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Alternative Provider Reimbursement Models—How Are They Treated Under MLR Rules?

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The new rules issued by the Centers for Medicare & Medicaid Services and Department of Health and Human Services regarding the calculation of the medical loss ratio (MLR) pursuant to the Patient Protection and Affordable Care Act (45 CFR Part 158) require individual and group health plans, other than self-funded health plans, to spend a minimum percentage of premium towards medical expense or ''medical loss,'' or else provide rebates to enrollees. Other expenses are generally considered ''administrative'' and not counted toward the minimum. For purposes of this article, medical expense—or medical loss—is defined primarily as ''incurred claims'' and certain quality improvement activities (QIA).

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The line differentiating administrative expense and medical expense can be difficult to determine. Historically, most health insurers have reimbursed providers for clinical services rendered on a ''fee for service'' basis. Such fees clearly qualify as incurred claims.

Increasingly, alternative payment models are being used, including ''pay for performance'' bonuses that measure a provider's performance against quality and/or cost (efficiency) criteria; bundled payment models; sharing ''pools'' of funds based on relative value units; and capitation models. Sometimes these arrangements involve intermediary entities, such as independent practice associations (IPAs) or pharmacy benefit management companies (PBMs) that may also perform administrative services that include utilization review and claims payment.

This article addresses whether such alternative reimbursement models qualify as medical expense, for purposes of calculating MLR.

Regulatory Background—Incurred Claims and Quality Improvement Activities

Federal regulations define incurred claims, which is a component of the numerator for determining MLR. These regulations also permit activities that improve health care quality to be counted as medical loss for purposes of calculating MLR.

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The MLR regulations specify that QIAs must be 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 and achievements.
- Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage, as long as no additional costs are incurred due to the non-enrollees.
- Be 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.[1]

In addition, the activities must be primarily designed to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
- Prevent hospital readmissions through a comprehensive program for hospital discharge.
- Improve patient safety, reduce medical errors, and lower infection and mortality rates.
- Implement, promote, and increase wellness and health activities.[2]

The regulations specifically exclude certain expenditures and activities from the definition of QIA:

(1) Those that are designed primarily to control or contain costs;

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to those that are for, or benefit, self-funded plans;

(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;

(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended, including the new ICD–10 requirements);

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

(7) All retrospective and concurrent utilization review;

(8) Fraud prevention activities;

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(10) Provider credentialing;

(11) Marketing expenses;

(12) Costs associated with calculating and administering individual enrollee or employee incentives;

(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

(14) Any function or activity not expressly included in paragraph (c) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this Part or otherwise support monitoring, measuring or reporting health care quality improvement.[3]

As payers and providers or other entities enter into more complex arrangements that provide for compensation that is not solely based on the fee-for-service model, but include bonuses for medical cost reduction or payment for administrative services, consideration should be given to whether those payments to providers or other entities are treatable as QIA, for MLR purposes.

CONSIDERATION OF VARIOUS PAYMENT OPTIONS FOR DETERMINING MLR

Pay-for-Performance Bonuses to Providers

Since activities designed primarily to control or contain costs are specifically defined by regulation as constituting administrative expense (not incurred claims or QIA), any bonus paid to a provider based primarily on cost-saving measures is not likely to qualify as medical expense. But a fee schedule that gets ''adjusted'' retroactively or prospectively after measuring provider per-

[1] 45 C.F.R. § 158.150(b)(1).
[2] 45 C.F.R. § 158.150(b)(2). Examples omitted.
[3] 45 C.F.R. § 158.150(c).

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formance could arguably be considered to fall within the definition of incurred claims.[4]

Therefore, a bonus paid to a hospital for reducing its average length of stay, or to a hospital and/or physician group for reducing total claim costs for patients assigned to such providers would typically not qualify as medical expense—even if the patients receive an alternative, less costly type of service.

However, there appear to be at least two circumstances where the payment of a performance bonus could justifiably be included in the MLR numerator: (1) where the payment is based on criteria that meet the definition of QIA (as described above), and (2) if a bonus meets the four-part test for ''clinical risk-bearing entities,'' described below.

Capitation Payments to Physicians and Non-Physician Clinical Providers

The regulations only mention capitation payments to physicians, but CMS has provided the following technical guidance with respect to capitation payments to non-physician clinical providers.

> Question #8: ''Is the entire amount paid to a clinical provider in a capitation arrangement considered an incurred claim?''
>
> Answer: ''Generally, yes. Where an issuer has arranged with a clinical provider for capitation payments rather than fee-for-service reimbursement for covered services to enrollees, and such capitation payments include reimbursement for certain provider administrative costs, then the entire per member per month capitation payment paid to the provider may be included in incurred claims, as provided in 45 CFR § 158.140(a). The term ''provider'' in this question and answer does not refer to or include third party vendors.''
>
> Question #9: ''Is the entire payment to a non-physician clinical provider in a capitation arrangement considered an incurred claim?''
>
> Answer: ''Generally, yes. Although 45 CFR § 158.140(a) refers to the fact that it includes capitation arrangements with *physicians*, the intent was to include capitation arrangements with non-physician providers that are licensed, accredited, or certified to perform clinical health services, consistent with State law, and who are engaged in the delivery of medical services to enrollees.''[5]

The answers to questions 8 and 9 are important for a number of reasons. First, the guidance recognizes that even though a component of the capitation payment does, in some cases, cover a portion of the provider's administrative expenses, the entire capitation amount will be treated as incurred claims.

Secondly, although the regulation specifies capitation payments to physicians, the intention is to recognize capitation payments to all providers appropriately licensed or otherwise authorized to provide clinical services.

Payments to Third Parties

a. ***Payments to Clinical Risk-Bearing Entities.*** CMS recently issued additional guidance for payments made to ''clinical risk-bearing entities.''[6] Question and Answers 20, 21 and 22 attempt to clarify treatment of such payments. Question 20 addresses whether payments to third parties, such as IPAs, Physician Hospital Organizations (PHOs), and Accountable Care Organizations (ACOs),[7] constitute incurred claims.

The guidance provides that payments to such entities will generally be treated as incurred claims, where each component of a four-pronged test is satisfied.

The four factors are:

1. The entity contracts with an issuer to deliver, provide or arrange for the delivery and provision of clinical services to the issuer's enrollees, but the entity is not the issuer with respect to those services;

2. The entity contractually bears financial and utilization risk for the delivery, provision or arrangement of specific clinical services to enrollees;

3. The entity delivers, provides or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as provider performance reviews, tracking clinical outcomes, communicating evidence-based guidelines to the entity's clinical providers and other, similar care delivery efforts; and

4. Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incident to the clinical services, and must be performed on behalf of the entity or the entity's providers.

> If the entity satisfies this four-part test, payments for clinical services for which the entity takes on the financial risk for utilization as provided in #2 above will be considered incurred claims. Conversely, when an entity takes on only pricing risk, Question and Answer 19[8] applies. Q&A #19 addresses payments to third-party vendors who pay others—not employees—to provide clinical services to enrollees and perform administrative functions. It provides that the entirety of the payment by an issuer to an entity that only takes on pricing risk (e.g., payments to pharmacy benefit managers (PBMs) for retail pharmacy claims) should not be reported as incurred claims.''

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[4] But see Q and A #22 (footnote 16 below) which states, in the context of payments for administrative services made to clinical risk-bearing entities: ''Payments for non-clinical services for which the contract between the IPA and the issuer contains a ''clawback'' provision are not considered incurred claims for MLR reporting purposes.''

[5] CCIIO Technical Guidance (CCIIO 2011-002), dated May 13, 2011, ''REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES (INCURRED CLAIMS) (45 CFR § 158.140)''). (http://cciio.cms.gov/resources/files/2011_05_13_mlr_q_and_a_guidance.pdf).

[6] CCIIO Technical Guidance (CCIIO 2012-001), dated February 10, 2012, ''REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES (INCURRED CLAIMS) (45 CFR 158.140): Payments to Clinical Risk-bearing Entities''). (http://cciio.cms.gov/resources/files/20120210_mlr_guidance.pdf).

[7] It does not appear that CCIIO has provided guidance on what it considers to be an ACO for purposes of Q and A #20.

[8] Q&A 19 is quoted in footnote 16 below.

The four-part test attempts to delineate the requirements through which payments to clinical risk-bearing entities qualify as incurred claims. The elements provide interesting asides; for example, it appears that the entity can be an insurer, but only where the entity ''is not the issuer with respect to those services.'' The term ''financial and utilization risk'' (in #2 above) is not defined in the guidance. This creates some confusion given that activities designed primarily to control or contain costs are specifically treated as administrative expense per the definition of QIA.

In addition, any functions that are not clinical services must be ''reasonably related or incident'' (a term not defined) to the medical services being provided in order to qualify as incurred claims. The guidance distinguishes this model from an arrangement where the entity takes on only pricing risk.[9] Question and Answer 19[10] addresses the pricing risk model, describing an arrangement whereby payments are made to third-party vendors who pay others who are not employees for the provision of clinical services to enrollees and who perform administrative functions. Under the Q and A #19 guidance, all of the payment by the issuer to an entity that assumes only pricing risk should not be reported as incurred claims. As an example, the guidance notes that payments to PBMs for retail pharmacy claims are not to be treated as incurred claims.

Q and A # 21[11] addresses the scenario where the payment to the clinical risk-bearing entity includes payment for administrative functions performed on behalf of the entity's providers. Under those circumstances, the payment will constitute incurred claims if the four factors above are established. However, per Q and A #22,[12] if the administrative functions are performed on behalf of the issuer, the portion of the payment attributable to such administrative functions is not includable as incurred claims.

b. ***Payments to Non-Clinical Entities.*** When a third-party entity is not a clinical entity, Question and Answer 12 (in the May 13, 2011, guidance) and Question and Answer 19 (in the July 18, 2011, guidance) apply. Q and A #12[13] addresses third-party vendors who provide clinical services to enrollees through employees. The guidance provides that the entire portion of the payment to the vendor for the provision of clinical services constitutes incurred claims, even if some of the payment is attributable to the vendor's administrative costs, as long as those costs are directly related to the provision of clinical services. It is important to note that contracted providers do not constitute employees, limiting the reach of this exception.

Q&A #19[14] addresses payments to third-party vendors who pay others (not employees) to provide clinical

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[9] The regulations do not define what constitutes ''pricing risk.'' The reference to Q&A #19 (see footnote 16 below) at the end of Q&A #20 seems to imply Q&A #19 applies to clinical entities that do not take on financial risk for utilization, but Q&A #19 applies to third party vendors who pay others to provide clinical services, which implies such vendor is not a clinical entity itself. Thus there appears to be no clear guidance on how payments to clinical entities that do not take on ''financial and utilization risk'' are treated for MLR purposes.

[10] See footnote 16 below.

[11] CCIIO Technical Guidance (CCIIO 2012-001), dated February 10, 2012, ''REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES (INCURRED CLAIMS) (45 CFR 158.140): Payments to Clinical Risk-bearing Entities''):

Question #21: ''Are payments by issuers to such clinical risk-bearing entities that include payment for administrative functions performed on behalf of the entity's providers incurred claims under 45 CFR 158.40?''

Answer: ''Yes, if all four factors set forth in Answer #20 are met. For example, a bundled payment to an IPA or similar entity for providing clinical services to enrollees which includes: the IPA processing claims payments to its member providers and submitting claims reports to issuers on behalf of its providers; performing provider credentialing to determine a provider's acceptability into the IPA network; and developing a network for its providers' benefit, would be included in incurred claims.''

[12] Ibid. Question #22: ''Are payments by issuers to clinical risk-bearing entities, such as Independent Practice Associations (IPAs), for administrative functions performed on behalf of the issuer, incurred claims under 45 CFR 158.140?''

Answer: ''To the extent that administrative functions are performed on behalf of the issuer, that portion of the issuer's payment that is attributable to the administrative functions may not be included in incurred claims (See Questions and Answers 11, 12 and 13 in the May 13, 2011 guidance . . . . This is the case regardless of whether payment is made according to a separate, fee-for-service payment schedule or as part of a global, capitated fee payment for all services provided. For example, payment for processing claims in order to issue explanations of benefits (EOBs) to enrollees and handling any stage of enrollee appeals would not be included in incurred claims. Payments for non-clinical services for which the contract between the IPA and the issuer contains a ''clawback'' provision are not considered incurred claims for MLR reporting purposes.''

[13] CCIIO Technical Guidance (CCIIO 2011-002), dated May 13, 2011, ''REIMBURSEMENT FOR CLINICAL SERVICES PROVIDED TO ENROLLEES (INCURRED CLAIMS) (45 CFR 158.140) *(emphasis added)*:

Question #12: ''When a third party vendor provides clinical services directly to enrollees, how does 45 CFR § 158.140(b)(3)(ii)—which excludes from incurred claims amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management—affect how an issuer reports payments to that third party vendor?''

Answer: ''Section 158.140 treats payments to providers as reimbursement for clinical services to enrollees (also referred to as incurred claims). Section 158.140(b)(3)(ii) recognizes that issuers often pay third party vendors to perform services such as network development, administrative fees, claims processing, and utilization management, that are considered non-claims administrative costs if performed by the issuer and thus should be considered non-claims administrative costs if performed by a third party vendor.

However, *when a third-party vendor, through its own employees, provides clinical services* directly to enrollees, the entire portion of the amount the issuer pays to the third party vendor that is attributable to the third party vendor's direct provision of clinical services should be considered incurred claims, even if such amount includes reimbursement for third party vendor administrative costs directly related to the vendor's direct provision of clinical services. The term ''through its own employees'' does not include a third party vendor's contracted network of providers because such network providers are not considered employees of the third party vendor

For example, an issuer may contract with a PBM to provide clinical services directly to enrollees through a mail order pharmacy. The amount the issuer pays to the PBM for mail order pharmacy services provided directly by the PBM's employees, including administrative costs related to the PBM's direct provision of such mail order pharmacy services, would be included in the issuer's incurred claims.''

[14] CCIIO Technical Guidance (CCIIO 2011-004), dated July 18, 2011, ''REIMBURSEMENT FOR CLINICAL SERVICES

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services to enrollees and perform administrative functions. It provides that the entirety of the payment by an issuer to an entity that only takes on pricing risk (e.g., payments to PBMs for retail pharmacy claims) should not be reported as incurred claims.[15]

PROVIDED TO ENROLLEES (INCURRED CLAIMS) (45 CFR 158.140):

Question #19: ''How should an issuer report amounts paid to third party vendors who pay others to provide clinical services to enrollees and who perform network development, administrative functions, claims processing, and utilization management?''

Answer: ''In general, an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees. Where the third party vendor is performing an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense as provided in 45 CFR § 158.140(b)(3)(ii).

Some third-party vendors provide reimbursement for clinical services to enrollees and provide administrative functions such as claims processing and network development. Payments by an issuer to a third party vendor to provide clinical services directly to enrollees through its own employees are considered to be incurred claims. However, the amounts paid by the issuer to a third party vendor for the functions that are not direct clinical services to enrollees through its own employees are governed by § 158.140(b)(3)(ii), and only the amounts the third party vendor pays to providers may be included in incurred claims. (Questions and Answers 8 and 9 address what is meant by the term ''providers''. . . .) The amounts attributable to network development, administrative fees, claims processing, and utilization management by the third party vendor and the third party vendor's profits on those activities must not be included by an issuer in its incurred claims.

For example, when a pharmacy benefit manager (PBM) pays a retail pharmacy one amount for prescription drugs covered by the plan and charges the issuer a higher amount (the retail spread), the issuer may only claim the amounts paid by the PBM to the retail pharmacy as incurred claims.

As stated in the May 13, 2011 guidance posted on the Internet . . . the third party vendor (in this example, the PBM) must report to the issuer only the aggregate amount it pays all providers (in this example, retail pharmacies) for clinical services to enrollees on behalf of the issuer, by market in each State. No claim by claim or provider by provider reporting is required.''

Bundled Payments to Providers

Bundled payments are payments made to a group of providers for an ''episode of care'' and are in place of separate fee-for-service payments to each such provider and thus would be considered incurred claims since they are ''direct claims paid to providers.''

Payments to Members

Some health plans have experimented with paying members to go to providers that charge less for particular services. Assuming such payments are made to members of health plans subject to the MLR rules, these payments are not incurred claims or QIA. It is unclear if such payments could constitute QIA if they were based on quality measures and not ''designed primarily to control or contain costs'' (the latter being a specific exclusion to the definition of QIA).

Conclusion

The guidance issued to date answers many questions as to how various alternative provider reimbursement models should be treated for purposes of MLR, but leaves a number of questions unanswered. Combined with the rapidly changing legal and business landscapes, counsel working on such arrangements should stay tuned for further insight and guidance from CMS as such models continue to evolve.

[15] Note that the scenario of a third party vendor taking on financial and utilization risk is not addressed by the guidance.