

Medicaid Managed Care Program: Medical Loss Ratio Calculation

Rhode Island, Executive Office of Health and Human Services

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Background

Milliman, Inc. (Milliman) has been retained by the Rhode Island Executive Office of Health and Human Services (EOHHS) to develop a Medical Loss Ratio (MLR) reporting tool for completion of the federal MLR reporting requirements for state fiscal year (SFY) 2018.

The final Medicaid and Children's Health Insurance Program rule (Final Rule), released on May 6, 2016, requires that all Medicaid managed care programs ensure, through contracts for rating periods starting on or after July 1, 2017, that each managed care organization (MCO) calculate and report an MLR in accordance with 42 CFR 438.8, Medical loss ratio standards.

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

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

EOHHS operated a risk/gain sharing program during the SFY 2018 contract period. The risk/gain sharing is based upon the reported medical expense and revenue of the MCOs, although the medical expense and revenue definitions are different for purposes of the risk/gain share program relative to the federally mandated MLR reporting. In Rhode Island, there are no financial consequences associated with the MLR requirements.

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

The Medicaid MLR reporting instructions are to be used in completing and submitting the Medicaid MLR Tool for all Medicaid health plans participating in the Rhode Island Medicaid managed care program in SFY 2018. EOHHS and Milliman will rely on the accuracy and completeness of the submitted Rhode Island Medicaid MLR tool for each MCO based on the attestation of the MCO executive signing off on this request. During the review and data validation process, we may request additional information or documentation supporting the data on an as-needed basis to gain clarification on any information provided in the Medicaid MLR Tool.

Medicaid MLR Formula Summary

The Medicaid MLR calculation as documented in this report provides our interpretation of the MLR guidance presented by CMS in the Final Rule, released on May 6, 2016. In general, the MLR formula is defined as follows:

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

This section outlines key inclusions and exclusions for each component of the Medicaid MLR formula.

INCURRED CLAIMS

Total Medicaid incurred claims, paid and accrued, for SFY 2018 are defined as follows:

Include

- Claims paid or owed to providers for Medicaid covered services;
- Sub-capitated claims attributed to state plan services provided;
- Incentives, bonuses, withholds, and other settlements paid (or accrued) to providers;
- Recoveries from third party liability, subrogation, overpayments, and supplemental prescription drug rebates (including accruals);
- Net payments or receipts related to state mandated solvency funds (not applicable in Rhode Island);
- Reserves for contingent benefits and the medical claims portion of lawsuits;
- Recoveries related to state mandated reinsurance arrangements; and,
- Fraud recoveries exceeding expenses related to fraud recovery activities.

For example:

- \$500k – Fraud recoveries;
- \$300k – Expenses related to fraud recovery activities;
- Reported in MLR formula
 1. \$200k – Total fraud recoveries **included** in incurred claims (reducing incurred claims);
 2. \$300k – Fraud recoveries **excluded** from incurred claims.

Exclude

- Sub-capitation paid amounts related to administrative expenses;
- Pass-through payments (not applicable in Rhode Island);
- Fraud recoveries up to total expenses related to fraud recovery activities (see example above);
- Fines and penalties assessed by regulatory authorities;
- Prior year Medicaid MLR remittance (not applicable in Rhode Island); and,
- Recoveries related to MCO elected reinsurance contracts.

QUALITY IMPROVEMENT EXPENSES

Quality improvement expenses are designed to improve health care quality and health outcomes. Quality improvement expenses are defined, but not limited to, the lists below:

Include

- Activities that improve health outcomes;
- Activities to prevent hospital readmissions;
- Activities that improve patient safety and reduce medical errors;
- Wellness and health promotion activities;
- Health information technology expenses related to improving health care quality; and,
- Activities related to External Quality Review.

Refer to 45 CFR 158.150(b) for activities that may qualify as quality improvement expenses.

Exclude

- Costs associated with establishing or maintaining a claims adjudication system; and,
- Activities that are designed primarily to control and contain costs, such as fraud prevention activities.

Refer to 45 CFR 158.150(c) for activities that must be excluded from quality improvement expenses.

PREMIUM REVENUE

Rhode Island Medicaid premium revenue for SFY 2018 is defined as follows:

Include

- Medicaid capitation payments;
- Quality withhold earned back;
- Copays waived by MCO from provider's collection responsibility;
- Hepatitis C stop loss payments;
- Unearned premium reserve changes;
- Premiums related to state mandated reinsurance arrangements; and,
- Capitation payment revenue related to the Health Insurer Fee.

Exclude

- Revenue for Health System Transformation Program Accountable Entity incentive, Hospital and Nursing Home Incentive Program Provider Incentive Program, and Performance Goal Program incentive amounts;
- Pass-through payments (not applicable in Rhode Island); and,
- Premiums related to MCO elected reinsurance contracts.

TAXES AND FEES

Allowable taxes and fees on the Rhode Island Medicaid business for SFY 2018 are defined as follows:

Include

- Federal taxes and federal assessments, including the health insurer fee;
- State insurance, premium, and other taxes;
- Regulatory licenses and fees; and,
- Community benefit expenditures if exempt from federal income taxes.

CREDIBILITY ADJUSTMENT

The credibility adjustment is determined by the total number of SFY 2018 Medicaid member months.

General Instructions

This section outlines the general instructions for MCOs to complete the requested information in the accompanying Excel-based Medicaid MLR Tool. The SFY 2018 Medicaid MLR as defined in Section II will be calculated for each MCO based on plan-submitted data.

The Medicaid MLR Reporting Tool contains the following four tabs:

- Attestation
- Data Collection
- Detailed Calculation
- Summary Calculation

MCOs are requested to populate the Attestation and Data Collection tabs. The Detailed Calculation and Summary Calculation tabs are populated from the MCO-submitted data and calculate the MCO-specific Medicaid MLR.

ATTESTATION

The purpose of the attestation page is to collect company specific data as well as confirmation that the information provided is complete and accurate. On this tab, MCOs must provide the health plan name from the drop down menu, the preparer's name and contact information, and the attesting officer's name and signature. The attesting officer must be designated as a CEO, CFO, or COO of the organization. Failure to complete the attestation will be considered an incomplete submission and will not be accepted by EOHHS.

DATA COLLECTION

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

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

The MLR reporting tool has been developed to stratify the major elements of the MLR formula, with the intent of identifying key components that should be included and excluded to ensure adherence to the MLR guidance established by CMS in the Final Rule. As documented in Section II, Summary of MLR Calculation, CMS provides specific guidance on inclusions and exclusions for each component of the MLR formula. The inputs outlined below are intended to illustrate compliance with the Final Rule by documenting each item specifically identified in the MLR guidance. To allow MCOs flexibility for components that may not be easily isolated, the formulas in the Medicaid MLR tool are adjusted to reflect MCO-specific inputs. In instances when a requested data item cannot be isolated, the MCO should provide an estimated value and indicate if the impact is excluded in a previous line item using the Yes/No Exclusion Indicator in column G of the Medicaid MLR Tool.

Incurred Claims

This section provides guidance on the incurred claims portion of the MLR formula.

Line I - Paid Claims to Providers Incurred July 2017 – June 2018, paid through December 31, 2018

Line I should reflect total SFY 2018 paid and incurred claims, with claims run-out through December 31, 2018, consistent with the inclusions and exclusions provided below. Please note that the majority of the items excluded from Line I are specifically requested to be quantified in a subsequent line item in Section I.

1 – Paid Claims to Medical Providers

Include

- Non-subcapitated claims paid to providers that represent direct compensation for medical services covered under the managed care contract; and,
- Claims paid to providers that represent direct compensation for non-state plan medical services that the MCO voluntarily provides through the Medicaid managed care program.

2 – Paid Claims to Pharmacies

Include

- Claims paid to the pharmacies that represent direct compensation for pharmaceutical services covered under the managed care contract; and,
- Claims paid to pharmacies that represent direct compensation for non-state plan services that the MCO voluntarily provides through the Medicaid managed care program.
- Please note that for MCOs utilizing a pharmacy benefit manager (PBM), claims paid should represent the amount paid by the PBM to the pharmacy on behalf of the MCO, not the total amount paid to the PBM.

Paid Claims to Providers (Medical and Pharmacy)

Exclude

- Payments made to providers under capitated contracts (i.e., sub-capitated claims);
- Incentives, bonuses, and withholds paid to providers;
- Net payments or receipts related to state mandated solvency funds (not applicable in Rhode Island);
- Fraud recoveries and expenses related to fraud recovery activities;
- Fines and penalties assessed by regulatory authorities;
- Third party liabilities (coordination of benefits);
- Subrogation recoveries;
- Prescription drug rebates;
- Overpayment recoveries received from network providers; and,
- Reinsurance recoveries.

Line I.a – Confirm Line I Excludes Additional Payments for the Following Items:

For inputs 1 through 8 under Line I.a, please input the requested dollar amount. If the item was unable to be excluded from Line I, enter 'No' in the Yes/No Exclusion toggle.

1 – Sub-capitation Paid Attributed to Services Provided

Include The benefit expense portion of sub-capitated amounts paid to providers that represent direct compensation for medical services provided to an enrollee during SFY 2018.

Please note that this amount should equal the amount paid to the provider rendering services. In the case of a sub-capitated sub-contractor (e.g., a dental benefit manager), the amount paid by the sub-contractor to the provider should be included. For sub-capitated providers, the amount of the sub-capitation payment allocated for the provision of services should be reported.

2 – Sub-capitation Paid Related to Administrative Expenses

Include The non-benefit expense portion (generally the administrative amount) of sub-capitated amounts paid to providers that do not represent direct compensation for medical services provided to an enrollee during SFY 2018.

3 – Incentives, Bonuses, Withholds, and Other Settlements Paid to Providers

Include Incentive, bonus, withhold, and other settlement amounts paid to participating providers.

4 – Pass-through payments (Not applicable in Rhode Island)

Include Any expense associated with pass-through payments. This amount is expected to be exactly equal to the premium revenue for these payments as reported in Line IV.b.5.

5 – Net Payments (or Receipts) Related to State Mandated Solvency Funds (Not applicable in Rhode Island)

Include Market stabilization payments (or receipts) required by the state to provide protection to members in the event of health plan insolvency.

6 – Expenses Related to Fraud Recovery Activities

Include The amount of fraud reduction expenses directly related to fraud recovery activities. The amount of fraud reduction expenses must not include expenditures on activities related to fraud prevention as defined for the private market in 45 CFR part 158, Commercial Issuer Use of Premium Revenue: Reporting and Rebate Requirements.

7 – Fines and Penalties Assessed by Regulatory Authorities

Include Fines and penalties assessed by regulatory authorities based on an examination or audit.

8 – Prior Year Medicaid MLR Remittance (Not applicable in Rhode Island)

Include Amount paid, if any, as a result of the Medicaid minimum MLR requirement for the prior contract year.

Line I.b – Confirm Line I Excludes Reductions for the Following Items:

For inputs 1 through 5 under Line I.b, please input the requested dollar amount as a positive value. If the item was unable to be excluded from Line I, enter 'No' in the Yes/No Exclusion toggle.

1 – Third Party Liability (Coordination of Benefits) Recoveries

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

2 – Subrogation Recoveries

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

3 – Prescription Drug Rebates Collected

Include Supplemental rebates received by the MCO related to pharmaceutical expenditures during SFY 2018.

4 – Fraud Recoveries

Include Fraudulent claim payments recovered as a result of fraud reduction efforts. Please note that fraud recoveries up to total fraud recoveries expense as reported in Line I.a.6 are excluded from the incurred claims calculation.

5 – Overpayment Recoveries Received from Network Providers

Include Recoveries received as a result of overpayment to a network provider.

Line I.c – Confirm Line I Excludes Reductions for Recoveries related to State Mandated Reinsurance Contracts

Reinsurance premiums and recoveries are excluded from the MLR calculation, with the exception of state-mandated reinsurance contract requirements. For inputs 1 through 2 under Line I.c, please input the requested dollar amount as a positive value. If the item was unable to be excluded from Line I, enter 'Yes' in the Yes/No Inclusion toggle.

1 – Recoveries related to State Mandated Reinsurance Contracts

Include For state-mandated reinsurance contracts, provide the total dollar amount of payments received by the MCO from reinsurance or stop-loss contractual arrangements.

2 – Recoveries related to MCO Elected Reinsurance Contracts

Include For voluntary MCO-elected reinsurance contracts, provide the total dollar amount of payments received by the MCO from reinsurance or stop-loss contractual arrangements. **Line II – Unpaid Claim Reserves**

Unpaid claim reserves reflect the estimated outstanding liabilities for all medical and prescription drug health care services for SFY 2018. This includes items such as incurred but not reported (IBNR) claims, claims in course of settlement (ICOS), and claims that are adjudicated but not yet paid. Provide the total reserve balance held at December 31, 2018 for claims incurred through June 30, 2018.

Line II.a – Unpaid Claim Reserves and Liabilities at December 31, 2018 (Incurred July 2017 – June 2018)

Include

- Unpaid claim reserves related to medical and prescription drug health care services;
- Accruals for anticipated coordination of benefits and subrogation recoveries

Exclude

- Unpaid claim reserves (accruals) for incentives, bonuses, and withholds payable to providers;
- Contingent benefit and lawsuit reserves; and,
- Supplemental prescription drug rebate accruals.

Line II.b – Confirm Line II.a Excludes Additional Reserves for the Following Items:

For inputs 1 through 3 under Line II.b, please input the requested dollar amount. If the item was unable to be excluded from Line II.a, enter 'Yes' in the Yes/No Inclusion toggle for the July 2017 – June 2018 period.

1 – Reserve for Incentives, Withhold Adjustments, and Bonus Amounts Payable to Providers

Include Unpaid claims obligations related to incentives, bonuses, and withhold amounts for participating network providers or hospitals.

2 – Contingent Benefit and Lawsuit Reserves

Include Unpaid claims obligations related to contingent benefit and lawsuit reserves.

3 – Prescription Drug Rebates Accrued

Include Supplemental rebates accrued but not yet collected by the MCO related to pharmaceutical expenditures during SFY 2018. Please input the dollar amount as a positive value.

Quality Improvement Expenses

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

Line III – Incurred Health Care Quality Improvement Expenses during SFY 2018

Consistent with NAIC guidelines for the Supplemental Health Care Exhibit Part 3, Quality Improvement Expenses are defined as expenses that control or contain cost with the primary purpose of improving health care quality. These expenses should be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical societies, accreditation bodies, government agencies or other nationally recognized

health care quality organizations. These expenses can be objectively measured, and must not be billed or allocated as clinical or claims costs¹.

Line III.a – Improve Health Outcomes

Include Activities that are primarily designed to improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

Line III.b – Activities to Prevent Hospital Readmission

Include Activities that prevent hospital readmissions through a comprehensive program for hospital discharge.

Line III.c – Improve Patient Safety and Reduce Medical Errors

Include Activities that improve patient safety, reduce medical errors, and lower infection and mortality rates.

Line III.d – Wellness & Health Promotion Activities

Include Costs to implement, promote, and increase wellness and health activities.

Line III.e – Health Information Technology Expenses Related to Improving Health Care Quality

Include Activities that 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.

Line III.f – Activities Related to External Quality Review (EQR)

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

Refer to 45 CFR 158.150(c) for activities that must be excluded from quality improvement expenses.

Premium Revenue

This section provides guidance on the premium revenue portion of the MLR formula.

Line IV – Total State Capitation Payments during SFY 2018

Line IV should reflect total state capitation payments consistent with the inclusions and exclusion lists provided below. Please note that the majority of the items excluded from Line IV are explicitly requested in a subsequent premium revenue line item.

Include

- Capitation payment revenue for the Rhode Island Medicaid managed care program for the SFY 2018 contract year.

Exclude

- The portion of the capitation rate related to withhold (Rhody Health Options MMP / Integrity only) amounts;
- Incentive program amounts, such as the Health System Transformation Program Accountable Entity incentive, Hospital and Nursing Home Incentive Program Provider Incentive Program, and Performance Goal Program;
- Pass-through payments (not applicable in Rhode Island);
- Total amount of copays waived by MCO from provider's collection responsibility;
- Hepatitis C stop loss amounts;
- Unearned premium changes;
- State mandated reinsurance premiums; and,
- Capitation payment revenue related to the health insurer fee that is included in Line V.a (Federal Taxes and Federal Assessments).

¹ Official NAIC Annual Statement Instructions: Health; for the 2016 reporting year printed September 2016

Line IV.a – Confirm Line IV Excludes Revenue for the Following MCO Quality and Withhold Reporting items:

For inputs 1 through 3 under Line IV.a, please input the requested dollar amount. If the item was unable to be excluded from Line IV, enter 'Yes' in the Yes/No Exclusion toggle.

1 - Total MCO Withhold

Include Total quality withhold, representing 1.0% of the July to December 2017 capitation revenue and 2.0% of the January to June 2018 capitation revenue for the Rhody Health Options MMP / Integrity program.

2 – MCO Withhold Earned Back related to July 2017 – June 2018

Include The amount of the quality withhold earned back based on quality metrics established by EOHHS for the SFY 2018 contract period. The quality withhold is measured and paid on a calendar year basis. As such, the MCO withhold that should be reported in the MLR formula will include a portion of the quality withhold payments from two calendar years. Please allocate the portion of each calendar year withhold payout related to the MLR reporting period (SFY 2018). For withholds that have not yet been measured and reported by EOHHS, MCOs should provide an estimated quality withhold payout.

Line IV.b – Confirm Line IV Excludes Revenue for the Following Items:

For inputs 1 through 7 under Line IV.b, please input the requested dollar amount. If the item was unable to be excluded from Line IV, enter 'Yes' in the Yes/No Exclusion toggle.

1 – MCO Incentive Payments

Include Incentive payments received for the SFY 2018 contract period, including amounts for the Health System Transformation Program Accountable Entity incentive, Hospital and Nursing Home Incentive Program Provider Incentive Program, and Performance Goal Program.

2 – Total Amount of Copays Waived by MCO from Provider's Collection Responsibility

Include Total amount of unpaid member cost-sharing dollars where an MCO intentionally waived the provider's responsibility to collect the member copay.

3 – Hepatitis C Stop Loss Payments for SFY 2018

Include Total amount of MCO recoupment related to the SFY 2018 Hepatitis C stop loss program.

4 – Risk/Gain Share Settlements

Include Total MCO settlement related to the risk/gain share arrangement, inclusive of Integrated Health Home (IHH) risk sharing settlements.

5 – Unearned Premium Reserve Change

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

6 – Pass-Through Payments (Not applicable in Rhode Island)

Include This amount is expected to be exactly equal to the claims expense as reported in Line I.a.4. These amounts are not applicable in Rhode Island.

7 – Health Insurer Fee

Include The portion of the total capitation revenue related to the SFY 2018 Health Insurer Fee.

Line IV.c – Confirm Line IV Excludes Reductions in Revenue for State Mandated Reinsurance Premiums for the Following Reinsurance Items:

Reinsurance premiums and recoveries are excluded from the MLR calculation, with the exception of state-mandated reinsurance contract requirements. For inputs 1 through 2 under Line IV.c, please input the requested dollar amount as a positive value. If the item was unable to be excluded from Line IV, enter 'Yes' in the Yes/No Inclusion toggle.

1 – State Mandated Reinsurance Premiums

Include Total premiums paid by the MCO for state-mandated reinsurance contracts. The RI Medicaid program does not require MCO reinsurance coverage. As such, this line item does not apply and should remain blank.

2 – MCO Elected Reinsurance Premiums

Include Total premiums paid by the MCO for voluntary, MCO-elected reinsurance contracts.

Taxes and Fees

Consistent with National Association of Insurance Commissioners (NAIC) guidelines for completion of the Supplemental Health Care Exhibit Part 1, taxes and fees pertain to amounts a governmental or regulatory body charges the MCO to perform a service which is allocated to Medicaid business in Rhode Island.

Line V – Taxes and Fees²

Line V.a – Federal Taxes and Federal Assessments

Include

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

Exclude

- Federal income taxes on investment income and capital gains.

Line V.b – State Insurance, Premium, and Other Taxes

Include

- “Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the state directly;
- Assessments of state industrial boards or other boards for operating expenses or for benefits to sick unemployed persons in connection with disability benefit laws or similar taxes levied by Rhode Island;
- Advertising required by law, regulation or ruling, except advertising associated with investments;
- State income, excise and business taxes other than premium taxes;
- State premium taxes plus state taxes based on policy reserves, if in lieu of premium taxes; and,

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

- In lieu of reporting state premium taxes, the reporting entity may choose to report payment for community benefit expenditures (Line V.d) limited to the highest premium tax rate for Rhode Island, but not both.”

Exclude

- “State sales taxes, if company does not exercise the option of including such taxes with the cost of goods and services purchased;
- Any portion of commissions or allowances on reinsurance assumed that represents specific reimbursement of premium taxes; and,
- Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.”

Line V.c – Regulatory Authority Licenses and Fees

Include

- “Statutory assessments to defray operating expenses of any State or Federal department; and,
- Examination fees in lieu of premium taxes as specified by Rhode Island state law.”

Exclude

- Fines and penalties of regulatory authorities; and,
- Fees for examinations by EOHHS other than as referenced above.

Line V.d – Community Benefit Expenditures if Exempt from Federal Income Taxes

Include Expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden, as defined in the NAIC supplemental health care exhibit.

1 – Input the highest premium tax rate in Rhode Island.

2 – Using the Yes/No toggle, please indicate if the MCO is exempt from federal income taxes.

Credibility Adjustment

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

Line VI – Credibility

On July 31, 2017, CMS published an Information Bulletin, Medical Loss Ratio (MLR) Credibility Adjustments³, which provides an overview and methodology for credibility adjustments in the Medicaid MLR formula. The credibility adjustment is used to account for random statistical variation related to the number of enrollees in a managed care plan. The credibility adjustment categorizes managed care plans into three groups:

- **Fully-credible:** Managed care plans with sufficient claims experience, measured in terms of member months, are assumed to experience MLRs that are not subject to random variation as observed in statistically insignificant samples. Such managed care plans will not receive a credibility adjustment for their MLRs.
- **Partially-credible:** Managed care plans with sufficient claims experience, measured in terms of member months, to calculate an MLR with a reasonable chance that the difference between the actual and target medical loss ratios is statistically significant. Such managed care plans will receive a partial credibility adjustment to their calculated MLRs.
- **Non-credible:** Managed care plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR. Such plans will not be measured against the MLR standard; managed care plans in this group are presumed to meet or exceed the target MLR standard.

³ CMS Information Bulletin: MLR Credibility Adjustments; available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf>

The following table illustrates the Medicaid and Children’s Health Insurance Program (CHIP) credibility adjustment factors utilized in the MLR formula.

MLR CREDIBILITY ADJUSTMENT TABLE
CREDIBILITY ADJUSTMENT TABLE FOR MEDICAID AND CHIP MANAGED CARE PLANS

STANDARD PLANS MEMBER MONTHS IN MLR REPORTING YEAR	STANDARD PLANS CREDIBILITY ADJUSTMENT
<5,400	Non-Credible
5,400	8.4%
12,000	5.7%
24,000	4.0%
48,000	2.9%
96,000	2.0%
192,000	1.5%
380,000	1.0%
>380,000	Fully Credible

Line VI.a – Total Member Months for SFY 2018

Include The number of member months covered by the MCO during the 12-month reporting period.

DETAILED CALCULATION

The “Detailed Calculation” tab applies inputs entered on the “Data Collection” tab to calculate the value for each major component of the Medicaid MLR formula:

- Incurred claims;
- Quality improvement expenses;
- Premium revenue;
- Taxes and fees; and,
- Credibility adjustment.

Each major component is dependent on the completion of the Yes/No Exclusion Indicator for each input as discussed throughout the General Instructions section.

SUMMARY CALCULATION

The “Summary Calculation” tab calculates MLR as defined in 42 CFR 438.8. In Rhode Island, there are no financial consequences associated with MLR requirements.

Limitations and Qualifications

The information contained in this correspondence, including any enclosures, has been prepared for the Rhode Island Executive Office of Health and Human Services (EOHHS), related agencies, and their advisors. These results may not be distributed to any other party without the prior consent of Milliman. We understand this information will be shared with contracted MCOs. To the extent that the information contained in this correspondence is provided to any approved third parties, the correspondence should be distributed in its entirety. Any user of the data must possess a certain level of expertise in 42 CFR 438.8 MLR requirements that will allow appropriate use of the data presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for EOHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

Milliman has relied upon certain data and information provided by EOHHS and its vendors. The values presented in this correspondence are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented will need to be reviewed for consistency and revised to meet any revised data. The MCOs are responsible for complete and accurate MLR reporting as specified in 42 CFR 438.8 and should rely on their own consultants and advisors to ensure compliance with these requirements.

The services provided by Milliman to EOHHS were performed under the signed contract agreement between Milliman and EOHHS dated November 29, 2018.

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