CMS Posts MLR Guidance: Payments to Entities such as IPAs, PHOs, and ACOs

By M. Daria Niewenhous and Gary Bacher on February 12th, 2012

CMS posted additional sub-regulatory guidance regarding the Medicare Loss Ratio (MLR) under Section 2718 of the Public Health Service Act, as added by the Affordable Care Act (ACA). The MLR requires health insurance issuers to submit a MLR report to the Secretary of Health and Human Services and issue a rebate to enrollees if the issuer's MLR is less than the applicable percentage threshold established in Section 2718.

This additional guidance provides an important clarification sitting at the intersection of the MLR, payment reform, and more collaborative approaches to payment and care coordination arrived at between private payers and providers.

The new guidance specifically addresses the question of whether "payments by issuers to clinical risk-bearing entities, such as Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), and Accountable Care Organizations (ACOs), are incurred claims under 45 CFR 158.140."

The answer under the guidance is "generally yes," provided that both the payment and risk-bearing entity meet four factors set out in the guidance. The four factors are as follows:

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.

The guidance provides several examples related to application of the four part test and emphasizes that prong #2 of the test requires financial risk for *utilization* as opposed to "pricing risk" alone.

The guidance provides an important clarification that is likely to be of interest to payers and providers alike.