TEXAS Health and Human Services

UNIFORM MANAGED CARE MANUAL

CHAPTER 5.3.13.3
Medicare-Medicaid Dual Demonstration (MMDD) Medical Loss Ratio (MLR) Report Instructions

Version 2.1

Effective Date: October 01, 2022

Applicability of Chapter 5.3.13.3

This chapter applies to Medicare-Medicaid Plans (MMPs) participating in the Dual Demonstration. In this chapter, references to "Medicare and Medicaid" or the "Medicaid Managed Care Program(s)" apply to the Dual Demonstration.

Report Schedule

Each MMP must submit an annual medical loss ratio (MLR) report in accordance with these instructions and the "Resource Documents" listed in the Report Template section below. The first Report due under this chapter shall include the results of SFY 2020 and will be due as outlined in Section II.C. Table 2. MLR Reporting Schedule of these instructions. MMPs should file an aggregate MLR report (Report) for all plan codes.

Report and MLR Calculation Overview

The Report expresses the ratio of MCO incurred claims, including quality improvement expenditures, 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 by a credibility adjustment factor. This final ratio is the MLR.

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. 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.

The Administrative Expense Cap can potentially affect the Report 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 should complete a consolidated Report including all such legal entities, across all MMP 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

I. Background

Medicare-Medicaid Plans (MMPs, also known as STAR+PLUS MMPs) participating in the Texas Dual Eligibles Integrated Care Demonstration Project (the Demonstration) must submit to the Centers for Medicare & Medicaid Services (CMS) and the Texas Health and Human Services

Commission (HHSC) their Medical Loss Ratio (MLR) for coverage provided in the capitated financial alignment demonstration. MLR is the portion of plan revenues that are spent on claims and activities that improve health care quality. MMPs participating in the Demonstration are required to submit their MLR for all state fiscal years beginning with SFY 2018 (September 1, 2017 - August 31, 2018). Texas MMPs will report their MLR on a state fiscal year (September 1 – August 31), rather than Demonstration Year, basis.

This document provides instructions on submitting MLR reports for Texas MMPs participating in the Demonstration periods as shown below in Section II.A. Table 1. The instructions generally follow CMS' MLR Report Filing Instructions for Medicare Advantage (MA) organizations and Prescription Drug Plan (PDP) sponsors. However, the instructions also incorporate state-specific variations to address Medicaid-related issues not anticipated by CMS's MLR Report Filing Instructions for MA organizations and Part D sponsors, as well as requirements per the three-way contract. Please note that in cases where these instructions do not provide detail, the detailed guidance for each line item included in CMS' MA organizations and Part D sponsors applies.

A. Resource Documents

- 42 CFR Part 422, Subpart X for MA organizations & Part 423, Subpart X for Part D sponsors
- CMS' MLR Report Filing Instructions for MA organizations and Part D sponsors for CY2014through CY2019, available at: https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/medicallossratio.html
- The three-way contract for the Demonstration, available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and- Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXContract08012017.pdf
- MLR Requirements for the MA and Medicare Prescription Drug Benefit Programs; Final Rule, 78 Fed. Reg. 31284 (May 23, 2013), available at https://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf
- The CY2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program final rule [CMS-4182-F] may be found at:

https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf

- 42 CFR Part 438.8 for Medicaid managed care plans
- Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016), available at https://www.gpo.gov/fdsys/pkg/FR- 2016-05-06/pdf/2016-09581.pdf

II. MLR Coverage Year and Reporting Schedule

A. Coverage Year

The MLR coverage periods for MMPs participating in the Demonstration are as follows:

Table 1. MLR Coverage Years

COVERAGE YEAR	DEMONSTRATION YEARS	CALENDAR DATES
Year 1 (SFY 2018)	Partial 2, partial 3	September 1, 2017 to August 31, 2018
Year 2 (SFY 2019)	Partial 3, partial 4	September 1, 2018 to August 31, 2019
Year 3 (SFY 2020)	Partial 4, partial 5	September 1, 2019 to August 31, 2020
Year 4 (SFY 2021)	Partial 5, partial 6	September 1, 2020 to August 31, 2021
Year 5 (SFY 2022)	Partial 6, partial 7	September 1, 2021 to August 31, 2022
Year 6 (SFY 2023)	Partial 7, partial 8	Contingent on STAR+PLUS procurement and or a further bridge amendment for Contract Year 2023, Demonstration Year 8: September 1, 2022 to August 31, 2023[1]

End date of a Coverage Year may be adjusted pending Demonstration end date.

B. Claims Runout

The MLR for each Coverage Year is calculated using claims incurred during the coverage year and paid through 11 months after the end of the coverage year.

C. Reporting Schedule

For Coverage Year 1 and beyond, MMPs will follow the reporting schedule in Table 2 below. Following submission of the Report, CMS

and HHSC will have ninety (90) days to review, edit, and return the MLR calculation to the MMPs. Subsequently, MMPs will have sixty (60) days to review and respond to CMS and HHSC-edits of the MLR calculation. After the sixty (60) day review period by the MMPs, HHSC will review MMP-proposed changes to the report and finalize the report. Once the report is finalized, it is not restated, updated, or recalculated.

Table 2. MLR Reporting Schedule *(Due dates pending completion of quality withhold analysis for the applicable coverage year. Due dates may be extended by CMS and HHSC at a later date)*

COVERAGE YEAR	CALENDAR DATES	MLR REPORT DUE	CMS AND HHSC REVIEW COMPLETE	MMP REVIEW PERIOD COMPLETE
Year 1 (SFY 2018)	September 1, 2017 to August 31, 2018	April 1, 2021	April 30, 2022	June 30, 2022
Year 2 (SFY 2019)	September 1, 2018 to August 31, 2019	August 31, 2021	August 31, 2022	October 31, 2022
Year 3 (SFY 2020)	September 1, 2019 to August 31, 2020	August 31, 2023	November 30, 2023	January 31, 2024
Year 4 (SFY 2021)	September 1, 2020 to August 31, 2021	August 31, 2024	November 30, 2024	January 31, 2025
Year 5 (SFY 2022)	September 1, 2021 to August 31, 2022	August 31, 2025	November 30, 2025	January 31, 2026
Year 6 (SFY 2023)	September 1, 2022 to August 31, 2023	August 31, 2026	November 30, 2026	January 31, 2027

III. MLR Calculation

MLR is the portion of revenue, less taxes and regulatory fees, that a plan spends on claims and on activities that improve health care quality QI, which includes care coordination, with an adjustment added for plan credibility, as applicable. The formula is:

$$MLR = \left(\frac{(Claims + Quality\ Improvement)}{(Revenue - Taxes\ \&\ Regulatory\ Fees)}\right) + Credibility\ Adjustment$$

Prior to adding the Credibility Adjustment to the calculation, we refer to

the calculated MLR as the "unadjusted" MLR. CMS' MLR regulations for MA organizations and Part D sponsors increase a contract's calculated MLR by a Credibility Adjustment factor to account for the inherent claim fluctuations for contracts with low enrollment. We likewise add a Credibility Adjustment factor to the MLR calculation for MMPs. As a result, MMPs will add an amount—between 1.0% and 8.4%—to their "unadjusted" MLR to determine their MMP MLR. See the MLR Credibility Adjustment Section M below for more detail.

The MLR is expressed as a percentage rounded to the second decimal point.

IV. MLR Instructions for MMPs

We provide instructions below for MMPs to complete and submit their MLR reports. These instructions generally follow MLR rules promulgated for MA organizations and Part D sponsors. Where necessary, we modify the requirements in order to accommodate the inclusion of Medicaid data as well as the requirements of the three-way contract.

a. Submission of MLR Reports

Submit MLR reports via email to CMS at mmcocapsmodel@cms.hhs.gov and to HHSC per UMCM Chapter 5.0.1

- Deliverables Requirements Matrix. Use the following naming convention for the MLR Report Tool and Attestation for the files:

- HXXXX-Contract Name-SFY20XX-TX-MLR-Date.xlsx
- HXXXX-Contract Name-SFY20XX-TX-MLR-Attestation-Date.pdf.

where HXXXX is the contract reference number assigned to each MMP.

b. Accounting Principles

Use Statutory Accounting Principles to explain how revenue is used to pay for non-claims expenditures. Non-claims and QI expenses should be those allocated specifically to the MMP contract.

If this is not feasible, then the MMP must apportion the costs using a generally accepted accounting method that yields the most accurate results.

Add expenses for QI activities to incurred claims in the MLR calculation and indicate which activities qualify to be treated as QI for MLR reporting purposes.

c. Reporting Level

Report MLR at a state-wide level. The Report should include Medicare (inclusive of Medicare Parts A/B and Part D) and Medicaid combined. Combine all Plan Benefit Packages (PBPs) under a state contract.

d. Allocation of Expenses

Allocate expenses in accordance with the provisions in 42 CFR §§ 422.2420(d) and 423.2420(d).

e. Commercial Reinsurance

Do not adjust the MLR for commercial reinsurance, as commercial reinsurance premiums and recoveries are excluded from the MLR calculation. Report both costs and revenues 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).

f. Sequestration

Enter Medicare Sequestration amounts as negative amounts in Lines 1.0a (Medicare Parts A and B) and 1.0b (Part D). The expectation—for periods in which sequestration applies—is that sequestration amounts will be approximately 2% of the applicable CMS plan payments to MMPs prior to quality withholds. Note that the Part A/B capitation amounts from the Monthly Membership Detail Data Files (MMDDF) are prior to quality withholds.

For Part D, the 2% sequestration is applied only to the non-premium portion of the risk-adjusted National Average Monthly Bid Amount (NAMBA).[1] Note, starting with CY 2015, the "Direct Subsidy" field of the Monthly Membership Reports (MMR) includes the full risk-adjusted NAMBA, i.e., the combined premium and non-premium portions.

[1] See the March 11, 2015 Health Plan Management System (HPMS) memo, "CMS Update on Medicare Parts A/B and Part D Payments to Medicare-Medicaid Plans for Contract Year 2015." HPMS memos may be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data- and-Systems/HPMS/HPMS-Memos-Archive-Annual-Items/SysHPMS-Memo-Archive-%3F-2015-Qtr1. Plans can also access these memos directly through HPMS.

Therefore, for estimating Part D sequestration, MMPs can estimate the premium portion by multiplying the Low-Income Premium Subsidy Amount (LIPSA) by the MMR member months and subtracting that amount from the amount reported in the "Direct Subsidy" field prior to multiplying by 2% to estimate Part D sequestration, as follows:

$$\boldsymbol{Non-Premium\ Portion\ of\ Risk\ Adjusted\ NAMBA} = \left(\sum_{\substack{Coverage \\ Period}} \text{Direct Subsidy}\right) - \left(\text{LIPSA x} \sum_{\substack{Coverage \\ Period}} \text{member months}\right)$$

$$\boldsymbol{Part\ D\ Sequestration} = 2\%\ x \left(\left(\sum_{\substack{Coverage \\ Period}} \text{Direct Subsidy}\right) - \left(\text{LIPSA x} \sum_{\substack{Coverage \\ Period}} \text{member months}\right)\right)$$

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), enacted on March 27, 2020, suspended the sequestration of Medicare programs between May 1, 2020, and December 31, 2020. The Consolidated Appropriations Act, 2021, enacted December 27, 2020, extended this suspension for three more months, through March 31, 2021. H.R. 1868, enacted on April 14, 2021, further extended the suspension through December 31, 2021.

g. Revenue

Revenues must be reported for MLR purposes using all applicable categories in this section. The reporting categories are derived from MLR instructions for MA organizations and Part D sponsors; some categories may not be applicable to MMPs. Report revenue in all applicable categories.

- Medicare Revenue – enter payments made to the MMP for the coverage year in the following categories (as applicable):
  - Capitation Payments for A/B services, net of earned and unearned quality withholds, using final risk scores
  - Capitation Payments for Part D, using final risk scores
  - Part D federal reinsurance subsidy (prospective and reconciliation adjustments)
  - Part D Low Income Premium Subsidy Amount (LIPSA)
  - Part D risk corridor payments
  - Earned Quality Withhold: Quality withholds amounts earned back are

included as an adjustment to revenue.
- Note that Low Income Cost Sharing subsidy (LICS) and Coverage Gap Discount Program (CGDP) payments are not included in MLR reporting and are excluded from the numerator and denominator in MLR calculations.
- Note that Experience Rebates will be treated as a reduction in revenues in the MLR denominator.

- Medicaid Revenue– enter payments made to the MMP for the coverage year for the following categories (as applicable):
- Capitation Payments for Medicaid covered services net of earned and unearned quality withholds
- Other Medicaid Revenue
- Earned Quality Withhold: Quality withholds earned back as part of the MMP Quality Withhold are included as an adjustment to revenue.

- Note that Experience Rebates will be treated as a reduction in revenue in the MLR denominator.

To verify the material accuracy of MLR revenue data, CMS will compare the revenue included in the MMPs' MLR reports to internal CMS data. For Medicare revenue, this includes Monthly Membership Detail Data Files (MMDDF) (Note, Capitation A/B amounts will be calculated net of earned and unearned quality withholds), Payment Reconciliation System (PRS) Reconciliation Results Report to Plans, Contract Trailer "CTR" version (PRS CTR) data), earned quality withholds. CMS calculates sequestration amounts based on CMS-reported revenue amounts (see Section f above). For Medicaid revenue, CMS and HHSC will compare MMP revenue data to State Medicaid revenue data and earned quality withholds. If there are discrepancies between MMP- and CMS-reported Medicare revenue and enrollment amounts and/or State-reported Medicaid revenue, we will follow the procedure described below:

For revenue discrepancies for each line item within +/- 2%, CMS and HHSC will calculate MLR using MMP-reported data.

For revenue discrepancies for each line item greater than +/-2%, CMS and HHSC will request the MMP either explain the difference and reconcile to the CMS/State value, or revise their MLR report to resolve the discrepancy.

- If the MMP can reconcile their reported revenue to CMS/State values and explain why the MMP revenue value is correct (for example, due to differences in timing or the methodology to capture

data), CMS and HHSC may use the MMP-reported data for the MLR calculation.
    - If the MMP revises the MMP report, CMS and HHSC will determine next steps based upon any remaining discrepancy.

For experience rebate discrepancies, HHSC experience rebate data, as of the submission date of the MLR report, is considered accurate. The experience rebate data used by the MMP on the MLR report should be from the Final 334-Day Financial Statistical Report (FSR) and any changes to this data, either by CMS or HHSC, after the fact, will not be represented in the MLR report.

h. Claims

Enter the MMP's claims expenses for the reporting period.

1. Incurred Claims

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

- Direct claims that the MMP pays to providers (including under capitation contracts with physicians or other providers) for covered services provided to any enrollees under the contract, including any services purchased in lieu of more-costly Covered Services, as defined by the three-way contract. Refer to page 6 of the CMS' MLR Report Filing Instructions for MAOs and MAPDs for CY2014, CY2015, CY2016, CY 2017, CY2018, and CY2019 available at: https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/medicallossratio.html for treatment of payments to third party vendors.
- Any direct claims paid to providers for activities to address social determinants of health (SDOH).[2]
- Service Coordination Expense. That portion of the personnel costs

[2] CMS has published information and guidance regarding mechanisms to address SDOH under Medicaid and MA, at the following links:
Medicaid: January 7, 2021 SHO#21-00, "Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)" https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf
MA: April 24, 2019 HPMS memo "Implementing Supplemental Benefits for Chronically Ill Enrollees" https://www.cms.gov/Medicare/Health-Plans/HealthPlansGenInfo/Downloads/Supplemental_Benefits_Chronically_Ill_HPMS_042419.pdf and the final rule, Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program" June 2, 2020 (https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf)

for Care Coordinators whose primary duty is direct enrollee contact that is attributable to this Contract shall be included as a Benefit Expense. That portion of the personnel costs for Contractor's Medical Director that is attributable to this Contract shall be included as a Benefit Expense.

- Direct drug costs that are actually paid by the MMP, net of prescription drug rebates and other direct and indirect remuneration. (Note: this is consistent with the CMS's MLR Report Filing Instructions for MAOs and MAPDs for CY2014, CY2015, CY2016, CY 2017, CY2018, and CY2019 available at: https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/medicallossratio.html for treatment of payments to third party vendors as noted on p. 18)
- Unpaid claims reserves for the reporting period, including claims reported in the process of adjustment.
- Quality withholds from payments made to contracted providers. For example, a plan that uses a 2% quality withhold from provider payments, must include that 2% in the incurred claims reported for MLR purposes; the plan does not have the option of excluding this 2% from MLR incurred claims (even if the 2% was NOT paid out).
- Incurred but not reported claims based on past experience and modified to reflect current conditions such as changes in exposure, claim frequency, or severity.
- Changes in other claims-related reserves.
- Claims that are recoverable for anticipated coordination of benefits.
- Claims payments recoveries received as a result of subrogation.
- For MMPs opting to report fraud-related expenses (See Section j.) following the MLR guidance applicable to Medicaid Managed Care plans, claims payments recovered through fraud reduction efforts, the value of which may not exceed the value of the MMP's fraud reduction expenses. Fraud reduction expenses do not include fines and/or penalties assessed by regulatory authorities.

Adjustments that must be deducted from incurred claims include:

- Overpayment recoveries received from providers.

2. Exclusions from Incurred Claims

The following amounts must not be included in incurred claims:

- Non-claims costs, as defined in §§ 422.2401 and 423.2401, which include the following:
    - Amounts paid to third party vendors for secondary network savings.

- Amounts paid to third party vendors (for any of the following:
  - Network development.
  - Administrative fees.
  - Claims processing.
  - Utilization management.
- 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:
  - Medical record copying costs.
  - Attorneys' fees.
  - Subrogation vendor fees.
  - Bona fide service fees.
  - Compensation to any of the following:
    - Paraprofessionals.
    - Janitors.
    - Quality assurance analysts.
    - Administrative supervisors.
    - Secretaries to medical personnel.
    - Medical record clerks.

i. Federal and State Taxes and Licensing or Regulatory Fees

Federal and State taxes and assessments and licensing or regulatory fees are reported consistent with MLR reporting requirements for MA organizations and Part D sponsors under §§ 422.2420(c)(2) and 423.2420(c)(2).

The Health Insurance Provider fee (HIPF) is considered incurred in the year in which it is paid. For CY2019, the HIPF[3] is zero, as Congress imposed a moratorium on the fee for CY2019.

The HIPF is in effect for CY2020; therefore, report the HIPF as a non-zero amount.4

The HIPF does not apply beyond CY2020.[5]

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[3] The Health Insurance Providers Fee (HIPF) is imposed under §9010 of the Patient Protection and Affordable Care Act, the unofficial full text version (that is more readable) is available at: http://housedocs.house.gov/energycommerce/ppacacon.pdf

[4] See IRS Notice 2019-50, under "Legal Guidance/Notices" here: https://www.irs.gov/affordable-care-act/affordable-care-act-of-2010-news-releases-multimedia-and-legal-guidance

[5] H.R. 1865, Sec 502, and as explained here: https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

j. Fraud-Related Expenses

MMPs may opt to report fraud-related expenses by following the guidance applicable either to MA organizations and Part D sponsors or to Medicaid Managed Care plans (choose one).
Effective 2019, CMS instructs MA organizations and Part D sponsors to report fraud-related expenses as QI expense.[6] Therefore, MMPs opting to follow the MLR guidance applicable to MA organizations and Part D sponsors report all fraud-related expenditures as QI (See Section k.).[7]
Fraud-related expenses include fraud prevention, fraud detection, and fraud recovery.
MMPs opting to follow the MLR guidance applicable to Medicaid Managed Care plans will include claims payments recovered through fraud reduction efforts, the value of which may not exceed the value of the MMP's fraud reduction expenses (see Section h). Under the guidance applicable to Medicaid Managed Care plans, expenses attributed to fraud prevention activities are not included in the MLR calculation.

k. Health Care Quality Improvement (QI) Expenses

Except for fraud-related expenses as discussed below and in Section j., add expenses QI activities to incurred claims in the MLR calculation. For FAI MLR reporting purposes, QI expenses are for activities defined under any of the following federal regulations:

- 42 CFR §§ 422.2430(a) and 423.2430(a) (see note below)
- 42 CFR §438.8(e)(3), which includes, by reference, those QI activities listed under 45 CFR § 158.150

If the MMP opts, under Section j., to report fraud-related expenses following the guidance applicable to MA organizations and Part D sponsors, the plan will report its expenses for fraud reduction, fraud recovery and fraud prevention under the QI expense category.

To the extent the MMP incurs any non-claims expenses for activities that address SDOH, report the expenses under QI if the activity meets the requirements for QI activities applicable to MA sponsors and Part D plans or to Medicaid Managed Care plans.

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[6] Prior to CY2019, fraud-related expenses were reported under MA and Part D as a positive adjustment to incurred claims.
[7] 83 FR 16670, "Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program" publication date April 16, 2018 [CMS-4182-F] available at: https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf

Note that under the Financial Alignment Initiative demonstrations, MMPs uniformly report care coordination expense as a QI expense under line 4.1 Improve health outcomes.

l. Non-Claims Costs

Report non-claims costs, as defined in §§ 422.2401 and 423.2401, for 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 (4));
(2) Expenditures on QI 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)).

m. Total Member Months

Enter the member months associated with the contract, ensuring the reported months entered are consistent with the revenue and claims information provided.

n. MLR Credibility Adjustments

Per §§ 422.2440 and 423.2440, a MMP may add a credibility adjustment factor as published in the Final Rate Announcement for MA-PD Contracts for the applicable payment years to its calculated MLR if the contract's experience is partially credible. See the Excel MMP MLR template, the table reflects the 2020 credibility adjustment factors[8] however, these factors may be subject to change for future periods. Note, the credibility adjustment factor will be calculated automatically based on the member months provided in the Excel MMP MLR template spreadsheet. For those reporting periods for which a contract has non-credible experience, as determined per the table referenced above, an MLR report must still be submitted.

V. Attestation

Submit an attestation to accompany each MLR Report submitted to CMS

[8] Information on the applicable credibility adjustment for each reporting year can be found at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.

and HHSC. Populate the "Attestation" tab in the Excel MMP MLR template with attestation by the MMP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or Chief Operating Officer (COO). See Section IV A. for the naming convention for the submitted attestation file.

VI. Audit

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

VII. Questions

Address questions on these instructions and the associated reporting tool to CMS at mmcocapsmodel@cms.hhs.gov and to HHSC at HHSC_FRAC@hhs.texas.gov

Table 3. DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	2.0	February 1, 2021	Initial version Uniform Managed Care Manual Chapter 5.3.13.3, "Medicare-Medicaid Dual Demonstration (MMDD) Medical Loss Ratio (MLR) Report Instructions." This chapter applies to Medicare- Medicaid Plans (MMPs) in the Dual Demonstration
Revision	2.0.1	June 25, 2021	Accessibility approved version.
Revision	2.1	October 1,2022	The following updates were made: • Streamlining language throughout document for readability. • Updating references to resource documents to reflect the most currently applicable guidance for the Medicare and Medicaid programs (Section I.A. Resource Documents and throughout). • Updating State Fiscal Year to SFY 2020 in "Report Schedule". • Deleting language on how MLR may be expressed in "Report and MLR Calculation Overview". Language was unclear and not needed. • Updating language in "Implications of the Administrative Expense Cap and Reinsurance Cap" for clarity. Went from "should not" to "can potentially" in language. • Updating "Coverage Period" to "Coverage Year"

			throughout the document, but especially in "II. MLR Coverage Year and Reporting Schedule". • Updating "Table 1. MLR Coverage Years" coverage years, demonstration years, and calendar dates. Also, updating footnote on table. • Updating C. Reporting Schedule with additional detail for clarity. Review periods and finalized reporting required additional elaboration. • Updating "Table 2. MLR Reporting Schedule" to reflect changes to review periods. Also, added additional years as new rows. • Updating "IV. MLR Instructions for MMPs" with introductory language for the MMPs to understand the section. • Removing language on QI choice from "IV.b. Accounting Principles" • Adding information on the suspension of Medicare Sequestration from May 1, 2020, through December 31, 2021 (Section IV.f. Sequestration). • Including information on CMS and HHSC review of MMP-reported revenue and what revenue differences CMS/HHSC consider immaterial (Section IV.g. Revenue). • Adding additional language on the handling of revenue discrepancies in Section IV.g. Revenue. • Adding language on direct claims and SDOH to IV.h. Claims. • Adding information on the applicability of the Health Insurance Providers Fee (HIPF) (Section IV.i. Federal and State Taxes and Licensing or Regulatory Fees). • Streamlining reporting for

			Quality Improvement (QI) activities (including removing an Appendix regarding Quality Improvement (QI) Activities), including: ○ Expanding what plans may report as QI to include any claimed expenditure that meets the categorical and design requirements listed at §§ 422.2430(a)(3) and 423.2430(a)(3) or the conditions for inclusion and activity design requirements listed at § 438.8(e) (with reference to 45 CFR § 158.150). ○ Adding a section on the treatment of fraud related expenses (Section IV.j. Fraud Related Expenses). As of CY2019, MLR for MA organizations and Part D sponsors includes, within QI activities, all fraud-related expenses. (Sections IV.j and IV.k address treatment of fraud-related expenses and Quality Improvement Activities). ○ Updating information on Quality Improvement (QI) Activities, including treatment of fraud-related expenses for MA organizations and Part D sponsors, for consistency with current regulation

[1] Status should be represented as "Baseline" for initial issuances and "Revision" for changes to the Baseline version.
[2] Revisions should be numbered 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.
[3] Brief description of the changes to the document made in the revision.