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# Medical Loss Ratio (MLR) in the Mega Reg

## MLR Reporting Update

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CMS published the "Mega-Reg" CMS-2390-F (final rule) on May 6, 2016, and over a year later state Medicaid agencies (states) continue to work through the implications for their managed care programs.

One final rule requirement that states are currently working through is the development of reporting templates and processes to comply with medical loss ratio (MLR) oversight. For rating periods starting July 1, 2017[1] or later, states are required to collect and report MLR results from their managed care organizations (MCOs).

States need to report high level summarized MLR results to CMS for each MCO as required in Section 438.74 of the final rule. At a minimum, states must report the numerator, denominator, MLR, member months, and any remittance (i.e., refund) amounts. If MCOs owe remittance amounts, states also need to provide a separate report documenting the federal share methodology and remittance amounts. Section 438.8(k) of the final rule requires states to collect more detailed information than what is required to be reported to CMS under 438.74 (see sidebar). The remainder of this report discusses specific considerations in the development of the MLR reporting template.[2]

## Separate MLR versus Comprehensive Financial Reporting

States may incorporate MLR reporting requirements into their current financial reporting template(s) or create a separate MLR reporting template. While it may be easier initially to create a separate MLR reporting template, states may consider developing a comprehensive financial reporting template for two primary reasons:

- To avoid MCOs completing multiple financial templates with different reporting items and financial reconciliations, as well as prevent potential discrepancies in amounts between different sources.
- To help actuaries and states acquire a better understanding of MCO financial reporting than separate fragmented reports used for difference purposes.

For example, even though non-state plan services are typically not used in capitation development, non-state plan services are included in MLR results and are also useful for validating data between financial reporting and encounter data for capitation development. Fragmented reporting may lead to confusion of how treatment of specific items such as non-state plan services are treated in each report as well as how the two reports compare overall to each other and GAAP financial statements.

States may, perhaps, prefer a separate MLR reporting template if the MLR reporting is collected later than the financial reporting template used for capitation development. States will need to consider the advantages of using an integrated financial reporting template for both capitation development and MLR reporting versus the advantages of using a stand-alone MLR template.

### MCO reporting requirements to states in Section 438.8(k):

- Incurred claims
- Quality improvement expenses
- Fraud prevention activities
- Non-claim expenses
- Premium revenue
- Taxes, licensing, and regulatory fees
- Methodologies for allocation of expenditures
- Any credibility adjustments applied
- Calculated MLR
- Any remittance owed
- Comparison to audited GAAP financial report
- Description of aggregation method
- Member months

[1] Effective dates for different provisions in the final rule vary: https://www.medicaid.gov/medicaid/managed-care/downloads/implementation-dates.pdf.

[2] Please see http://www.milliman.com/insight/2016/Medical-loss-ratio-MLR-in-the-Mega-Reg/ for more information on the MLR definition and requirements in the final rule.

## Data Collection Considerations

States may want to collect more detailed information than the minimum requirements for reporting historical MLRs. For example, states can gain useful knowledge from collecting data on various types of taxes separately from licensing and regulatory fees for both capitation development and MLR reporting. Capitation development may include licensing and regulatory fees but may exclude income taxes. The separate reporting of specific items such as income taxes should also help with projected MLRs because income taxes may be materially different between the experience period and the projected rating period. States should additionally consider whether MLR results will be determined by various eligibility category groupings or in aggregate across all eligibility categories.

States can require actual amounts to be reported separately from estimated amounts, so actuaries can review any estimated amounts for reasonableness in capitation development. For example, claim reserves, subrogation, and provider risk sharing amounts may include estimates for receivables or liabilities not yet finalized.

States with rating periods on a calendar year basis have the option of collecting the MLR results on an incurred year or financial statement basis. If a state elects a financial statement basis, MCOs estimates in financial statements may have more uncertainty in the current year's results than estimated amounts in re-stated incurred year reporting with additional months of run-out. As a result, financial statement results for a given year could materially differ from the actual year's ultimate results from both the prior year's financial statement estimates as well as uncertainty in the current year financial statement reporting estimates. These issues may also make it more difficult to project rate year MLRs. However, reporting MLRs on a financial statement basis may ease the administrative burden of MLR reporting for MCOs. States with rating periods on a fiscal year basis are required to complete the MLR reports on an incurred year basis.

MCOs should take responsibility for accurately reporting MLR results. However, it is prudent for states and their actuaries to review reported amounts for reasonableness. For example, instead of relying on MCOs to ensure expenses directly used for fraud recoveries do not exceed fraud recoveries, the reporting template can ask for both amounts separately to check for compliance with MLR requirements. Similarly, the reporting template can collect community benefit expenses separately from other taxes, licensing, and regulatory fees and ask about federal tax-exempt status to check for compliance with maximum allowed community benefit expense amounts.

MLR reporting should be flexible enough to handle unique MCO specific items and allow MCOs to identify whether items should be included or excluded from MLR results. For example, the financial template can include a standard reconciliation format for comparing incurred year reporting to GAAP financials, yet it can allow an MCO to provide its own custom reconciliation if the MCO's comparison does not fit nicely in the standard format or the MCO prefers its own format.

## Federal Share of MLR Remittances

CMS requires states to determine and report its methodology for determining the federal share of any MLR remittances. If minimum MLR requirements apply across multiple populations with varying federal medical assistance percentages (FMAPs), the federal share of the remittance may vary depending on the state's selected allocation methodology.

We have described below some potential methodologies for determining the federal share of any minimum MLR remittances.

1. **Composite FMAP based on MLR Denominator (Revenue minus Taxes, Licensing, and Fees) –** Under this methodology, the federal share of the remittance is allocated by the MLR denominator amounts for each population. We think this allocation method may be reasonable since federal participation is determined based on capitation revenue, which is the main component of the denominator. This methodology has the advantage of allocating the remittance based primarily upon capitation payments; claims expense does not need to be allocated by population.
2. **Composite FMAP based on Remittance –** Under this methodology, the federal share of the remittance is allocated by the total (state and federal) remittance amounts for each population. We think this allocation method makes intuitive sense. However, the implied federal remittance share can result in a negative amount when a high-FMAP population is above the minimum MLR, but the total remittance amount is positive. We illustrate this scenario later in this report. Similarly, the state remittance share could result in a negative amount.
3. **Composite FMAP based on MLR Numerator (Claims plus Quality Improvement Expenses)** – Under this methodology, the federal share of the remittance is allocated by the MLR numerator amounts for each population. We think this methodology makes the least intuitive sense and would be the hardest to justify, but we included it as an example.

Figure 1 illustrates a scenario where an MCO covers two populations under a managed care contract, one with a FMAP of 50% and the other with a FMAP of 90%. The MCO has full MLR credibility (i.e., no credibility adjustment) and an 85% minimum MLR is required at the program level (i.e., all populations combined). Under this scenario, the MCO owes a $20.0 million remittance, and the state needs to determine the federal share.

The last two rows of Figure 1 illustrate the composite FMAP and implied federal remittance, respectively, based on the three FMAP methodologies resulting in federal share amounts ranging from $12.0 million to $14.3 million.

Figure 2 illustrates a scenario similar to Figure 1, except Population 2 has a MLR of 95% (above the minimum 85%). Under this scenario, the MCO owes a $5.0 million remittance, and the state needs to determine the federal share. The resulting range of federal share remittances is a $1.5 million federal liability to a $3.7 million federal receivable. We show an additional adjusted remittance in Column (6) where we only allocate the federal share of the remittance by the positive remittance amounts. Similarly, a state liability could occur in Column (5) if we switched the MLRs of the two populations.

As mentioned above, each of these methods may be reasonable but result in different federal share allocations of the remittance. States will need to determine their federal share allocation methodologies and support their calculations. Alternatively, states could avoid these FMAP complications by structuring the minimum MLR requirements in their MCO contracts to group only similar FMAP populations together. This approach would result in less credible cohorts for the minimum MLR calculations, but would also eliminate the issues highlighted above.

**FIGURE 1: FMAP METHODOLOGY SCENARIO 1**
**(DOLLARS IN MILLIONS)**

| POPULATION | (1) FMAP | (2) NUMERATOR | (3) DENOMINATOR | (4)=(2)/(3) MLR | (5)=(3)*85%-(2) REMITTANCE |
|---|---|---|---|---|---|
| POPULATION 1 | 50.0% | $70.0 | $100.0 | 70.0% | $15.0 |
| POPULATION 2 | 90.0% | $80.0 | $100.0 | 80.0% | $5.0 |
| **TOTAL** | | **$150.0** | **$200.0** | **75.0%** | **$20.0** |

| COMPOSITE FMAP METHODOLOGY BASED ON | NUMERATOR | DENOMINATOR | REMITTANCE |
|---|---|---|---|
| COMPOSITE FMAP* | 71.3% | 70.0% | 60.0% |
| IMPLIED FEDERAL REMITTANCE** | $14.3 | $14.0 | $12.0 |

*Composite FMAP is column (1) weighted by either column (2), (3), or (5)
**Implied Federal Remittance is the total in (5) multiplied by the Composite FMAP

**FIGURE 2: FMAP METHODOLOGY SCENARIO 2**
**(DOLLARS IN MILLIONS)**

| POPULATION | (1) FMAP | (2) NUMERATOR | (3) DENOMINATOR | (4)=(2)/(3) MLR | (5)=(3)*85%-(2) REMITTANCE | (6) ADJUSTED REMITTANCE |
|---|---|---|---|---|---|---|
| POPULATION 1 | 50.0% | $70.0 | $100.0 | 70.0% | $15.0 | $5.0 |
| POPULATION 2 | 90.0% | $95.0 | $100.0 | 95.0% | $(10.0) | $0.0 |
| **TOTAL** | | **$165.0** | **$200.0** | **82.5%** | **$5.0** | **$5.0** |

| COMPOSITE FMAP METHODOLOGY BASED ON | NUMERATOR | DENOMINATOR | REMITTANCE | ADJUSTED REMITTANCE |
|---|---|---|---|---|
| COMPOSITE FMAP* | 73.0% | 70.0% | (30.0%) | 50.0% |
| IMPLIED FEDERAL REMITTANCE** | $3.7 | $3.5 | ($1.5) | $2.5 |

*Composite FMAP is column (1) weighted by either column (2), (3), (5), or (6)
**Implied Federal Remittance is the total in (5) multiplied by the Composite FMAP

## Timing

States should consider the timing around financial reporting versus MLR reporting. States need to report MLR results to CMS within 12 months after the end of the MLR reporting year. States may need financial reporting for data validation and capitation development earlier than final information is ready for MLR results. One item in particular that could delay MLR reporting is pay-for-performance (P4P) withhold returns. The regulations appear to require revised MLR results if P4P withhold returns are determined after the original MLR reporting (considered a state capitation change). If states cannot settle P4P withhold returns sooner, states may need to report preliminary MLRs to CMS within 12 months after the end of the MLR reporting year and then provide revised MLR results to CMS once states finalize P4P withhold returns.

MCOs will need time to understand and properly complete the financial templates. States and their actuaries will need to review the completed financial templates and may need to discuss the results with the MCOs to understand how they are completed. The timing of historical MLR reports will also impact the ability of an actuary to practically consider the results in the capitation development for the rate year. Financial reporting will likely evolve and continue to improve over time to fit the changing needs of state-specific Medicaid programs and participating MCOs.

## Conclusion

While states have implemented many provisions of the final rule, we believe states can still make significant improvements to achieve CMS's goal of modernizing Medicaid managed care. In particular, states can develop robust financial reporting templates to meet the needs for capitation development, MLR reporting, and overall financial oversight for Medicaid managed care programs.

## Qualifications

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

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