CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

MEDICAL LOSS RATIO (MLR) REPORT

FOR MEDICARE ADVANTAGE ORGANIZATIONS AND PRESCRIPTION DRUG PLAN SPONSORS FOR THE CONTRACT YEAR (CY) 2014 MLR REPORTING YEAR

FILING INSTRUCTIONS

As of October 28, 2013

TABLE OF CONTENTS

GENERAL INSTRUCTIONS

Introduction

Medicare Advantage (MA) organizations and Prescription Drug Plan (PDP) sponsors must submit an MLR Report to the Centers for Medicare & Medicaid Services (CMS) for each contract offered during the Contract Year (CY) under the Medicare Advantage Program and the Medicare Prescription Drug Benefit Program (Part D).

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in the CMS-approved electronic format—the MLR Reporting Tool (a.k.a. MLR Report).

All contracts that received Medicare revenue during the contract year must submit an MLR report, with the following qualifications/clarifications:

- Cost/HCPPs: The MLR Report must be completed for the Part D portion of the benefits offered under their contract with CMS for Section 1876 Cost plans, Section 1833 Cost plans, and employers/unions offering Cost plans or Health Care Prepayment Plans (HCPPs).
- PACE: The MLR Report is not to be completed for Programs of All-Inclusive Care for the Elderly (PACE) plans.
- EGWPs: The MLR statutory provision does not provide for an exemption for EGWPs and thus applies; EGWPs are to report costs and revenue on the Medicare-funded portion of each contract.
- Dual-SNPs: Medicaid costs and revenue are not included in the MLR calculation.
- State demonstrations to integrate care for dually eligible Medicare and Medicaid beneficiaries: Unless granted a specific waiver during the demonstration development process, the MLR requirements apply and the MLR Report is required.

The data included in the MLR Reporting Tool will be used to calculate the Medicare medical loss ratio (MLR) and remittance amount, if any.

These filing instructions apply to the Contract Year (CY) 2014 MLR reporting year.

An attestation must be submitted in HPMS for each MLR Report.

The submitted MLR Reports will be subject to review and audit by CMS or by any person or organization that CMS designates. As part of the review and audit process, CMS or its representative may request additional documentation supporting the information contained in the MLR Report. Organizations must be prepared to provide this information in a timely manner.

MLR reporting for a contract year will occur in December following the contract year. The exception will be for contracts that fail to meet the MLR threshold for 2 consecutive years; MLR reporting will occur in the following contract year prior to December, in a month that will be specified by CMS and that will allow time to implement, prior to the open enrollment period, an enrollment sanction for any contract that fails to meet the MLR threshold for 3 or more consecutive

years and contract termination for any contract that fails to meet the MLR threshold for 5 consecutive years.

Reporting Considerations

Accounting Principles

The preamble to the final rule contained the following language regarding accounting principles:

> *Comment:* A commenter requested clarification regarding the alignment with the commercial MLR in reference to the proposal that, MA organizations and Part D sponsors must use Statutory Accounting Principles for the purposes of MLR determination except in cases when another regulatory authority such as state insurance departments requires other reporting for a particular contract or product using Generally Accepted Accounting Principles (GAAP).
>
> *Response:* We agree that use of Statutory Accounting Principles for Medicare MLR requirements would align with current practices in determining commercial MLR and minimize administrative burden on issuers. We thus are adopting this approach by requiring MA organizations and Part D sponsors to explain how revenue is used to pay for non-claims expenditures. MA organizations and Part D sponsors must allocate their nonclaims and quality improving expenses by contract. If an expense is attributable to a specific activity, then MA organizations and Part D sponsors should allocate the expense to that particular activity. However, if this is not feasible, then the MA organization or Part D sponsor must apportion the costs using a generally accepted accounting method that yields the most accurate results. After consideration of the public comments received, we are finalizing these provisions as proposed.

Allocation of Expenses

The final rule contained the following guidance regarding the allocation of expenses:

> **§ 422.2420 Calculation of the medical loss ratio.**
>
> (d) *Allocation of expense—*
>
> (1) *General requirements.*
>
> (i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses.
>
> (ii) Expenditures that benefit multiple contracts, or contracts other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.
>
> (2) *Description of the methods used to allocate expenses.*
>
> (i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories in § 422.2420(b) or (c) will generally be the most accurate method.
>
> (ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contracts incurring the expense.
>
> (iii)(A) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.
>
> (B) Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

§ 423.2420 Calculation of medical loss ratio.

(d) *Allocation of expenses—*

(1) *General requirements.*

(i) Each expense must be included under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses.

(ii) Expenditures that benefit multiple contracts, or contracts other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.

(2) *Description of the methods used to allocate expenses.*

(i) Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results.

(ii) Specific identification of an expense with an activity that is represented by one of the categories in § 423.2420(b) or (c) will generally be the most accurate method.

(ii) Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.

(iii)(A) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, premium ratios or similar analyses.

(B) Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

Capitated Arrangements

The preamble to the final rule contained the following language regarding capitated arrangements:

> *Comment:* A few commenters requested that CMS clarify whether MA organizations employing capitated provider reimbursement arrangements may consider the full capitation amount as a benefit expense unless the provider contract specifies a distinct fee for administrative services. A commenter noted that an approach including the full capitation amount in incurred claims would mirror the commercial MLR requirements. Another commenter noted that capitated services often may include care management or disease management activities and other activities intended to improve quality.
>
> *Response:* In § 422.2420(b)(2), we are following the commercial MLR approach where incurred claims are direct claims paid to providers, including under capitation contracts. Where an MA organization of Part D sponsor has arranged with a clinical provider for capitation payments rather than fee-for-service reimbursement for covered services to enrollees, and such capitation payments include reimbursement for certain provider administrative costs, then the entire per member per month capitation payment paid to the provider may be included in incurred claims. The full capitation amount paid to a provider for covered services described at § 422.2420(a)(2) could be reported as a benefit expense, unless, as the commenters noted, the provider contract specifies a distinct fee for administrative services. Note that if the capitated payment includes payment for quality-improving activities that also would meet the requirements under § 422.2430 and § 423.2430 (activities that improve health care quality), the MA organization must ensure that costs for these activities are only counted once in the numerator.

In addition, the below Q&As were released by CMS regarding capitated arrangements for commercial MLR reporting. The guidelines in these responses also apply to MLR reporting for Medicare contracts.

Source: May 13, 2011 Guidance at
http://www.cms.gov/CCIIO/Resources/Files/Downloads/mlr-guidance-20110513.pdf

Question #8:
Is the entire amount paid to a clinical provider in a capitation arrangement considered an incurred claim?
Answer #8:
Generally, yes. Where an issuer has arranged with a clinical provider for capitation payments rather than fee-for-service reimbursement for covered services to enrollees, and such capitation payments include reimbursement for certain provider administrative costs, then the entire per member per month capitation payment paid to the provider may be included in incurred claims, as provided in 45 CFR §158.140(a).

The term "provider" in this question and answer does not refer to or include third party vendors.

Question #9:
Is the entire payment to a non-physician clinical provider in a capitation arrangement considered an incurred claim?
Answer #9:
Generally, yes. Although 45 CFR §158.140(a) refers to the fact that it includes capitation arrangements with *physicians*, the intent was to include capitation arrangements with non-physician providers that are licensed, accredited, or certified to perform clinical health services, consistent with State law, and who are engaged in the delivery of medical services to enrollees.

Question #12:
When a third party vendor provides clinical services directly to enrollees, how does 45 CFR §158.140(b)(3)(ii) -- which excludes from incurred claims amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management -- affect how an issuer reports payments to that third party vendor?
Answer #12:
Section 158.140 treats payments to providers as reimbursement for clinical services to enrollees (also referred to as incurred claims). Section 158.140(b)(3)(ii) recognizes that issuers often pay third party vendors to perform services such as network development, administrative fees, claims processing, and utilization management, that are considered non-claims administrative costs if performed by the issuer and thus should be considered non-claims administrative costs if performed by a third party vendor.

However, when a third party vendor, through its own employees, provides clinical services directly to enrollees, the entire portion of the amount the issuer pays to the third party vendor that is attributable to the third party vendor's direct provision of clinical services should be considered incurred claims, even if such amount includes reimbursement for third party vendor administrative costs directly related to the vendor's direct provision of

clinical services. The term "through its own employees" does not include a third party vendor's contracted network of providers because such network providers are not considered employees of the third party vendor.

For example, an issuer may contract with a PBM to provide clinical services directly to enrollees through a mail order pharmacy. The amount the issuer pays to the PBM for mail order pharmacy services provided directly by the PBM's employees, including administrative costs related to the PBM's direct provision of such mail order pharmacy services, would be included in the issuer's incurred claims.

Question #14:
Does the IFR allow portions of the amounts paid to third party vendors to be counted as expenditures for activities that improve health care quality?
Answer #14:
Yes. An issuer may count a vendor's expenses as activities that improve health care quality to the extent that the issuer and vendor can show that these expenses were incurred for performing allowable quality improving activities on behalf of the issuer. Accordingly, the concept addressed specifically in 45 CFR §158.140(b)(3)(ii) regarding incurred claims and third party vendors applies, to the extent permitted under §158.150 and §158.151, to expenditures for activities that improve health care quality.

For example, to the extent that a PBM performs functions that are designed primarily to identify quality concerns, such as potential adverse drug interactions, those costs may be reported, in aggregate, as expenditures for activities that improve health care quality.

Source: July 18, 2011 Guidance at
http://www.cms.gov/CCIIO/Resources/Files/Downloads/20110718_mlr_guidance.pdf

Question #19:
How should an issuer report amounts paid to third party vendors who pay others to provide clinical services to enrollees and who perform network development, administrative functions, claims processing, and utilization management?
Answer #19:
In general, an issuer may only include as reimbursement for clinical services (incurred claims) the amount that the vendor actually pays the medical provider or supplier for providing covered clinical services or supplies to enrollees. Where the third party vendor is performing an administrative function such as eligibility and coverage verification, claims processing, utilization review, or network development, expenditures and profits on these functions would be considered a non-claims administrative expense as provided in 45 CFR §158.140(b)(3)(ii).

Some third party vendors provide reimbursement for clinical services to enrollees and provide administrative functions such as claims processing and network development. Payments by an issuer to a third party vendor to provide clinical services directly to enrollees through its own employees are considered to be incurred claims. However, the amounts paid by the issuer to a third party vendor for the functions that are not direct clinical services to enrollees through its own employees are governed by §158.140(b)(3)(ii), and only the amounts the third party vendor pays to providers may be included in incurred claims. (Questions and Answers 8 and 9 address what is meant by the

term “providers”;
http://cciio.cms.gov/resources/files/2011_05_13_mlr_q_and_a_guidance.pdf.) The amounts attributable to network development, administrative fees, claims processing, and utilization management by the third party vendor and the third party vendor’s profits on those activities must not be included by an issuer in its incurred claims.

For example, when a pharmacy benefit manager (PBM) pays a retail pharmacy one amount for prescription drugs covered by the plan and charges the issuer a higher amount (the retail spread), the issuer may only claim the amounts paid by the PBM to the retail pharmacy as incurred claims.

As stated in the May 13, 2011 guidance posted on the internet at http://cciio.cms.gov/resources/regulations/index.html#mlr), the third party vendor (in this example, the PBM) must report to the issuer only the aggregate amount it pays all providers (in this example, retail pharmacies) for clinical services to enrollees on behalf of the issuer, by market in each State. No claim by claim or provider by provider reporting is required.

Source: February 10, 2012 Guidance at
http://www.cms.gov/CCIIO/Resources/Files/Downloads/2012-02-10-guidance-mlr-ipas.pdf

Question #20:

Are payments by issuers to clinical risk-bearing entities, such as Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), and Accountable Care Organizations (ACOs), incurred claims under 45 CFR 158.140?

Answer #20:

Generally, yes. We will consider such payments to be incurred claims provided that both the payment and risk-bearing entity meet all four factors stated here. 45 CFR 158.140 treats payments by issuers to providers as reimbursement for clinical services to enrollees (also referred to as incurred claims), but does not address situations in which issuers pay a third party, such as an IPA, to perform services that are considered provider services when performed by a provider’s medical practice.

Payments to a clinical risk-bearing entity are considered incurred claims if the following four factors are met:
• The entity contracts with an issuer to deliver, provide, or arrange for the delivery and provision of clinical services to the issuer’s enrollees but the entity is not the issuer with respect to those services;
• The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to enrollees;
• The entity delivers, provides, or arranges for the delivery and provision of clinical services through a system of integrated care delivery that, as appropriate, provides for the coordination of care and sharing of clinical information, and which includes programs such as provider performance reviews, tracking clinical outcomes, communicating evidence-

based guidelines to the entity's clinical providers, and other, similar care delivery efforts; and
• Functions other than clinical services that are included in the payment (capitated or fee-for-service) must be reasonably related or incident to the clinical services, and must be performed on behalf of the entity or the entity's providers.

If the entity satisfies this four-part test, payments for clinical services for which the entity takes on the financial risk for utilization as provided in prong two above will be considered incurred claims. Conversely, when an entity takes on only pricing risk, Question and Answer 19 in the July 18, 2011 guidance applies (http://cciio.cms.gov/resources/files/20110718_mlr_guidance.pdf). Q&A #19 addresses payments to third party vendors who pay others to provide clinical services to enrollees and who perform administrative functions. It provides that the entirety of the payment by an issuer to an entity that only takes on pricing risk (e.g., payments to pharmacy benefit managers (PBMs) for retail pharmacy claims) should not be reported as incurred claims.

Question #21:
Are payments by issuers to such clinical risk-bearing entities that include payment for administrative functions performed on behalf of the entity's providers incurred claims under 45 CFR 158.40?
Answer #21:
Yes, if all four factors set forth in Answer #20 are met. For example, a bundled payment to an IPA or similar entity for providing clinical services to enrollees which includes: the IPA processing claims payments to its member providers and submitting claims reports to issuers on behalf of its providers; performing provider credentialing to determine a provider's acceptability into the IPA network; and developing a network for its providers' benefit, would be included in incurred claims.

Question #22:
Are payments by issuers to clinical risk-bearing entities, such as Independent Practice Associations (IPAs), for administrative functions performed on behalf of the issuer, incurred claims under 45 CFR 158.140?
Answer #22:

To the extent that administrative functions are performed on behalf of the issuer, that portion of the issuer's payment that is attributable to the administrative functions may not be included in incurred claims (See Questions and Answers 11, 12 and 13 in the May 13, 2011 guidance at http://cciio.cms.gov/resources/files/2011_05_13_MLR_Q_and_A_Guidance.pdf. This is the case regardless of whether payment is made according to a separate, fee-for-service payment schedule or as part of a global, capitated fee payment for all services provided. For example, payment for processing claims in order to issue explanations of benefits (EOBs) to enrollees and handling the any stage of enrollee appeals would not be included in incurred claims. Payments for non-clinical services for which the contract between the IPA and the issuer contains a "clawback" provision are not considered incurred claims for MLR reporting purposes.

Commercial MLR

The preamble to the final rule contained the following language regarding commercial MLR:

- Overall, commenters supported our decision to model Medicare MLR policy after the commercial MLR rules.
- Several commenters supported the proposed rule and CMS's general approach of using the commercial MLR rules as a reference point for developing the Medicare MLR requirements.
- As we stated in the preamble to the proposed rule, we only intended to depart from the commercial MLR rule to the extent necessary and appropriate given the Medicare context.

Commercial Reinsurance

The preamble to the final rule contained the following language regarding reinsurance:

Comment: A commenter determined that the proposed treatment of commercial reinsurance in the proposed rule deviated from the commercial MLR regulation. The commenter noted that under 45 CFR 158.130(a)(3) of the commercial regulation, the only instances in which the premiums and claims associated with a ''100 percent indemnity reinsurance treaty'' are reported as part of the MLR calculation by the ''assuming entity'' instead of by the ''ceding entity'' are—(1) when the reinsurance treaty was in force prior to the date of enactment of the Affordable Care Act; and (2) in situations in which the assuming entity is also completely responsible for performing administrative functions.

Response: We thank the commenter for pointing out this unintended inconsistency with the commercial MLR regulation in our proposed provisions at § 422.2420(b)(1)(iv), § 422.2420(c)(4), § 423.2420(b)(1)(iv) and § 423.2420(c)(4). Our proposed regulation would require that claims and revenue be reported on a direct basis, at § 422.2420(b)(2)(i), § 422.2420(c)(1), § 423.2420(b)(2)(i), and § 423.2420(c)(1). We agree that our proposed regulations about the exceptions to direct reporting should be corrected to mirror the commercial regulation as we intended. As we stated in the preamble to the proposed rule, we only intended to depart from the commercial MLR rule to the extent necessary and appropriate given the Medicare context. In this case, the provisions at issue do not involve Medicare. Thus, we are revising the proposed regulation text to mirror more exactly the commercial regulation at 45 CFR 158.130(a)(2) and (a)(3). We are separating provisions on assumptive and 100 percent indemnity reinsurance, and incorporating the commercial rule language at 45 CFR 158.130(a)(3), which provides that the only instance in which the premiums (revenue) and claims associated with a 100 percent indemnity reinsurance treaty are reported by the assuming entity, instead of by the ceding entity, is when the reinsurance treaty was in force prior to the date of enactment of the Affordable Care Act. In short, with this change our provisions now mirror the distinction between paragraphs § 158.130(a)(2) and (a)(3) in the commercial rule. We are including these reinsurance provisions under § 422.2420 and § 423.2420 for both the MLR numerator (costs) and MLR denominator (revenue.) (The commercial MLR rule addresses the treatment of reinsurance for the MLR numerator at § 158.103 through a definition of direct paid claims.) Finally, we are moving the numerator provision at § 158.103 (b)(1)(iv) to (b)(5) and adding paragraph (b)(6).

Comment: One commenter requested clarification regarding the exclusion of commercial reinsurance from total revenue and inquired whether the ''commercial reinsurance'' exclusion means net reinsurance (that is, reinsurance premium less reinsurance recoveries) or whether both premiums and recoveries are excluded from the MLR calculation.

Response: We followed the commercial MLR approach by not allowing MA organizations and Part D sponsors to adjust the MLR for commercial reinsurance (we note that this

response is addressing commercial insurance and not the federal reinsurance provision under the Part D program). That is, both reinsurance premiums and recoveries are excluded from the MLR calculation. Both costs and revenues must be reported on a direct basis, that is, before ceded reinsurance as stated at § 422.2420(b)(2)(1) regarding incurred claims as direct claims direct drug costs that are actually paid, and § 422.2420(c)(1) and § 423.2420(c)(1) regarding total revenue reported on a direct basis.

EGWPs

The preamble to the final rule contained the following language regarding EGWPs:

> We expect EGWPs to report costs and revenue per § 422.2420 and § 423.2420 on the Medicare-funded portion of each contract. …
> We note that though we currently do not collect information on EGWP benefit packages, we have the authority to request this information if needed.

To determine the Medicare-funded portion of the contract, organizations may either:

- Use actual cost information to separate the employer-funded versus Medicare-funded portions of the EGWPs under the contract, or
- Allocate the Medicare-funded portion of the EGWP costs under the contract based on the Medicare portion of revenue for the contract (i.e., report Medicare-funded costs as the total costs multiplied by the ratio of Medicare revenue (as reported in Worksheet 1 Line 1) to total revenue).

The preamble to the final rule contained the following language regarding non-CY EGWPs:

> For non-CY EGWPs, we expect that MLR calculations and remittances would occur on a calendar year basis, similar to how payments and most submissions to CMS are on a calendar year basis.

Low Income Cost Sharing Subsidy (LICS) and Coverage Gap Discount Program (CGDP)

The preamble to the final rule contained the following language:

> *Comment:* Several commenters recommended that all low income premium and cost sharing subsidies (LIPS and LICS) and discounts on brand drugs advanced to beneficiaries as part of the Coverage Gap Discount Program be taken into account in the numerator (and denominator), similar to the treatment of Part D reinsurance.
> *Response:* We make LIPS payments to MA organizations and Part D sponsors to make the sponsor whole for reduced premiums that eligible beneficiaries are paying the plan. Beneficiary premiums are revenue, not costs, and thus LIPS payments are taken into account in the denominator of the MLR. We view LICS payments and coverage gap discount payments as pass-through payments, unlike federal reinsurance, which pays for a portion—but not all—of plan liability in the catastrophic phase of the benefit. Thus, LICS and CGDP amounts do not belong in the MLR numerator or the MLR calculation.

MA Optional Supplemental Benefits

The preamble to the final rule contained the following language regarding MA optional supplemental benefits:

> *Comment:* A commenter stated that CMS' proposal to include costs and revenues for optional supplemental benefits in the MLRs for MA contracts is unjustified because revenue

for these benefits comes solely from beneficiary premium, and by law beneficiaries do not share in any remittances that must be made by MA organizations and Part D sponsors for contracts that fail to meet the MLR requirement. The commenter believed that the MLR should only include benefits funded by the Medicare program.

Response: The commenter is correct that we intend for the MA MLR to include all of the MA benefits defined at § 422.100(c): Basic benefits, mandatory supplemental benefits, and optional supplemental benefits. We believe that all Medicare costs and revenues under an MA contract should be included in the MLR, and the optional supplemental benefit package is defined by law as a type of Medicare benefit under the MA program. The fact that the optional supplemental benefit is funded completely by beneficiary premiums is a reason for including these benefits in the MLR. A key goal of the MLR provision is to provide beneficiaries with information needed to better understand how much of revenue—including beneficiary premiums—is being used to pay for their Medicare services and quality improving activities.

Sequestration

Generally speaking, MLR reporting is based on actual incurred costs and actual revenues, which would reflect sequestration reductions. For example, if reduced amounts are paid to providers due to sequestration, the reporting of incurred costs would reflect the reduction. The reporting of revenue received from CMS would reflect any sequestration reductions.

MLR requirements

The final rule establishes MLR reporting requirements as follows:

§ 422.2460 Reporting requirements.

For each contract year, each MA organization must submit a report to CMS, in a timeframe and manner specified by CMS, which includes but is not limited to the data needed by the MA organization to calculate and verify the MLR and remittance amount, if any, for each contract, such as incurred claims, total revenue, expenditures on quality improving activities, non-claims costs, taxes, licensing and regulatory fees, and any remittance owed to CMS under § 422.2410.

§ 423.2460 Reporting requirements.

(a) For each contract year, each Part D sponsor must submit a report to CMS, in a timeframe and manner specified by CMS, which includes but is not limited to the data needed by the Part D sponsor to calculate and verify the MLR and remittance amount, if any, for each contract, such as incurred claims, total revenue, costs for quality improving activities, non-claims costs, taxes, licensing and regulatory fees, and any remittance owed to CMS under § 423.2410.

(b) Total revenue reported as part of the MLR report must be net of all projected reconciliations.

(c) The MLR will be reported once, and will not be reopened as a result of any payment reconciliation processes.

The final rule establishes the consequences of not meeting the MLR reporting requirements as follows:

§ 422.510 Termination of contract by CMS.

(a) * * *

(15) Has failed to report MLR data in a timely and accurate manner in accordance with § 422.2460.

§ 423.509 Termination of contract by CMS.

(a) * * *

(14) Has failed to report MLR data in a timely and accurate manner in accordance with § 423.2460.

The final rule establishes that penalties and sanctions apply when minimum medical loss ratios are not achieved as follows:

§ 422.2410 General requirements

(a) For contracts beginning in 2014 or later, an MA organization (defined at § 422.2) is required to report an MLR for each contract under this part for each contract year.

(b) *MLR requirement.* If CMS determines for a contract year that an MA organization has an MLR for a contract that is less than 0.85, the MA organization has not met the MLR requirement and must remit to CMS an amount equal to the product of the following:

(1) The total revenue of the MA contract for the contract year.

(2) The difference between 0.85 and the MLR for the contract year.

(c) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 3 or more consecutive contract years, CMS does not permit the enrollment of new enrollees under the contract for coverage during the second succeeding contract year.

(d) If CMS determines that an MA organization has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS terminates the contract per § 422.510(b)(1) and (d) effective as of the second succeeding contract year.

§ 422.2470 Remittance to CMS if the applicable MLR requirement is not met.

(a) *General requirement.* For each contract year, an MA organization must provide a remittance to CMS if the contract's MLR does not meet the minimum MLR requirement required by § 422.2410(b) of this subpart.

(b) *Amount of remittance.* For each contract that does not meet the MLR requirement for a contract year, the MA organization must remit to CMS the amount by which the MLR requirement exceeds the contract's actual MLR multiplied by the total revenue of the contract, as provided in § 422.2420(c), for the contract year.

(c) *Timing of remittance.* CMS deducts the remittance from plan payments in a timely manner after the MLR is reported, on a schedule determined by CMS.

(d) *Treatment of remittance.* Payment to CMS must not be included in the numerator or denominator of any year's MLR.

§ 423.2410 General requirements.

(a) For contracts beginning in 2014 or subsequent contract years, a Part D sponsor (defined at § 423.4) is required to report an MLR for each contract under this part for each contract year.

(b) If CMS determines for a contract year that a Part D sponsor has an MLR for a contract that is less than 0.85, the Part D sponsor must remit to CMS an amount equal to the product of the following:

(1) The total revenue of the prescription drug plan for the contract year.

(2) The difference between 0.85 and the MLR for the contract year.

(c) If CMS determines that a Part D sponsor has an MLR for a contract that is less than 0.85 for 3 or more consecutive contract years, CMS does not permit the enrollment of new enrollees under the contract for coverage during the second succeeding contract year.

(d) If CMS determines that a Part D sponsor has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS does terminate the contract under the authority at § 423.509(a)(11) and (14) effective as of the second succeeding contract year.

§ 423.2470 Remittance to CMS if the applicable MLR requirement is not met.

(a) *General requirement.* For each contract year, a Part D sponsor must provide a remittance to CMS if the contract's MLR does not meet the minimum percentage required by § 423.2410(b).

(b) *Amount of remittance.* For each contract that does not meet MLR requirement for a contract year, the Part D sponsor must remit to CMS the amount by which the MLR requirement exceeds the contract's actual MLR multiplied by the total revenue of the contract, as provided in § 423.2420(c), for the contract year.

(c) *Timing of remittance.* CMS will deduct the remittance from plan payments in a timely manner after the MLR is reported, on a schedule determined by CMS.

(d) *Treatment of remittance.* Payment to CMS must not be included in the numerator or denominator of any year's MLR.

The final rule establishes the following requirements regarding MLR review:

§ 422.2480 MLR review and noncompliance.

To ensure the accuracy of MLR reporting, CMS conducts selected reviews of reports submitted under § 422.2460 to determine that that the MLRs and remittance amounts under § 422.2410(b) and sanctions under § 422.2410(c) and (d), were accurately calculated, reported, and applied.

(a) The reviews include a validation of amounts included in both the numerator and denominator of the MLR calculation reported to CMS.

(b) MA organizations are required to maintain evidence of the amounts reported to CMS and to validate all data necessary to calculate MLRs.

(c)(1) Documents and records must be maintained for 10 years from the date such calculations were reported to CMS with respect to a given MLR reporting year.

(2) MA organizations must require any third party vendor supplying drug or medical cost contracting and claim adjudication services to the MA organization to provide all underlying data associated with MLR reporting to that MA organization in a timely manner, when requested by the MA organization, regardless of current contractual limitations, in order to validate the accuracy of MLR reporting.

(d) Reports submitted under § 422.2460, calculations, or any other MLR submission required by this subpart found to be materially incorrect or fraudulent—

(1) Is noted by CMS;

(2) Appropriate remittance amounts are recouped by CMS; and

(3) Sanctions may be imposed by CMS as provided in § 422.752.

§ 423.2480 MLR review and noncompliance.

To ensure the accuracy of MLR reporting, CMS conducts selected reviews of reports submitted under § 423.2460 to determine that the MLRs and remittance amounts under § 423.2410(b) and sanctions under § 423.2410(c) and (d), were accurately calculated, reported, and applied.

(a) The reviews will include a validation of amounts included in both the numerator and denominator of the MLR calculation reported to CMS.

(b) Part D sponsors are required to maintain evidence of the amounts reported to CMS and to validate all data necessary to calculate MLRs.

(c)(1) Documents and records must be maintained for 10 years from the date such calculations were reported to CMS with respect to a given contract year.

(2) Part D sponsors must require any third party vendor supplying drug cost contracting and claim adjudication services to the Part D sponsors to provide all underlying data associated with MLR reporting to that Part D sponsor in a timely manner, when requested

by the Part D sponsor, regardless of current contractual limitations, in order to validate the accuracy of MLR reporting.
(d) Reports submitted under § 423.2460, calculations, or any other MLR submission required by this subpart found to be materially incorrect or fraudulent—
(1) Are noted by CMS;
(2) Appropriate remittance amounts are recouped by CMS; and
(3) Sanctions may be imposed by CMS as provided in § 423.752.

Additional Resources

In addition to these instructions, the following resources provide additional information regarding CY2014 MLR reporting:

- The Medicare MLR implementing regulation may be found at:
  http://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf
- Commercial MLR regulations, guidance, reporting instructions, and other resources may be found at:
  http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Medical-Loss-Ratio.html
- The Advance Notice, Rate Announcement, and Call Letter may be found at:
  http://cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html
- For technical questions about the MLR Reporting Tool, HPMS, or the upload process, refer to the following resources:
  HPMS Help Desk: 1-800-220-2028 or hpms@cms.hhs.gov

WORKSHEET 1

The purpose of Worksheet 1 is to capture contract-specific experience for the reporting period.

Section 1 – General Information

Line 1 – Contract Year

This field is pre-populated with the year to which the contract applies.

Line 2 – Contract Number

Enter the contract number, which begins with a capital letter H, R, S or E and includes four Arabic numerals (for example, H9999). Be sure to include all leading zeros (for example, H0001).

Line 3 – Organization Name

Enter the organization's legal entity name. This information also appears in HPMS.

Line 4 – Date MLR Report finalized

This field is populated with the date when the MLR Report is finalized. See the Technical Instructions section for more information.

Line 5 – Contact Information

Plan sponsors must identify two contacts that will be readily available and authorized to discuss the information submitted in the MLR Report.

In this section, enter the name, position, phone number, and e-mail information for both contacts. Do not leave any part of this section blank.

Section 2 – Data Collection

Enter total dollars; PMPMs are calculated.

Line 1 – Revenue

Enter the contract's revenue amounts for the reporting period by the various categories.

The final rule contained the following guidance regarding the reporting of revenue information:

> **§ 422.2420 Calculation of the medical loss ratio.**
> (3) The following amounts must not be included in total revenue:

(i) The amount of unpaid premiums for which the MA organization can demonstrate to CMS that it made a reasonable effort to collect.
(ii) The following EHR payments and adjustments:
(A) EHR incentive payments for meaningful use of certified electronic health records by qualifying MAOs, MA EPs and MA-affiliated eligible hospitals that are administered under 42 CFR part
495 subpart C.
(B) EHR payment adjustments for a failure to meet meaningful use requirements that are administered under 42 CFR part 495 subpart C.
(iii) Coverage Gap Discount Program payments under § 423.2320 of this chapter.
(4) Total revenue (as defined at § 422.2420(c)) for policies issued by one MA organization and later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year during which the policies were assumed and no revenue under this part for that contract year must be reported by the ceding MA organization.
(5) Total revenue (as defined at § 422.2420(c)) that is reinsured for a block of business that was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

§ 423.2420 Calculation of medical loss ratio.

(3) The following amounts must not be included in total revenue:
(i) The amount of unpaid premiums for which the Part D sponsor can demonstrate to CMS that it made a reasonable effort to collect.
(ii) Coverage Gap Discount Program payments under § 423.2320.
(4) Total revenue (as defined at § 422.2420(c)) of this chapter) for policies issued by one Part D sponsor and later assumed by another entity must be reported by the assuming entity for the entire MLR reporting year during which the policies were assumed and revenue under this part for that contract year must be reported by the ceding Part D sponsor.
(5) Total revenue (as defined at § 422.2420(c) of this chapter) that is reinsured for a block of business that was subject to indemnity reinsurance and administrative agreements effective before March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

CMS provides organizations with revenue information via several reports. Below is a mapping of CMS reports to the revenue categories of the MLR Report. The following two CMS reports are used in this mapping:

- MMDDF = Monthly Membership Detail Data File (through September 2015)
- PRS CTR = Payment Reconciliation System (PRS) Reconciliation Results Report to Plans, Contract Trailer "CTR" version

MLR Report	Brief Description	CMS revenue report
Line 1.1	Beneficiary Premiums	N/A
Line 1.2	MA payment including 3 rebates	MMDDF item 66

Line 1.3	Part B rebate	MMDDF items 60+61
Line 1.4	Part D Basic rebate	MMDDF item 72
Line 1.5	MSA Enrollee Deposit	N/A
Line 1.6	Part D Direct Subsidy	MMDDF item 74
Line 1.7	Part D Federal Reinsurance	PRS CTR field 20
Line 1.8	LIPSA	MMDDF item 35
Line 1.9	Part D risk corridor payments	PRS CTR field 33

More information about the CMS revenue reports may be found at:

- http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/mapdhelpdesk/Plan_Communications_User_Guide.html
- http://www.csscoperations.com/internet/cssc3.nsf/docsCat/CSSC~CSSC%20Operations~Prescription%20Drug%20Event~Report%20Layouts?open&expand=1&navmenu=Prescription^Drug^Event||

Line 1.1 – Beneficiary Premium

Beneficiary premiums include all premiums by or on behalf of enrollees, all unpaid premium amounts that an organization could have collected from enrollees minus any premium amounts that remain unpaid after reasonable collection efforts, and all changes in unearned premium reserves.

Beneficiary premiums are net of MA rebates (i.e., after application of MA rebates to reduce premium).

Line 1.1a – MA (Basic + Mandatory Supplemental + Optional Supplemental)

MA portion of Line 1.1.

Line 1.1b – Part D (Basic + Supplemental)

Part D portion of Line 1.1

Line 1.2 – MA plan payments (based on A/B bid), using final risk scores including MA Rebate for Cost Sharing Reduction, MA Rebate for Other Mandatory Supplemental Benefits, and MA Rebate for Part D Supplemental Benefits

See the mapping to CMS revenue reports provided above.

Line 1.3 – MA Rebate for Part B Premium Reduction

See the mapping to CMS revenue reports provided above.

Line 1.4 – MA Rebate for Part D Basic Premium Reduction

See the mapping to CMS revenue reports provided above.

Line 1.5 – MSA Enrollee Deposit

Applies to MSA plans only.

Line 1.6 – Part D direct subsidy, using final risk scores

See the mapping to CMS revenue reports provided above.

Line 1.7 – Part D federal reinsurance subsidy (prospective and reconciliation adjustments)

See the mapping to CMS revenue reports provided above.

Line 1.8 – Part D Low Income Premium Subsidy Amount (LIPSA)

See the mapping to CMS revenue reports provided above.

Line 1.9 – Part D risk corridor payments

See the mapping to CMS revenue reports provided above.

Line 1.10 – Total

Calculated as the sum of Lines 1.1 through 1.9.

Line 2 – Claims

Enter the contract's expenses for the reporting period by the various categories.

The final rule contained the following guidance regarding the reporting of claims information:

> **§ 422.2420 Calculation of the medical loss ratio.**
> (2) *Incurred claims for clinical services and prescription drug costs.*
> Incurred claims must include the following:
> (i) Direct claims that the MA organization pays to providers (including under capitation contracts with physicians) for covered services, described at paragraph (a)(2) of this section provided to all enrollees under the contract.
> (ii) For an MA contract that includes MA–PD plans (described in paragraph (a)(2) of this section), drug costs provided to all enrollees under the contract, as defined at § 423.2420(b)(2)(i) of this chapter.
> (iii) Unpaid claims reserves for the current contract year, including claims reported in the process of adjustment.
> (iv) Percentage withholds from payments made to contracted providers.
> (v) Incurred but not reported claims based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.
> (vi) Changes in other claims-related reserves.
> (vii) Claims that are recoverable for anticipated coordination of benefits.
> (viii) Claims payments recoveries received as a result of subrogation.

(ix) Claims payments recoveries as a result of fraud reduction efforts, not to exceed the amount of fraud reduction expenses.
(x) Reserves for contingent benefits and the medical claim portion of lawsuits.
(xi) The amount of incentive and bonus payments made to providers.
(3) Adjustments that must be deducted from incurred claims include the following:
(i) Overpayment recoveries received from providers.
(4) *Exclusions from incurred claims.*
The following amounts must not be included in incurred claims:
(i) Non-claims costs, as defined in § 422.2401, which include the following:
(A) Amounts paid to third party vendors for secondary network savings.
(B) Amounts paid to third party vendors for any of the following:
(*1*) Network development.
(*2*) Administrative fees.
(*3*) Claims processing.
(*4*) Utilization management.
(C) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, such as the following:
(*1*) Medical record copying costs.
(*2*) Attorneys' fees.
(*3*) Subrogation vendor fees.
(*4*) Bona fide service fees.
(*5*) Compensation to any of the following:
(*i*) Paraprofessionals.
(*ii*) Janitors.
(*iii*) Quality assurance analysts.
(*iv*) Administrative supervisors.
(*v*) Secretaries to medical personnel.
(*vi*) Medical record clerks.
(ii) Amounts paid to CMS as a remittance under § 422.2410(b).
(5) Incurred claims under this part for policies issued by one MA organization and later assumed by another entity must be reported by the assuming organizations for the entire MLR reporting year during which the policies were assumed and no incurred claims under this part for that contract year must be reported by the ceding MA organization.
(6) Reinsured incurred claims for a block of business that was subject to indemnity reinsurance and administrative agreements effective before March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

§ 423.2420 Calculation of medical loss ratio.

(2) *Incurred claims for prescription drug costs.* Incurred claims must include the following:
(i) Direct drug costs that are actually paid (as defined in § 423.308, which are net of prescription drug rebates and other direct or indirect remuneration as defined herein) by the Part D sponsor.
(ii) Unpaid claims reserves for the current contract year, including claims reported in the process of adjustment.
(iii) Percentage withholds from payments made to contracted providers.
(iv) Claims incurred but not reported based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.
(v) Changes in other claims-related reserves.

(vi) Claims that are recoverable for anticipated coordination of benefits.
(vii) Claims payments recoveries received as a result of subrogation.
(viii) Claims payments recoveries received as a result of fraud reduction efforts, not to exceed the amount of fraud reduction expenses.
(ix) Reserves for contingent benefits and the Part D claim portion of lawsuits.
(3) Adjustments that must be deducted from incurred claims include the following:
(i) Overpayment recoveries received from providers.
(4) *Exclusions from incurred claims.*
The following amounts must not be included in incurred claims:
(i) Non-claims costs, as defined in § 423.2401, which include the following:
(A) Amounts paid to third party vendors for secondary network savings.
(B) Amounts paid to third party vendors for any of the following:
(*1*) Network development.
(*2*) Administrative fees.
(*3*) Claims processing.
(*4*) Utilization management.
(C) Amounts paid, including amounts paid to a pharmacy, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, such as the following:
(*1*) Medical record copying costs.
(*2*) Attorneys' fees.
(*3*) Subrogation vendor fees.
(*4*) Bona fide service fees.
(*5*) Compensation to any of the following:
(*i*) Paraprofessionals.
(*ii*) Janitors.
(*iii*) Quality assurance analysts.
(*iv*) Administrative supervisors.
(*v*) Secretaries to medical personnel.
(*vi*) Medical record clerks.
(ii) Amounts paid to CMS as a remittance under § 423.2410(b).
(5) Incurred claims under this part for policies issued by one Part D sponsor and later assumed by another entity must be reported by the assuming organization for the entire MLR reporting year during which the policies were assumed and no incurred claims under this part for that contract year must be reported by the ceding Part D sponsor.
(6) Reinsured incurred claims for a block of business that was subject to indemnity reinsurance and administrative agreements effective before March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

Line 2.1 – Claims incurred only during CY 2014, paid through 9/30/2015

This line is consistent with the commercial MLR reporting form Part 2 Line 2.1

Line 2.2 – Liability and reserves for claims incurred only during CY 2014, calc'd as of 9/30/2015

This line is consistent with the commercial MLR reporting form Part 2 Lines 2.2 and 2.4

Line 2.3 – Incurred medical incentive pool and bonuses

This line is consistent with the commercial MLR reporting form Part 2 Line 2.11

Line 2.3a - Paid medical incentive pools and bonuses MLR Reporting year

This line is consistent with the commercial MLR reporting form Part 2 Line 2.11a

Line 2.3b - Accrued medical incentive pools and bonuses MLR Reporting year

This line is consistent with the commercial MLR reporting form Part 2 Line 2.11b

Line 2.4 - Contingent benefit and lawsuit reserves

This line is consistent with the commercial MLR reporting form Part 2 Line 2.13

Line 2.5 – MA Rebate for Part B Premium Reduction

Calculated field that refers to Line 1.3

Line 2.6 – MSA Enrollee Deposit (MSA plans only)

Calculated field that refers to Line 1.5

Line 2.7 – Allowable fraud reduction expense (the smaller of lines 2.7a or 2.7b)

This line is consistent with the commercial MLR reporting form Part 2 Line 2.17

Line 2.7a – Total fraud reduction expense

This line is consistent with the commercial MLR reporting form Part 2 Line 2.17a

Line 2.7b – Total fraud recoveries that reduced paid claims in Line 2.1

This line is consistent with the commercial MLR reporting form Part 2 Line 2.17b

Line 2.8 – Total

Calculated as the sum of Lines 2.1 through 2.7

Line 2.8a – Part D (informational only; already included in Line 2.8)

Required data entry; do not leave blank.

For plan types that are only reporting Part D experience for MLR (such as PDPs), Line 2.8a should equal Line 2.8.

This line is similar to the commercial MLR reporting form Part 1 Line 2.2

Line 2.8b - Direct and Indirect Remuneration (DIR) (informational only; already excluded from Line 2.8)

Required data entry; do not leave blank.

This line is similar to the commercial MLR reporting form Part 1 Line 2.3

Line 3 – Federal and State Taxes and Licensing or Regulatory Fees

The categories under Line 3 are consistent with the commercial MLR reporting form.

The final rule contained the following guidance regarding taxes and fees:

> **§ 422.2420 Calculation of the medical loss ratio.**
> (2) The following amounts must be deducted from total revenue in calculating the MLR:
> (i) *Licensing and regulatory fees.*
> (A) Statutory assessments to defray the operating expenses of any State or Federal department, such as the ''user fee'' described in section 1857(e)(2) of the Act.
> (B) Examination fees in lieu of premium taxes as specified by State law.
> (ii) *Federal taxes and assessments.* All Federal taxes and assessments allocated to health insurance coverage.
> (iii) *State taxes and assessments.*
> State taxes and assessments such as the following:
> (A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly.
> (B) Guaranty fund assessments.
> (C) 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.
> (D) State income, excise, and business taxes other than premium taxes.
> (iv) *Community benefit expenditures.*
> Community benefit expenditures are payments made by a Federal income tax-exempt MA organization for community benefit expenditures as defined in paragraph (c)(2)(iv)(A) of this section, limited to the amount defined in paragraph (c)(2)(iv)(B) of this section, and allocated to a contract as required under paragraph (d)(1) of this section.
> (A) Community benefit expenditures means 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.
> (B) Such payment may be deducted up to the limit of either 3 percent of total revenue under this part or the highest premium tax rate in the State for which the Part D sponsor is licensed, multiplied by the Part D sponsor's earned premium for the contract.
> **§ 423.2420 Calculation of medical loss ratio.**
> (2) The following amounts must be deducted from total revenue in calculating the MLR:
> (i) *Licensing and regulatory fees.*
> Statutory assessments to defray operating expenses of any State or Federal department, such as the ''user fee'' described in section 1857(e)(2) of the Act, and examination fees in lieu of premium taxes as specified by State law.
> (ii) *Federal taxes and assessments.* All Federal taxes and assessments allocated to health insurance coverage.
> (iii) *State taxes and assessments.*
> State taxes and assessments, such as the following:

(A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly.
(B) Guaranty fund assessments.
(C) 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.
(D) State income, excise, and business taxes other than premium taxes.
(iv) *Community benefit expenditures.*
Community benefit expenditures are payments made by a Federal income tax-exempt Part D sponsor for community benefit expenditures as defined in paragraph (c)(2)(iii)(A) of this section, limited to the amount defined in paragraph (c)(2)(iii)(B) of this section, and allocated to a contract as required under paragraph (d)(1) of this section.
(A) Community benefit expenditures means 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.
(B) Such payment may be deducted up to the limit of either 3 percent of total revenue under this part or the highest premium tax rate in the State for which the Part D sponsor is licensed, multiplied by the Part D sponsor's earned premium for the contract.

Line 4 - Health Care Quality Improvement (QI) Expenses Incurred

The categories under Line 4 are consistent with the commercial MLR reporting form.

The final rule contained the following guidance regarding activities that improve health care quality:

§ 422.2430 Activities that improve health care quality.
(a) *Activity requirements.* Activities conducted by an MA organization to improve quality must fall into one of the categories in paragraph (a)(1) of this section and meet all of the requirements in paragraph (a)(2) of this section.
(1) *Categories of quality improving activities.* The activity must be designed to achieve one or more of the following:
(i) To improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage.
(ii) To prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.
(iii) To improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage.
(iv) To promote health and wellness.
(v) To enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Such activities, such as Health Information Technology (HIT) expenses, are required to accomplish the activities

that improve health care quality and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, and are consistent with meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improving activities or make new quality improvement initiatives possible.

(2) The activity must be designed for all of the following:

(i) To improve health quality.

(ii) To increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) To be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) To 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.

(b) *Exclusions.* Expenditures and activities that must not be included in quality improving activities include, but are not limited to, the following:

(1) Those that are designed primarily to control or contain costs.

(2) 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.

(3) Those which otherwise meet the definitions for quality improving activities but which were paid for with grant money or other funding separate from premium revenue.

(4) Those activities that can be billed or allocated by a provider for care delivery and that are reimbursed as clinical services.

(5) 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 ICD–10 implementation costs in excess of 0.3 percent of total revenue under this part, and maintenance of ICD–10 code sets adopted in accordance with to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended.

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.

(7) All retrospective and concurrent utilization review.

(8) Fraud prevention activities.

(9) 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.

(10) Provider credentialing.

(11) Marketing expenses.

(12) Costs associated with calculating and administering individual enrollee or employee incentives.

(13) That portion of prospective utilization review that does not meet the definition of activities that improve health quality.

(14) Any function or activity not expressly permitted by CMS under this part.

§ 423.2430 Activities that improve health care quality.

(a) *Activity requirements.* Activities conducted by a Part D sponsor to improve quality fall into one of the categories in paragraph (a)(1) of this section and meet all of the requirements in paragraph (a)(2) of this section.
(1) *Categories of quality improving activities.* The activity must be designed to achieve one or more of the following:
(i) To improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage.
(ii) To prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.
(iii) To improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage.
(iv) To promote health and wellness.
(v) To enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Activities, such as Health Information Technology (HIT) expenses, are required to accomplish the activities that improve health care quality and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, and are consistent with meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improving activities or make new quality improvement initiatives possible.
(2) The activity must be designed for all of the following:
(i) To improve health quality.
(ii) To increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.
(iii) To be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.
(iv) To 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. (b) *Exclusions.* Expenditures and activities that must not be included in quality improving activities include, but are not limited to, the following:
(1) Those that are designed primarily to control or contain costs.
(2) 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.
(3) Those which otherwise meet the definitions for quality improving activities but which were paid for with grant money or other funding separate from premium revenue.
(4) Those activities that can be billed or allocated by a pharmacy for care delivery and that are reimbursed as clinical services.
(5) 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 ICD–10 implementation costs in excess of 0.3 percent of total revenue under this part, and maintenance of ICD–10 code sets adopted in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.
(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
(7) All retrospective and concurrent utilization review.
(8) Fraud prevention activities.
(9) The cost of developing and executing pharmacy contracts and fees associated with establishing or managing a pharmacy network, including fees paid to a vendor for the same reason.
(10) Pharmacy network credentialing.
(11) Marketing expenses.
(12) Costs associated with calculating and administering individual enrollee or employee incentives.
(13) That portion of prospective utilization review that does not meet the definition of activities that improve health quality.
(14) Any function or activity not expressly permitted by CMS under this part.

Line 5 – Non-Claims Costs

The categories under Line 5 are consistent with the commercial MLR reporting form.

The final rule contained the following guidance regarding non-claims costs:

§ 422.2401 Definitions.
Non-claims costs means those expenses for administrative services that are not—
(1) Incurred claims (as provided in § 422.2420(b)(2) through (4));
(2) Expenditures on quality improving activities (as provided in § 422.2430);
(3) Licensing and regulatory fees (as provided in § 422.2420(c)(2)(ii));
(4) State and Federal taxes and assessments (as provided in § 422.2420(c)(2)(i) and (iii)).

§ 423.2401 Definitions.
Non-claims costs means those expenses for administrative services that are not—
(1) Incurred claims (as provided in § 423.2420(b)(2) through (b)(4));
(2) Expenditures on quality improving activities (as provided in § 423.2430);
(3) Licensing and regulatory fees (as provided in § 423.2420(c)(2)(i)); or
(4) State and Federal taxes and assessments (as provided in § 423.2420(c)(2)(ii) and (iii)).

Line 6 – Methodology for determining the Medicare-funded portion of the contract for EGWP plans

This information will be used during CMS review/audit. See the Reporting Considerations EGWP section for more information.

Line 6.1 - Option 1 "Actual EGWP costs", or Option 2 "Allocated based on revenue"

Enter the option used to determine the Medicare-funded portion of the contract for EGWP plans. If there are no EGWP plans under the contract, enter “N/A”.

Line 6.2 - Enter percentage used to allocate EGWP costs (i.e., Medicare % of total revenue)

If Option 2 "Allocated based on revenue" is entered in line 6.2, enter the percentage used to allocate EGWP costs under the contract. Otherwise enter "N/A".

Line 7 – Total Member Months

This field is calculated as the sum of the member months entered in line 8 column (c).

Line 8 – Plan-Specific Data

Column (b) Plans offered under the contract in CY 2014

Enter the list of plans offered under the contract in CY 2014, in the format of Hxxxx-xxx-xx. There are rows available to enter up to 150 plans. Do not leave blank rows between plans.

Column (c) CY2014 Member Months

Enter the member months associated with each plan entered.

Member months entered should be on a consistent basis with the revenue and claims information entered in Lines 1 and 2.

The preamble to the final rule contained the following guidance regarding member months:

> …member months for a contract year equal the sum across the 12 months of a year of the total number of enrollees for each month. This includes enrollees who are in ESRD and hospice status for a month.

Column (d) Is the plan a Dual-Eligible Special Needs Plan (i.e., D-SNP)? (Yes/No)

For each plan entered, enter a Yes/No to indicate if the plan is a D-SNP.

Column (e) Does the plan's defined service area include territories? (Yes/No)

For each plan entered, enter a Yes/No to indicate if the plan's defined service area includes one of more territories (ex: Puerto Rico, Guam, Virgin Islands, American Somoa).

The plan's defined service area is in HPMS. (The corresponding county codes are also entered in the CY MA Bid Pricing Tool (BPT), for those plans that complete and submit the MA BPT.)

Column (f) Is the plan a D-SNP in a territory? (Yes/No)

Calculated field: If column (d) and column (e) both equal "Yes", then column (f) populates with a "Yes".

Columns (g) through (n)

Columns (g) through (n) must be completed only for plan rows where column (f) equals "Yes" (i.e., only for D-SNP plans in territories).

The label Medicaid in this Report is used to refer to a State/Territory program for Dual-Eligible beneficiaries (ex: Platino).

Column (g) Member Months in territories

Enter the subset of member months entered in column (c) that are in territories.

Column (h) Medicaid Revenue PMPM

Enter the Medicaid Revenue for member months entered in column (g) on a PMPM basis.

This revenue was not included in Worksheet 1 Line 1.

Column (i) Medicaid Cost PMPM

Calculated field: Column (j) + (k) + (l) + (m)

Column (j) Medicaid Non-Claims Cost PMPM

Enter the Medicaid non-claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 5.

Column (k) Medicaid Claims Cost: Medical Cost Sharing Reduction PMPM

Enter the Medicaid claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 2.

Column (l) Medicaid Claims Cost: Medical Other Benefits PMPM

Enter the Medicaid claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 2.

Column (m) Medicaid Claims Cost: Pharmacy PMPM

Enter the Medicaid claims cost for member months entered in column (g) on a PMPM basis.

This amount was not included in Worksheet 1 Line 2.

Column (n) Medicaid Gain/(Loss) PMPM

Calculated field: Column (h) - (i)

WORKSHEET 2

The purpose of Worksheet 2 is to compute the Medicare medical loss ratio (MLR) and remittance amount, if any.

Section 1 – Medicare MLR and Remittance Calculation

The final rule contained the following guidance regarding the MLR calculation:

§ 422.2420 Calculation of the medical loss ratio.

(a) *Determination of MLR.* (1) The MLR for each contract under this part is the ratio of the numerator (as defined in paragraph (b) of this section) to the denominator (as defined in paragraph (c) of this section). An MLR may be increased by a credibility adjustment according to the rules at § 422.2440, or subject to an adjustment determined by CMS to be warranted based on exceptional circumstances for areas outside the 50 states and the District of Columbia.

(2) The MLR for an MA contract—

(i) Not offering Medicare prescription drug benefits must only reflect costs and revenues related to the benefits defined at § 422.100(c); and

(ii) That includes MA–PD plans (defined at § 422.2) must also reflect costs and revenues for benefits described at § 423.104(d) through (f) of this chapter.

(b) Determining the *MLR numerator.*

(1) For a contract year, the numerator of the MLR for an MA contract (other than an MSA contract) must equal the sum of paragraphs (b)(1)(i) through (iii) of this section, and the numerator of the MLR for an MSA contract must equal the sum of paragraphs (b)(1)(i), (iii), and (iv) of this section. The numerator must be determined in accordance with paragraphs (b)(5) and (6) of this section.

(i) Incurred claims for all enrollees, as defined in paragraphs (b)(2) through (4) of this section.

(ii) The amount of the reduction, if any, in the Part B premium for all MA plan enrollees under the contract for the contract year.

(iii) The expenditures under the contract for activities that improve health care quality, as defined in § 422.2430.

(iv) The amount of the annual deposit into the medical savings account described at § 422.4(a)(2).

(c) *Determining the MLR denominator.* For a contract year, the denominator of the MLR for an MA contract must equal the total revenue under the contract. Total revenue under the contract is as described in paragraph

(c)(1) of this section, net of deductions described in paragraph (c)(2) of this section, taking into account the exclusions described in paragraph (c)(3) of this section, and in accordance with paragraph (c)(4) of this section. (1) CMS' payments to the MA organization for all enrollees under a contract, reported on a direct basis, including the following:

(i) Payments under § 422.304(a)(1) through (3) and (c).

(ii) The amount applied to reduce the Part B premium, as provided under § 422.266(b)(3).

(iii) Payments under § 422.304(b)(1), as reconciled per § 423.329(c)(2)(ii) of this chapter.

(iv) All premiums paid by or on behalf of enrollees to the MA organization as a condition of receiving coverage under an MA plan, including CMS' payments for low income premium subsidies under § 422.304(b)(2).
(v) All unpaid premium amounts that an MA organization could have collected from enrollees in the MA plan(s) under the contract.
(vi) All changes in unearned premium reserves.
(vii) Payments under § 423.315(e) of this chapter.

PART 423—VOLUNTARY MEDICARE PRESCRIPTION DRUG BENEFIT

§ 423.2420 Calculation of medical loss ratio.

(a) *Determination of the MLR.* (1) The MLR for each contract under this part is the ratio of the numerator (as defined in paragraph (b) of this section) to the denominator (as defined in paragraph (c) of this section). An MLR may be increased by a credibility adjustment according to the rules at § 423.2440, or subject to an adjustment determined by CMS to be warranted based on exceptional circumstances for areas outside the 50 states and the District of Columbia.
(2) The MLR must reflect costs and revenues for benefits described at § 423.104(d) through (f). The MLR for MA–PD plans (defined at § 422.2 of this chapter) must also reflect costs and revenues for benefits described at § 422.100(c) of this chapter.
(b) *Determining the MLR numerator.*
(1) For a contract year, the numerator of the MLR for a Part D prescription drug contract must equal the sum of paragraphs (b)(1)(i) through (iii) of this section and must be in accordance with paragraph (b)(1)(iv) of this section.
(i) Incurred claims for all enrollees, as defined in paragraphs (b)(2) through (4) of this section.
(ii) The expenditures under the contract for activities that improve health care quality, as defined in
§ 423.2430;
(c) *Determining the MLR denominator.* For a contract year, the denominator of the MLR for a Part D prescription drug contract must be in accordance with paragraph (c)(4) of this section and equal the total revenue under the contract. Total revenue is as described in paragraph (c)(1) of this section, net of deductions described in paragraph (c)(2) of this section, taking into account the exclusions described in paragraph and (c)(3) of this section, and be in accordance with (c)(4) of this section.
(1) CMS' payments to the Part D sponsor for all enrollees under a contract, reported on a direct basis, including the following:
(i) Payments under § 423.329(a)(1) and (2).
(ii) Payment adjustments resulting from reconciliation per § 423.329(c)(2)(ii).
(iii) All premiums paid by or on behalf of enrollees to the Part D sponsor as a condition of receiving coverage under a Part D plan, including CMS' payments for low income premium subsidies under § 422.304(b)(2) of this chapter.
(iv) All unpaid premium amounts that a Part D sponsor could have collected from enrollees in the Part D plan(s) under the contract.
(v) All changes in unearned premium reserves.
(vi) Payments under § 423.315(e).

Line 1- Medical Loss Ratio Numerator

Line 1.1 – Claims

Calculated field that refers to Worksheet 1 Line 2.8

Line 1.2 – Quality improvement expenses

Calculated field that refers to Worksheet 1 Line 4.7

Line 1.3 – MLR numerator

Calculated field: Worksheet 2 Lines 1.1 + 1.2

Line 2 - Medical Loss Ratio Denominator

Line 2.1 – Revenue

Calculated field that refers to Worksheet 1 Line 1.10

Line 2.2 – Federal and State taxes and licensing or regulatory fees

Calculated field that refers to Worksheet 1 Line 3.4

Line 2.3 – MLR denominator

Calculated field: Worksheet 2 Lines 2.1 - 2.2

Line 3 - Credibility Adjustment

Line 3.1 – Member months to determine credibility

Calculated field that refers to Worksheet 1 Line 7

Line 3.2 – MLR credibility adjustments table

Refers to either the MA or PD credibility adjustment table in Worksheet 2 Section 2. If Worksheet 1 Line 2.8a (Part D claims) equals Line 2.8 (Total claims), then the PD adjustment factors are utilized; otherwise MA adjustment factors are utilized.

Line 3.3 – Credibility Adjustment

Linear interpolation calculated based on member months (Worksheet 2 Line 3.1) and the MA or PD credibility table (Worksheet 2 Line 3.2 and Section 2)

Line 4 - Medical Loss Ratio (MLR) Calculation

Line 4.1 – Unadjusted MLR

Calculated field: Worksheet 2 Line 1.3 divided by Worksheet 2 Line 2.3

Line 4.2 – Credibility adjustment

Calculated field that refers to Worksheet 2 Line 3.3

Line 4.3 – Adjusted MLR

Calculated field: Worksheet 2 Lines 4.1 + 4.2, then rounded.

Line 5 – Remittance Calculation

Line 5.1 – Contract subject to remittance for CY 2014?

"Yes"/"No" populated based on member months (Worksheet 2 Line 3.1) and the MA or PD credibility table (Worksheet 2 Line 3.2 and Section 2)

Line 5.2 – MLR standard

Pre-populated with 85.0%

Line 5.3 – Adjusted MLR

Calculated field that refers to Worksheet 2 Line 4.3

Line 5.4 – MLR denominator

Calculated field that refers to Worksheet 2 Line 2.3

Line 5.5 – Remittance amount due to CMS for CY 2014 experience

Calculated field: Worksheet 2 (Lines 5.2 – 5.3) x Line 5.4

when Adjusted MLR (Worksheet 2 Line 5.3) is less than MLR standard (Worksheet 2 Line 5.2)

Line 5.5a – Remittance amount allocated to Parts A&B (For CMS system purposes only)

Calculated field to allocate Line 5.5 based on Worksheet 1 Line 1 Revenue data entries.

Line 5.5b – Remittance amount allocated to Part D (For CMS system purposes only)

Calculated field to allocate Line 5.5 based on Worksheet 1 Line 1 Revenue data entries.

Section 2 – MLR Credibility Adjustment Table

MA and PD credibility adjustments per CMS, based on member months.

The final rule contained the following guidance regarding credibility:

> **§ 422.2440 Credibility adjustment.**
> (a) An MA organization may add a credibility adjustment to a contract's MLR if the contract's experience is partially credible, as determined by CMS.
> (b) An MA organization may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as determined by CMS.
> (c) For those contract years for which a contract has non-credible experience for their MLR, sanctions under § 422.2410(b) through (d) will not apply.
> (d) CMS defines and publishes definitions of partial credibility, full credibility, and non-credibility and the credibility factors through the notice and comment process of publishing the Advance Notice and Final Rate Announcement.
> **§ 423.2440 Credibility adjustment.**
> (a) A Part D sponsor may add a credibility adjustment to a contract's MLR if the contract's experience is partially credible, as determined by CMS.
> (b) A Part D sponsor may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as determined by CMS.
> (c) For those contract years for which a contract has non-credible experience for their MLR, sanctions under § 423.2410(b) through (d) will not apply.
> (d) CMS defines and publishes definitions of partial credibility, full credibility, and non-credibility and the credibility factors through the notice and comment process of publishing the Advance Notice and Final Rate Announcement.

WORKSHEET 3

The fields on Worksheet 3 are consistent with the commercial MLR reporting form, and refer to the data entry lines of Worksheet 1.

Worksheet 3 is used by the organization to describe the methods used to allocate expenses, as reported on the MLR Report, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs.

A detailed description of each expense element should be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized.

See the "Allocation of Expenses" Reporting Consideration in the General Instructions section of this document for more information.

ATTESTATION

An attestation must be submitted in the HPMS attestation module to accompany each MLR Report uploaded to HPMS.

Below is language used in the attestation module in HPMS:

CY 2014 MLR Attestation

The officers of this reporting issuer being duly sworn, each attest that he/she is the described officer of the reporting issuer, and that this MLR Report is a full and true statement of all the elements related to the health insurance coverage issued for the MLR reporting year stated above, and that the MLR Report has been completed in accordance with the Department of Health and Human Services reporting instructions and regulations, according to the best of his/her information, knowledge and belief. Furthermore, the scope of this attestation by the described officer includes any related electronic filings and postings for the MLR reporting year stated above, that are required by Department of Health and Human Services under implementing regulations.

Chief Executive Officer/President

Chief Financial Officer

TECHNICAL INSTRUCTIONS

MLR Add-in File

The MLR Report utilizes a separate add-in file to contain code that supports the MLR workbook functionality. Below are the steps to set up the add-in file:

- Create a folder called MLR2014 in the C:\MLR path on your PC.
- In Excel 2007 or Excel 2010, set your Excel Macro Security Settings to "Disable all macros with notifications."
- Enable macros when you open the MLR workbook.
- Copy the MLR Add-in (MLR2014.xlam) in the C:\MLR\MLR2014 folder.

If you do not save the MLR Add-in file in the designated folder, you will receive a message in the MLR workbook stating that the MLR2014.xlam (MLR Add-in) file cannot be found. The MLR will open in read-only mode. If the MLR Add-in is not saved in the correct folder, you will not be able to use the MLR workbook.

If necessary, CMS may deploy a new version of the MLR Add-in file to update the MLR workbook. If CMS deploys an updated version of the MLR Add-in (MLR2014.xlam) file, you must download this file from HPMS and overwrite the existing MLR Add-in with the most current version in the C:\MLR\MLR2014 folder.

You will need to update all MLR workbooks with the latest add-in file. If you have finalized a MLR with an old version of the add-in file but not yet uploaded it, you must download the new Add-in file, update the working file, and re-finalize the MLR.

The MLR workbook is updated automatically when first opened after downloading the new Add-in file. When you receive a pop-up message stating that the MLR is out of date, click "OK" and the update process will begin. You should not need to transfer any data from one workbook to another to apply an MLR Add-in update.

MLR Workbook Protection

Data entry fields are formatted in yellow.

The print area of Worksheet 1 will include all rows where plan IDs were entered in Line 8 column (b).

The MLR Report is password protected. You may not modify the structure of the workbook or worksheets. Each data item must be located in its pre-defined cell location for successful processing by the HPMS.

Tampering with the file's protection, including but not limited to un-protecting and re-protecting any parts of a workbook will permanently compromise the file and prevent successful finalization of that workbook. If a workbook is compromised in this way, you must discard the compromised file, download and complete a new MLR Report.

MLR Workbook Finalization

The MLR Report employs three versions of the workbook that serve different purposes:

- Working file **–** are read-write enabled files that allow users to enter data in specified input fields; specified calculated fields are automatically calculated via formulas resident in the files. Users may edit, save, name, and re-name working versions of the MLR workbook.
- Finalized file – are read-only files created by a process called finalization, which modifies the format of working files to prepare them for submission/upload to CMS. Finalization saves the file using a standard naming convention, and populates a "timestamp" within the finalized MLR Report.
- Backup file – are also read-only files created by the finalization process. The backup file uses the same filename as the finalized file with the word "backup" and a timestamp appended to it. The data in the backup file is the same as that in the working file; removal of the text "backup" from the filename will make the backup file editable. As such, backup files enable users to convert backup files back into working files—if needed—for further modification.

The Finalize MLR function prepares the workbook for submission to HPMS. MLR Report workbooks must be finalized in order to upload to HPMS. When the finalization function is triggered, the following actions are performed:

- Recalculate the MLR working file.
- Check any required fields (Section 1: Contract Number, Organization Name, and contact information) must be entered for finalization to be successful.
- Check any critical validations of data fields.
- Save the working file.
- Create a backup file—this is a read-only file that contains the same data as the working file; it can be used to restore data in a working file.
- Create a finalized file with a "timestamp" footnote is added within the finalized MLR Report. The finalized file will retain the MLR Report formulas.

Finalized MLR workbooks are saved using the following standardized naming convention: Contract ID+MLR+CY.xlsx Use of this convention is a requirement for a successful upload to the HPMS.

Example: H1111MLR2014.xlsx

Finalized files are saved in the same directory where the working file is located.

Backup files use the same naming convention as finalized files with a timestamp appended to the end of the name: finalized filename +_"_Backup_"+YYYY-MM-DD-HHmmss.xlsm

Example: H1111MLR2014_Backup_2015-11-15-100000.xlsm

Back up files are saved in the same directory where the working file is located.

The working file name can be changed at any time. The finalized and backup files are read-only files. If you need to make additional changes prior to submission (i.e., prior to upload to HPMS), modify the working file and finalize the file again; the previous finalized file will be overwritten. A new backup file will be created; backup files will not be overwritten (as they are time-stamped).