



**TEXAS**  
Health and Human  
Services

# HHSC UNIFORM MANAGED CARE MANUAL

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## MEDICAL LOSS RATIO (MLR) REPORT

EFFECTIVE DATE
<b>August 16, 2021</b>

**Version 2.1.2**

### DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	2.0	November 1, 2018	Initial version Uniform Managed Care Manual Chapter 5.3.13, "Medical Loss Ratio (MLR) Report."  This chapter applies to contracts issued as a result of HHSC RFP numbers X29-08-0001, X29-10-0020, X29-12-0002, X29-12-0003, X29-13-0042, X29-13-0071, and X29-15-0001; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.
Revision	2.1	July 1, 2019	Chapter number is modified from 5.3.13 to 5.3.13.1.  "Applicability of Chapter 5.3.13.1" is modified to delete applicability for Medicare Medicaid Plans. This chapter applies to contracts issued as a result of HHSC RFP numbers 529-08-0001, 529-10-0020, 529-12-0002, 529-13-0042, 529-13-0071, and 529-15-0001.  "Report 5.3.13.1" section is modified for the due date information.  "Report Revisions" paragraph is removed.  "Report and MLR Calculation Review" section is modified to clarify what the report is to include, delete the paragraphs on "Calculation as broadly defined by CMS" and "Data ties to the FSR and conforms to the Cost Principles," clarify Experience Rebate information, and delete MMP references and MLR comparison data information.  "Report Template 5.3.13.2" section is modified to provide instructions and data to be provided for each report line-item for the new report template.
Revision	2.1.1	October 15, 2019	Accessibility approved version.



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STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Revision	2.2	August 16, 2021	<p>Revised section titled, "Applicability of 5.3.13.1" by removing language stating, "or Medical Transportation Organizations." Also added language to the section clarifying Nonemergency Medical Transportation Services are included effective August 1, 2021 for reporting transactions occurring on or after September 1, 2020 per the implementation of HB 1576, 86<sup>th</sup> Legislature.</p> <p>Added section titled, "Attestation." section.</p>

<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

<sup>2</sup> Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

<sup>3</sup> Brief description of the changes to the document made in the revision.



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### Applicability of Chapter 5.3.13.1

This chapter applies to each Managed Care Organization (MCO) that contracts with HHSC to provide services in STAR, STAR+PLUS, CHIP, STAR Kids, or STAR Health. This chapter specifically does not apply to Dental Contractors. In accordance with the implementation of HB 1576, 86th Legislature; the requirements of this chapter also apply to NonEmergency Medical Transportation (NEMT) activities effective August 1, 2021, for reporting transactions occurring on or after September 1, 2020, with the exclusion of CHIP, as NEMT activities are not provided by CHIP. The term MCO includes health maintenance organizations, exclusive provider organizations, insurers, and any other entities licensed or approved by the Texas Department of Insurance.

### Report 5.3.13.1

Each MCO must submit a medical loss ratio (MLR) report in accordance with 42 CFR § 438.8 and in conformance with this chapter. The MLR report (Report), along with the 334-day FSR, must be submitted annually to HHSC in accordance to HHSC's UCMC Chapter 5.0.1 Deliverable Requirements Matrix. The first Report due under this chapter shall include the results of State Fiscal Year (SFY) 2018 and will be due to HHSC on August 31, 2019.

### Report and MLR Calculation Overview

The Report expresses the ratio of MCO incurred claims, including quality improvement expenditures and fraud prevention activities, to premium payments received, adjusted for Federal, State, and local taxes and licensing and regulatory fees. For each completed SFY, the Report collects data regarding certain medical expenses incurred by the MCO, along with some related expenses and adjustments, which in total are compiled into a "numerator." Per CMS rules, some of the amounts included in the adjusted medical expenses are not actual direct beneficiary services. The Report also collects data regarding certain premium payments made to the MCO, along with certain related amounts and adjustments, which in total are compiled into a "denominator." The defined numerator is then divided by the defined denominator, and a ratio is calculated, which may then be further adjusted. This final ratio is the MLR. This ratio or percentage may be expressed as a simple number, whereby, for example, a ratio of 0.85, or 85%, may be expressed simply as an MLR of 85. Additional digits may be used; for example, a MLR of 85.1.

**Calculation on a post-Experience Rebate basis.** MLR results will be reported on a post-Experience Rebate basis. This means that the Experience Rebate, if any, will be part of the calculation; an Experience Rebate reduces the total amount of premiums in the capitation.



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***Implications of capitation withholds, at-risk premiums, liquidated damages, interest assessments, and similar items.*** Any withholds or at-risk amounts will be treated in the MLR calculation as though they were paid in full by HHSC and retained by the MCO. Liquidated damages and HHSC interest assessments, if any, are unallowable costs under the Cost Principles and are neither medical expenses nor premium payments. As such, they will not be included in the MLR calculation.

***Implications of the Administrative Expense Cap and Reinsurance Cap.***

Administrative Expense Cap will only indirectly impact the report, rather than directly, via the Cap's possible impact on the amount of Experience Rebate payable. Any reinsurance amounts deemed unallowable via the Reinsurance Cap may impact the Report.

***Consolidation.*** If an MCO contracts with HHSC under more than one legal name, then the MCO must complete a consolidated Report including all such legal entities, across all MCO Programs and Service Areas.

***Implications of results.*** While there may be target MLR levels to achieve, there is no monetary impact, such as rebates, awards, or recoupments, associated with the MLR level attained for a given SFY by a given MCO. HHSC assesses a monetary impact instead via the Experience Rebate methodology, which serves a similar purpose.

### Report Template 5.3.13.2

HHSC developed a report template based on the requirements described in 42 CFR § 438.8, Medical loss ratio (MLR) standards, in particular §438.8(b), (d)-(h), (k), (m)-(n), and can be found in UMCM Chapter 5.3.13.2. The template has five separate components briefly described below; however, 42 CFR §438.8 contains the complete listing of items to be considered in the calculation, specifically for the numerator and denominator. Certain line-items in the template may pull from other pre-existing FSR line-items, others may reconcile to certain existing FSR line-items, and a few line-items may have no tie to other FSR line-items. Report line-items will include data such as the following:

#### 1 Number of Member Months

#### 2 Medical Loss Ratio Numerator

2.1 Total incurred claims dollars including Pharmacy but excluding Quality Improvement which is reported on a separate line (see 2.3 below). For clarification on the claims to include, refer to 42 CFR §438.8(e)(2)(i).



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2.2 Adjustments to Incurred Claims – adjustments must only be included or populated to the extent that they (1) conform to the CFR and (2) are not included in 2.1 above. Refer to 42 CFR §438.8(e)(2)(ii-vi).

2.3 Certain expenditures on quality improvement activities. Refer to 42 CFR §438.8(e)(3).

2.4 Expenditures related to fraud prevention activities. Expenditures under this section do not include fraud reduction efforts. Refer to 42 CFR §438.8(e)(4).

**3 Medical Loss Ratio Denominator.**

3.1 Gross Revenues – premium revenue which includes state capitation payments, state-developed one-time payments, and other payments. Refer to 42 CFR §438.8(f)(2).

3.2 Federal, State, and local taxes and licensing and regulatory fees – Refer to 42 CFR §438.8(f)(3).

3.3 Experience Rebate, if any – such amounts are deemed to be a return of the State’s portion of profit share and, as such, would lower the amount of reported premium revenue. Experience Rebate amounts incorporated in the calculation would be those generated by the operating results of the year being reported.

3.4 Any other CFR-specific adjustments not reported in 3.1 above. Refer to 42 CFR §438.8(f)(2).

**4 Calculated Medical Loss Ratio (MLR)** – the ratio of the numerator to the denominator.

**5 Adjustments to the Medical Loss Ratio (MLR)** – a creditability adjustment may be added to the calculated MLR if the MLR reporting year experience is partially credible. This would only be applicable to certain narrowly defined small-population situations; the MCO would demonstrate how it qualifies for such an adjustment, how it calculated the adjustment, and why that calculation is appropriate. This is not an actual cost and, therefore, will not tie to the FSRs. Refer to 42 CFR §438.8(h).

**6 Adjusted Medical Loss Ratio (MLR)** – the sum of the calculated MLR from item four and the adjustment in item five above.

**Attestation**

The MCO must complete and submit an attestation form with each MLR Report submitted to HHSC as provided in the HHSC’s UMCM Chapter 5.3.13.2 Medical Loss



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Ratio (MLR) Template and in accordance to 42 CFR §438.8(n). The attestation form must be signed by one of the following MCO officers : Chief Executive Officer (CEO), Chief Financial Officer (CFO), or equivalent.

### **Audit**

All line-items in the Report will be subject to HHSC's internal desk review process, and to audit in the annual FSR audits.