

DEPARTMENT OF HEALTH & HUMAN SERVICES

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CENTER FOR MEDICARE

DATE: July 10, 2020

TO: All Medicare Advantage Organizations, Part D Sponsors, and Cost Plans

FROM: Jennifer R. Shapiro, Director, Medicare Plan Payment Group

SUBJECT: Medicare Loss Ratio and Expenditures Related to COVID-19 Permissive Actions – Questions and Answers

On May 22, 2020, the Centers for Medicare & Medicaid Services (CMS) issued an HPMS memorandum entitled “Information Related to Coronavirus Disease 2019 - COVID-19” that revises and expands on an earlier version of the same document (issued March 10, 2020 and revised on April 21, 2020). The memo notifies Medicare Advantage (MA) organizations and Part D sponsors of permissive actions and flexibilities they may implement during the coronavirus disease 2019 (COVID-19) public health emergency to support efforts that can help curb the spread of the virus and to help ensure MA and Part D enrollees do not experience disruptions in care or in pharmacy and prescription drug access. In addition, we published related guidance in an HPMS memo titled “Updated Guidance for Medicare Advantage Organizations” on April 24, 2020 and a set of questions and answers (also under the title “Updated Guidance for Medicare Advantage Organizations”) on May 13, 2020. The present document provides guidance to MA organizations and Part D sponsors regarding how they should account for expenditures related to the COVID-19 permissive actions and other costs in the medical loss ratio (MLR) calculation for contract years (CY) 2020 and 2021.

Questions related to the guidance in this document may be sent to MLRreport@cms.hhs.gov.

Q1. Does the CY 2020 MLR numerator include amounts that an MA organization or Part D sponsor spends on additional or expanded benefits that it offers as part of the COVID-19 permissive actions?

A1. Expenditures related to permissive actions within the scope of the May 22, 2020 HPMS memo should only be included in the CY 2020 MLR numerator if they are either:

- incurred claims as defined in the Medicare MLR rules¹ or
- expenditures for activities that improve health care quality (also known as quality improvement activities, or QIAs) in accordance with the Medicare MLR rules.²

For MA contracts, incurred claims include direct claims that the MA organization pays to providers (including under capitation contracts) for covered services that are provided to enrollees under the contract.³ In addition, for MA contracts that include MA-PD plans and for Part D-only contracts, incurred claims include drug costs that are “actually paid” (that is, net of direct or indirect remuneration from any source) by the Part D sponsor.⁴

To be a QIA-related expenditure, the benefit must be an activity that falls into one or more of the categories identified in the regulations,⁵ and it must be designed for the following purposes:⁶

- (1) to improve health quality;
- (2) to increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results;
- (3) to be directed toward individual enrollees, specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities; and
- (4) to 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 Defined in 42 CFR § 422.2430(b)(2) through (4) for MA contracts and § 423.2420(b)(2) through (4) for Part D contracts. All regulatory citations in this document are to Title 42 of the Code of Federal Regulations.

² The requirements for QIAs are described in detail at §§ 422.2430 (for MA contracts) and 423.2430 (for Part D contracts).

³ § 422.2420(b)(2)(i). The regulation text states that incurred claims include “[d]irect claims that the MA organization pays to providers (*including under capitation contracts with physicians*) for covered services...” (emphasis added). We believe the parenthetical “including under capitation contracts with physicians” in § 422.2420(b)(2)(i) is intended to provide an example of a form of payment that is considered a direct claims payment for MLR purposes; we do not believe this language would exclude payments under capitation contracts with providers other than physicians. This interpretation is consistent with our interpretation of nearly identical language in the commercial MLR regulation at 45 CFR 158.40(a), and it is reflected in our annual MLR Data Form Filing Instructions, which state that incurred claims include 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.

⁴ §§ 422.2420(b)(2)(ii) and 423.2420(b)(2)(i).

⁵ §§ 422.2430(a)(2) and 423.2430(a)(2).

⁶ §§ 422.2430(a)(3) and 423.2430(a)(3).

On June 2, 2020, we published in the Federal Register a final rule titled “Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program” (85 FR 33796) (referred to hereafter as the June 2020 final rule),⁷ which finalized our proposal to amend § 422.2420(b)(2)(i) so that incurred claims include all amounts that an MA organization pays (including under capitation contracts) for covered services, regardless of whether the recipient of the payment is a provider as defined in § 422.2. However, this amendment applies to the MLR calculation for CY 2021 and subsequent years. Therefore, for purposes of CY 2020 MLR reporting, incurred claims only include amounts paid for covered services if the payment is made to a provider.

In the questions that follow, we address the MLR treatment of expenditures related to specific permissive actions.

Q2: If an MA organization waives or reduces enrollee cost-sharing for a covered service as a mid-year benefit enhancement in connection with the COVID-19 outbreak and increases its payment to providers to replace the waived or reduced amount of cost-sharing, does the MLR numerator include the additional amount that the MA organization pays for the service (that is, the portion of the cost that is shifted from the beneficiary to the MA organization)?

A2. Yes, any additional amount paid by the MA organization may be included in the numerator if it meets the definition of incurred claims in § 422.2420(b)(2) or if it is a QIA-related expenditure in accordance with § 422.2430. Stated another way, any additional amount that an MA organization pays for a covered service as a result of a waiver or reduction in enrollee cost-sharing in connection with the COVID-19 outbreak should be included in the MLR numerator if the portion of the cost that the MA organization would otherwise have paid for the service (that is, in the absence of the cost-sharing reduction or waiver) would be included in the MLR numerator.

For CY 2020, if an MA organization’s payment for a covered service is made to an individual or entity that is not a provider, the amount paid by the MA organization, including any portion paid by the MA organization that the beneficiary would have been responsible for paying if the MA organization had not waived or reduced cost-sharing, can only be included in the MLR numerator if the benefit meets the requirements to be a QIA under § 422.2430.

Q3. If a Part D sponsor fully or partly waives cost-sharing for a covered Part D drug with medically accepted indications for COVID-19 for CY 2020 as a temporary permissive action within the scope of the Addendum to the May 22, 2020 HPMS memo, and increases its payment to pharmacies to replace the waived or reduced amount of cost-sharing, does the MLR numerator include the additional amount that the sponsor pays for the drug?

A3. Yes.

⁷ Available at <https://www.federalregister.gov/d/2020-11342/>.

Q4. If an MA organization offers a primarily health related supplemental benefit to all enrollees or a non-primarily health related supplemental benefit to chronically ill enrollees as a mid-year benefit enhancement in connection with the COVID-19 outbreak, can amounts paid for these supplemental benefits be included in the MLR numerator?

A4. Payments for primarily health related supplemental benefits that are furnished by a provider, as defined in § 422.2, can be included in the CY 2020 MLR numerator as incurred claims.⁸ Payments for covered services that are furnished by individuals or entities that do not meet the definition of provider in § 422.2, can only be included in the CY 2020 MLR numerator if the benefit meets the requirements for QIA-related expenditures at § 422.2430. This applies for both primarily health related supplemental benefits and non-primarily health related services for chronically ill enrollees.

Q5. If an MA plan facilitates coverage of a supplemental benefit through a debit card mechanism, can the total coverage amount that is available through the debit card mechanism be included in the MLR numerator? Does it matter if the covered supplemental benefits for which payment is facilitated through the debit card are primarily health related items and services or non-primarily health related items and services that are covered only for chronically ill enrollees?

A5. The MLR numerator for an MA contract must reflect amounts actually paid for incurred claims or QIA. Therefore, if an MA plan offers a supplemental benefit and facilitates coverage through a debit card reimbursement mechanism, amounts that the plan uses to fund the debit card are only included in the MLR numerator to the extent that those amounts are actually used to pay (via the debit card) incurred claims or QIA-related costs. Any unused portion of the supplemental benefit allowance or debit card balance at the end of the contract year would be excluded from the MLR numerator as that amount was not used to pay for incurred claims or QIA. Debit card balances must not roll over from one year to the next.

In order for an MA organization to include in the incurred claims portion of the CY 2020 MLR numerator amounts that beneficiaries charge to their plan-issued debit cards, the organization must either prohibit the use of the debit card for purposes other than making payment to providers for covered services, consistent with the applicable regulatory definition of incurred claims,⁹ or the organization must only include in incurred claims the amount paid for a covered service via debit card if the organization has a record of the transaction that demonstrates that the payment was made to a provider.

In order for an MA organization to include in the CY 2020 MLR numerator as QIA-related expenditures the full amounts that are paid via a debit card for primarily health related supplemental benefits or non-primarily health related supplemental benefits, the organization either restrict the use of the debit card to expenditures for activities that satisfy the requirements for QIA at § 422.2430, or the organization must only include in the QIA portion of the MLR

⁸ See § 422.2420(b)(2)(i).

⁹ *Id.*

numerator the amount paid for a covered service via debit card if the organization has a record of the transaction that demonstrates that the payment was QIA-related.

MA organizations may include in the CY 2021 MLR numerator the full amount that beneficiaries charge to plan-issued debit cards to pay for supplemental benefits, regardless of whether payment is made to a provider as defined at § 422.2, consistent with the definition of incurred claims that applies for CY 2021, as finalized in the June 2020 final rule (85 FR 33849).

Q6. If an MA organization offers as a mid-year benefit enhancement in connection with the COVID-19 outbreak a new Part C over-the-counter (OTC) supplemental benefit, or if the organization increases the allowance for a Part C OTC supplemental benefit that was included in its plan bid, can the cost to the MA organization in providing that benefit be included in the MLR numerator?

A6. Amounts paid by an MA organization for Part C OTC supplemental benefits (including both new OTC benefits and increased OTC allowances for plans that already covered OTC benefits) that are offered as a mid-year benefit enhancement in connection with the COVID-19 outbreak can be included in the CY 2020 MLR numerator as incurred claims only if payment for the OTC benefit is made to an individual or entity that satisfies the definition of provider under § 422.2. If payment for the OTC benefit is made to an individual or entity that is not a provider, the amount paid for the OTC benefit be included in the CY 2020 MLR numerator only if the OTC benefit meets the requirements for QIA at § 422.2430. For guidance on how to account for expenditures related to a Part C OTC supplemental benefit for which coverage is facilitated through a debit card mechanism, see the preceding question and answer (Q5 and A5).

Q7. Can amounts that an MA organization spends on smartphones/tablets or cellular data plans offered as a mid-year benefit enhancement in connection with the COVID-19 outbreak be included in the CY 2020 MLR numerator?

A7. Amounts that an MA organization spends on smartphones/tablets and data plans offered as a mid-year benefit enhancement in connection with the COVID-19 outbreak may be included in the CY 2020 MLR numerator as QIA-related expenditures only if the benefit meets the QIA requirements at § 422.2430.

Q8. Can a smartphone/tablet that an MA organization provides as a supplemental benefit to all enrollees, or a cellular data plan that an MA plan provides to chronically ill-enrollees as non-primarily health related SSBCI, be included in the MLR numerator for CY 2021?

A8. Yes. Amounts that an MA organization spends on supplemental benefits, including SSBCI, are included in the CY 2021 MLR numerator as incurred claims.

Q9. If an MA organization waives or reduces Part C premiums as a COVID-19 permissive action, should that be reflected in the MLR calculation?

A9. The MLR denominator includes all premiums paid by or on behalf of enrollees to the MA organization as a condition of receiving coverage under an MA plan, as well as unpaid premium

amounts that the MA organization could have collected from enrollees.¹⁰ Although an MA plan is not required to disenroll members who do not pay Part C premiums, the unpaid premium amounts are included in the MLR denominator unless they remain unpaid after reasonable collection efforts.¹¹ Premium amounts that MA plan enrollees are not obligated to pay because they have been waived as a COVID-19 permissive action will not be considered “unpaid premiums that the MA organization could have collected” for purposes of § 422.2420(c)(1)(v). The MLR denominator excludes premium amounts that beneficiaries are not required to pay as a result of the MA organization waiving or reducing Part C premiums in connection with the COVID-19 outbreak.

Q10. Can an MA organization include the full amount that it pays for an original Medicare service in the incurred claims portion of the MLR numerator if the cost of providing the service increases during the contract year?

A10. Incurred claims in the MLR numerator include amounts paid by an MA organization to providers for covered services.¹² The cost of an original Medicare service at the beginning of a contract year does not serve as a cap on the amount that can be included in incurred claims if the MA organization actually paid a higher amount.

¹⁰ § 422.2420(c)(1)(iv)-(v).

¹¹ See § 422.2420(c)(1)(v); Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs Final Rule (78 FR 31284, 31291) (May 22, 2013).

¹² § 422.2420(b)(2)(i).