

CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

MEDICAL LOSS RATIO (MLR) REPORT

**FOR MEDICARE ADVANTAGE ORGANIZATIONS AND PRESCRIPTION DRUG
PLAN SPONSORS FOR THE CONTRACT YEAR (CY) 2014 MLR REPORTING YEAR**

FILING INSTRUCTIONS

As of April 8, 2015

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GENERAL INSTRUCTIONS

Introduction

Medicare Advantage (MA) organizations and Prescription Drug Plan (PDP) sponsors must submit an MLR Report to the Centers for Medicare & Medicaid Services (CMS) for each contract offered during the Contract Year (CY) under the Medicare Advantage Program and the Medicare Prescription Drug Benefit Program (Part D).

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in an MLR Report generated by the CMS MLR Reporting Tool.

All contracts that received Medicare revenue during the contract year must submit an MLR report, with the following qualifications/clarifications:

- PACE: The MLR Report is not to be completed for Programs of All-Inclusive Care for the Elderly (PACE) plans.
- Cost/HCPPs: The MLR Report must be completed for the Part D portion of the benefits offered under their contract with CMS for Section 1876 Cost plans, Section 1833 Cost plans, and employers/unions offering Cost plans or Health Care Prepayment Plans (HCPPs).
- EGWPs: EGWPs are to report costs and revenue only on the Medicare-funded portion of each contract.
- Dual-SNPs: Complete the MLR Report. Note that Medicaid costs and revenue are not included in the MLR calculation.
- State demonstrations to integrate care for dually eligible Medicare and Medicaid beneficiaries (i.e., Medicare-Medicaid Plans (MMPs)): While MMPs do not complete this particular MLR Report, they may be required to complete a separate MLR report (that is specific to MMPs) based on the requirements defined during the demonstration development process.

The data included in the MLR Reporting Tool will be used to calculate the Medicare medical loss ratio (MLR) and remittance amount, if any.

These filing instructions apply to the CY 2014 MLR reporting year.

An attestation must be submitted in HPMS for each MLR Report.

The submitted MLR Reports will be subject to review and audit by CMS or by any person or organization that CMS designates. As part of the review and audit process, CMS or its representative may request additional documentation supporting the information contained in MLR Reports. Organizations must be prepared to provide this information in a timely manner.

MLR reporting for a contract year will occur in December following the contract year. However, for contracts that fail to meet the MLR threshold for 2 consecutive years, MLR reporting for the following year will be required prior to December. CMS will specify a month that will allow

time to implement (1) an enrollment sanction for any contract that fails to meet the MLR threshold for 3 or more consecutive years, or (2) contract termination for any contract that fails to meet the MLR threshold for 5 consecutive years.

Additional Resources

In addition to these instructions, the following resources provide additional information regarding CY 2014 MLR reporting:

- Questions regarding this MLR reporting may be addressed to:
MLRreport@cms.hhs.gov
- The Medicare MLR implementing regulation may be found at <http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf>
- Commercial MLR regulations, guidance, reporting instructions, and other resources may be found at <http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html>
- The Advance Notice, Rate Announcement, and Call Letter may be found at <http://cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html>
- For technical questions about the MLR Reporting Tool, HPMS, or the upload process, refer to the following resources:
HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov

Reporting Considerations

Accounting Principles

MA organizations and Part D sponsors should use Statutory Accounting Principles to explain how revenue is used to pay for non-claims expenditures. Non-claims and quality improving expenses should be allocated by contract. If an expense is attributable to a specific activity, MA organizations and Part D sponsors should allocate the expense to that particular activity. However, if this is not feasible, then the MA organization or Part D sponsor must apportion the costs using a generally accepted accounting method that yields the most accurate results.

Allocation of Expenses

Expenses must be allocated in accordance with the provisions in 42 CFR §§ 422.2420(d) and 423.2420(d):

Capitated Arrangements

As stated at § 422.2420(b)(2), incurred claims include direct claims paid to providers, including under capitation contracts. Where an MA organization or Part D sponsor has arranged with a clinical provider¹ 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, the entire per member per month capitation payment paid to the provider may be included in incurred claims. The full capitation amount paid to a provider for covered services described at § 422.2420(a)(2) or § 423.2420(a)(2) could be reported as a benefit expense, unless, the provider contract specifies a distinct fee for administrative services. If the capitated payment includes payment for activities that improve health care quality, as defined in §§ 422.2430 and 423.2430, the MA organization must ensure that costs for these activities are only counted once in the numerator.

Third Party Vendors

Payments by MA organizations or Part D sponsors to third party vendors as reimbursement for providing clinical services or supplies directly to plan enrollees are incurred claims. Payments to third party vendors to perform services such as network development, administrative fees, claims processing, and utilization management, are non-claims administrative costs and are excluded from incurred costs.

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

¹ Includes capitation arrangements with both physician and 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.

considered incurred claims, even if such amount includes reimbursement for administrative costs directly related to the vendor's direct provision of clinical services. The phrase "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, a Part D sponsor may contract with a pharmacy benefit manager (PBM) to provide clinical services directly to enrollees through a mail order pharmacy. The sponsor's payments 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, are included in the sponsor's incurred claims.

In circumstances where a third party vendor pays a non-employee provider or supplier to provide covered clinical services or medical supplies to plan enrollees, the MA organization or Part D sponsor may only include as reimbursement for clinical services (i.e., 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 and must not be included by the MA organization or Part D sponsor 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 sponsor a higher amount (the retail spread), the sponsor may only claim the amounts paid by the PBM to the retail pharmacy as incurred claims. The third party vendor (in this example, the PBM) must report to the sponsor only the aggregate amount it pays all providers (in this example, retail pharmacies) for clinical services or medical supplies to enrollees on behalf of the issuer, by market in each State. No claim-by-claim or provider-by-provider reporting is required.

An MA organization or Part D sponsor may count a third party vendor's expenses as activities that improve health care quality to the extent that the issuer and vendor can show that these expenses were incurred for performing allowable quality improving activities on behalf of the issuer.

- For example, to the extent that a PBM performs functions that are designed primarily to identify quality concerns, such as potential adverse drug interactions, those costs may be reported, in aggregate, as expenditures for activities that improve health care quality.

Payments by MA organizations and Part D sponsors to clinical risk-bearing entities, such as Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), and Accountable Care Organizations (ACOs) are treated as incurred claims if the following four factors are met:

- (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 bears the financial risk for utilization as provided in prong two above will be considered incurred claims. By contrast, payments to third party vendors that only take on pricing risk (e.g., payments to pharmacy benefit managers (PBMs) for retail pharmacy claims) should not be reported as incurred claims.

Payments to risk-bearing entities that include payments for administrative functions performed on behalf of the entity's member providers are incurred claims if all four factors outlined above 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.

To the extent that administrative functions are performed on behalf of the MA organization or Part D sponsor, however, that portion of the issuer's payment that is attributable to administrative functions may not be included in incurred claims. 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.

Commercial MLR

CMS modelled Medicare MLR policy after the commercial MLR rules, and only departed from the commercial MLR rules to the extent necessary and appropriate given the Medicare context.

Commercial Reinsurance

MA organizations and Part D sponsors may not adjust the MLR for commercial reinsurance. Commercial reinsurance premiums and recoveries are excluded from the MLR calculation. Both costs and revenues must be reported on a direct basis (i.e., before ceded reinsurance) as required under §§ 422.2420(b)(2)(i) and 423.2420(b)(2)(i), and §§ 422.2420(c)(1) and 423.2420(c)(1).

The only instance in which the premiums (revenue) and claims associated with a 100 percent indemnity reinsurance treaty are reported by the assuming entity, instead of by the ceding entity, is when the reinsurance treaty was in force prior to the date of enactment of the Affordable Care Act (i.e., March 23, 2010).

EGWPs

CMS expects EGWPs to report costs and revenue per §§ 422.2420 and 423.2420 on the Medicare-funded portion of each contract. Although CMS does not currently collect information on EGWP benefit packages, we have the authority to request this information if needed.

To determine the Medicare-funded portion of the contract, organizations may either:

- Use actual cost information to separate the employer-funded versus Medicare-funded portions of the EGWPs under the contract, or
- Allocate the Medicare-funded portion of the EGWP costs under the contract based on the Medicare portion of revenue for the contract (i.e., report Medicare-funded costs as the total costs multiplied by the ratio of Medicare revenue (as reported in Worksheet 1 Line 1) to total revenue).

For non-CY EGWPs, we expect that MLR calculations and remittances would occur on a calendar year basis, similar to how payments and most submissions to CMS are on a calendar year basis.

Low Income Premium and Cost Sharing Subsidies (LIPS and LICS) and Coverage Gap Discount Program (CGDP)

CMS makes LIPS payments to MA organizations and Part D sponsors so that they can be made whole for the reduced premiums paid by eligible low income plan beneficiaries. LIPS payments are revenue to the plan and are taken into account in the denominator of the MLR. Because CMS views LICS and coverage gap discount payments as pass-through payments, they are not part of the numerator calculation for the MLR.

MA Optional Supplemental Benefits

The MA MLR includes all of the MA benefits defined at § 422.100(c): basic benefits, mandatory supplemental benefits, and optional supplemental benefits. All Medicare costs and revenues under an MA contract should be included in the MLR, and the optional supplemental benefit package is defined by law as a type of Medicare benefit under the MA program.

Medication Therapy Management (MTM)

MTM programs may be included in the MLR calculation, provided they satisfy the requirements for quality improving activities as set forth in §§ 422.2430 and 423.2430.

Sequestration

Generally speaking, MLR reporting is based on actual incurred costs and actual revenues, which would reflect sequestration reductions. For example, if reduced amounts are paid to providers due to sequestration, the reporting of incurred costs would reflect the reduction. The reporting of revenue received from CMS would reflect any sequestration reductions.

Territories

CMS is authorized under §§ 422.2420(a) and 423.2420(a) to make adjustments to the MLR produced by the standard formula to address exceptional circumstances for areas outside the 50 states and the District of Columbia. At this time, CMS does not believe it has sufficient information to determine whether and how to make such an adjustment. Therefore, CMS will collect CY 2014 MLR Reports in December 2015, and subsequently determine if an adjustment to the CY 2014 MLR calculation is warranted for contracts serving territories. CMS will analyze the data collected in Worksheet 1 (including Section 2 Line 8) to help inform this determination. If CMS decides that an adjustment is warranted, it will announce the methodology to affected contracts.

Reporting Requirements

For each contract year, each MA organization or Part D sponsor must submit a report to CMS, in a timeframe and manner specified by CMS, which includes but is not limited to the data needed by the MA organization or Part D sponsor to calculate and verify the MLR and remittance amount, if any, for each contract, such as incurred claims, total revenue (net of reconciliations), expenditures on quality improving activities, non-claims costs, taxes, licensing and regulatory fees, and any remittance owed to CMS under §§ 422.2410 or 423.2410. See §§ 422.2460 and 423.2460.

MLR Review and Non-Compliance

CMS conducts selected reviews of submitted MLR reports to validate amounts included in both the numerator and denominator of the MLR calculation reported to CMS and to determine that

that the MLRs and remittance amounts and sanctions are accurately calculated, reported, and applied. See §§ 422.2480 and 423.2480.

MA organizations and Part D sponsors are required to maintain evidence of amounts reported to CMS and to validate all data necessary to calculate MLRs in accordance with the requirements in §§ 422.2460 and 423.2460.

Documents and records must be maintained for 10 years from the date such calculations were reported to CMS with respect to a given MLR reporting year (for MA organizations, per § 422.2480) or contract year (for Part D sponsors, per § 423.2480).

MA organizations and Part D sponsors must require any third party vendor supplying drug or medical cost contracting and claim adjudication services to the MA organization or Part D sponsor to provide all underlying data associated with MLR reporting to that MA organization or Part D sponsor in a timely manner, when requested by the MA organization or Part D sponsor, regardless of current contractual limitations, in order to validate the accuracy of MLR reporting. See §§ 422.2480(c)(2) and 423.2480(c)(2).

Reports submitted under § 422.2460 or § 423.2460, calculations, or any other required MLR submissions found to be materially incorrect or fraudulent—

- (1) Are noted by CMS;
- (2) Appropriate remittance amounts are recouped by CMS; and
- (3) Sanctions may be imposed by CMS as provided in §§ 422.752 and 423.752.

Penalties and Sanctions

Beginning in 2014, an MA organization or Part D sponsor is required to report an MLR for each contract for each contract year.

If CMS determines for a contract year that an MA organization or Part D sponsor has an MLR for a contract that is less than 0.85, the MA organization or Part D sponsor has not met the MLR requirement and must remit to CMS an amount equal to the product of the following:

- (1) The total revenue of the MA or Part D contract for the contract year, per § 422.2420(c) and § 423.2420(c).
- (2) The difference between 0.85 and the MLR for the contract year.

If CMS determines that an MA organization or Part D sponsor has an MLR for a contract that is less than 0.85 for 3 or more consecutive contract years, CMS does not permit the enrollment of new enrollees under the contract for coverage during the second succeeding contract year.

If CMS determines that an MA organization or Part D sponsor has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS terminates the contract per § 422.510(b)(1) and (d) or § 423.509(b)(1) and (d) effective as of the second succeeding contract year.

WORKSHEET 1

The purpose of Worksheet 1 is to capture contract-specific experience for the reporting period.

Section 1 – General Information

Line 1 – Contract Year

This field is pre-populated with the year to which the contract applies.

Line 2 – Contract Number

Enter the contract number, which begins with a capital letter H, R, S or E and includes four Arabic numerals (e.g., H9999). Be sure to include all leading zeroes (e.g., H0001).

Line 3 – Organization Name

Enter the organization's legal entity name. This information also appears in HPMS.

Line 4 – Date MLR Report finalized

This field is populated with the date when the MLR Report is finalized. See the Technical Instructions section for more information.

Line 5 – Contact Information

Plan sponsors must identify two contacts that will be readily available and authorized to discuss the information submitted in the MLR Report.

In this section, enter the name, position, phone number, and e-mail information for both contacts. Do not leave any part of this section blank.

Section 2 – Data Collection

Enter total dollars; PMPMs are automatically calculated.

Line 1 – Revenue

Enter the contract's revenue amounts for the reporting period by the various categories.

In accordance with §§ 422.2420(c)(3) and 423.2420(c)(3), the following amounts must not be included in total revenue:

- The amount of unpaid premiums for which the MA organization or Part D sponsor can demonstrate to CMS that it made a reasonable effort to collect.
- The following EHR payments and adjustments:

- EHR incentive payments for meaningful use of certified electronic health records by qualifying MAOs, MA Eps, and MA-affiliated eligible hospitals that are administered under 42 CFR part 495 subpart C.
- EHR payment adjustments for a failure to meet meaningful use requirements that are administered under 42 CFR part 495 subpart C.
- Coverage Gap Discount Program payments under § 423.2320.

Total revenue (as defined at §§ 422.2420(c) and 423.2420(c)) for policies issued by an MA organization or Part D sponsor and later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year during which the policies were assumed and no revenue under this part for that contract year must be reported by the ceding MA organization or Part D sponsor. See §§ 422.2420(c)(4) and 423.2420(c)(4).

Total revenue (as defined at §§ 422.2420(c) and 423.2420(c)) that is reinsured for a block of business that was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 % of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer. See §§ 422.2420(c)(5) and 423.2420(c)(5).

CMS provides organizations and sponsors with revenue information via several reports. Below is a mapping of CMS reports to the revenue categories of the MLR Report. The following two CMS reports are used in this mapping:

- MMDDF = Monthly Membership Detail Data File (through September 2015)
- PRS CTR = Payment Reconciliation System (PRS) Reconciliation Results Report to Plans, Contract Trailer "CTR" version

MLR Report	Brief Description	CMS revenue report
Line 1.1	Beneficiary Premiums	N/A
Line 1.2	MA payment including 3 rebates	MMDDF item 66
Line 1.3	Part B Rebate	MMDDF items 60+61
Line 1.4	Part D Basic Rebate	MMDDF item 72
Line 1.5	MSA Enrollee Deposit	N/A
Line 1.6	Part D direct subsidy	MMDDF item 74
Line 1.7	Part D federal reinsurance	PRS CTR field 20
Line 1.8	LIPSA	MMDDF item 35
Line 1.9	Part D risk corridor payments	PRS CTR field 33

More information about the CMS revenue reports may be found at:

- http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html

- <http://www.csssoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Prescription%20Drug%20Event~Report%20Layouts?open&expand=1&navmenu=Prescription^Drug^Event>

Line 1.1 – Beneficiary Premium

Beneficiary premiums include all premiums by or on behalf of enrollees, all unpaid premium amounts that an organization could have collected from enrollees minus any premium amounts that remain unpaid after reasonable collection efforts, and all changes in unearned premium reserves.

Beneficiary premiums are net of MA rebates (i.e., after application of MA rebates to reduce premium).

Line 1.1a – MA (Basic + Mandatory Supplemental + Optional Supplemental)

MA portion of Line 1.1.

Line 1.1b – Part D (Basic + Supplemental)

Part D portion of Line 1.1

Line 1.2 – MA plan payments (based on A/B bid), using final risk scores including MA Rebate for Cost Sharing Reduction, MA Rebate for Other Mandatory Supplemental Benefits, and MA Rebate for Part D Supplemental Benefits

See the mapping to CMS revenue reports provided above.

Line 1.3 – MA Rebate for Part B Premium Reduction

See the mapping to CMS revenue reports provided above.

Line 1.4 – MA Rebate for Part D Basic Premium Reduction

See the mapping to CMS revenue reports provided above.

Line 1.5 – MSA Enrollee Deposit

Applies to MSA plans only

Line 1.6 – Part D direct subsidy, using final risk scores

See the mapping to CMS revenue reports provided above.

Line 1.7 – Part D federal reinsurance subsidy (prospective and reconciliation adjustments)

See the mapping to CMS revenue reports provided above.

Line 1.8 – Part D Low Income Premium Subsidy Amount (LIPSA)

See the mapping to CMS revenue reports provided above.

Line 1.9 – Part D risk corridor payments

See the mapping to CMS revenue reports provided above.

Line 1.10 – Total

Calculated as the sum of Lines 1.1 through 1.9

Line 2 – Claims

Enter the contract's expenses for the reporting period by the various categories.

Incurred claims for clinical services and prescription drug costs must include the following:

1. Direct claims that the MA organization pays to providers (including under capitation contracts with physicians) for covered services (described at § 422.2420(a)(2)) provided to all enrollees under the contract.
2. Direct drug costs that are actually paid (as defined in § 423.308) by the Part D sponsor.
3. For an MA contract that includes MA–PD plans (described at § 422.2420(a)(2)), drug costs provided to all enrollees under the contract, as defined at § 423.2420(b)(2)(i).
4. Unpaid claims reserves for the current contract year, including claims reported in the process of adjustment.
5. Percentage withholds from payments made to contracted providers.
6. Incurred but not reported claims based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.
7. Changes in other claims-related reserves.
8. Claims that are recoverable for anticipated coordination of benefits.
9. Claims payments recoveries received as a result of subrogation.
10. Claims payments recoveries as a result of fraud reduction efforts, not to exceed the amount of fraud reduction expenses.
11. Reserves for contingent benefits and the medical or Part D claim portion of lawsuits.
12. The amount of incentive and bonus payments made to providers.

Adjustments that must be deducted from incurred claims include overpayment recoveries received from providers.

The following amounts must not be included in incurred claims:

1. Non-claims costs, as defined in §§ 422.2401 and 423.2401, which include the following:
 - a. Amounts paid to third party vendors for secondary network savings.
 - b. Amounts paid to third party vendors for any of the following:
 - i. Network development.
 - ii. Administrative fees.
 - iii. Claims processing.
 - iv. Utilization management.
 - c. Amounts paid, including amounts paid to a provider or pharmacy, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, such as the following:
 - i. Medical record copying costs.
 - ii. Attorneys' fees.
 - iii. Subrogation vendor fees.
 - iv. Bona fide service fees.
 - v. Compensation to any of the following:
 1. Paraprofessionals.
 2. Janitors.
 3. Quality assurance analysts.
 4. Administrative supervisors.
 5. Secretaries to medical personnel.
 6. Medical record clerks.
2. Amounts paid to CMS as a remittance under §§ 422.2410(b) or 423.2410(b).

Incurred claims under this part for policies issued by one MA organization or Part D sponsor and later assumed by another entity must be reported by the assuming organizations for the entire MLR reporting year during which the policies were assumed and no incurred claims under this part for that contract year must be reported by the ceding MA organization or Part D sponsor.

Reinsured incurred claims for a block of business that was subject to indemnity reinsurance and administrative agreements effective before March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

Line 2.1 – Claims incurred only during CY 2014, paid through 9/30/2015

This line is consistent with the commercial MLR reporting form Part 2 Line 2.1.

Line 2.2 – Liability and reserves for claims incurred only during CY 2014, calculated as of 9/30/2015

This line is consistent with the commercial MLR reporting form Part 2 Lines 2.2 and 2.4.

Line 2.3 – Incurred medical incentive pool and bonuses

This line is consistent with the commercial MLR reporting form Part 2 Line 2.11.

Line 2.3a – Paid medical incentive pools and bonuses MLR Reporting year

This line is consistent with the commercial MLR reporting form Part 2 Line 2.11a.

Line 2.3b – Accrued medical incentive pools and bonuses MLR Reporting year

This line is consistent with the commercial MLR reporting form Part 2 Line 2.11b.

Line 2.4 – Contingent benefit and lawsuit reserves

This line is consistent with the commercial MLR reporting form Part 2 Line 2.13.

Line 2.5 – MA Rebate for Part B Premium Reduction

Calculated field that refers to Line 1.3

Line 2.6 – MSA Enrollee Deposit (MSA plans only)

Calculated field that refers to Line 1.5

Line 2.7 – Allowable fraud reduction expense (the smaller of lines 2.7a or 2.7b)

This line is consistent with the commercial MLR reporting form Part 2 Line 2.17.

Line 2.7a – Total fraud reduction expense

This line is consistent with the commercial MLR reporting form Part 2 Line 2.17a.

Line 2.7b – Total fraud recoveries that reduced paid claims in Line 2.1

This line is consistent with the commercial MLR reporting form Part 2 Line 2.17b.

Line 2.8 – Total

Calculated as the sum of Lines 2.1 through 2.7

Line 2.8a – Part D (informational only; already included in Line 2.8)

Required data entry; do not leave blank.

For plan types that are only reporting Part D experience for MLR (such as PDPs), Line 2.8a should equal Line 2.8.

This line is similar to the commercial MLR reporting form Part 1 Line 2.2.

Line 2.8b – Direct and Indirect Remuneration (DIR) (informational only; already excluded from Line 2.8)

Required data entry; do not leave blank.

This line is similar to the commercial MLR reporting form Part 1 Line 2.3.

Line 3 – Federal and State Taxes and Licensing or Regulatory Fees

The categories under Line 3 are consistent with the commercial MLR reporting form.

Federal and State taxes and assessments and licensing or regulatory fees must be reported in accordance with the provisions in §§ 422.2420(c)(2) and 423.2420(c)(2).

Line 4 – Health Care Quality Improvement (QI) Expenses Incurred

The categories under Line 4 are consistent with the commercial MLR reporting form.

The regulations at §§ 422.2430(a) and 423.2430(a) define the expenditures and activities that improve health care quality and can therefore be reported for MLR purposes. Sections 422.2430(b) and 423.2430(b) identify the excluded expenditures and activities that must not be reported.

Line 5 – Non-Claims Costs

The categories under Line 5 are consistent with the commercial MLR reporting form.

Non-claims costs, as defined in §§ 422.2401 and 423.2401, are those expenses for administrative services that are not—

- (1) Incurred claims (as provided in §§ 422.2420(b)(2) through (4) and 423.2420(b)(2) through (b)(4));
- (2) Expenditures on quality improving activities (as provided in §§ 422.2430 and 423.2430);
- (3) Licensing and regulatory fees (as provided in §§ 422.2420(c)(2)(ii) and 423.2420(c)(2)(i));
- (4) State and Federal taxes and assessments (as provided in §§ 422.2420(c)(2)(i) and (iii), and 423.2420(c)(2)(ii) and (iii)).

Line 6 – Methodology for determining the Medicare-funded portion of the contract for EGWP plans

This information will be used during CMS review/audit. See the Reporting Considerations EGWP section for more information.

Line 6.1 – Option 1 "Actual EGWP costs", or Option 2 "Allocated based on revenue"

Enter the option used to determine the Medicare-funded portion of the contract for EGWP plans. If there are no EGWP plans under the contract, then leave this field blank.

Line 6.2 – Enter percentage used to allocate EGWP costs (i.e., Medicare % of total revenue)

If Option 2 “Allocated based on revenue” is entered in Line 6.1, then enter the percentage used to allocate EGWP costs under the contract. Otherwise, leave this field blank.

Line 7 – Total Member Months

This field is calculated as the sum of the member months entered in Line 8 column (c).

Line 8 – Plan-Specific Data

Column (b) Plans offered under the contract in CY 2014

Enter the list of plans offered under the contract in CY 2014, in the format of Hxxxx-xxx-xx, Rxxxx-xxx-xx, Sxxxx-xxx-xx, or Exxxx-xxx-xx. There are rows available to enter up to 150 plans. Do not leave blank rows between plans.

Column (c) CY 2014 Member Months

Enter the member months associated with each plan entered.

Member months entered should be on a consistent basis with the revenue and claims information entered in Lines 1 and 2.

Member months for a contract year equal the sum across the 12 months of a year of the total number of enrollees for each month. This includes enrollees who are in ESRD and hospice status for a month.

Column (d) Is the plan a Dual-Eligible Special Needs Plan (i.e., D-SNP)? (Yes/No)

For each plan entered, enter Yes/No to indicate if the plan is a D-SNP.

Column (e) Does the plan's defined service area include territories? (Yes/No)

For each plan entered, enter Yes/No to indicate if the plan's defined service area includes counties in one or more territories (e.g., Puerto Rico, Guam, Northern Mariana Islands, Virgin Islands, American Samoa).

The plan's defined service area is in HPMS. (The corresponding county codes are also entered in the CY MA Bid Pricing Tool (BPT), for those plans that complete and submit the MA BPT.)

Column (f) Is the plan a D-SNP in a territory? (Yes/No)

Calculated field: If column (d) and column (e) both equal "Yes", then column (f) populates with a "Yes".

Columns (g) through (n)

The label Medicaid in this Report is used to refer to a State/Territory program for Dual-Eligible beneficiaries.

Column (g) Member Months in territories

Enter the subset of member months entered in column (c) that are in territories.

Column (h) Medicaid Revenue PMPM

Enter the Medicaid Revenue for member months entered in column (g) on a PMPM basis.

This revenue was not included in Worksheet 1 Line 1.

Column (i) Medicaid Cost PMPM

Calculated field: Column (j) + (k) + (l) + (m)

Column (j) Medicaid Non-Claims Cost PMPM

Enter the Medicaid non-claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 5.

Column (k) Medicaid Claims Cost: Medical Cost Sharing Reduction PMPM

Enter the Medicaid claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 2.

Column (l) Medicaid Claims Cost: Medical Other Benefits PMPM

Enter the Medicaid claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 2.

Column (m) Medicaid Claims Cost: Pharmacy PMPM

Enter the Medicaid claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 2.

Column (n) Medicaid Gain/(Loss) PMPM

Calculated field: Column (h) - (i)

WORKSHEET 2

The purpose of Worksheet 2 is to compute the Medicare medical loss ratio (MLR) and remittance amount, if any.

Section 1 – Medicare MLR and Remittance Calculation

The MLR and remittance must be calculated in accordance with the provisions in §§ 422.2420(a) through (c), and 423.2420(a) through (c).

Line 1 – Medical Loss Ratio Numerator

Line 1.1 – Claims

Calculated field that refers to Worksheet 1 Line 2.8

Line 1.2 – Improving health care quality expenses

Calculated field that refers to Worksheet 1 Line 4.7

Line 1.3 – MLR numerator

Calculated field: Worksheet 2 Lines 1.1 + 1.2

Line 2 – Medical Loss Ratio Denominator

Line 2.1 – Revenue

Calculated field that refers to Worksheet 1 Line 1.10

Line 2.2 – Federal and State taxes and licensing or regulatory fees

Calculated field that refers to Worksheet 1 Line 3.4

Line 2.3 – MLR denominator

Calculated field: Worksheet 2 Lines 2.1 - 2.2

Line 3 – Credibility Adjustment

Line 3.1 – Member months to determine credibility

Calculated field that refers to Worksheet 1 Line 7

Line 3.2 – MLR credibility adjustments table

Refers to either the MA or PD credibility adjustment table in Worksheet 2 Section 2.

The PD adjustment factors are utilized for S contracts, contracts where total claims (Worksheet 1 Line 2.8) equal Part D claims (Line 2.8a), and contracts where total revenue (Line 1.10) equals Part D revenue. Otherwise MA adjustment factors are utilized.

Line 3.3 – Credibility Adjustment

Linear interpolation calculated based on member months (Worksheet 2 Line 3.1) and the MA or PD credibility table (Worksheet 2 Line 3.2 and Section 2)

Line 4 – Medical Loss Ratio (MLR) Calculation**Line 4.1 – Unadjusted MLR**

Calculated field: Worksheet 2 Line 1.3 divided by Worksheet 2 Line 2.3

Line 4.2 – Credibility adjustment

Calculated field that refers to Worksheet 2 Line 3.3

Line 4.3 – Adjusted MLR

Calculated field: Worksheet 2 Lines 4.1 + 4.2, then rounded

Line 5 – Remittance Calculation**Line 5.1 – Contract subject to remittance for CY 2014?**

“Yes”/”No” populated based on member months (Worksheet 2 Line 3.1) and the MA or PD credibility table (Worksheet 2 Line 3.2 and Section 2)

Line 5.2 – MLR standard

Pre-populated with 85.0%

Line 5.3 – Adjusted MLR

Calculated field that refers to Worksheet 2 Line 4.3

Line 5.4 – MLR denominator

Calculated field that refers to Worksheet 2 Line 2.3

Line 5.5 – Remittance amount due to CMS for CY 2014 experience

Calculated field: Worksheet 2 (Lines 5.2 – 5.3) x Line 5.4 when Adjusted MLR (Worksheet 2 Line 5.3) is less than MLR standard (Worksheet 2 Line 5.2)

Line 5.5a – Remittance amount allocated to Parts A&B (For CMS system purposes only)

Calculated field to allocate Line 5.5 based on Worksheet 1 Line 1 Revenue data entries

Line 5.5b – Remittance amount allocated to Part D (For CMS system purposes only)

Calculated field to allocate Line 5.5 based on Worksheet 1 Line 1 Revenue data entries

Section 2 – MLR Credibility Adjustment Table

MA and PD credibility adjustments per CMS, based on member months.

An MA organization or Part D sponsor may add a credibility adjustment to a contract's MLR if the contract's experience is partially credible, as determined by CMS.

MA organization or Part D sponsor may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as determined by CMS.

For those contract years for which a contract has non-credible experience for their MLR, sanctions under §§ 422.2410(b) through (d) or 423.2410(b) through (d) will not apply.

CMS defines and publishes definitions of partial credibility, full credibility, and non-credibility and the credibility factors through the notice and comment process of publishing the Advance Notice and Final Rate Announcement.

WORKSHEET 3

Section 1 – Description of Expense Allocation Methods

The fields on Worksheet 3 are consistent with the commercial MLR reporting form, and refer to the data entry lines of Worksheet 1.

Worksheet 3 is used by the organization to describe the methods used to allocate expenses, as reported on the MLR Report, including incurred claims, quality improvement expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs.

A detailed description of each expense element should be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized.

Note that the fields on Worksheet 3 are limited to 4,000 characters each.

See the “Allocation of Expenses” Reporting Consideration in the General Instructions section of this document for more information.

ATTESTATION

An attestation must be submitted in the HPMS attestation module to accompany each MLR Report uploaded to HPMS.

The language below is used in the electronic attestation module in HPMS:

CY 2014 MLR Attestation

The officers of this reporting issuer being duly sworn, each attest that he/she is the described officer of the reporting issuer, and that this MLR Report is a full and true statement of all the elements related to the health insurance coverage issued for the MLR reporting year stated above, and that the MLR Report has been completed in accordance with the Department of Health and Human Services reporting instructions and regulations, according to the best of his/her information, knowledge and belief. Furthermore, the scope of this attestation by the described officer includes any related electronic filings and postings for the MLR reporting year stated above, that are required by Department of Health and Human Services under implementing regulations.

Chief Executive Officer/President

Chief Financial Officer

TECHNICAL INSTRUCTIONS

The MLR Report is comprised of two parts: an add-in file and a workbook. The MLR add-in file contains code that enables the formulas, macros, and verification logic of the tool. The workbook provides the visual interface for the user to enter MLR data for a contract.

MLR Add-in File

Setup Instructions

The MLR Report requires a separate add-in file that supports the MLR workbook functionality. Below are the steps to download and set up the add-in file:

1. Create a folder with the file path C:\MLR\MLR2014.
2. Download the MLR add-in zip file from HPMS.
3. Unzip the downloaded add-in file into the C:\MLR\MLR2014 directory.

If an older version of the add-in file exists, select the option to replace this file when prompted.

If the MLR add-in file is not saved in the designated folder, a message is displayed in the MLR workbook stating that the MLR2014.xlam (MLR Add-in) file cannot be found.

After saving the add-in file in the correct location, the following macro security settings must be set to allow the add-in to function properly:

1. Set the macro security setting to 'Disable macros with notifications (Recommended)' or 'Enable all Macros'. To change the macro security setting in Excel 2007, click the Office Button and select Excel Options > Trust Center > Trust Center Settings > Macro Settings. For Excel 2010, click the File tab and select Options > Trust Center > Trust Center Settings > Macro Settings.
2. If the macro security setting is set to 'Disable macros with notifications' in Excel 2007, click the Option button and select 'Enable this content'. In Excel 2010, click File > Info and select Enable Content > Enable All Content.

Add-in Updates

If necessary, CMS may deploy a new version of the MLR add-in file to update the MLR workbook. If CMS deploys an updated version of the MLR add-in (MLR2014.xlam) file, the existing add-in file must be replaced with the new version. The new add-in file must be downloaded from HPMS and copied into the C:\MLR\MLR2014 folder.

All existing MLR workbooks must be updated with the latest add-in file. If the old version of the add-in file has been used to finalize an MLR workbook and has not yet been uploaded to HPMS, the user must download the new add-in file, update the working file, and re-finalize the workbook.

After installing the new add-in file, the workbook updates automatically on first use when the workbook is opened. A pop-up message displays stating that the workbook is out of date. Select

the “OK” button to continue and the update process will begin. Data does not need to be transferred from one workbook to another to apply an add-in update.

MLR Workbook

Workbook Versions

The MLR Report employs three versions of the workbook that serve different purposes:

- Working file – a read-write enabled file that allows users to enter data in specified input fields; specified calculated fields are automatically calculated via formulas resident in the files. Users may edit, save, name, and re-name working versions of the MLR workbook.
- Finalized file – a read-only file created by a process called finalization, which modifies the format of the working file to prepare it for submission to CMS. Finalization saves the file using a standard naming convention and populates a “timestamp” within the finalized MLR Report. Note that finalized files retain the workbook formulas, and macro functionality is removed.
- Backup file – also a read-only file created by the finalization process. The backup file uses the same file name as the finalized file with the word “backup” and a timestamp appended to it. The data in the backup file is the same as that in the working file. Users can remove the text “backup” from the filename to enable editing of the backup file. As such, backup files enable users to convert backup files back into working files—if needed—for further modification.

Workbook Formatting and Protection

Data entry cells are formatted in yellow. Keyboard users may use the ‘Tab’ key on the keyboard to cycle through the input cells.

All other cells prevent the user from keying in data. A dialog box alerts the user if the user has selected a protected cell. Cutting and pasting are not recommended, to prevent structural changes to the workbook. Users may copy and paste data into the workbook, and link the workbook to external files.

The MLR Report is password protected. The user may not modify the structure of the workbook or worksheets. Each data item must be located in its pre-defined cell location for successful processing.

Tampering with the file’s protection, including but not limited to un-protecting and re-protecting any parts of a workbook, will permanently compromise the file and prevent successful finalization of the workbook. If a workbook is compromised in this way, you must discard the compromised file, download and complete a new MLR Report.

Workbook Macros

The workbook includes six macros under the Add-Ins menu that assist the user with data entry, data validation, and workbook finalization.

Finalize MLR

The finalization macro prepares the workbook for submission to CMS. The workbook must be finalized before uploading to HPMS. When the finalization macro is triggered, the following actions are performed:

- Recalculates the formula cells within the MLR working file. Note that the finalized file will retain the workbook formulas.
- Checks any required fields (Section 1: Contract Number, Organization Name, and Contact information) must be entered for finalization to be successful.
- Checks any critical validations of data fields.
- Saves the working file.
- Creates a backup file – this is a read-only file that contains the same data as the working file; it can be used to restore data in a working file.
- Creates a finalized file with a date stamp on Line 4 of the ‘Data’ worksheet.

Finalized MLR workbooks are saved using the following naming convention: Contract Number+MLR-CY+yyyy.xlsx. Use of this convention is a requirement for a successful upload to the HPMS.

Example: H1111MLR-CY2014.xlsx

Finalized files are saved in the same directory where the working file is located.

Backup files use the same naming convention as finalized files with a timestamp appended to the end of the name: finalized filename +“_Backup_”+YYYY-MM-DD-HH:mm:ss.xlsm.

Example: H1111MLR-CY2014_Backup_2014-11-15-100000.xlsm

Back up files are saved in the same directory where the working file is located.

If additional changes are needed prior to submission (i.e., prior to upload to HPMS), modify the contents of the working file and finalize the file again; the previous finalized file will be overwritten and a new backup file will be created (backup files will not be overwritten as they are time-stamped).

In the instance that the working copy has become corrupted, the backup file may be renamed and used as the working copy. Removing the word ‘backup’ from the filename of the backup file will convert the file into a working copy that is read-write enabled.

Circle Invalid

This macro function displays red circles around cells that have failed validation. The validations are updated each time the file is saved, and when the “Circle Invalid” macro is run.

Validation Report

This macro function displays a worksheet that lists any validation errors. Visually impaired users will be able to use the validation report with textual readers to determine cells requiring correction. The ‘Validation Report’ worksheet is separated into an Active and Failed validation report.

- Active Cell Validation Report – displays the worksheet name, cell location, cell value, and validation criteria for the cell the user currently has selected. Critical validations are indicated by an additional column in the report.
- Failed Validation Report – displays the worksheet name, cell location, cell value, and validation criteria for all cells failing validation. Critical validations are indicated by an additional column in the report.

Hide/Unhide Validation Cell Labels

This macro function hides or displays tooltip labels for validated cells when the user selects a cell using the keyboard or cursor. Cell labels display the cell type (Input/Formula) and a short description of the required contents. By default, the validation messages macro is enabled, allowing the user to view information about the cells that are validated by the tool.

Hide/Unhide Non-Validation Cell Labels

This macro function hides or displays tooltip labels for non-validated cells when the user selects a cell using the keyboard or cursor. Cell labels display the cell type (Input/Formula) and a short description of the required contents. This macro is disabled by default, hiding information about the cells that are not validated by the tool.

Hide/Unhide Formula Worksheet

This macro function hides or displays the Formula worksheet that contains the formulas used to calculate the white cell values. By default, the MLR Formulas worksheet is hidden.