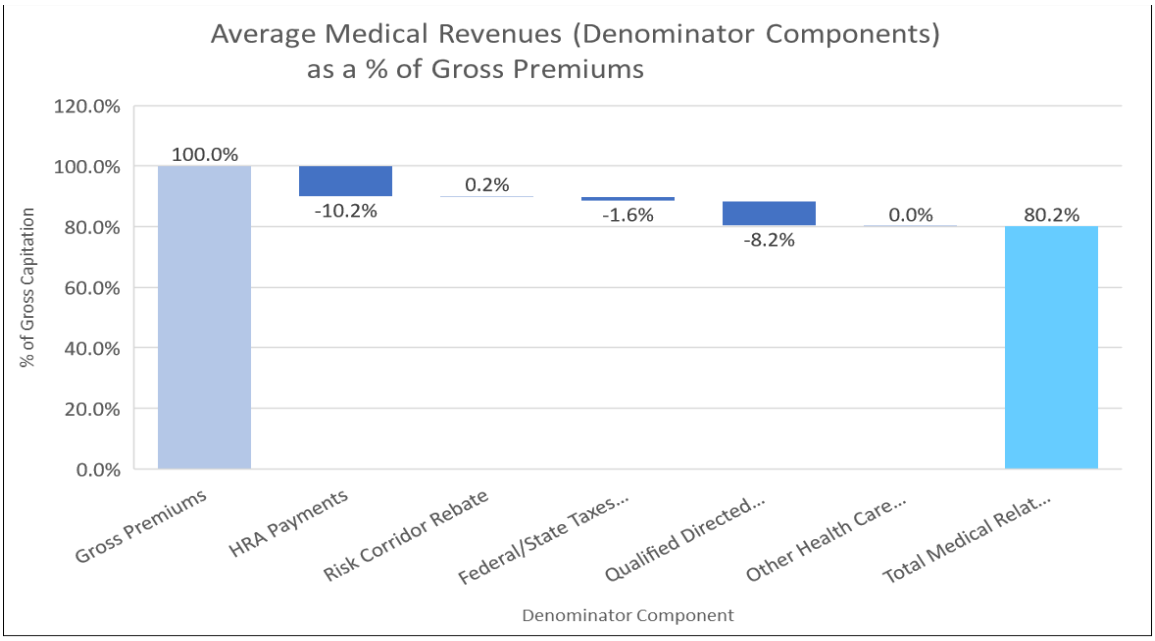


Figure 4

[9] MLR calculations reported by CCOs use net premium rather than gross premium. Both gross premium and net premium are shown to illustrate the relative average size of denominator components that offset gross premium.



The average MLR for the reporting period CY 2019 was 93.5 percent, which was calculated by dividing the total incurred medical related costs (75 percent) by the total medical related revenues (80.2 percent). In the numerator, paid claims, sub-capitated payments, and incentive payments accounted for 97.3 percent of the numerator, with the other six components only accounting for a combined 2.7 percent of gross premiums. In the denominator, HRA payments and QDPs accounted for 18.4 percent of the gross premium, and these along with risk corridor payments, federal and state taxes, and licensing or regulatory fees were subtracted from gross premium to calculate net premium.

Results of the Audit

Based on the results of this audit, Oregon's CCOs did not always follow federal requirements when reporting MLRs. While the errors identified in this audit did not result in any remittances that should have been paid, CMS identified several findings and recommendations for improvement in future MLR reporting.

1. State Oversight of CCO MLR Reporting

In the 2016 Medicaid Managed Care Final Rule,[10] CMS established requirements for state oversight of MLR reporting at 42 CFR § 438.74. The requirements at § 438.74(a) require states to submit an annual summary description of the MLR reports received from MCPs. The summary description is to be submitted with the related rate certifications under 42 CFR § 438.7.

[10] Medicaid and CHIP Managed Care Final Rule, 81 Fed. Reg. 27587-27592 (May 6, 2016) (to be codified at 42 CFR § 438.6)

The summary description is required to include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each MCP for the MLR reporting year. Effective state oversight of MLR reporting is key to ensuring MLR reporting and remittance calculations are accurate for rate setting.

This audit reviewed Oregon's oversight efforts of CCOs' MLR reporting. CMS identified three overarching observations where Oregon could improve its oversight efforts. **Specifically, CMS found that Oregon did not have predefined, quantifiable tolerance levels indicating when further review of CCO-provided information should occur**. Oregon acknowledged that its review of the 2019 MLR rebate submissions was not as thorough as its review of MLR rebate submissions in prior years due to a compressed timeframe from providing CCOs COVID-related extensions on their filings and the notion that MLR rebates were unlikely due to CMS regulation to exclude managed care plan incentive payments from revenue. **In addition, although Oregon gave CCOs adequate instructions on which MLR line items should match line items of separate financial statements, CMS identified several instances in which the finalized MLR line item amounts differed from their corresponding financial statement line items. Finally, CMS also identified instances where the tools provided by Oregon to the CCOs for MLR reporting could be improved by making updates to the MLR reporting instructions to ensure the instructions are accurate and reflect Federal requirements, correcting errors in the MLR submission templates, and adding instructions to ensure that CCOs sufficiently provide and archive documentation and implement measures to ensure expenses and revenues are reported in appropriate categories**. By providing the CCOs with accurate, well defined instructions, Oregon can obtain more relevant, accurate data to review to ensure MLR reporting is accurate.

Other more specific observations applicable to focus areas of this audit are discussed in the relevant sections, below.

- ✓ **Observation #1:** CMS recommends that Oregon consider using predefined, quantifiable tolerance levels, both on a line-item and aggregated basis, to indicate when Oregon should further request CCO substantiation of information reported.

- ✓ **Observation #2:** CMS recommends that Oregon consider sufficiently reviewing CCO-provided information to ensure MLR line items are appropriately reconciled with line items from corresponding financial statements.

- ✓ **Observation #3:** CMS recommends that Oregon consider updating its tools provided to CCOs for MLR reporting by updating MLR reporting instructions to ensure they reflect federal requirements, correcting errors in MLR submission templates, adding instructions to ensure that CCOs sufficiently provide and archive documentation, and implementing measures to ensure expenses and revenues are reported in appropriate categories.

2. Provider Incentives Payments and Contracts

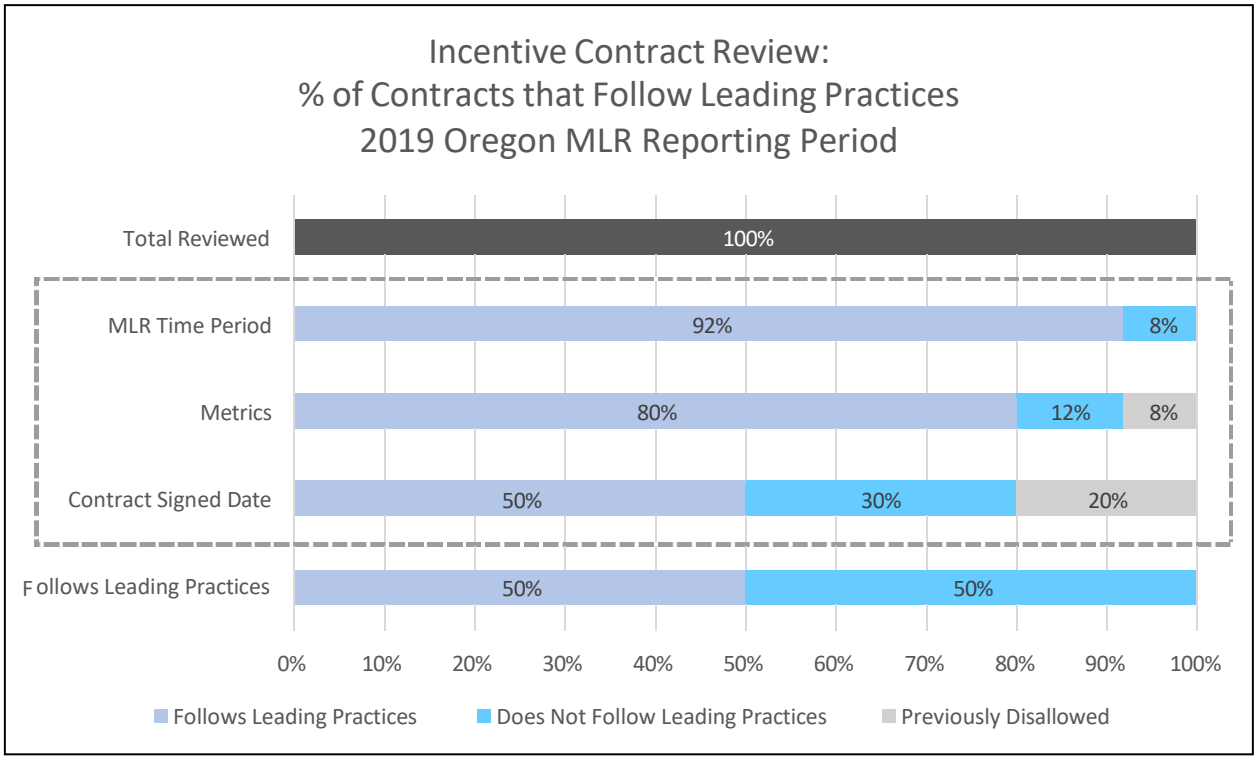
CMS regulations at 42 CFR § 438.3(i) require Medicaid contracts to comply with the MA program requirements set forth in 42 CFR § 422.208, which allows MCPs to enter into a physician incentive plan with a healthcare provider as long as the incentive plan does not act as an inducement to reduce or limit medically necessary services, and that if the incentive plan places the provider at substantial financial risk, the MCP must assure that all provider groups have appropriate reinsurance arrangements in place. State MCPs often use these incentive plans as a way to increase and maintain their provider network.

Under this audit, all CCOs were reviewed and assessed as to whether each contract followed specified leading practices. The leading practices are not currently a Federal or state requirement; however, CMS believes that following these leading practices could help ensure that Medicaid dollars are appropriately paid to providers and included in the MLR calculation. The leading practices related to incentive payment contracting are as follows:

1. The contract effective period was within the MLR period.
2. Some form of metrics was included within the contract.
3. The contract was signed by both parties, with the signed date evaluated in comparison to the listed effective date.

Inconsistent documentation practices by the CCOs led to difficulties in confirming and verifying the appropriateness of some incentive payments. As noted above, because these leading practices are not currently Federal or state requirements, no findings were identified in this audit. However, CMS identified two observations where the CCO incentive payment documentation did not always follow the leading practices. The results of the incentive payment analysis shown as percentages related to each decision are shown in Figure 5, below.

Figure 5[11]



Within the audit period, 50 percent of contracts followed the leading practices and the remaining 50 percent did not follow leading practices. **Four CCOs (ALLC, CHA, TCHP, and WVCH) did not have contracts in place for provider incentives**. If there was a Federal or state requirement for states and CCOs to follow the three leading practices, one CCO (CHA) would have fallen below the 85 percent MLR remittance threshold and been required to return the estimated overpayment of $19,893,086 to the state and CMS.

CMS identified a minor inconsistency in instructional language for required provider incentive expense amounts of the MLR rebate template. In its 2019 MLR reporting instructions, Oregon requested a reporting of incurred medical incentive pools and bonuses in its MLR rebate calculation report. This reporting line item included provider incentives payments that aligned with Oregon's Quality/Challenge Pool incentive metrics, as well as other provider incentive payments unrelated to Oregon's Quality Pool. In the 2019 MLR Rebate Calculation Report Instructions, Oregon confirmed that incentive payments aligned with the Quality Pool be reported on a cash basis and all other incentives outside of the Quality Pool be reported on an

[11] Figure 5 illustrates the results of the incentive payment analysis, with each category shown as a percent of the total incentive payment dollars reported by CCOs. CMS evaluated a contract's compliance with each leading practice in the same order in which they are listed in Figure 5. If a contract did not meet a leading practice, CMS did not further review its compliance with subsequent leading practices. All incentive payment dollars from contracts that had violated a previously evaluated leading practice are classified under "previously disallowed."

accrual basis. CMS believes that separate reporting lines and a consistent reporting basis for incentives may assist in clarifying reporting requirements.[12]

CMS noted more state oversight is needed on verification of timely incentive payments made to providers. Oregon did not have comprehensive detail on incentive payments at the provider-level. CMS requested proof of payment by provider from CCOs in the form of copies of checks, bank statements, or some other audited financial report and verified that most CCOs made incentive payments to providers in a timely manner. All 15 CCOs provided supporting documentation on contract terms, verification of payments, and payment cycles. While seven CCOs did not have incentive payment distribution terms in their written agreements with providers, they provided an explanation of their payment cycles.

- ✓ **Observation #4:** CMS recommends that Oregon consider ensuring that incentive payment contracts between the CCOs and providers follow leading practices to strengthen consistency and accuracy of incentives reporting and benchmarking among CCOs.

- ✓ **Observation #5:** CMS recommends that Oregon consider collecting additional data from CCOs to substantiate evidence of timely payments to provider to ensure incentive payments are made to providers in a timely manner.

3. Special Payments and State Directed Payments (SDPs)

Under § 438.6(c), SDPs are payments directed by a state that are permissible under Federal regulation provided that the payments reconcile to the utilization of services (e.g., by number of inpatient hospital discharges, outpatient visits, physician visits, etc.); advance at least one of the state's goals in quality strategy in a way that is regularly measured and evaluated; be directed equally and under the same performance terms among providers covered under contract; do not require provider participation in intergovernmental transfer agreements; and are not automatically renewed. The Medicaid MLR regulation in 42 CFR § 438.8(e)(2)(i)(A) noted that direct claims for services or supplies covered under the contract and services meeting the requirements of 42 CFR § 438.3(e) provided to enrollees must be included in the numerator of the MLR.

CMS confirmed three special payment programs applicable to this audit: Oregon's Quality Pool,[13] QDPs, and HRA payments.[14] In December 2020, prior to both this audit and final CCO CY 2019 MLR submissions, CMS advised Oregon to remove Quality Pool incentive revenue from the denominator of the MLR calculation because these payments are paid outside of CCOs'

[12] CMS acknowledges that Oregon has resolved this for the 2020 MLR reporting period by separating Quality Pool-aligned incentive payments and non-Quality Pool incentives into two distinct reporting lines and requiring that both lines now be reported on an accrual basis.

[13] An incentive arrangement between Oregon and its CCOs.

[14] Optumas. (2018). *CCO 2.0 Procurement Rate Methodology.*

certified capitation rates. On behalf of the CCOs, Oregon removed the Quality Pool revenue from the denominator and recalculated the MLRs before finalizing the submissions.[15]

CMS observed that Oregon's 2019 MLR rebate template excluded SDPs from the numerator and denominator. QDPs are a type of SDP approved by CMS under 42 CFR § 438.6(c). **Accordingly, CMS observed that the CCO expenditures and revenues associated with these payments should have been reported in the MLR numerator and denominator.**

To substantiate special payment amounts, CMS requested documentation on QDP and HRA amounts disbursed monthly to each qualifying provider. Fourteen of fifteen CCOs provided supporting documentation. Of these 14 CCOs, 10 provided supporting documentation that successfully tied back to the reported HRA and QDP amounts in the 2019 MLR rebate template. The five CCOs with discrepancies gave the following explanation and/or correction to their MLR reporting.

- PACSC and PACSG had significant HRA payment differences between MLR and supplemental reporting. For 2018, the variance between MLR and supplemental reporting was -8.0 percent and -6.3 percent for PACSC and PACSG, respectively. For 2019, the differences in reporting were 11.0 percent and 7.2 percent for PACSC and PACSG, respectively. PacificSource did not offer an explanation or correction to their MLR reporting.
- PHJC has not provided services since 2019 and was not able to provide documentation.
- TCHP requested corrections for reported HRA and QDP amounts in the MLR rebate template.
- WVCH exhibited a 13.8 percent variance between the value provided in documentation versus the value reported on the MLR rebate template for 2019. An accrual for 2019 which was paid in 2020 accounted for 12.2 percent of the variance. The remainder of the difference "may be attributed to estimated QDP expense on 12/31/19 that was not booked."

The impact of corrections made to the MLR based on these identified inconsistencies were not significant and did not result in any CCO's recalculated MLR falling below the remittance threshold of 85 percent.

- ✓ **Recommendation #1:** In accordance with 42 CFR 438.6(c)(2)(ii)(A) and 42 CFR § 438.8(e)(2)(i)(A), Oregon should closely monitor receipt of QDP and passthrough payments, including Oregon's HRAs, and reconcile all amounts with CCO's MLR reporting.

[15] CMS notes that Oregon's MLR remittance reporting instructions for reporting period CY 2020 correctly instructed CCOs to exclude Quality Pool revenue from the MLR denominator.

- ✓ **Observation #6:** As indicated by the August 4, 2021 technical assistance correspondence, QDPs should be included in both the numerator and denominator of the MLR calculation as part of state oversight of CCOs' payments to providers. SDPs to CCO providers should be included in the numerator and SDP revenue from the state to the CCOs should be reflected in the denominator – both as line items.

4. Third-Party Vendor Data and Contracts

In May 2019, CMS issued a Center for Medicaid and CHIP Services (CMCS) informational bulletin (CIB) to provide further guidance on current federal regulations surrounding MLR requirements related to third-party vendors.[16] This guidance clarified 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) for when an MCP uses a third-party vendor in a subcontracted agreement. The guidance provided examples to assist states in ensuring MCPs appropriately classified revenues, expenditures, and amounts for MLR reporting.

CMS requested documentation on underlying third-party vendor data related to MLR reporting and remittance calculations. **Three CCOs (ALLC, PHJC, and UHA) did not provide any underlying third-party vendor data. Based on this audit, Oregon CCOs' reporting and documentation of data for third-party vendors did not align with regulations. Correspondingly, Oregon did not adequately collect and review the CCOs' third-party vendor data for these MLR-related reporting requirements.**

Treatment of Pharmacy Benefit Manager Non-Claims Costs

Under the federal guidance, non-medical costs of any subcontractor, whether sub-capitated or not, should be excluded from incurred costs in the MLR calculation.

Oregon did not require CCOs to provide detailed data on subcontractors on a regular basis and required CCOs to collect data only from a subset of subcontractors. A section in Oregon's 2019 MLR reporting instructions only required sub-capitated providers, not necessarily all PBMs, to report incurred amounts net of non-claims costs. Oregon did not provide sufficient oversight of PBM administrative costs because it did not require detailed reporting of these costs for PBMs that were not capitated by plans.

Six CCOs reported contracts with PBMs that provided claims adjudication activities and did not operate under a capitated model. Four CCOs (CPC, JCC, PACSC, PACSG), with a combined 2019-member months comprise 13.25 percent of total CCO 2019-member months, were unable to provide sufficient documentation to validate the exclusion of non-medical expenditures from the reported PBM contractors. **While some of these CCOs noted that the non-medical portion of the PBMs' costs were netted out for reporting purposes, the CCOs did not provide**

[16] CIB: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors

documentation with sufficient detail for CMS to validate the exclusion of these non-medical amounts from MLR reporting. Due to the lack of sufficient documentation, CMS was unable to estimate the potential impact MLR if the non-medical portion of the PBMs costs were not netted out as stated by the CCOs.

Treatment of Prescription Drug Rebates

Under 42 CFR § 438.8(e)(2)(ii)(B), prescription drug rebates received and accrued must be deducted from incurred claims. Oregon's structure of the 2019 MLR rebate template aggregated paid claims in one-line item, making it difficult to examine whether third-party vendors were reporting pharmacy incurred claims net of prescription drug rebates. While CCOs appear to follow this requirement based on the provided documentation, it is a leading practice to separate the line item of paid claims from pharmacy rebates to reduce potential for misreporting.

Reporting of Additional Third-Party Non-Medical Costs

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

(i) Amounts paid to third-party vendors for secondary network savings;
(ii) Amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management;
(iii) 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
(iv) Fines and penalties assessed by regulatory authorities.

For instructions specific to sub-capitated payments, Oregon developed criteria for the reporting of these types of non-claims costs based on the percentage of net premiums made to sub-capitated providers. The criteria were not based on federal regulation or guidance. In 2019 MLR reporting instructions, Oregon defined sub-capitation payments as: "A per member payment on a regular basis made to a Sub-capitated Provider/Vendor that is meant to cover specific services and/or members and puts the Provider/Vendor at risk if costs are higher than the total payment received. Sub-capitated payments typically include a factor to cover administrative costs incurred and underwriting gains allowed to the Sub-capitated Provider/Vendor." Figure 6 provides Oregon's criteria for the reporting treatment of these non-medical costs. **Oregon instructed the inclusion of some non-medical costs for CCOs with sub-capitated entities categorized in Group 3. Therefore, the guidance provided by Oregon does not comply with 42 CFR § 438.8(e)(2)(v)(A) because it allows for the inclusion of non-medical costs as part of the MLR calculation.**

Figure 6

Oregon 2019 Minimum MLR Rebate Calculation Report Instructions for Sub-Capitation Payment Groups			
Group	**Criteria**	**Oregon's Instructions to CCOs**	**Note**
1	**Sub-capitation payments are greater than or equal to 5% of CCO's net premiums**	CCOs are required to only report sub-capitated entities' actual incurred medical costs (not to exceed the total amount of the entities sub-capitated payments) and provide detailed financial information of what was included for medical costs and what was excluded for non-medical costs.	*Costs that must be excluded from sub-capitated payments must be consistent with 42 CFR § 438.8(e)(2)(v).*
2	**Sub-capitation payments are between 0.5% and 5% of the CCO's net premiums *AND* the sub-capitated entity is either a mental health or dental care provider**	CCOs are required to only report sub-capitated entities' actual incurred medical costs (not to exceed the total amount of the entities sub-capitated payments) and provide detailed financial information of what was included for medical costs and what was excluded for non-medical costs.	*Costs that must be excluded from sub-capitated payments must be consistent with 42 CFR § 438.8(e)(2)(v).*
3	**Sub-capitation payments are less than or equal to 5% of CCO's net premiums *AND* the sub-capitated entity does not meet the definition of Group #2**	CCOs do not have to exclude non-medical costs for these sub-capitated entity payments. Include the entire amount of the sub-capitation payments.	

Establishment and Maintenance of Third-Party Vendor Data and Contracts

Under 42 CFR § 438.230(c)(1), if a CCO delegates any of its activities or obligations under its contract with the state to a subcontractor, then:

(i) The delegated activities or obligations, and related reporting responsibilities, must be specified in a contract or written agreement;
(ii) The subcontractor must agree to perform the delegated activities and reporting responsibilities specified in compliance with the CCO's contract obligations; and
(iii) 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 MCP determine that the subcontractor has not performed satisfactorily.

Four CCOs (ALLC, PHJC, TCHP, WVCH) were not in compliance with 42 CFR § 438.230(c)(1) because they did not provide contracts that outlined third-party obligations to their respective subcontractors.

In addition to the four CCOs that did not provide underlying third-party vendor data, CMS observed varying degrees of completeness of supporting documentation for amounts paid for non-medical administrative function costs, expenditures for activities that improve health care

quality, and other non-claims costs. **Because this data must be reported by third-party vendors to their CCO for accurately reporting of MLR expenditures, CMS was not able to confirm that all CCOs are complying with 42 CFR § 438.8(k)(3).**

- ✓ **Recommendation #2:** In accordance with 42 CFR § 438.8(e)(2)(v)(A), Oregon should update its instructions and augment its oversight activities to disallow the inclusion of non-medical costs of any third-party vendor, including sub-capitated entities. Oregon should also include in its instructions to CCOs guidance on the treatment of medical and non-medical costs from PBMs.

- ✓ **Recommendation #3:** In accordance with 42 CFR § 438.8(k)(3), Oregon should ensure CCOs collect all underlying data associated with MLR reporting from third-party vendors providing claims adjudicating activities so that the CCO can reliably calculate and validate the accuracy of the reported MLR.

- ✓ **Recommendation #4:** In accordance with 42 CFR § 438.230(c)(1), Oregon should ensure that CCOs are establishing and maintaining contracts with their subcontractors to reinforce compliance with third-party reporting responsibilities.

5. Allocation of Expenses Methodology

Federal regulations at 42 CFR § 438.8(g) contain general requirements and methodological requirements for the allocation of expenses. To accurately report the annual MLR to the state, CCOs must allocate expenses using an appropriate method. If CCOs fail to provide sufficient documentation on the methodology used for expense apportionment, certain reported expense amounts in the MLR report cannot be verified. In addition, improper allocation of expenditures may require adjustment.

Federal requirements at 42 CFR § 438.8(g)(1) define the general requirements for allocation of expenses:

(i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of, or criteria for, one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses
(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis

In addition, 42 CFR § 438.8(k)(1)(vii) further requires that CCOs include a description of their allocation of expenses methodologies in their MLR report submitted to the state annually.

CMS requested documentation from CCOs to understand how each plan determined Medicaid non-claims expenses for 2018 and 2019 relative to the total non-claims expenses incurred across

all LOBs. Allocation between LOBs for other expense types (e.g., taxes, licensing fees, QIA, fraud reduction expenditures) were not reviewed under this audit. While non-claims costs are reported on the MLR rebate template for reference purposes and are not a component of Oregon's MLR calculation formula, accurate reporting is essential for financial reporting and benchmarking.

Three CCOs (IHN, PHJC, TCHP) did not provide a response for allocation of expenses methodologies for their CY 2019 MLR submission and were thus out of compliance with 42 CFR § 438.8(k)(1)(vii). The remaining 12 CCOs provided a brief explanation of how the type of expenses were determined in line with regulations at 42 CFR § 438.8(g)(1)(i), but none provided a sufficient description of the methodology used to allocate expenses between Medicaid and non-Medicaid LOBs as required by 42 CFR § 438.8(g)(1)(ii). Examples of CCO responses provided in the original CY 2019 MLR rebate submission include:

- UHA stated, "Expenditures allocated based upon Oregon guidance document 'Minimum Medical Loss Ratio Rebate Calculation Report Instructions: For the Reporting Period Ending December 31, 2019'."
- WVCH stated, "All expenditures are based on actual figures."
- YCCO stated, "Expenditures were allocated consistent with DMAP reporting methodology."

In response to CMS' follow-up questions, CCOs did provide detailed explanations of their methodology of allocation of expenditures across LOBs for non-claims expenses and how the values reported the Medicaid MLR rebate template were obtained. Additionally, CCOs verified that only Medicaid-related expenses were reported or indicated any necessary corrections to the amounts reported in the MLR rebate template form. Examples of commonly used and acceptable methods of allocation between LOBs used by CCOs included share of premium revenue, share of population (measured in member months), or a blend of the two. Many CCOs used one allocation method across all non-claims expenses, which may not be appropriate for all types of expenditures reported in the MLR. For example, member months may be used as the allocation basis for salaries expenses while premium revenue may be used for taxes and licensing fees.

Treatment of Cover All Kids Program

Separate from Oregon's Medicaid Program, the state-funded Cover All Kids (CAK) program took effect on January 1, 2018 to expand primary and preventive health care access to all children and teens, regardless of immigration status.[17] Twelve CCOs had an active CAK and three of the twelve CCOs also had a Medicare LOBs during the 2018 and 2019 reporting periods.

[17] PowerPoint Presentation: SB 558/Cover All Kids Update

CMS regulations at 42 CFR § 438.8(g) requires that only Medicaid expenses be reported on the annual Medicaid MLR report. CCOs must separate non-claims expenses, taxes, licensing fees, and QIAs between Medicaid and all other LOBs. If erroneously included in Medicaid revenues and expenses, the CAK LOB[18] would contribute less than 1 percent of Medicaid revenue and expenses. CCOs that failed to exclude these amounts do not significantly impact their overall Medicaid revenues and expenses reported.

Three CCOs did not follow CMS regulations in their method of allocation between LOBs for non-claims expenses:

- ADH included CAK LOB administrative expenses for 2018 and 2019 in the Medicaid MLR report.
- PHJC did not separate out the non-claims expenses between the Medicaid and CAK LOBs for 2018 and 2019.
- WVCH did not allocate salary expense between CAK and Medicaid in 2018 or 2019.

Non-Claims Expense Recalculation

Three CCOs did not appropriately allocate non-claims expenses between Medicaid and non-Medicaid LOBs. As a result, the following CCOs overstated their non-claims expense on the MLR rebate template form:

- ADH incorrectly included CAK expenses for the 2018 and 2019 reporting periods, overstating non-claims expenses by $3,876 in 2018 and $5,807 in 2019.
- PHJC incorrectly included CAK expenses for the 2018 and 2019 reporting periods. PHJC was unable to retroactively estimate these amounts.
- WVCH incorrectly included CAK expenses for the 2018 reporting period, overstating non-claims expenses by $169,652.

✓ **Recommendation #5:** Oregon should update future Medicaid MLR reporting instructions to clearly state that any non-Medicaid LOB expenses, including CAK expenses, should not be included within the Medicaid MLR reporting and remittance calculations in accordance with 42 CFR § 438.8(g).

✓ **Recommendation #6:** Oregon should request information on how allocation percentages were determined across LOBs in accordance with 42 CFR § 438.8(k)(1)(vii). For example, Oregon should request specific information on how certain types of non-claims expenditures

[18] Oregon confirmed for CMS that CAK is a fully state-funded program that should not be included in Medicaid reporting.

(e.g., salaries, human resource) are allocated across LOBs, as well as request information on how QIA program expenditures that affect multiple LOBs were allocated across LOBs.

- ✓ **Observation #7:** CMS recommends that Oregon consider increasing oversight activities and updating future MLR reporting instructions to provide a clear and detailed description of the information required, to ensure that CCOs provide a detailed, targeted methodology as part of their MLR submission.

6. Quality Improvement Activity (QIA) Expenditures and Contracts

To qualify as a QIA expenditure, expenditures must be directly related to quality improvement activities. QIAs are designed to improve health quality; increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results; be directed toward enrollees, specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities; and grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations. Incorrectly including unqualified QIA expenses can inappropriately inflate the reported MLR. According to 42 CFR § 438.8(e)(3), activities that improve health care quality must be within specified categories, including but not limited to, activities related to any EQR-related activity as described in 42 CFR § 438.358(b) and (c). In addition, 45 CFR § 158.150(b)(2) describes what the activity must primarily be designed to do, including but not limited to, improve health outcomes and reduce health disparities among specified populations, and implement, promote, and increase wellness and health activities. Finally, 45 CFR § 158.150(c) specifies the expenditures and activities that must not be included in quality improving activities, including but not limited to, those that are designed primarily to control or contain costs and those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.

Oversight of QIAs can be a challenge for states due to several categories of expenditures included in the above regulations. CMS encourages states to implement strong documentation, clinical expertise, and appropriate cost accounting methodologies. Such leading oversight practices should include standard reporting templates and prior approval processes.

Upon request by CMS, all 15 CCOs were able to provide a breakdown of expenses that summed to the amount reported as QIA expenditures of the MLR rebate template. While all 15 CCOs were generally able to explain the purpose of these activities, such that they qualify as QIAs in accordance with federal regulations, the overall quality of responses varied among CCOs. To conduct these QIAs, the majority of CCOs use third-party contractors rather than internal staff. Of the CCOs who were requested to provide contracts with vendors for QIAs, two (IHN, WVCH) did not provide them. For internally performed activities, many CCOs have indicated

that costs go through an internal process and are deemed to be allowable as defined by 45 CFR § 158.150(b)(2) before they are incurred.

Health-Related Services (HRS) Costs – Community Benefit Initiatives (CBIs) and Flexible Services

HRS costs described in Oregon's section 1115 Medicaid demonstration are composed of flexible services and CBIs; these expenses are reported to the State on a separate financial statement. The Special Terms and Conditions (STCs) for the section 1115 demonstration in effect for 2019 noted that HRS costs that met the QIA definitions in 45 CFR §§ 158.150 or 158.151 should be reported in the MLR numerator as QIA. The STCs did not delineate any differences in MLR reporting for CBIs and flexible services.[19]

CCOs inconsistently reported flexible services as the QIA expenditures line item or as non-encounterable service costs. In a written response regarding QIA oversight, Oregon stated that "Oregon provided CCOs with extensive guidance on reporting QIA," and that Oregon considered data provided through financial reports to be "sufficient for purposes of reviewing QIA reporting. Oregon has provided an extensive guidance document to help CCOs provide sufficient data for Oregon to review the HRS spending data in [the financial report]. When it is unclear if reported HRS spending meets HRS criteria, Oregon requested additional information from the CCO to make a final determination. Oregon may review underlying documentation at the CCO level as part of the CCO examination process. [Oregon is] currently working to implement pursuant to recent state legislation."

Because some HRS costs qualify as QIA expenditures as defined by 45 CFR § 158.150 or 45 CFR § 158.151, the 2019 MLR reporting instructions were unclear on where CCOs should report these costs. **Oregon's instructions do not clarify that flexible service costs that qualify as QIA expenditures should only be reported as QIA, and not reported as non-encounterable service costs.**

Non-encounterable service costs and QIA expenditures are both reported in the numerator of the MLR calculation, meaning that MLR was not impacted by a difference in the classification of flexible services. CMS notes that CCOs that included flexible services within the QIA expenditures line item did not also report them within the non-encounterable service costs line item, so the expenses were not double counted on the MLR rebate template.

As defined in 45 CFR § 158.162(c), CBEs are programs that benefit Medicaid as well as non-Medicaid members. CBEs can be included in the MLR as an adjustment to premium revenue, subject to limitations outlined in 42 CFR § 438.8(3)(v). CBEs are reported in the MLR denominator and are subject to limitations as outlined in 42 CFR § 438.8(f)(3)(v). This

[19] Since the time of this review, CMS has worked with Oregon to revise the STCs to improve MLR reporting. The STCs now make it clear that HRS expenditures should only be reported as QIA if they meet the qualifications and CBIs should be considered community benefit expenditures and reported in the MLR denominator.

distinction between CBEs and the CBIs in the section 1115 demonstration was not noted in the STCs and resulted in Oregon instructing the MCPs to report CBIs as other HRS. **Oregon's 2019 MLR reporting instructions did not specify that "community benefit initiatives" were equivalent to CBEs and should be reported in the MLR numerator.**

Recalculated QIA and MLR from Removing Unqualified Expenses

CMS identified CCOs that incorrectly included expenses that do not meet the qualifications outlined in the federal regulations to be considered QIA expenses:

- ADH included CBEs of $247,533 and $201,763 as QIA expenses in 2018 and 2019, respectively. CBEs are not considered QIA and, in accordance with 42 CFR § 438.8(f)(3)(v), should be reported in the denominator subject to limitations. ADH also included $19,424 of "Community Health Assessment - related expenses (Not QIAs)" in 2018. Removing this expense for 2018 results in decrease to the numerator but no impact to the overall MLR due to its negligible magnitude.
- EOCCO included community benefit initiative reinvestment program costs of $1,633,543 and $1,687,743 in 2018 and 2019, respectively, as QIA expenses. CBEs are not considered QIA and should be reported in the denominator subject to limitations.

✓ **Recommendation #7:** Oregon should remove HRS costs and community benefit initiatives from the description of items to include as non-encounterable service costs. HRS costs should be included within QIA expenditures if the services qualify as QIAs as defined by 45 CFR § 158.150 or 45 CFR § 158.151.

✓ **Recommendation #8:** Oregon should update the MLR template and instructions to require CCOs to report CBI expenditures as CBEs as specified in 42 CFR § 438.8(f)(3)(v). Because Oregon's CBIs meet the definition of CBEs, they should be included as an offset to premium revenue in the denominator, rather than in the numerator of the MLR calculation. Since this audit was conducted, Oregon has implemented this recommendation.

7. Other High-Risk Expenditures

Reinsurance Expenditures

Under 42 CFR § 438.8(f)(2)(vi), risk sharing mechanisms should be reported as adjustments to premium revenue. Unlike Medicare and private insurance, Medicaid regulations do not explicitly prohibit the reporting of private reinsurance arrangements in the MLR. The state may allow plans to report the results of state-mandated reinsurance arrangements as an adjustment to premium revenue.

Oregon's 2019 MLR instructions defines the amount reported as reinsurance/stop loss premiums paid net for various types of recoveries as "premiums paid/accrued for reinsurance or stop loss insurance but does not include reinsuring all or substantially all of Contractor's risk. This amount should be reduced by any reinsurance recoveries, Third Party Reimbursement (TPR), Coordination of Benefits (COB), subrogation or similar payments received, and payments recovered through fraud prevention efforts." In the 2019 MLR rebate template form, the reported net reinsurance amount is included in the numerator of the MLR calculation. **CMS noted that Oregon's reporting instructions and rebate template incorrectly included state-mandated private reinsurance reconciliations in the numerator of the MLR calculation.**

- ✓ **Recommendation #9:** In accordance with 42 CFR § 438(f)(2)(vi), Oregon should update its reporting instructions and rebate template to remove state-mandated private reinsurance reconciliations from the numerator of the MLR calculation.

Fraud Prevention Activity Expenditures

The 2016 Medicaid Managed Care Final Rule finalized 42 CFR § 438.8(e)(4), which served as a placeholder for fraud prevention expenditures. This regulation mirrored private market regulations at 45 CFR Part 158, and, at that time, fraud prevention expenditures were (and continue to be) undefined for the private market. Expenditures for fraud prevention cannot be included in the Medicaid MLR calculation until the expenditures are defined in regulation.

Oregon's 2019 MLR reporting template erroneously included a line item for fraud prevention activity expenditures. CMS instructed Oregon that it would not be required to recalculate the annual MLR reports if expenditures identified as fraud prevention activities were included in the earlier MLR reports. Given the delay in finalizing the 2020 managed care final rule that corrected a related technical error in the Medicaid MLR regulations, CMS did not identify this issue as a finding.

The removal of 2018 and 2019 fraud prevention activity expenditures would result in no change in MLR for six CCOs, a decrease in MLR by 0.10 percent or less for eight CCOs, and a decrease in MLR by 0.32 percent for one CCO (UHA).

- ✓ **Observation #8:** CMS recommends that Oregon exclude fraud prevention activities from the MLR numerator of the reporting template until fraud prevention activities are defined in federal regulation.

Paid Claims and Incurred but Not Reported (IBNR) Analysis

According to Oregon's 2019 MLR reporting instructions, paid claims include claims paid on a fee-for-service basis, and therefore, do not include sub-capitated claims. CCOs also report an estimate of IBNR, alternatively named "unpaid claims reserve" on the MLR rebate template, which represents the number of claims that were incurred in the reporting period but had not yet been paid. Federal regulations at 42 CFR § 438.8(e)(2) outline the components to be reported as

incurred claims and unpaid claims liabilities. Regarding claim reserves, Oregon stated that they ensure the reported IBNR is within a reasonable range. Separate financial reports are used as benchmarks to assess reasonableness. In general, 85 to 95 percent of unpaid claims are paid after three months, so it may be reasonable that an in-depth review is not performed.

All 15 CCOs provided CMS documentation on paid claims triangles[20] for claims incurred in 2018 and 2019 and paid through March of the following year.

CMS developed an estimate for IBNR[21] using the provided paid claims triangles, along with any noted adjustments, within an internal model. CMS compared the sum of the paid claims and IBNR amounts reported by CCOs to the sum of the paid claims and IBNR amounts produced by the CMS analysis. For all CCOs, the difference between these two values was within 2 percent, which is considered acceptable because the IBNR amounts reported were estimates at the time of submission. While a change to the amounts reported impacts the MLR calculation, none of the CCOs would be impacted by a change in paid claims by +/-2 percent to the point of a remittance.

As such, CMS did not identify any recommendations or observations for this focus area.

MLR Remittance Recalculation

Based on the results of the audit, CMS identified 37 errors across all CCOs that CMS applied to recalculate CY 2019 MLR remittance calculations to determine if any CCO's MLR fell below the 85 percent threshold, thus owing money back due to errors. CMS included changes to the remittance calculations based on the following corrections:

- Financial statement reconciliations
- Costs that do not qualify as QIA, including corrections related to CBEs and HRS errors
- Exclusion of state-mandated private reinsurance from MLR numerator
- Exclusion of fraud prevention activity expenditures
- Changes to paid claims or IBNR amounts based on CMS' IBNR analysis
- Additional corrections to reporting lines acknowledged by CCOs

CMS incorporated recalculations to non-claims costs based on CAK-related errors, but they did not affect the revised MLR remittance calculations based on Oregon's rebate template structure.

Figure 7 summarizes the original MLR remittance calculations reported by CCOs on the 2019 MLR rebate template, the revised MLR remittance calculations based on CMS' recalculations, and the variance between the two. Nine CCOs exhibited no change to their MLR. Three CCOs (ALLC, EOCCO, and TCHP) exhibited a decrease in their MLRs of 0.50 percent or less. Three

[20] Claims triangles use historical payment patterns for a certain line of business to estimate future claims completion factors to estimate the expected incurred claims.

[21] Because this amount is an estimate, variance is expected between the results produced by the model results and those reported by the CCO.

CCOs (ADH, IHN, and WVCH) exhibited an increase in their MLRs. None of these corrections resulted in a recalculated MLR that fell below the 85 percent remittance threshold.

Figure 7

CCO	Original 2019 MLR Remittance Calculation	Revised 2019 MLR Remittance Calculation	Variance (Revised MLR minus Original MLR)
ADH	90.38%	91.33%	0.95%
ALLC	90.45%	90.01%	-0.44%
CHA	90.40%	90.40%	0.00%
CPC	93.01%	93.01%	0.00%
EOCCO	92.71%	92.14%	-0.58%
HSO	94.31%	94.31%	0.00%
IHN	94.47%	95.03%	0.56%
JCC	101.44%	101.44%	0.00%
PACSC	91.67%	91.67%	0.00%
PACSG	95.39%	95.39%	0.00%
PHJC	90.01%	90.01%	0.00%
TCHP	92.79%	92.57%	-0.21%
UHA	92.85%	92.85%	0.00%
WVCH	95.58%	95.80%	0.21%
YCCO	93.03%	93.03%	0.00%

Figure 8 summarizes the original 2019-only MLR calculations prior to this audit and the revised 2019-only MLR calculations based on CMS' recalculations. Figure 8 incorporates MLRs for only one year illustrating the potential impact to Oregon's MLR calculations for ratemaking purposes rather than MLR remittance calculations. Figure 8 illustrates that nine CCOs exhibited no change to their 2019-only MLR, three CCOs (ALLC, EOCCO, TCHP) exhibited a decrease of less than 1 percent to their 2019-only MLR, and three CCOs exhibited an increase to the 2019-only MLR.

Figure 8

CCO	Original 2019-Only MLR	Revised 2019-Only MLR	Variance (Revised MLR minus Original MLR)
ADH	89.70%	90.03%	0.33%
ALLC	91.31%	90.45%	-0.86%
CHA	89.99%	89.99%	0.00%
CPC	93.61%	93.61%	0.00%
EOCCO	93.32%	92.35%	-0.98%
HSO	93.97%	93.97%	0.00%
IHN	96.29%	97.43%	1.14%
JCC	98.21%	98.21%	0.00%
PACSC	91.77%	91.77%	0.00%
PACSG	99.08%	99.08%	0.00%
PHJC	91.71%	91.71%	0.00%
TCHP	92.71%	92.65%	-0.07%
UHA	92.27%	92.27%	0.00%
WVCH	96.18%	96.60%	0.42%
YCCO	92.09%	92.09%	0.00%

Appendix A: Audit Scope and Methodology

Scope

CMS' audit covered the MLR reported for Oregon's 15 CCOs for the reporting period CY 2019. CMS performed audit work from January 2021 to February 2022.

Methodology

To accomplish the objectives, CMS:

Annually Reported MLR

1. Reviewed applicable federal regulations for the annually reported MLR and Oregon-specific methodology requirements regarding the minimum MLR remittance requirements.
2. Notified and met with Oregon to discuss and understand State policies and procedures for overseeing its Medicaid MLR reporting and remittance calculations.
3. Requested from Oregon available data, financial statements, and contractual documentation necessary for a proper analysis.
4. Requested from CCOs available data and contractual documentation necessary for a proper analysis and not already provided by Oregon.
5. Verified completeness of available data and contractual documentation; requested additional documentation from CCOs as necessary.
6. Reconciled MLR data received against available financial statements.
7. Performed data benchmarking using all CCO data to identify CCOs with relatively high or low MLR components.
8. Sent questions to both Oregon and CCOs on data and contract observations.
9. Identified and recalculated, by year and CCO, reporting components that were not properly incorporated in the annually reported minimum MLR remittance calculation.
10. Updated recalculated MLR components in the MLR final calculation to determine potential changes in remittance payments to Oregon and CMS.
11. Discussed the audit with Oregon via a written report and an exit meeting.

Review of State Oversight of MLR Reporting

1. Reconciled financial statements, provided by Oregon, to MLR reporting.
2. Determined whether Oregon's MLR rebate template was structured correctly to calculate the MLR results consistent with the applicable regulations and guidelines.

3. Verified that Oregon's oversight of MLR reporting process and remittance calculations was consistent with the applicable regulations and guidelines. Specifically, determined due diligence in oversight of the following items:
    A. MLR data and documentation collected by Oregon.
    B. Guidance provided to CCOs for remittance calculations including methodologies and implemented timeframes.
    C. State procedures related to annual MLR reporting and minimum MLR calculation reconciliation, including any exceptions made in reviewing data and the impact on the final calculation.
    D. Frequency and topics of ongoing meetings between Oregon and CCOs relating to financial reporting indicators.

Focus Areas for Audit

CMS identified focus areas to help guide this audit. These focus areas are considered by CMS an area of oversight risk and were selected based on several factors. (See Audit Objectives section.) The following steps were taken to conduct the audit of these focus areas:

1. Treatment of Third-Party Vendor Data:
    a. Reviewed applicable federal regulations and CMS guidance on third-party vendors and their treatment in MLR reporting.
    b. Requested CCO available data and documentation on third-party vendor costs. Requested information from Oregon on their oversight of third-party vendor data.
    c. Evaluated Oregon instructions to CCOs. Assessed compliance of reporting requirements against federal regulations outlined in the May 2019 CIB.
    d. Verified completeness of available documentation. As necessary, requested additional documentation on an ongoing basis.
2. Treatment of QIA Expenditures:
    a. Reviewed applicable federal regulations related to treatment and categorization of QIA activities in MLR reporting.
    b. Requested CCOs' available data and documentation on QIA expenditure categorization. Requested and analyzed Oregon oversight of QIA categorization.
    c. Verified compliance of reporting requirements outlined in 42 CFR §§ 438.8(e)(3) & 438.8(k)(1)(ii).
    d. Verified completeness of available documentation. As necessary, requested additional documentation on an ongoing basis.
    e. Requested additional substantiation on accurate categorization of QIA activities based on 45 CFR §§ 158.150 and 158.151.

f. Recalculated reported QIA amounts as necessary.

3. Treatment of Special Contract Provisions Related to Payment (with an emphasis on SDPs):
    a. Reviewed applicable federal regulations and CMS guidance special contract provisions related to payment and their treatment in MLR reporting.
    b. Discussed with Oregon to confirm applicable special payment programs (Quality Pool incentive arrangement between Oregon and CCO; SDP; passthrough payment)
    c. Assessed current treatment of special payments in minimum MLR remittance calculation:
        i. Exclusion of incentive arrangement revenue from denominator.
        ii. Exclusion of passthrough payments from numerator and denominator.
        iii. Inclusion of SDPs in numerator and denominator.
    d. Provided guidance to Oregon on treatment of SDPs in minimum MLR remittance calculation for future MLR reporting periods.
    e. Requested from Oregon and CCOs available data and documentation on special payment data and contracts, including documentation separated out by provider where applicable.
    f. Verified completeness of available data and documentation.
    g. Cross-checked reported passthrough and SDP amounts against available financial statement documentation.
    h. Recalculated reported special payment amounts as necessary.
4. Treatment of Provider Incentives Data and Contracts:
    a. Reviewed applicable federal regulations related to the treatment of incentive pools and bonus payments in MLR reporting.
    b. Requested from Oregon and CCOs available data and documentation on provider incentives data and contracts, including provider contracts aligned with Oregon's Quality Pool incentive arrangement and additional contracts outside of the Quality Pool.
    c. Verified compliance of incentive and bonus payment reporting requirements outlined in 42 CFR §§ 438.8(e)(2)(i)(C) & 438.8(e)(2)(iii)(A).
    d. Verified completeness of available documentation. As necessary, requested additional documentation on an ongoing basis.
    e. Developed three leading practices for an analysis of available provider incentives contracts.
    f. Analyzed provider incentives amounts and contracts against three leading practices and hypothetical impacts to the minimum MLR remittance calculation.

5. Methodology for Allocation of Expenses:
    a. Reviewed applicable federal regulations related to the methodologies for the allocation of expenses in MLR reporting.
    b. Requested from Oregon and CCOs available data and documentation on methodologies for the allocation of QIA expenditures and non-claims expense across LOBs
    c. Verified compliance of data reporting requirements outlined in 42 CFR § 438.8(k)(1)(vii).
    d. Verified completeness of available data and documentation. As necessary, requested additional data to understand allocation methodologies for non-claims expense across LOBs.

Appendix B: Coordinated Care Organizations

CCO Abbreviation	CCO Full Name	CCO Number of 2019 Member Months	Ranked Size of CCO (by 2019 Member Months)
ADH	Advanced Health	245,650	12
ALLC	Allcare CCO	602,184	6
CHA	Cascade Health Alliance	216,025	13
CPC	Columbia-Pacific CCO	308,086	10
EOCCO	Eastern Oregon Coordinated Care Org.	609,491	5
HSO	Health Share of Oregon	3,849,487	1
IHN	InterCommunity Health Network	686,210	4
JCC	Jackson County CCO	384,197	8
PACSC	PacificSource Community Solutions (Central)	583,710	7
PACSG	PacificSource Community Solutions (Gorge)	144,924	14
PHJC	Primary Health of Josephine County	122,013	15
TCHP	Trillium Community Health Plan	1,111,289	3
UHA	DCIPA d.b.a. Umpqua Health Alliance	325,756	9
WVCH	Willamette Valley Community Health	1,231,891	2
YCCO	Yamhill Community Care	299,794	11

Appendix C: Medicaid MLR Audit Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	In accordance with 42 CFR § 438.6(c)(2)(ii)(A) and 42 CFR § 438.8(e)(2)(i)(A), Oregon should closely monitor receipt of QDP and passthrough payments, including Oregon's HRAs, and reconcile all amounts back to CCO's MLR reporting.	**X** OHA is implementing a new reporting requirement to get up to date data on qualified directed payments to reconcile with MLR reporting.	
Recommendation #2	In accordance with 42 CFR § 438.8(e)(2)(v)(A), Oregon should update its instructions and augment its oversight activities to disallow the inclusion of non-medical costs of any third-party vendor, including sub-capitated entities. Oregon should also include in its instructions to CCOs guidance on the treatment of medical and non-medical costs from PBMs.	**X** OHA believes this has already been addressed by the current inclusion in the instructions to exclude non-medical cost from sub-capitated entities and the recent inclusion in the contract of Exhibit C-Part 10 paragraph d.	
Recommendation #3	In accordance with 42 CFR § 438.8(k)(3), Oregon should ensure CCOs collect all underlying data associated with MLR reporting from third-party vendors providing claims	**X** OHA believes this has been addressed by the recent inclusion	

Classification	Issue Description	Agree	Disagree
	adjudicating activities so that the CCO can reliably calculate and validate the accuracy of the reported MLR.	in the contract of Exhibit C-Part 10 paragraph d.	
Recommendation #4	In accordance with 42 CFR § 438.230(c)(1), Oregon should ensure that CCOs are establishing and maintaining contracts with their subcontractors to reinforce compliance with third-party reporting responsibilities.	**X** OHA believes the planned contract changes to comply with the recent 1115 waiver will significantly enhance these requirements on subcontractors.	
Recommendation #5	Oregon should update future Medicaid MLR reporting instructions to clearly state that any non-Medicaid LOB expenses, including CAK expenses, should not be included within the Medicaid MLR reporting and remittance calculations in accordance with 42 CFR § 438.8(g).	**X** OHA believes this change has already been included in the instructions with: "Member means a client who is enrolled with a Contractor under Medicaid Contract with OHA. Cover All Kids members should be excluded from the MLR analysis." These instructions will be further refined with the implementation of the Healthier Oregon Program (HOP) in 2022, wherein the	

Classification	Issue Description	Agree	Disagree
		Medicaid-eligible portion of HOP revenue and expenses are to be included in the CCO's overall MLR calculation.	
Recommendation #6	Oregon should request information on how allocation percentages were determined across LOBs in accordance with 42 CFR § 438.8(k)(1)(vii). For example, Oregon should request specific information on how certain types of non-claims expenditures (e.g., salaries, human resource) are allocated across LOBs, as well as request information on how QIA program expenditures that affect multiple LOBs were allocated across LOBs.	**X** OHA believes this change has already been included in instructions below that OHA is working to further specify what methodology choice are acceptable: "Description of Methodology(ies) for allocation of expenditures include a description of methods for allocating expenses, including but not limited to cost allocations by line of business. See 42 CFR 438.8(g) for guidance. If additional space is needed, please indicate in the box that the	

Classification	Issue Description	Agree	Disagree
		scratch sheet is being used."	
Recommendation #7	Oregon should remove HRS costs including community benefit initiatives from the description of items to include as non-encounterable service costs. HRS costs should be included within QIA expenditures if the services qualify as QIA as defined by 45 CFR § 158.150 or 45 CFR § 158.151.	**X** OHA believes this has already been included in the instruction with: "Note: "Health-related services", "flexible services" and "community benefit initiatives" as described in the CMS section 1115 Waiver and OAR 410-141-3845 should be included on this line. Only include the portion of health-related services that is reviewed and approved by OHA."	
Recommendation #8	Oregon should update the MLR template and instructions to require CCOs to report CBI expenditures as CBEs as specified in 42 CFR § 438.8(f)(3)(v). Because Oregon's CBIs meet the definition of CBEs, they should be included as an offset to premium revenue in the denominator, rather than in the numerator of the MLR calculation. Since this audit was conducted, Oregon has implemented this recommendation.	**X**	

Classification	Issue Description	Agree	Disagree
Recommendation #9	In accordance with 42 CFR § 438(f)(2)(vi), Oregon should update its reporting instructions and rebate template to remove state-mandated private reinsurance reconciliations from the numerator of the MLR calculation.	**X** OHA believes this has already been addressed by moving net reinsurance premiums less recoveries to the MLR denominator.	

Acknowledged by:

David Baden, CFO

[Name], [Title]

December 20, 2022

Date (MM/DD/YYYY)