Instructions for Minimum Loss Ratio (MLR) Report

Updated December 2019

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Introduction

These instructions are for the Excel-based MLR Reporting. The Excel workbook is designed to collect the information needed for the calculation and reporting of MLRs as required by the MO HealthNet Managed Care Program Contract between the Health Plan and the MO HealthNet Division (MHD). The MLR will be taken into account while setting actuarially sound capitation rates.

This report is to be completed by each Health Plan and submitted to the MHD within 10 months following the end of the MLR reporting year. For example, for the State Fiscal Year (SFY) 2019 Contract Period, the MLR reporting year is July 1, 2018 - June 30, 2019, and the report is due to MHD on or before April 30, 2020. MHD requests that paid claims runout through at least the end of February 2020 be utilized when completing the report.

The MLR report that is submitted to MHD will include the following information for each MLR reporting year:

1. Total incurred claims.
2. Expenditures on quality improving activities.
3. Non-claims costs.
4. Premium revenue.
5. Taxes, licensing and regulatory fees.
6. Methodology(ies) for allocation of expenditures.
7. Any credibility adjustment applied.
8. The calculated MLR.
9. Any remittance owed to the State.
10. A comparison of the information related to the MLR calculation components with the audited financial report.
11. A description of the aggregation method.
12. The number of member months.

Health Plans must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to that Health Plan within 180 days of the end of the MLR reporting year or within 30 days of being requested by the Health Plan, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

1. Plan Information

Please fill out the contact information of your Health Plan. The contact person should be someone familiar with the information contained in the MLR template and be the main point person who can respond to questions or coordinate responses to the completion of the MLR template.

2. Numerator

This worksheet collects information for items that are included or deducted from the numerator. Note that incurred claims by one Health Plan that are later assumed by another entity must be reported by the assuming Health Plan for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding Health Plan.

Please fill in the cells that are formatted with blue font.

Detail for each line of the numerator is provided below.

Line 1.1 Incurred claims, including unpaid claim liabilities for the MLR reporting year. Note that this amount should be net of all fraud recoveries, including what is reported in or out of the claims system. This amount should also include costs associated with other contractual arrangements such as Full Medicaid Pricing (FMP) and Medicaid Access to Physician Services (MAPS). Incurred claims include direct claims and unpaid claims liabilities as described below.

(a) Direct claims that the Health Plan paid to providers (including under capitated contracts with network providers) for services or supplies covered under the contract and other services the Health Plan may provide to members that qualify as direct claims as follows:

(1) A Health Plan may cover, for members, services that are in addition to those covered under the State plan as follows:

(i) Any services that the Health Plan voluntarily agrees to provide and are approved by the MHD.

(ii) Any services necessary for compliance by the Health Plan to the extent such services are necessary for the Health Plan to comply with the mental health parity rules for financial requirements and treatment limitations.

(2) A Health Plan may cover, for members, services or settings that are in lieu of services or settings covered under the State plan as follows:

(i) The State determines that the alternative service or setting is a medically appropriate and cost effective substitute for the covered service or setting under the State plan;

(ii) The member is not required by the Health Plan to use the alternative service or setting;

(iii) The approved in lieu of services are authorized and identified in the MO HealthNet Managed Care Program Contract between the Health Plan and the MHD, and will be offered to members at the option of the Health Plan; and

(iv) The utilization and actual cost of in lieu of services is taken into account in developing the component of the capitation rates that represents the covered State plan services, unless a statute or regulation explicitly requires otherwise.

(b) Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported and represents estimated paid liabilities.

Note: As clarified by CMS in the May 15, 2019 bulletin, health plans should also report amounts for all subcontractors that administer claims as incurred claims. This includes expenditures for activities that improve health care quality. Subcontractors should also be submitting information about mandatory deductions or exclusions from incurred claims (overpayment recoveries, rebates, other non-claims costs, etc.) to the managed care plan. The reporting must be in sufficient detail to allow a managed care plan to accurately incorporate the expenditures associated with the subcontractor's activities into the amount reported in line 1.1.
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https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf

Line 1.2 IBNR for claims incurred in the period expected to be paid in months after the known runout.

Incurred but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity.

Line 1.3 Withholds from payments made to network providers.

Line 1.4 Amount of incentive and bonus payments made, or expected to be made, to network providers. This includes retroactive one-time provider fee increases.

Line 1.5 Changes in other claims-related reserves.

Line 1.6 Reserves for contingent benefits and the medical claim portion of lawsuits.

Line 1.7 Net payment or receipts related to state-mandated solvency funds.

Amounts that must either be included in or deducted from incurred claims include, respectively, net payments or receipts related to State mandated solvency funds.

Line 1.8a Amount spent on fraud reduction.

Line 1.8b Amount of claims payments recovered through fraud reduction.

Note that Line 1.1 should be net of all fraud recoveries, including what is reported in and out of the claims system. That same recoveries amount is then reported here as a positive amount. This amount is limited to the lesser of the total fraud reduction expenses reported in Line 1.8a or the actual fraud recoveries collected

on paid claims reported on Line 1.8b. If either Line 1.8a or Line 1.8b is equal to zero (0) then the allowable amount is equal to zero (0).

Line 1.9 Claims that are recoverable for anticipated coordination of benefits.

Line 1.10 Claims payments recoveries received as a result of subrogation.

Line 1.11 Overpayment recoveries received from network providers.
MHD expects this to include any anticipated settlements for claims incurred during the MLR reporting year, including those outside of the claims system.

Line 1.12 Prescription drug rebates received and accrued.

Line 2.1 A Health Plan activity that improves health care quality.
Includes all care management, care coordination, and disease management fees or expenses paid to entities for improving health care quality. This would include providing these services through an approved LCCCP plan.

(a) Activities conducted by a Health Plan and approved by the MHD to improve quality must meet the following requirements:
  (1) The activity must be designed to:
    (i) Improve health quality.
    (ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
    (iii) Be directed toward individual members or incurred for the benefit of specified segments of members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members.
    (iv) 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.
  (2) The activity must be primarily designed to:
    (i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.
      (A) Examples include the direct interaction of the Health Plan (including those services delegated by contract for which the Health Plan retains ultimate responsibility under the insurance policy), providers and the member or the member's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:
        (1) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including

through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.
(2) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
(3) Quality reporting and documentation of care in non-electronic format.
(4) Health information technology to support these activities.
(5) Accreditation fees directly related to quality of care activities.

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:
(A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital.
(B) Patient-centered education and counseling.
(C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.
(D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.
(E) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.
(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:
(1) The appropriate identification and use of best clinical practices to avoid harm.
(2) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.
(3) Activities to lower the risk of facility-acquired infections.
(4) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.
(5) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.
(B) Health information technology to support these activities.

(iv) Implement, promote, and increase wellness and health activities.
(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include -
(1) Wellness assessments;
(2) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;
(3) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;
(4) Public health education campaigns that are performed in conjunction with State or local health departments;

(5) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the Public Health Service Act;
(6) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;
(7) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and
(8) Health information technology to support these activities.

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology.

(b) Exclusions. Expenditures and activities that must not be included in quality improving activities are:

(1) Those that are designed primarily to control or contain costs, such as utilization management activities;
(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, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.
(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 and education;
(11) Marketing expenses and outreach programs;
(12) Cost associated with calculating and administering individual member 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 (a) or (b) of this section, unless otherwise approved by and within the discretion of the Secretary of the Department of Health and Human Services.

Line 2.2 A Health Plan activity related to any mandatory or optional EQR-related activity as specified in the Agreement.

(a) Mandatory activities.
- (1) Validation of performance improvement projects that were underway during the preceding 12 months.
- (2) Validation of Health Plan performance measures or Health Plan performance measures calculated by the State during the preceding 12 months.
- (3) A review, conducted within the previous 3-year period, to determine the Health Plan compliance with the quality assessment and performance improvement requirements.

(b) Optional activities.
- (1) Validation through a medical record review process of encounter data reported by a Health Plan.
- (2) Administration or validation of consumer or provider surveys of quality of care.
- (3) Calculation of performance measures in addition to those reported by a Health Plan.
- (4) Conduct of performance improvement projects in addition to those conducted by a Health Pan and validated by an EQRO in accordance with (a)(1) of this section.
- (5) Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.

Line 2.3 Health Plan expenditure that is related to Health Information Technology and meaningful use requirements.

Any Health Plan expenditure that is related to Health Information Technology and meaningful use requirements and is not considered incurred claims.

A Health Plan may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities that improve health care quality and that are designed for use by health plans, health care providers, or members for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

- (a) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their “meaningful use” as defined by HHS to the extent such payments are not included in reimbursement for clinical services provided to members.
- (b) Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments.

(c) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies.
(d) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.
(e) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.
(f) Advancing the ability of members, providers, health plans or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by members and appropriate providers to monitor and document an individual patient's medical history and to support care management.
(g) Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.
(h) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

3. Excluded Amounts

This worksheet collects information for items excluded from the numerator, but that are required to be reported. Note that incurred claims by one Health Plan that are later assumed by another entity must be reported by the assuming Health Plan for the entire MLR reporting year, and no incurred claims for the MLR reporting year may be reported by the ceding Health Plan.

Please fill in the cells that are formatted with blue font.
Line 3.1 Amounts paid to third party vendors for secondary network savings.

Line 3.2 Amounts paid to third party vendors for network development, admin fees, claims, processing, and utilization management.

As clarified in the CMS Bulletin issued May 15, 2019, when third party vendors are performing an administrative function not attributable to its direct provision of Medicaid covered services, such as eligibility and coverage verification, claims processing, utilization review, or network development, payment by the managed care plan to the subcontractor for such functions should be reported in this line as a non-claims administrative expense.
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Line 3.3 Amounts paid to a provider for professional or administrative services outside of providing services to members.

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 other services that may be provided by a Health Plan (see these instructions for Line 1.1).

Line 3.4 Fines and penalties assessed by regulatory authorities.

Line 3.5 Amounts paid to the MHD as remittance for prior MLR experience.

Line 3.6 Amounts for pass-through payments.

Note that FMP and MAPS do not meet the definition of a pass-through payment. MHD will notify Health Plans if pass-through payments exist under the contract.

4. Denominator

This worksheet collects information for the denominator. Note that the total amount of the denominator for a Health Plan, which is later assumed by another entity, must be reported by the assuming Health Plan for the entire MLR reporting year, and no amount for that year may be reported by the ceding Health Plan.

Please fill in the cells that are formatted with blue font.

Line 4.1 State capitation payments, including revenue for other contractual payment arrangements such as FMP and MAPS. This line should exclude Federally-approved pass-through payments. See instructions for Line 3.6 for a description of pass-through payments. Additionally, this line should exclude earned premium withhold payments, which should be separately reported in line 4.3.

Line 4.2 State developed one time payments for specific life events of members. Examples would include the delivery and neonatal intensive-care unit (NICU) kick payments.

Line 4.3 Earned premium withholds.

Other payments to the Health Plan under a withhold arrangement with the State. Amounts earned under the Performance Withhold Program described in the Agreement would also be reported on this line.

Line 4.4 Unpaid cost-sharing amount that the Health Plan could have collected from members under the contract, except those amounts the Health Plan can show it made a reasonable, but unsuccessful, effort to collect.

Line 4.5 All changes to unearned premium reserves.

Line 4.6 Net payments/receipts related to risk sharing mechanisms: The risk-sharing mechanisms are risk adjustment, risk corridors, reinsurance, and stop loss limits.

Line 5.1 Statutory assessments to defray the operating expense of any state or federal department.

Line 5.2 Examination fees in lieu of premium taxes as specified by state law.

Line 5.3 Federal taxes and assessments allocated to Health Plans, excluding Federal income taxes on investment income and capital gains and Federal employment taxes. Includes Health Insurer Provider Fee (HIPF).

Line 5.4 State and local taxes and assessments.

State and local taxes and assessments including:

(a) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State or locality directly.
(b) Guaranty fund assessments.
(c) Assessments of State or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
(d) State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments.
(e) State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes.

Line 5.5 Amounts otherwise exempt from Federal income taxes for community benefit expenditures.

Payments made by a Health Plan that are otherwise exempt from Federal income taxes, for community benefit expenditures, limited to the highest of either:

(a) Three percent of earned premium; or
(b) The highest premium tax rate in the State for which the report is being submitted, multiplied by the Health Plan's earned premium in the State.

Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:

(a) Are available broadly to the public and serve low-income consumers;
(b) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);
(c) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;
(d) Leverage or enhance public health department activities such as childhood immunization efforts; and
(e) Otherwise would become the responsibility of government or another tax-exempt organization.

5. MLR Calculation

Using the amounts reported on the prior worksheets, this tab summarizes subtotals and calculates the unadjusted MLR, as well as the credibility-adjusted MLR.

The MLR credibility adjustment accounts for variation in Health Plans by categorizing them into three groups: fully-credible, partially-credible, and non-credible based on the minimum number of member months. CMS issues the MLR credibility adjustments annually, and the worksheet applies the appropriate credibility adjustment based on member months in the MLR reporting year. Once the Health Plan reports “Member Months” in the blue-shaded cell, the credibility adjustment will automatically calculate.

6. Expense Allocation

Certain expenses may not be attributable to one line of business. Describe methods used to allocate these expenses and how they factor into the MLR calculated for this report. A description can be included in the workbook or a reference can be made to an attached document.

Allocation of expense.

(a) General requirements.

(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.

(b) Methods used to allocate expenses.

(i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract incurring the expense.

(iii) Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities.

7. Remittance Calculation

If the credibility-adjusted MLR is below the minimum MLR threshold of 85.00%, then a remittance to the MHD is required. Include the calculation of the remittance here, or reference an attached document that shows and describes the calculation.

8. Financial Comparison

A comparison of the financial amounts included in this report and what is reported in audited financials is required. We understand there is a difference between the MLR reporting period (SFY) and your Audited Financial Statement (AFS) reporting period (CY basis). As an alternative and to avoid having to reconcile the MLR report against portions of separate CY AFS reports (one of which is not due until June 1st), MHD is comfortable with receiving a comparison of the values reported in the MLR report against your November 2019 HPFRF submissions. The comparison should be shown in this worksheet or referenced via an attached document with the comparison.

9. Aggregation Method

The MHD requires that the Health Plan's MLR and MLR report are to be calculated as one aggregate value representing all MO HealthNet Medicaid/Title XIX rate cells/populations and rating regions that are covered under the MO HealthNet managed care program including both Title XIX (MA) and Title XXI (CHIP). The MHD reserves the right to modify this requirement and obtain MLR information on a rate cell and/or region-specific basis

A description can be included in the workbook or a reference can be made to an attached document to explain the aggregation method.

10. MLR Report Summary

This worksheet summarizes the information requested by the Agreement and meets the reporting requirements specified on page 1 of these instructions.

11. Attestation

An attestation to the accuracy of this MLR report is required. Please include a digital signature or scanned PDF as part of the submitted MLR report.

> The attestation may be provided by the Health Plan's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification. The certification must attest that, based on best information, knowledge, and belief, the data, documentation, and information in the MLR report is accurate, complete and truthful.

The MHD reserves the right to obtain additional MLR information and/or submit questions to the Health Plan regarding information contained in the MLR template. Please contact the MHD if there are any questions about the requirements for this MLR report.