Medicaid Managed Care Program: Medical Loss Ratio Calculation

State of Nevada

Division of Health Care Financing and Policy

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I. BACKGROUND

The State of Nevada Division of Health Care Financing and Policy (DHCFP) has retained Milliman, Inc. (Milliman) to develop a Medical Loss Ratio (MLR) reporting tool for the calculation and assessment of the minimum MLR standards set forth in the July through December 2017 (2017H2) Managed Care Organization (MCO) contract.

The final Medicaid and Children's Health Insurance Program rule (Final Rule), released on May 6, 2016 requires that all Medicaid managed care programs ensure, through contracts for rating periods starting on or after July 1, 2017, that each Managed Care Organization (MCO) calculates and reports a Medical Loss Ratio (MLR) in accordance with 42 CFR 438.8, Medical loss ratio standards. In preparation for this requirement, we are requesting MCOs provide this information for 2017H2.

In 42 CFR 438.4(b)(9), CMS has proposed that the MLR for MCOs as calculated and reported under §438.8 be used in the development of actuarially sound capitation rates effective for rating periods starting on or after July 1, 2019. The MLR is used to assess whether capitation rates are appropriately set by generally illustrating how these funds are spent on claims and quality improvement activities as compared to administrative expenses; and demonstrating that adequate amounts under the capitation payments are spent on services for enrollees. CMS has also indicated that MLR reporting standards result in responsible fiscal stewardship of total Medicaid expenditures; as well as ensuring that states have insight and understanding into how capitation payments made for enrollees in managed care programs are being expended.[1]

The reporting requirements and MLR formula for Medicaid managed care programs as set forth in the Final Rule are generally consistent with previously established MLR formulas in the Medicare Advantage (MA) and commercial health insurance market, with a few key notable exceptions (among others):

- States are **not required** to collect capitation rate refunds when MCO MLRs are below a minimum requirement;
- States can choose the level of aggregation for calculating the MLR (e.g., population level stratifications vs. composite across all population);
- States are given flexibility to determine the minimum MLR requirement, as long as the minimum MLR percentage is **at least as** high as the CMS guidelines of 85%; and,
- Commercial MLR reporting period is a rolling 3 year period, while the MA and Medicaid MLR reporting period is aligned with a single calendar year.

DHCFP adopted the minimum MLR and remittance requirement with contracts effective for the contract period beginning July 1, 2017. Additionally, DHCFP established a minimum MLR requirement of 85% to be assessed on the composite Medicaid managed care program experience for each MCO during the contract period.

The Medicaid MLR calculation as documented in this report provides our interpretation of the MLR guidance presented by CMS in the Final Rule. In general, the MLR calculation is defined as the sum of incurred claims and quality improvement expenses divided by premium revenue that is reduced by taxes and regulatory fees. Additionally, a credibility adjustment is applied to this formula to account for random statistical variations related to the number of enrollees in an MCO. If an MCO does not meet the minimum size requirement for full credibility, then their MLR will be increased by a credibility adjustment published by CMS. Plan-reported data as submitted in the Medicaid MLR reporting tool will be used to calculate the MCO's Medicaid MLR and remittance amount, if any, to the State of Nevada.

The Medicaid MLR reporting instructions are to be used in completing and submitting the Medicaid MLR Tool for all Medicaid MCOs participating in the Nevada Medicaid managed care program in 2017H2. DHCFP and Milliman will rely on the accuracy and completeness of the submitted Nevada Medicaid MLR tool for each MCO based on the attestation of the MCO executive signing off on this request. During the review and data validation process, we may request additional information or documentation supporting the data on an as-needed basis to gain clarification on any information provided in the Medicaid MLR Tool. Complete documentation on the CMS regulation establishing the Medicaid MLR guidance can be found in §438.8 at the following link: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-healthinsurance -program-chip-programs-medicaid-managed-care-chip-delivered.

[1] Source: CMS. Final Rule: Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

II. GENERAL INSTRUCTIONS

This section outlines the general instructions for MCOs to complete the requested information in the accompanying Excel-based Medicaid MLR template. The 2017H2 Medicaid MLR will be calculated for each MCO based on plan-submitted data. It is expected that each MCO will submit a completed version of the Excel template to DHCFP no later than **October 31st, 2018**.

The Medicaid MLR Reporting Tool contains the following five tabs:

- Attestation
- Expense Allocation Narrative
- Data Collection
- Summary Calculation
- Financial Reconciliation

MCOs are requested to populate the Attestation, Data Collection, Expense Allocation Narrative, and Financial Reconciliation tabs. The Summary Calculation tab is populated from the MCO-submitted data and calculates the MCO-specific Medicaid MLR and remittance amount, if applicable.

Note that the 2017H1 (January – June 2017) data is also required to be reported on the Data Collection tab. Even though only the 2017H2 data will be used in MLR calculations, the calendar year (CY) 2017 totals will be used for financial reconciliation. We will refer to 2017H2 as the data "incurred period" throughout this report as well as in the Excel template for MLR reporting related descriptions.

MODEL INFORMATION

- Model name: Nevada Medicaid MLR Template Version 1.1.xlsx
- Release date: August 16, 2018
- Required software: Microsoft Excel (version 2013 or higher recommended)
- Technical reference:
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- Model version 1.1 is valid for data collected for the MLR period of July 1, 2017 through December 31, 2017 or until an updated version is supplied.

ATTESTATION

The purpose of the attestation page is to collect company specific data as well as confirmation that the information provided is complete and accurate. On this tab, MCOs must provide the MCO name from the drop down menu, the preparer's name and contact information, and the attesting officer's name and signature. The attesting officer could be designated as a CEO, CFO, or COO of the organization.

EXPENSE ALLOCATION NARRATIVE

The MCOs are required to fill out the Expense Allocation Narrative tab accompanying the Data Collection tab to demonstrate the methods used in expense allocation meets the requirements in accordance to § 438.8(g). This is similar to the narrative information requested in Medicare and Commercial MLR reporting.

(1) 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.
(2) 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.

DATA COLLECTION

The Data Collection tab is separated into the five major data elements of the MLR calculation: Incurred Claims, Quality Improvement Expenses, Premium Revenue, Taxes and Fees, and a Credibility Adjustment.

$$MLR\ Formula = \frac{Incurred\ Claims + Quality\ Improvement}{Premium\ Revenue - Taxes\ and\ Fees} + Credibility\ Adjustment$$

The MLR reporting template has been developed to stratify the major elements of the MLR formula by closely following the format of the MLR standards regulation § 438.8. References to regulation items are noted in column (B). The intent is to identify key components that should be included and excluded to ensure adherence to the MLR guidance established by CMS in the Final Rule. The inputs outlined below are intended to illustrate compliance with the Final Rule by documenting each item specifically identified in the MLR guidance. In instances when a requested data item cannot be isolated, the MCO should provide an estimated value and describe the situation and impact in Notes/Comments column of the Medicaid MLR Tool.

INCURRED CLAIMS

This section provides guidance on the incurred claims portion of the MLR formula according to § 438.8(e)(2).

(i) Incurred claims must include the following:

(A) Direct claims paid to providers for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees. Report separately,

- **Sub-capitation paid to contracted network providers attributed to services provided.**

Description: Line (A) should reflect total 2017H2 paid and incurred claims with claims run-out through March 31, 2018. Claims expenditures meeting requirements of § 438.3(e) include non-state plan services that the MCO voluntarily provides through the Medicaid managed care program. Please note that the majority of the items explicitly requested to be quantified on a subsequent line in this section are not supposed to be reported on Line (A).

The sub-capitation amount requested on its own line should only include the benefit expense portion of the sub-capitated payment for services provided to an enrollee during 2017H2. The non-benefit expense portion (generally the administrative amount) of the sub-capitated payments **do not** represent direct compensation for medical services provided to an enrollee, and thus should not be reported on this line.

The amount reported on Line (A) is expected to tie to the medical expenses incurred in 2017H2 that the MCO submitted for CY 2019 capitation rate setting.

(B) Unpaid claims liabilities on March 31, 2018 for claims incurred 2017H2.

- Report separately, if any, **reserve for incentive pool, withhold adjustments, and bonus amounts payable to providers.**

Description: Unpaid claim reserves reflect the estimated outstanding liabilities for all medical and prescription drug health care services for 2017H2. This includes items such as incurred but not reported (IBNR) claims, claims in course of settlement (ICOS), and claims that are adjudicated but not yet paid.

(C) Withholds from payments made to network providers.

(D) Claims that are recoverable for anticipated coordination of benefits (or third party liability).

Description: Recoveries received as a result of determining that another insurance plan has primary payment responsibility.

(E) Claims payments recoveries received as a result of subrogation.

Description: Recoveries received as a result of determining that another party is responsible for the medical expense.

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

(G) Changes in other claims-related reserves.

(H) Reserves for contingent benefits and the medical claim portion of lawsuits.

(ii) Amounts that must be deducted from incurred claims include the following:

(A) Overpayment recoveries received from network providers (please enter the amount as a positive value).

Description: Recoveries received as a result of overpayment to a network provider.

(B) Prescription drug rebates received and accrued (please enter the amount as a positive value).

Description: Supplemental rebates received by the MCO related to pharmaceutical expenditures during 2017H2.

(iii) Expenditures that must be included in incurred claims include the following:

(A) The amount of incentive and bonus payments made or expected to be made to network providers

Description: This item does not apply to Nevada, and is included for completeness.

(B) The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses. Report separately:

- **The amount of fraud reduction expense directly related to fraud recovery activities.**

  Description: As specified in § 438.8(e)(4), this amount must not include expenditures on activities related to fraud **prevention** as adopted for the private market in 45 CFR part 158, Commercial Issuer Use of Premium Revenue: Reporting and Rebate Requirements.

- **Total fraud recoveries (please enter the amount as a positive value).**

  Description: Please note that fraud recoveries up to the total fraud recoveries expense reported above are excluded from the incurred claims calculation.

(iv) Amounts that must either be included in or deducted from incurred claims:

- **Payments made to the State for the State mandated solvency funds (please enter the amount as a positive value).**
- **Receipts from the State for the State mandated solvency funds (please enter the amount as a positive value).**

Description: Not applicable, Nevada does not have a mandated solvency funds, as such these lines should remain blank.

(v) Amounts that must be excluded from incurred claims:

(A) Non-claims costs as defined in § 438.8(b). Report separately for the following if they have been reported on line (i)(A) or other lines above and indicate which lines contain these amounts in Notes/Comments column:

(1). Amounts paid to third party vendors for secondary network savings.
(2). Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.
(3). 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 services meeting the definition in § 438.3(e) and provided to an enrollee.
(4). Fines and penalties assessed by regulatory authorities based on an examination or audit.

(B) Amounts paid to the State as remittance under § 438.8(j).

Description: The amount paid, if any, as a result of the Medicaid minimum MLR requirement for the prior contract year. Note that this is not applicable in the 2017H2 reporting cycle but is included for completeness.

(C) Amounts paid to network providers under § 438.6(d).

Description: The pass-through payments made to safety net hospitals.

(D) Reinsurance recoveries related to State mandated reinsurance contracts (please enter amount as a positive value).

Description: Reinsurance premiums and recoveries are excluded from the MLR calculation with the exception of state-mandated reinsurance contract requirements. Provide the total dollar amount of payments received by the MCO from the current reinsurance contract in which the state reimburses MCOs for 75% of inpatient hospital costs above $100,000 for any individual member.

QUALITY IMPROVEMENT EXPENSES

This section provides guidance on the quality improvement expenses portion of the MLR formula in accordance with the provisions in 45 CFR 158.150(b) and 42 CFR 438.358(b) and (c).

(i) Activities meet the requirements of 45 CFR 158.150(b) and are not excluded under 45 CFR 158.150(c)

Consistent with NAIC guidelines for the Supplemental Health Care Exhibit Part 3, Quality Improvement Expenses are defined as expenses that control or contain cost with the primary purpose of improving health care quality. These expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized health care quality organizations. These expenses can be objectively measured, and must not be billed or allocated as clinical or claims costs[2].

1. Activities to improve health outcomes

Description: "Expenses for direct interaction of the insurer (including those services delegated by contract for which the insurer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representatives (e.g. face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes."

2. Activities to prevent hospital readmission

Description: "Expenses for implementing activities to prevent hospital readmissions."

3. Activities to improve patient safety and reduce medical errors

Description: "Expenses for implementing activities to improve patient safety and reduce medical errors."

4. Wellness and health promotion activities

Description: "Expenses for programs that provide wellness and health promotion activity (e.g., face-to-face, telephonic, web-based interactions or other means of communication)."

(ii) Activities related to external quality review (EQR)

Description: Mandatory and optional EQR-related activities as defined in 42 CFR 438.358.

(iii) Expenditures related to health information technology and meaningful use

[2] Official NAIC Annual Statement Instructions: Health; for the 2016 reporting year printed September 2016

Include "Health Information Technology expenses required to accomplish the activities designed for use by health plans, health care providers or enrollees for the electronic creation, maintenance, access or exchange of health information, consistent with Medicare/Medicaid meaningful use requirements."

Exclude "Costs associated with 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."

PREMIUM REVENUE

This section provides guidance on the premium revenue portion of the MLR formula according to § 438.8(f)(2).

Premium revenue includes the following for 2017H2:

(i) State capitation payments for all enrollees under a risk contract, excluding payments made under § 438.6(d)

Risk-adjusted capitation payment revenue for the Nevada managed care program for the 2017H2 contract period. The revenue from IMD add-on rates should be included in this line. Payments to the state or recoupments received from the state for retrospective risk adjustment for the 2017H2 contract period should be reported here if available.

Displayed on a separate line, the pass-through revenue related to safety net hospital payments should not be reported in the capitation payments revenue line above.

(ii) State-developed one time payments, for specific life events of enrollees

Description: Delivery case rate payments and Very Low Birth Weight (VLBW) case payments incurred in 2017H2.

(iii) Withhold payments approved under § 438.6(b)(3)

- **Total MCO withhold of 2017H2 capitation revenue**

  Description: This is the total revenue withheld. Capitation payment revenue in line 438.8(f)(2)(i) should be net of this withhold amount.

- **MCO withhold earned back related to 2017H2**

  Description: The amount of the quality withhold earned back based on quality metrics established for the 2017H2 contract period.

  The Nevada Medicaid program does not have quality and withhold arrangements with the MCOs, though these items are included for completeness. As such, these line items do not apply and should remain blank.

(iv) Total amount of copays waived by MCO from provider's collection responsibility

Description: The amount of unpaid member cost-sharing dollars where an MCO intentionally waived the provider's responsibility to collect the member copay. There is no cost sharing for Nevada's Medicaid program, so these items should be left blank.

(v) Changes to unearned premium reserves

Description: Change in the premium reserve for the portion of Medicaid insurance coverage that has not yet expired.

(vi) Net payments or receipts related to risk sharing mechanisms developed in accordance with § 438.5 or § 438.6

1. High cost drugs risk corridor settlements

Description: Total MCO settlement related to risk corridor arrangement for high-cost drugs. This is not applicable for the 2017 H2 contract period, but is included for completeness.

2. Risk sharing settlements for 2017H2

Description: The Nevada Medicaid program does not have other risk sharing arrangement for the 2017H2 contract period. As such, these line items do not apply and should remain blank.

3. Ceded premium for State mandated reinsurance contract

Description: Reinsurance premiums and recoveries are excluded from the MLR calculation with the exception of state mandated reinsurance contract requirements. The current state-run inpatient hospital reinsurance program requires no premium from the MCOs, as such, the amount reported on this line is expected to be 0.

TAXES AND FEES

Consistent with NAIC guidelines for completion of the Supplemental Health Care Exhibit Part 1, taxes and fees[3] pertain to amounts a governmental or regulatory body charges the MCO to perform a service which is allocated to Medicaid business in Nevada. Additionally, all Federal and State taxes and assessments and licensing or regulatory fees should be reported in accordance with the provisions in §§ 422.2420(c)(2) and 423.2420(c)(2) of the Medicare Advantage MLR regulations.

Taxes, licensing and regulatory fees for the MLR reporting year include:

(i) Statutory assessments to defray the operating expenses of any State or Federal department

(ii),(iv) Examination fees, state premium taxes, local taxes and assessments

Description:

- Examination fees in lieu of premium taxes as specified by Nevada State law
- Guaranty fund assessments
- Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the state directly
- Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by Nevada
- Advertising required by law, regulation or ruling, except advertising associated with investments
- State or locality income, excise, and business taxes other than premium taxes and State employment and similar taxes and assessments
- State or locality premium taxes plus State or locality taxes based on reserves, if in lieu of premium taxes
- In lieu of reporting state premium taxes, the reporting entity may choose to report payment for community benefit expenditures, on line (v) below, limited to the highest premium tax rate for Nevada, but not both

(iii) Federal taxes and assessments

Description:

Include

- All federal taxes and assessments allocated to health insurance coverage reported under Section 2718 of the Federal Public Health Service Act.

Exclude

- Federal income taxes on investment income and capital gains.
- The Health Insurer Fee

(v) Payments for community benefit expenditures as defined in 45 CFR 158.162(c) that are otherwise exempt from Federal income tax

Description: 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, as defined in the NAIC supplemental health care exhibit.

[3] Official NAIC Annual Statement Instructions: Health; for the 2016 reporting year printed September 2016

1. Input the highest premium tax rate in Nevada
2. Using the Yes/No toggle, please indicate if the MCO is exempt from federal income taxes

CREDIBILITY ADJUSTMENT

This section provides information related to the credibility adjustment in the MLR formula.

Credibility

On July 31, 2017, CMS published an Information Bulletin, Medical Loss Ratio (MLR) Credibility Adjustments[4], which provides an overview and methodology for credibility adjustments in the Medicaid MLR formula. The credibility adjustment is used to account for random statistical variation related to the number of enrollees in a managed care plan. The credibility adjustment categorizes managed care plans into three groups:

- Fully-credible: Managed care plans with sufficient claims experience, measured in terms of member months, are assumed to experience MLRs that are not subject to random variation as observed in statistically insignificant samples. Such managed care plans will not receive a credibility adjustment for their MLRs.

- Partially-credible: Managed care plans with sufficient claims experience, measured in terms of member months, to calculate an MLR with a **reasonable** chance that the difference between the actual and target medical loss ratios is statistically significant. Such managed care plans will receive a partial credibility adjustment to their calculated MLRs.

- Non-credible: Managed care plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR. Such plans will not be measured against the MLR standard; managed care plans in this group are presumed to meet or exceed the target MLR standard.

The following table illustrates the Medicaid and CHIP credibility adjustment factors utilized in the MLR formula:

MLR Credibility Adjustment Table for Medicaid and CHIP Managed Care Plans	
Standard Plans Member Months in MLR Reporting Year	Standard Plans Credibility Adjustment
< 5,400	Non-credible
5,400	8.4%
12,000	5.7%
24,000	4.0%
48,000	2.9%
96,000	2.0%
192,000	1.5%
380,000	1.0%
> 380,000	Fully Credible

Total Member Months for 2017H2

Enter the number of months a group of enrollees is covered by an MCO for the 6-month reporting period.

SUMMARY CALCULATION

The "Summary Calculation" tab calculates the MCO's MLR and the remittance amount. The remittance amount is calculated as follows:

$$(85.00\% - Adjusted\ MLR) \times (Premium\ Revenue - Taxes\ and\ Fees)$$

[5] CMS Information Bulletin: MLR Credibility Adjustments; available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf

In situations where the MCO is non-credible based on reported member months, it is assumed that the MCO meets the minimum MLR Standard. For situations where the MCO is partially-credible or fully-credible, the Adjusted MLR is compared to the MLR Standard. If the Adjusted MLR is greater than or equal to the MLR Standard, then the MCO meets the MLR Standard and no remittance is required. If the Adjusted MLR is less than the MLR standard, then the MCO does not meet the MLR Standard and may be subject to a remittance to DHCFP.

FINANCIAL RECONCILIATION

In accordance with § 438.5(c), the capitation rate development standards require reliance on audited financial reports as defined in §438.3(m). The "Financial Reconciliation" tab pulls information from the "Data Collection" tab and compares the CY 2017 totals to the audited financials. It is our understanding that the audited financials are reported at the composite Title XIX Medicaid level and therefore the comparison is at that level. The following sections need to be populated by the MCOs.

- **Section F – Administrative Costs**
- **Section H – Other Non-Benefit Costs**
- **NAIC Statutory Statements (column E)**
  If the MCO is using a different set of audited financials, please specify.
- **Commentary on Differences (column G)**
  For any significant differences (more than 1%) calculated in column F, please provide detailed descriptions including quantitative supports for the differences.

III. LIMITATIONS AND QUALIFICATIONS

The information contained in this correspondence has been prepared for DHCFP and its consultants and advisors. This letter may not be distributed to any other party without the prior consent of Milliman. It is our understanding that a copy of this report with the specific enclosure will be shared with each MCO participating in the Nevada Medicaid managed care program. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for DHCFP by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.

The services provided for this project were performed under the contract between Milliman and DHCFP, as amended April 10, 2018.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.