JOSH GREEN, M.D.
GOVERNOR
KE KIA'ĀINA

RYAN I. YAMANE
DIRECTOR
KA LUNA HO'OKELE

JOSEPH CAMPOS II
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

TRISTA SPEER
DEPUTY DIRECTOR
KA HOPE LUNA HO'OKELE

STATE OF HAWAII
KA MOKU'ĀINA O HAWAI'I
DEPARTMENT OF HUMAN SERVICES
KA 'OIHANA MĀLAMA LAWELAWE KANAKA
Med-QUEST Division
Health Care Services Branch
P. O. Box 700190
Kapolei, Hawaii 96709-0190

August 27, 2025

MEMORANDUM

MEMO NO.
QI-2519
CCS-2505

TO: QUEST Integration (QI) Health Plans
Community Care Services (CCS) Health Plans

FROM: Judy Mohr Peterson, PhD JMP
Med-QUEST Division Administrator

SUBJECT: MEDICAL LOSS RATIO (MLR) REQUIREMENTS FOR HEALTH PLAN SUBCONTRACTORS

Purpose
The purpose of this document is to establish MQD's policies and procedures for implementing the Medical Loss Ratio (MLR) requirements outlined in Special Terms and Conditions (STC) 11.8 of Hawaii's Section 1115 Demonstration, approved on January 8, 2025. This guidance clarifies how MQD and its health plans for the QUEST Integration (QI) and Community Care Services (CCS) programs shall operationalize new MLR reporting and remittance requirements for certain risk-bearing subcontractor arrangements.

Background
Federal regulations require states to ensure that health plans calculate and submit an annual MLR in accordance with 42 CFR § 438.8:

- 42 CFR § 438.8(k) specifies required MLR reporting requirements and report elements, such as incurred claims, quality improvement expenses, non-claims costs, and the calculated MLR for the reporting year.

- 42 CFR § 438.8(j) allows states to establish a minimum MLR standard of no less than 85 percent and to require plans to remit payments if their MLR falls below that standard.
- The Centers for Medicare & Medicaid Services (CMS) has issued additional guidance, including the May 15, 2019 and June 5, 2020 CMCS Informational Bulletins (CIBs), which further clarifies MLR requirements.

In addition to these federal requirements, MQD's Section 1115 Demonstration approval introduces new subcontractor-level MLR requirements under STC 11.8. These provisions require MQD to ensure that certain subcontractors assuming financial risk for Medicaid services are held to the same MLR reporting and remittance standards as the "primary health plans" for QI and CCS. Specifically:

- Effective January 1, 2026, per STC 11.8(b), MQD will require its primary health plans health plans to apply MLR reporting requirements equivalent to those in 42 CFR § 438.8(k) to designated risk bearing subcontractors, as defined in this document.
- Effective January 1, 2027, per STC 11.8(c), MQD will require its primary health plans to enforce MLR remittance obligations equivalent to those in 42 CFR § 438.8(j) on those subcontractors if their calculated MLR falls below state-identified levels.

Risk Bearing Subcontractors
The following framework must be used by the primary health plan to identify risk bearing subcontractor arrangements that are subject to the MLR reporting and remittance requirements as outlined in STC 11.8. Specifically, applicable subcontractor arrangements are those that meet each the following requirements:

- **Assumes financial risk**, excluding risk within Medicaid value-based payment arrangements primarily intended to incentivize provider performance or support care transformation goals, as determined by MQD (e.g., AHEAD or similar initiatives), from a primary health plan or one of its subcontractors for services provided beyond their own entity (i.e., assumes financial risk for services not directly delivered by the entity to Members);
- **Receives payment** for services that relate directly or indirectly to the performance of the primary health plan's obligations under its contract with MQD;
- **Meets materiality threshold**, defined as at least $1,500,000 in annual payments; and
- **Meets experience threshold,** defined as having at least one full MLR reporting year (January 1 through December 31) of experience.

Subcontractor MLR Reporting
Beginning with service dates starting January 1, 2026, primary health plans must require all applicable subcontractors to calculate and report an MLR. The upstream entity must report the subcontractor's data as part of its own MLR calculation and report, with MQD ultimately

receiving only MLR reports from the primary health plans. MQD will not accept submissions of MLR reports directly from subcontractors.

Reporting requirements, methodologies, and other reporting specifications for subcontractors are equivalent to those outlined in 42 CFR § 438.8(k), applicable CMS guidance,[2] and MQD policies and procedures, as outlined in the QI Health Plan and CCS contracts and the Health Plan Manual.

Primary health plans are expected to review and provide oversight of subcontractor MLR report submissions to ensure that MLR reports submitted by subcontractors are consistent with federal and state requirements. Primary health plans must attest to performing this review as part of its own MLR submission. Specific oversight expectations include, but are not limited to:

- Reviewing each subcontractor's reported data to identify and investigate outliers.
- Verifying that medical and non-medical expenses are accurately classified in the MLR calculation.
- Confirming that reported service volumes in MLR reporting align with encounter data.
- Verifying that reported revenues align with the payments reported by the upstream entity.
- For subcontractor agreements covering multiple lines of business, reviewing expenditure allocation methodologies for reasonableness.
- Assessing Incurred But Not Reported (IBNR) estimates for reasonableness.

Subcontractor MLR Remittance

Beginning with service dates starting January 1, 2027, for the CY 2027 MLR reporting year, primary health plans must impose remittance requirements on applicable subcontractors that fail to meet the established minimum MLR standard for the respective MLR reporting year. The upstream entity must account for this remittance in its own MLR report as a reduction to expenditures, with MQD ultimately receiving only remittance from the primary health plans. MQD will not accept remittance directly from subcontractors.

Remittance requirements for subcontractors are equivalent to those outlined in 42 CFR § 438.8(j) and MQD policies and procedures, as outlined in the QI Health Plan and CCS contracts and the Health Plan Manual.

Primary health plans are expected to facilitate and provide oversight of MLR remittance collection from applicable subcontractors to ensure compliance with federal and state requirements.

If you have any questions, please contact: HCSBInquiries@dhs.hawaii.gov