MINIMUM MEDICAL LOSS RATIO REBATE CALCULATION REPORT INSTRUCTIONS

FOR THE REPORTING PERIOD ENDING DECEMBER 31, 2020

INTRODUCTION

The following definitions and instructions outline the requirements for the Minimum Medical Loss Ratio (MMLR) process that is required by each CCO's Medicaid contract with OHA. The Coordinated Care Organizations (CCO) contract includes a provision that requires CCOs to be held to an 85% MMLR for the total Member population, and if a lower ratio occurs, then CCOs are required to rebate the difference back to OHA. CCOs are required to submit a MMLR Rebate Calculation Report that details the revenues and costs related to their OHP Line of Business to calculate whether a rebate is required. OHA may request additional supplemental information and/or data in order to substantiate the MMLR calculation.

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GENERAL DEFINITIONS

Contractor means a Coordinated Care Organization (CCO) under contract with the Oregon Health Authority (OHA) through a Health Plan Services Contract (Contract).

Credibility Adjustment means an adjustment to the Medical Loss Ratio (MLR) for a partially credible Contractor to account for a difference between the actual and target MLRs that may be due to random statistical variation.

Full Credibility means a standard for which the experience of a Contractor is determined to be sufficient for the calculation of a MLR with a minimal chance that the difference between the actual and target MLRs is not statistically significant. A Contractor that is assigned Full Credibility (Fully Credible) will not receive a Credibility Adjustment to its MLR.

Line of Business means revenues and costs associated with the Oregon Health Plan (OHP) Line of Business as reported on Exhibit L Report L6 OHP.

Member means a client who is enrolled with a Contractor under Medicaid Contract with OHA. Cover All Kids members should be excluded from the MMLR analysis.

Member Months means the number of Members times the months in which capitation payments were made by OHA to Contractor for those Members and should equal the amount reported on Exhibit L Report L4.

MLR means Medical Loss Ratio and equals Total Incurred Medical Related Costs, divided by Total Medical Related Revenues.

MMLR Standard means a Minimum MLR exceeding 85% for the total Member population.

No Credibility means a standard for which the experience of a Contractor is determined to be insufficient for the calculation of a MLR. A Contractor that is assigned No Credibility (Non-Credible) will not be measured against any MLR requirements.

Partial Credibility means a standard for which the experience of a Contractor is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target MLRs is statistically significant. A Contractor that is assigned Partial Credibility (Partially Credible) will receive a Credibility Adjustment to its MLR.

Rebate Period means Reporting Period 2020.

Reporting Period: The Reporting Period for this MMLR Rebate Calculation Report will be for the calendar year period of January 1, 2020 to December 31, 2020. Each Contractor is required to submit a MMLR Rebate Calculation Report with accurate data by August 31, 2021 based on capitation revenue and claims data paid through March 31, 2021, withhold amounts earned back via Quality Pool (or Challenge Pool incentive payments) through June 30, 2021, and accrued Quality Pool / Challenge Pool expenses as of June 30, 2021.

REPORT INSTRUCTIONS AND DEFINITIONS BY SECTION

SECTION #1: MEDICAL RELATED REVENUES

1. **Gross Premiums** means Capitation Payments (prior to any withholding) plus Case Rate Revenue and Qualified Directed Payments (QDP). Case Rate Revenue includes any payments made on a case rate basis, including maternity case rates.

2. **Withhold Reserved from Capitation Rates** means amounts withheld from capitation rates in line 1 prior to payment to the CCO. Line 1 less line 2 in this MLR template should balance to Line 1 from the Exhibit L Report L6 OHP, except for prior year adjustments.

3. **Federal and State Taxes and Licensing or Regulatory Fees** includes federal income taxes; other federal taxes and assessments; state income, excise, business and other taxes; state premium taxes; and regulatory authority licenses and fees. The following outlines instructions for each component:

    - **Federal income taxes** allocated to the OHP Line of Business.

        Exclude: Federal income taxes on investment income and capital gains.

    - **Other Federal Taxes (other than income tax) and assessments.**

        Include: Federal taxes and assessments (other than income taxes) allocated to the OHP Line of Business and the ACA Health Insurance Provider Fee pertaining to the OHP Line of Business.

        Exclude: Fines, penalties, and fees for examinations by any Federal departments.

    - **State income, excise, business, and other taxes** allocated to the OHP Line of Business that may be excluded from Gross Premiums under 45 CFR §158.162(b)(1).

Include:

- Any industry wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State that are authorized by State law.
- Market stabilization redistributions, or cost transfers for the purpose of rate subsidies (not directly tied to claims) that are authorized by State law.
- Guaranty fund assessments.
- Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.
- Advertising required by law, regulation or ruling, except advertising associated with investments.
- State income, excise, and business taxes other than premium taxes.

Exclude: Fines, penalties, and fees for examinations by any State departments.

- **State premium taxes.**

  Include: State premium taxes or State taxes based on policy reserves if in lieu of premium taxes related to the OHP Line of Business.

- **Regulatory authority licenses and fees.**

  Include: Statutory assessments to defray operating expenses of any State or Federal regulatory authority, and examination fees in lieu of premium taxes as specified by State law.

  Exclude: Fines, penalties, and fees for examinations by any State or Federal regulatory authority.

4. **Qualified Directed Payments** means amount paid or accrued for the Rural and Small (Type A/B) hospital and public academic health centers Qualified Directed Payments (as defined in 42 CFR §438.6(c)(1)(iii)). This value should balance to Line 1b of Exhibit L Report L6 OHP.

5. **Reinsurance/Stop Loss Premiums Paid net of Recoveries** is a combination of the following: Premiums paid/accrued for reinsurance or stop loss insurance should be recorded equal to Line 20

of Exhibit L Report L6 OHP. Reinsurance recoveries should be recorded equal to Line 21 of Exhibit L Report L6 OHP (i.e. subtracted from reinsurance premiums).

6. **Net Premiums** means Gross Premiums reduced by lines 2 through 5:

7. **Withhold Earned Back** means the withhold earned back through the Quality Pool Payment received by Contractor on or about June 30, 2021. Note that any accompanying Challenge Pool payment is not included under this line, as it is an incentive payment outside of adjusted premium revenue as defined under 42 CFR 438.8(f).

8. **Risk Corridor Settlements** means adjustments for risk corridor payments for OHP Line of Business for the reporting period. If a payment is due to OHA, enter as a negative number. If Contractor is owed an additional payment, enter as a positive number.

9. **Other Health Care Related Revenues** means other supplemental revenues received by Contractor that should be included under 42 CFR 438.8(f).

   Exclude: Quality Pool and Challenge Pool payments made by OHA to Contractor.

10. **Total Medical Related Revenues** means the sum of lines 6 through 9.

SECTION #2: INCURRED MEDICAL RELATED COSTS

Lines 11 through 19 reflect the requirements of 42 CFR 438.8(e)(2).

11. **Paid Claims** means amounts paid through March 31, 2021 that were for services incurred or provided during that Reporting Period.

    Include: Claims paid on a fee-for-service basis.

12. **Unpaid Claim Reserve** means reserves and liabilities established to account for claims incurred during the Reporting Period that were unpaid as of March 31, 2021.

    Review consideration: Supplemental information may be requested to substantiate these estimates (i.e. claim triangles, etc.).

13. **In lieu of services** means payments made that meet the requirements of 42 CFR 438.3(e)(2).

14. **Sub-Capitated Payments** means a per member payment on a regular basis made to a sub-capitated provider or vendor that is meant to cover specific services and/or members, and puts the

provider/vendor at risk if costs are higher than the total payment received. Sub-capitated payments typically include a factor to cover administrative costs incurred and underwriting gains allowed to the sub-capitated provider or vendor.

Include: Sub-capitated payments or other forms of alternative payments made to Participating Providers.

Exclude: Non-medical component of sub-capitated payments made to providers/vendors (see separate guidance starting on page 15).

15. **Incurred Medical Incentive Pools and Bonuses** – **Quality/Challenge Pools** means payments to Participating Providers which align with the Quality/Challenge Pool program for achieving the outcome and quality objectives.

16. **Incurred Medical Incentive Pools and Bonuses - Other** means risk sharing and other arrangements with Participating Providers whereby the Contractor agrees to share savings with Participating Providers or to pay bonuses based on achieving defined measures and/or outcomes outside the Quality/Challenge Pools.

17. **Other Incurred Medical Costs** means medical or health-related costs not otherwise classified.

18. **TPR, COB, and Subrogation** is a combination of the following: Third Party Reimbursement (TPR), Coordination of Benefits (COB), subrogation or similar payments received and payments recovered through fraud reduction efforts (not to exceed the amount of fraud reduction expenses) as reported on Line 23 of Exhibit L Report L6 OHP. These amounts should be recorded as offsets to medical costs (i.e. a negative entry).

    Exclude: Fraud prevention activities costs reported under line 22 of this report.

19. **Provider Stabilization Payments** means any payment, including Value-Based Payments, from a Contractor to a Provider that is:

    (i) Made during a COVID-19 Emergency;

    (ii) When combined with any other payments to the Provider made for Covered Services rendered during the period, no greater than a reasonable estimate (based on historic claims data) of the claims the Provider would have submitted to Contractor for Covered Services provided to Members under this Contract but for the COVID-19 pandemic; and

(iii) Made to ensure the availability of the Provider, both during and after any COVID-19 Emergency, to deliver Covered Services to Members under this Contract.

Note that Contractors should also provide supporting documentation in the Provider Stabilization Payments tab.

20. **Total Incurred Claims** means the sum of Lines 11 through 19.

21. **Activities that Improve Health Care Quality** includes expenses related to the following, as defined in 42 CFR 438.8(e)(3):
    - Activities to improve health outcomes
    - Activities to prevent hospital readmission
    - Activities to improve patient safety and reduce medical errors
    - Wellness and health promotion activities
    - Health information technology (HIT) expenses related to improving health care quality

    Note: "Health-related services", "flexible services" and "community benefit initiatives" as described in the CMS section 1115 Waiver and OAR 410-141-3845 should be included on line 21. Only include the portion of health-related services that is reviewed and approved by OHA.

22. **Fraud Prevention Activities** means expenditures on activities related to fraud prevention as defined in 42 CFR 438.8(e)(4).

23. **Total Incurred Medical Related Costs** means the sum of:
    - Total Incurred Claims;
    - Activities that Improve Health Care Quality; and
    - Fraud Prevention Activities.

24. **Total Non-Claims Costs** means **Total Operating Expenses** as reported on Line 30 of Exhibit L Report L6 OHP minus the sum of **Total Incurred Medical Related Costs** as reported on Line 23 above and **Reinsurance/Stop Loss Premiums Paid net of Recoveries** as reported on Line 5 above.

The following lines are then calculated in the MLR Rebate Calculation tab:

25. **Medical Loss Ratio** or **MLR** means Total Incurred Medical Related Costs, divided by Total Medical Related Revenues.

26. **Credibility Adjustment Factor** is added to the reported MLR if the MLR Reporting Period experience is Partially Credible. Contractors with non-credible or fully credible experience do not receive a Credibility Adjustment Factor. Credibility Adjustment Factor components are published in the Credibility Adjustment tab.

27. **Credibility Adjusted Medical Loss Ratio** or **CAMLR** means MLR, plus Credibility Adjustment Factor.

28. **Rebate** means the dollar amount which, if added to the Contractor's Total Incurred Medical Related Costs for the Rebate Period, would result in a CAMLR equal to the MMLR Standard. If CAMLR exceeds the MMLR Standard, the rebate is zero. In the event the Contractor's CAMLR falls below the MMLR standard for a Rebate Period, the Contractor will be obligated to OHA for a Rebate. Contractors who are subject to a Rebate will also need to provide additional reporting necessary for OHA to fulfill provisions of the SUPPORT Act. Please contact OHA to initiate this process.

    If the Contractor's contract is terminated or not renewed prior to the end of the full Rebate Period, the Contractor must submit the final MLR Rebate Report within 180 days following contract termination or non-renewal; the claims paid through date will be 90 days following the Contractor's contract termination or non-renewal. In such instance, the Rebate will be settled based on the average CAMLR using a shorter period ending on the Contractor's contract termination or non-renewal date.

LINE 21 – ACTIVITIES THAT IMPROVE HEALTH CARE QUALITY DEFINITIONS

The information contained in this section, as described in 45 CFR §158.150, outlines the expenses to include and exclude for **Line 21: Activities that Improve Health Care Quality** in the MMLR Rebate Calculation Report.

QUALITY IMPROVEMENT ACTIVITIES—GENERAL OVERVIEW

In general, expenses for Quality Improvement (QI) activities are costs incurred by Contractor that is designed to:

- Improve health quality;
- Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements;
- Be directed toward individual Members or incurred for the benefit of specified segments of Members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-members; and
- 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.

QI activities must be primarily designed to:

- Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations;
- Prevent hospital readmissions through a comprehensive program for hospital discharge;
- Improve patient safety, reduce medical errors, and lower infection and mortality rates;
- Implement, promote, and increase wellness and health activities; or
- Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 CFR §158.151.

Expenditures and activities that must not be included in quality improving activities are:

- Those that are designed primarily to control or contain costs.
- The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.

- Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from Total Medical Related Revenues included on Line 10.
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.
- 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, including maintenance of current code sets.
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.
- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.
- Provider credentialing.
- Marketing expenses.
- Costs associated with calculating and administering individual Member incentives.
- That portion of prospective utilization that does not meet the definition of activities that improve health quality.
- Any function or activity not expressly described below, unless otherwise approved by and within the discretion of OHA, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes in this section or otherwise support monitoring, measuring or reporting health care quality improvement.

ACTIVITIES TO IMPROVE HEALTH OUTCOMES

Include expenses for the direct interaction of the Contractor (including those services delegated by contract for which the Contractor retains ultimate responsibility for), providers, and the Member or the Member's representatives (e.g., face-to-face, telephonic, web-based interactions, or other means of communication) to improve health outcomes. This category can include costs for associated activities such as:

- Effective case management, care coordination, and chronic disease management, including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act.

- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in this section.
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
- Quality reporting and documentation of care in non-electronic format.

ACTIVITIES TO PREVENT HOSPITAL READMISSION

Include expenses for implementing activities to prevent hospital readmissions. This category can include costs for associated activities such as:

- Comprehensive discharge planning (e.g., arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital.
- Personalized post discharge counseling by an appropriate health care professional.
- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

ACTIVITIES TO IMPROVE PATIENT SAFETY AND REDUCE MEDICAL ERRORS

Include expenses for activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates. This category can include costs for associated activities such as:

- The appropriate identification and use of best clinical practices to avoid harm.
- Activities to identify and encourage evidence based medicine in addressing independently identified and documented clinical errors or safety concerns.
- Activities to lower risk of facility acquired infections.
- Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions.
- Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

WELLNESS AND HEALTH PROMOTION ACTIVITIES

Include expenses for activities primarily designed to implement, promote, and increase wellness and health activities. This category can include costs for associated activities such as:

- Wellness assessment.

- Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements.
- Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition.
- Public health education campaigns that are performed in conjunction with state or local health departments.
- Actual rewards/incentives/bonuses/reductions in co-pays, etc. (not administration of these programs) that are not already reflected in premiums or claims should be allowed as QI activities for the group market to the extent permitted by section 2705 of the PHSA.
- Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities.
- Coaching or education programs and health promotion activities designed to change member behavior (e.g., smoking, obesity).

HEALTH INFORMATION TECHNOLOGY (HIT) EXPENSES RELATED TO IMPROVING HEALTH CARE QUALITY

Report information technology expenses associated with the activities reported in this section (45 CFR §158.151 allows "Health Information Technology" expenses that are required to accomplish the activities allowed in 45 CFR §158.150).

Include: HIT expenses required to accomplish the activities reported in this section that are designed for use by health plans, health care providers, or members for the electronic creation, maintenance, access, or exchange of health information as well as activities that are consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

- Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their ''meaningful use'' as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in 45 CFR §158.140;
- Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;
- Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
- Monitoring, measuring, or reporting clinical effectiveness, including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations

such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law);

- Advancing the ability of Members, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately, and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic health records accessible by Members and appropriate providers to monitor and document an individual patient's medical history and to support care management;

- Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;

- Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or

- Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

Exclude: Costs associated with establishing or maintaining a claims adjudication system, including costs directly related to upgrades in HIT that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims (for example, costs of implementing new administrative simplification standards and code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §1320d-2).

FREQUENTLY ASKED QUESTIONS

Question 1: Can healthcare professional hotline expenses be included in the MMLR Calculation Report?

> **Answer**: Expenses for healthcare professional hotlines should be **excluded** to the extent they do not meet the criteria for **Line 21: Activities that Improve Health Care Quality** as defined in the previous section.

Question 2: Can expenses for Prospective Utilization Review be included in the MMLR Calculation Report?

> **Answer**: Expenses for prospective Utilization Review should be **excluded** to the extent they do not meet the criteria for **Line 21: Activities that Improve Health Care Quality** as defined in the previous section; AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

Question 3: Should medical incentive pools and bonuses reported on Lines 15 and 16 be reported on a cash or an accrual basis?

> **Answer**: Medical incentive pools and bonuses reported on Lines 15 and 16 should be reported on an accrual basis, consistent with Exhibit L templates and audited financials.

Question 4: Can you clarify as to whether or not Line 24 (Total Non-Claims Costs) should include any reconciling items to tie to audited financials, such as administrative load or provider losses excluded from reported sub-capitated arrangements?

> **Answer**: This is correct. Total Non-Claims Costs reported on Line 24 is a reconciling line to the audited financials and Exhibit L. Common examples of reconciling items included on this line are administrative costs incurred, underwriting gains allowed to the sub-capitated provider or vendor, and premium deficiency reserve (PDR).

INSTRUCTIONS FOR REPORTING SUB-CAPITATION PAYMENTS AS INCURRED MEDICAL RELATED COSTS

INTRODUCTION TO SUB-CAPITATION PAYMENT INSTRUCTIONS

The Oregon Health Authority (OHA) contracts with Coordinated Care Organizations (CCOs) that have a variety of different business models to cover Members of the Oregon Health Plan (OHP). Many of the CCOs have a mixture of provider contract types and alternative payment methodologies (APMs). A common payment practice is sub-capitation. Sub-capitation is when a CCO distributes a Per-Member rate on a regular basis to a provider or service organization to cover the costs of that Member for a specific service, and/or group of Members. This APM has demonstrated success across Oregon by putting providers at risk for costs related to specific Members, versus a traditional Fee-For-Service (FFS) payment methodology. This APM has also proven to control costs and encourage the provision of preventive services.

In light of CMS requirements, OHA developed a policy that considered the wide spectrum of business models that are present within the CCOs that exist in Oregon. The policy decision is necessary to ensure that all CCOs are treated fairly and consistently regardless of the operating model or business structure that each CCO operates under. OHA is developing a regulatory framework that balances reporting requirements, transparency and, most critical, the State's interest in sustainable health system transformation for Oregonians.

Because sub-capitated arrangements are a cornerstone of many of the CCO's business models, OHA has developed a consistent and transparent reporting structure for all CCOs' that is essential to ensure equitable treatment and the appropriate use of State and Federal funding. That being said, OHA has decided to limit the enhanced reporting requirement of excluding administrative expenses from sub-capitation arrangements in the incurred medical related cost section of the MLR calculation. The goals of the enhanced reporting requirement for sub-capitated arrangements are to:

- Create consistency across CCOs in reporting medical cost as it relates to sub-capitation payments
- Reasonably minimize administrative burden to the CCOs
- Limit the amount of sub-capitation arrangements that require enhanced reporting of subcontractors' medical costs

The following instructions outline OHA's requirements to CCOs when a settlement is taking place that requires a CCO to identify their incurred medical related costs.

SUB-CAPITATION PAYMENT DEFINITIONS

Sub-capitated Entity (Provider/Vendor): An individual or organization, including but not limited to a Participating Provider, Provider Panel or Provider Network (as defined in the CCO Contract) or any other risk accepting entity receiving a sub-capitation payment from a CCO as a payment for services provided to members .

Sub-capitation Payment: A per member payment on a regular basis made to a Sub-capitated Provider/ Vendor that is meant to cover specific services and/or members, and puts the Provider/Vendor at risk if costs are higher than the total payment received. Sub-capitated payments typically include a factor to cover administrative costs incurred and underwriting gains allowed to the Sub-capitated Provider/Vendor.

MMLR Report: The MMLR Rebate Calculation Report as defined in Exhibit C, Attachment 1 of the CCO Contract.

SUB-CAPITATION PAYMENT GROUPS AND INSTRUCTIONS

CCOs are generally required to exclude administrative expenses (such as eligibility and coverage verification, claims processing, utilization review, or network development) from incurred medical related costs when reporting Sub-capitation Payments in the MMLR Report. An exception to the general approach applies when a subcontractor (such as a provider group), through its own employees, provides Medicaid covered services directly to enrollees. In that circumstance, the expenditures are treated in the same manner as a payment to a network provider for the same services.

Medicaid managed care regulations require that prescription drug rebates must be deducted from incurred claims. CMS interprets this regulation to require that any time a managed care plan receives something of value for the provision of a Medicaid covered outpatient drug (e.g., manufacturer rebates), regardless from whom the item of value is received, the value of that rebate must be deducted from the amount of incurred claims used for calculating the MLR. CMS also interprets this requirement to apply when the prescription drug rebate is received indirectly through a subcontractor administering the covered outpatient drug benefit on behalf of the managed care plan.

Please refer to CMS' May 15, 2019 information bulletin describing these requirements. The information in that bulletin should be applied to Groups #1 and #2 on the following page.

Complete the Exhibit L Financial Reporting Supplemental Sub-capitated Entity (SE) Report (Excel Workbook) located on the Contract Reports Web Site based on the Groups outlined below and the instructions in the report template.

GROUP #1: OVER 5% OF NET PREMIUMS

Criteria	Non-medical Exclusion
A sub-capitated entity receives a total of 5% or more of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report)	CCOs are required to only report sub-capitated entities' actual incurred medical costs (not to exceed the total amount of the entities sub-capitated payments) and provide detailed financial information of what was included for medical costs and what was excluded for non-medical costs. ***Note**: Costs that must be excluded from sub-capitated payments must be consistent with 42 CFR §438.8(e)(2)(v).*

GROUP #2: UNDER 5% AND OVER 0.5% OF NET PREMIUMS

Criteria	Non-medical Exclusion
A sub-capitated entity receives a total of less than 5% or more than 0.5% of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report) AND the sub-capitated entity is either a Mental Health Provider/Organization or a Dental Care Provider/Organization	CCOs are required to only report sub-capitated entities' actual incurred medical costs (not to exceed the total amount of the entities sub-capitated payments) and provide detailed financial information of what was included for medical costs and what was excluded for non-medical costs. ***Note**: Costs that must be excluded from sub-capitated payments must be consistent with 42 CFR §438.8(e)(2)(v).*

GROUP #3: UNDER 5% OF NET PREMIUMS AND NOT INCLUDED IN GROUP #2

Criteria	Non-medical Exclusion
A sub-capitated entity receives a total of 5% or less of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report) AND the sub-capitated entity does not meet the definition of Group #2	CCOs do not have to exclude non-medical costs for these sub-capitated entity payments. Include the entire amount of the sub-capitation payments.

FREQUENTLY ASKED QUESTIONS

Question 1: My CCO has a Sub-capitation Payment contract with an Independent Physician Association (IPA). The IPA then contracts with individual providers. Payments from the CCO to the IPA exceed the 5% threshold, but payments to the individual providers are all less than the 5% threshold. Do these Sub-capitation Payments need to have the Administrative expenses excluded from incurred medical related costs in the MMLR Report?

> **Answer**: Yes. The determining factor is who the Sub-capitation Payment contract is with. In this case, since the contracted Sub-capitated Provider is the IPA, the total Sub-capitation Payments would be in excess of the threshold and therefore the Administrative expenses need to be excluded.

Question 2: My CCO has a Sub-capitation Payment contract with a Physician-Hospital Organization (PHO). The PHO then contracts with individual hospitals and physician providers/provider groups. Payments in total from the CCO to the PHO exceed the 5% threshold, as do the payments made from the PHO to the hospitals, but payments to the individual physician providers are all less than the 5% threshold. What portion of these Sub-capitation Payments need to have the Administrative expenses excluded from incurred medical related costs in the MMLR Report?

> **Answer**: The entire Sub-capitation Payments made to the PHO. Again, the determining factor is who the Sub-capitation Payment contract is with. In this case, since the contracted Sub-contracted Provider is the PHO, the total Sub-capitation Payments would be in excess of the threshold and therefore the Administrative expenses need to be excluded.