CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

MEDICAL LOSS RATIO (MLR) DATA FORM
FILING INSTRUCTIONS FOR CONTRACT YEAR (CY) 2023

FOR MEDICARE ADVANTAGE ORGANIZATIONS AND PRESCRIPTION DRUG PLAN SPONSORS

As of

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OMB expiration date:

PRA Disclosure Statement: *This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) with the ongoing management of Medicare programs and policies. This required information collection will be used to meet the statutory requirements at sections 1857(e)(4) and 1860D-12 of the Social Security Act to determine the medical loss ratio for each contract year and to apply remittances and sanctions. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1232 (CMS-10476). The time required to complete this information collection is estimated to average 61 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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). The instructions and guidance in this document are based on sections 1857(e) and 1860D-12 of the Act and the regulations at subparts X in 42 CFR Parts 422 and 423 (42 CFR §§ 422.2400 et. seq. and 423.2400 et. seq.), adopted in the final rule "Medicare Program; Medical Loss Ratio Requirements for the Medicare Advantage and the Medicare Prescription Drug Benefit Programs," which appeared in the Federal Register on May 23, 2013 (79 FR 31284).

Organizations must submit the information via the CMS Health Plan Management System (HPMS) in an MLR Report generated by the CMS MLR Reporting Tool workbook.

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

- Calendar Year 2021 Medicare Advantage Organization Participants of the Hospice Benefit Component of the Medicare Advantage Value-Based Insurance Design (VBID) Model: These MA Organizations must submit an MLR Data Form but there are additional instructions and guidance. Please refer to the memorandum released to plans on February 8, 2022 that contained guidance regarding reflecting the hospice benefit component in the MLR.
- PACE:[1] Programs of All-Inclusive Care for the Elderly (PACE) organizations are not required to complete or submit an MLR Report.
- Cost Plans and HCPPs:[2] The MLR Report must be completed for the Part D portion of the benefits offered under the entity's contract with CMS for Section 1876 Cost plans, Section 1833 Cost plans, and employers/unions offering Cost plans or Health Care Prepayment Plans (HCPPs). Cost plans that do not offer Part D are not required to complete or submit an MLR Report.
- EGWPs:[3] All EGWPs under the contract must be included in the MLR Report. EGWPs are to include costs and revenue only for the Medicare-funded portion of each contract.
- Dual-Special Needs Plans (D-SNPs): All D-SNPs under the contract must be included in the MLR Report. Note that, for all plans, Medicaid costs and revenues are not included in the MLR calculation.
- State demonstrations to integrate care for dually eligible Medicare and Medicaid beneficiaries (i.e., Medicare-Medicaid Plans (MMPs)): While MMPs do not complete this particular MLR Report, they may be required to complete and submit a separate, MMP-specific MLR report based on the requirements adopted for the demonstration.

[1] 78 FR 31285.
[2] *Id.*
[3] 78 FR 31286.

- Contracts that were terminated, consolidated, or withdrawn are still required to submit an MLR Report that accounts for revenue, including payment adjustments such as risk adjustment reconciliation amounts.

The data included in the MLR Report will be used to calculate the Medicare medical loss ratio (MLR) and remittance amount, if any, or to determine that the contract is non-credible.

These filing instructions apply to the CY 2023 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 MLR Reports. Organizations must be prepared to provide this information in a timely manner. See 42 CFR §§ 422.503(d), 422.504(d)–(e), 422.2480, 423.504(d), 423.505(d), and 423.2480.

If a CY 2023 remittance amount is due to CMS, there will be an adjustment to payment, likely occurring in mid-2024.

MLR reporting for a contract year will typically occur in December following the contract year. However, for contracts that fail to meet the MLR threshold for 2 or more consecutive years, MLR reporting for the following year will be required prior to the typical December timeframe. CMS will notify affected contracts. CMS will specify a month that will allow time to implement (1) an enrollment sanction for any contract that fails to meet the MLR threshold for 3 or more consecutive years, or (2) contract termination for any contract that fails to meet the MLR threshold for 5 consecutive years.

Please review any data flagged with a “red circle” validation in the MLR Report prior to upload to HPMS. See the Technical Instructions section for more information.

The MLR workbook must be finalized prior to upload to HPMS. If the workbook is not finalized, the upload will be rejected by HPMS. See the Technical Instructions section for more information on the finalization of the MLR workbook.

MLR Regulations Update

In the CY 2019 final rule (CMS-4182-F), CMS revised the MLR calculation so that all expenditures related to fraud reduction activities (including fraud prevention, fraud detection, and fraud recovery) and Medication Therapy Management (MTM) programs are included in the MLR numerator as expenditures for activities that improve healthcare quality.

For contract years prior to 2021, incurred claims in the MLR numerator include direct claims paid to providers as defined in § 422.2 (including under capitation contracts with physicians) for covered services furnished to all enrollees under an MA contract. In the CY 2021 final rule (CMS-4190-F) (85 FR 33796), CMS amended § 422.2420 so that beginning with CY 2021 the

incurred claims portion of the MLR numerator includes all amounts that an MA organization pays (including under capitation contracts) for covered services. This amendment also includes in the incurred claims portion of the MLR numerator amounts paid for covered services to individuals or entities that do not meet the definition of "provider" as defined at § 422.2.

In the CY 2021 final rule, CMS also amended the regulations at §§ 422.2440 and 423.2440 to codify the MLR credibility adjustment factors that were published in the May 23, 2013 Medicare MLR final rule (CMS-4173-F) (78 FR 31284). CMS further amended § 422.2440 to add a deductible factor to the MLR calculation for MA MSA contracts that receive a credibility adjustment for CY 2021 and later. The deductible factor functions as a multiplier on the credibility adjustment factor and applies to MLRs calculated for CY 2021 and subsequent years.

Additional Resources

The following resources provide additional information regarding the reporting and calculation of Part C and Part D MLR data:

- Questions regarding this MLR reporting may be addressed to: MLRreport@cms.hhs.gov.
- Further information regarding Medicare MLR may be found at https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/MedicalLossRatio.html.
- The May 2013 Medicare MLR implementing final rule is available at https://www.gpo.gov/fdsys/pkg/FR-2013-05-23/pdf/2013-12156.pdf.
- The CY 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program final rule [CMS-4182-F] may be found at https://www.govinfo.gov/content/pkg/FR-2018-04-16/pdf/2018-07179.pdf.
- Commercial MLR regulations, guidance, filing instructions, and other resources are available 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
- https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Announcements-and-Documents.html.
- Further information regarding Statutory Accounting Principles may be found at https://content.naic.org/cipr_topics/topic_statutory_accounting_principles.htm
- For technical questions about the MLR Reporting Tool workbook, HPMS, or the upload process, please contact the HPMS Help Desk at 1-800-220-2028 or hpms@cms.hhs.gov.

REPORTING CONSIDERATIONS

Accounting Principles

MA organizations and Part D sponsors should use Statutory Accounting Principles to explain how revenue is used to pay for non-claims expenditures. Non-claims and quality improving expenses should be allocated by contract. If an expense is attributable to a specific activity, 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.

Allocation of Expenses

Expenses must be allocated in accordance with the regulations at 42 CFR §§ 422.2420(d) and 423.2420(d), which require that each expense 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. Expenditures that benefit multiple contracts, or contracts other than those being reported, must be reported on a pro rata share.

Capitated Arrangements

Under the regulation at § 422.2420(b)(2), incurred claims include direct claims paid to providers, including under capitation contracts. Where an MA organization or 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, 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) or § 423.2420(a)(2) could be reported as a benefit expense, unless the provider contract specifies a distinct fee for administrative services. If the capitated payment includes payment for activities that improve health care quality, as defined in §§ 422.2430 and 423.2430, the MA organization or Part D sponsor must ensure that costs for these activities are only counted once in the numerator.

Third Party Vendors

Payments by MA organizations or Part D sponsors to third party vendors as reimbursement for providing clinical services or supplies directly to plan enrollees are incurred claims. Payments to third party vendors to perform services such as network development, administrative fees, claims processing, and utilization management, are non-claims administrative costs and are excluded from incurred claims.

However, when a third party vendor, through its own employees, provides clinical services directly to enrollees, the entire portion of the amount the MA organization or Part D sponsor 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 administrative costs directly related to the vendor's direct provision of clinical services. The phrase "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, a Part D sponsor may contract with a pharmacy benefit manager (PBM) to provide clinical services directly to enrollees through a mail order pharmacy. The sponsor's payments 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, are included in the sponsor's incurred claims.

In circumstances where a third party vendor pays a non-employee provider or supplier to provide covered clinical services or medical supplies to plan enrollees, the MA organization or Part D sponsor may only include as reimbursement for clinical services (i.e., 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 and must not be included by the MA organization or Part D sponsor 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 Part D plan sponsor a higher amount (the retail spread), the sponsor may only claim the amounts paid by the PBM to the retail pharmacy as incurred claims. The third party vendor (in this example, the PBM) must report to the sponsor only the aggregate amount it pays all providers (in this example, retail pharmacies) for clinical services or medical supplies to enrollees on behalf of the MA organization or Part D sponsor, by plan or contract number. No claim-by-claim or provider-by-provider reporting is required.

An MA organization or Part D sponsor may count a third party vendor's expenses as activities that improve health care quality to the extent that the organization or sponsor and the vendor can show that these expenses were incurred for performing allowable quality improving activities on behalf of the organization or sponsor.

- 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.

Payments by MA organizations and Part D sponsors to clinical risk-bearing entities, such as Independent Practice Associations (IPAs), Physician Hospital Organizations (PHOs), and Accountable Care Organizations (ACOs) are treated as incurred claims if the following four factors are met:

(1) The entity contracts with an MA organization or Part D sponsor to deliver, provide, or arrange for the delivery and provision of clinical services to the organization's or sponsor's MA or Part D plan enrollees, but the entity is not the plan sponsor with respect to those services;
(2) The entity contractually bears financial and utilization risk for the delivery, provision, or arrangement of specific clinical services to enrollees;
(3) 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
(4) 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 bears the financial risk for utilization as provided in prong two above will be considered incurred claims. By contrast, payments to third party vendors that only take on pricing risk (e.g., payments to pharmacy benefit managers (PBMs) for retail pharmacy claims) should not be included in incurred claims.

Payments to risk-bearing entities that include payments for administrative functions performed on behalf of the entity's member providers are incurred claims if all four factors outlined above 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 MA organizations or Part D sponsors 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.

To the extent that administrative functions are performed on behalf of the MA organization or Part D sponsor, however, that portion of the organization or sponsor's payment that is attributable to administrative functions must not be included in incurred claims. 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 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 MA organization or Part D sponsor contains a "clawback" provision are not incurred claims for MLR reporting purposes.

Commercial MLR

CMS initially modeled Medicare MLR policy after the commercial MLR rules, and only departed from the commercial MLR rules to the extent necessary and appropriate given the Medicare context.

Commercial Reinsurance

MA organizations and Part D sponsors may not adjust the MLR for commercial reinsurance. Commercial reinsurance premiums and recoveries are excluded from the MLR calculation. Both costs and revenues must be factored into the MLR calculation on a direct basis (i.e., without taking into account ceded reinsurance) as required under §§ 422.2420(b)(2)(i), 422.2420(c)(1), 423.2420(b)(2)(i), and 423.2420(c)(1).

The only instance in which the premiums (revenue) and claims associated with a 100 percent indemnity reinsurance treaty are included in the assuming entity's MLR calculation, instead of the ceding entity's MLR calculation, is when the reinsurance treaty was in force prior to the date of enactment of the Affordable Care Act (i.e., March 23, 2010).

EGWPs

EGWPs must include costs and revenue per §§ 422.2420 and 423.2420 for the *Medicare-funded* portion of each contract. Although CMS does not currently collect information on EGWP benefit packages, CMS has the authority to collect this information if needed.

All Medicare-funded revenue must be included.

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., allocate Medicare-funded costs as the total costs multiplied by the ratio of Medicare revenue to total revenue).

Note that plan-specific revenue amounts may be useful when allocating costs to yield the most accurate result. That is, for the purpose of allocating costs, it may be useful to first summarize the Medicare-funded revenue for the contract separately for EGWP plans under the contract and for non-EGWP plans under the contract.

Note that all categories of costs (claims, taxes and fees, quality improvement activities, non-claims costs) need to be separated/allocated between the employer-funded versus Medicare-funded portions of the contract.

For non-CY EGWPs, 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 Premium and Cost Sharing Subsidies (LIPS and LICS) and Coverage Gap Discount Program (CGDP) Payments

CMS makes LIPS payments to Part D sponsors so that they can be made whole for the reduced premiums paid by eligible low-income beneficiaries. LIPS payments are revenue to the plan and are taken into account in the denominator of the MLR. Because CMS views LICS and coverage gap discount program payments as pass-through amounts, they are excluded from both the numerator and denominator of the MLR.

MA Optional Supplemental Benefits

The MA MLR includes all of the MA benefits defined at § 422.100(c): basic benefits, mandatory supplemental benefits, and optional supplemental benefits. 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.

Medication Therapy Management (MTM) Programs

MTM programs that meet the requirements of § 423.153(d) are quality improving activities. §§ 422.2430(a)(4)(i) and 423.2430(a)(4)(i).

Sequestration

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

Territories

CMS is authorized under §§ 422.2420(a) and 423.2420(a) to make adjustments to the MLR produced by the standard formula to address exceptional circumstances for areas outside the 50 states and the District of Columbia. At this time, CMS does not believe it has sufficient information to determine whether and how to make such an adjustment. Therefore, CMS will collect CY 2023 MLR Reports and subsequently determine if an adjustment to the CY 2023 MLR calculation is warranted for contracts serving territories. If CMS decides that an adjustment is warranted, it will announce the methodology to the affected contracts.

Reporting Requirements

For each contract year, each MA organization or Part D sponsor must submit an MLR Report to CMS, in a timeframe and manner specified by CMS. For CY 2018 and subsequent contract years, MA organizations and Part D sponsors will report the MLR percentage (after any credibility adjustment) and the amount of any remittance owed to CMS for each contract, or that the contract is non-credible. §§ 422.2460 and 423.2460.

In accordance with §§ 422.2460(d) and 423.2460(d), the MLR is reported once, and is not reopened as a result of any payment reconciliation processes.

MLR Review and Non-Compliance

CMS conducts selected reviews of submitted MLR data under §§ 422.2480 and 423.2480.

MA organizations and Part D sponsors are required to maintain evidence of amounts reported to CMS and to validate all data necessary to calculate MLRs in accordance with the requirements in §§ 422.2480 and 423.2480. See also 42 CFR §§ 422.503(d), 422.504(d)–(e), 422.2480, 423.504(d), 423.505(d), and 423.2480.

Documents and records must be maintained for 10 years from the date such information was reported to CMS with respect to a given MLR reporting year (for MA organizations, per § 422.2480) or contract year (for Part D sponsors, per § 423.2480).

MA organizations and Part D sponsors must require any third party vendor supplying drug or medical cost contracting and claim adjudication services to the MA organization or Part D sponsor to provide all underlying data associated with MLR reporting to that MA organization or Part D sponsor in a timely manner, when requested by the MA organization or Part D sponsor, regardless of current contractual limitations, in order to validate the accuracy of MLR reporting. §§ 422.2480(c)(2) and 423.2480(c)(2).

MLR Reports submitted under § 422.2460 or § 423.2460, calculations, or any other required MLR submissions 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 §§ 422.752 and 423.752.

Penalties and Sanctions

An MA organization or Part D sponsor is required to report an MLR for each contract for each contract year.

If CMS determines for a contract year that an MA organization or Part D sponsor has an MLR for a contract that is less than 0.85, the MA organization or Part D sponsor 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 or Part D contract for the contract year, per §§ 422.2420(c) and 423.2420(c) and
(2) the difference between 0.85 and the MLR for the contract year.

If CMS determines that an MA organization or 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.

If CMS determines that an MA organization or Part D sponsor has an MLR for a contract that is less than 0.85 for 5 consecutive contract years, CMS terminates the contract in accordance with § 422.510 or § 423.509, effective as of the second succeeding contract year.

Value-Based Insurance Design (VBID) Model Hospice Benefit Component

Under MA program statutes and rules, when an enrollee in an MA plan elects hospice, Fee-for-Service (FFS) Medicare becomes financially responsible for most services, while the MA organization retains responsibility for certain services (e.g., supplemental benefits). On January 1, 2021, CMS began testing the inclusion of the Part A Hospice Benefit within the MA benefits package through the Hospice Benefit Component of the VBID model. Under the Hospice Benefit Component of the VBID Model, participating MA organizations cover Medicare-covered (that is, Medicare Part A) hospice benefits in addition to the Part A and Part B benefits that the MA organizations are required to cover by section 1852 of the Act and 42 CFR Part 422.

As discussed in the memorandum released on February 8, 2022 from CMS to MA Organizations that participate in the MA VBID Model, the MLR requirements for MA organizations have not been waived under the Model component and the MLR regulations provide for calculating the MLR based on basic benefits (which exclude hospice benefits) and payment as described in the Part 422 regulations for Medicare Advantage organizations (MAOs).[4] Under section 1857(e)(4) of the Act and 42 CFR § 422.2410, MAOs must not only report their MLR to CMS but also meet a MLR-specific requirement. Requirements for calculating and reporting the MLR are at 42 CFR §§ 422.2400 through 422.2490.

For MAOs that participate in the Hospice Component of the VBID Model, the following applies:

- Incurred claims for Hospice Care, as defined in Appendix 3, section 1 of the CY 2021 Addendum, shall not be included in the MLR numerator;
- Incurred claims for Palliative Care and Transitional Concurrent Care, as those terms are defined in Appendix 3, section 1 of the CY 2021 Addendum, shall be included in the MLR numerator to the extent that those incurred claims are for items and services that were included in the participating MAO's bid as basic benefits or non-Model supplemental benefits that are coverable for all enrollees in the MA plan (e.g., additional acupuncture benefits compared to the Part B acupuncture benefit);[5]
- Incurred claims for hospice supplemental benefits, including the mandatory hospice supplemental benefits as described in section 2, subsection H of the CY 2021 Addendum, shall be included in the MLR numerator;
- The Hospice Capitation Amount, as described in Appendix 3, section 3 of the CY 2021 Addendum, shall not be included in the MLR denominator; and

[4] The VBID Model includes waivers to permit coverage of Part A hospice benefits and payment by CMS to participating MAOs in accordance with the terms of the VBID Model for coverage of Medicare Part A hospice benefits.

[5] See sections 2.2 and 2.3 of the CY 2021 Request for Applications for the Hospice Benefit Component of the VBID Model, which describe how these benefits were expected to be items and services otherwise coverable by Parts A and B of Medicare and therefore were to be addressed in the participating MAO's bid for basic benefits.

- Expenditures for activities that improve healthcare quality which relate specifically to the hospice benefit may be included in the MLR numerator, to the extent that they meet the requirements of 42 CFR 422.2430. However, any expenditures that are funded with the Hospice Capitation Amount shall not be included in the MLR numerator.

CY 2023 MLR REPORT FIELDS

WORKSHEET 1

Section 1: General Information

The MLR Report captures contract-specific information for the reporting period.

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 (e.g., H9999). Be sure to include all leading zeroes (e.g., 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 automatically calculated.

Line 1 – Revenue

In accordance with §§ 422.2420(c)(3) and 423.2420(c)(3), the following amounts must not be included in total revenue:

- The amount of unpaid premiums for which the MA organization or Part D sponsor can demonstrate to CMS that it made a reasonable effort to collect.
- The following EHR payments and adjustments:
    - EHR incentive payments for meaningful use of certified electronic health record technology by qualifying MAOs, MA EPs, and MA-affiliated eligible hospitals that are administered under 42 CFR part 495 subpart C.
    - EHR payment adjustments for a failure to meet meaningful use requirements that are administered under 42 CFR part 495 subpart C.
- Coverage Gap Discount Program payments under § 423.2320.

LICS payments are not included as revenue for MLR reporting.

Total revenue (as defined at §§ 422.2420(c) and 423.2420(c)) for policies issued by an MA organization or 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 no revenue for that contract year must be reported by the ceding MA organization or Part D sponsor. §§ 422.2420(c)(4) and 423.2420(c)(4).

Total revenue (as defined at §§ 422.2420(c) and 423.2420(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% 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. §§ 422.2420(c)(5) and 423.2420(c)(5).

CMS provides organizations and sponsors with revenue information via several reports. The following CMS reports are used in this mapping:

- MMDDF = Monthly Membership Detail Data Files
  NOTE for CY 2023 MLR: Payments for contract year 2023, which would include contract year (CY 2023) payment adjustments generally through the last completed quarter prior to MLR reporting (generally through September 30, 2024 for CY 2023 MLR) and would include payment adjustments for the contract year (CY 2023) risk adjustment reconciliations which appear in the MMR under adjustment reason code 25 for Part C and code 37 for Part D.
- PRS CTR = Payment Reconciliation System (PRS) Reconciliation Results Report to Plans, Contract Trailer "CTR" version

MLR Report template field	CMS revenue report
Sequestration Adjustments: MA and PD	N/A*
Beneficiary Premiums: MA and PD	N/A
MA payment including 3 MA Rebate categories	MMDDF item 65
MA Rebate for Part B	MMDDF items 59+60
MA Rebate for Part D Basic	MMDDF item 71
MSA Enrollee Deposit	N/A
Part D direct subsidy	MMDDF item 73
Part D federal reinsurance	PRS CTR field 20
LIPSA	MMDDF item 35
Part D risk corridor payments	PRS CTR field 33

* Sequestration Adjustments are included on the monthly contract-level Plan Payment Report (PPR), produced by the Automated Plan Payment System (APPS), on a paid basis. The MLR Report template contains a default sequestration adjustment calculation as 2% reduction of certain/applicable revenue lines. The MA organization or Part D sponsor can override this default calculation with a plan-reported sequestration amount (for example, to reflect when sequestration is suspended for specific time periods by legislation). Sequestration adjustment must be a negative amount.

Note that the MMDDF amounts do not reflect the sequestration adjustment. The following MMDDF amounts are subject to sequestration: MA payment including 3 rebates (MMDDF item 65), Part B Rebate (MMDDF items 59+60), Part D Basic Rebate (MMDDF item 71), and Part D Direct Subsidy (MMDDF item 73).

Note that Beneficiary premiums, Part D federal reinsurance, Low Income Premium Subsidy Amount, and Part D risk corridor payments are not subject to sequestration.

Note that sequestration applied to MA Rebates, including MA Rebates for Part D Basic Premium Reduction, are considered Part C payment adjustments (not Part D payment adjustments).

Note that federal reinsurance includes both prospective payments and reconciliation adjustments.

Plan revenue related to the Part D Enhanced MTM Model is included in the MLR denominator.

NOTE: The MMDDF item numbers referenced above correspond to version 15 of the Plan Communications User Guide, released March 30, 2021, available at: https://www.cms.gov/files/document/plan-communications-user-guide-february-22-2021-v150-revised-march-30-2021.pdf.

CY 2023 contracts that were terminated, consolidated, or withdrawn are required to submit an MLR that accounts for revenue, including risk adjustment reconciliation amounts. CMS will post the Part C and Part D risk adjustment reconciliation amounts for contract year (CY 2023) contracts that terminated, consolidated, or withdrew at: HPMS Home > Risk Adjustment > Risk Adjustment Reconciliation Amount. These values are from the MMR with adjustment reason code (ARC) 25 and 37. These values are prior to application of sequestration (i.e., “gross” of sequestration). This information may be used in the development of (CY 2023) MLR reporting.

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

- https://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||

In accordance with §§ 422.2460(c) and 423.2460(c), total revenue included as part of the MLR calculation must be net of all projected reconciliations.

Line 1.0 – Sequestration Adjustment

See the mapping to CMS revenue reports provided above.

The MLR Report contains a default sequestration adjustment calculation as 2% reduction of Lines 1.2, 1.3, 1.4, and 1.6. The organization may also choose to override this default calculation with a plan-reported sequestration amount but is still expected to be approximately 2% of the affected revenue lines. Sequestration adjustment must be entered as a negative amount.

Note that lines 1.1, 1.7, 1.8, and 1.9 are not subject to sequestration.

Note that sequestration applied to MA Rebates, including MA Rebates for Part D Basic Premium Reduction, are considered Part C payment adjustments (not Part D payment adjustments). Therefore, sequestration applied to Line 1.4 (MA Rebate for Part D Basic Premium Reduction) should be reported in Line 1.0a (MA Sequestration Adjustment), not Line 1.0b.

Line 1.0a – MA Sequestration Adjustment

MA portion of Line 1.0

Line 1.0b – Part D Sequestration Adjustment

Part D portion of Line 1.0

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). Beneficiary premiums include MA Basic, MA Mandatory Supplemental, MA Optional Supplemental, Part D Basic, and Part D Supplemental.

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.

Note that federal reinsurance includes both prospective payments and reconciliation adjustments.

Line 1.8 – Part D Low Income Premium Subsidy Amount

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 1.0 through 1.9.

Line 2 – Claims

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

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

1. Direct claims that the MA organization pays to providers (including under capitation contracts) for covered services (described at § 422.2420(a)(2)) provided to all enrollees under the contract.
2. Direct drug costs that are actually paid (as defined in § 423.308) by the Part D sponsor.
3. For an MA contract that includes MA–PD plans (described at § 422.2420(a)(2)), drug costs provided to all enrollees under the contract, as defined at § 423.2420(b)(2)(i).
4. Unpaid claims reserves for the current contract year, including claims reported in the process of adjustment.
5. Percentage withholds from payments made to contracted providers.
6. Incurred but not reported claims based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.
7. Changes in other claims-related reserves.
8. Claims that are recoverable for anticipated coordination of benefits.
9. Claims payments recoveries received as a result of subrogation.
10. Reserves for contingent benefits and the medical or Part D claim portion of lawsuits.
11. The amount of incentive and bonus payments made to providers.

Note: The MLR Report Template used for contract years prior to 2018 included lines for "Total fraud reduction expense" (Line 2.7a) and "Total fraud recoveries that reduced paid claims in Line 2.1" (Line 2.7b). For CY 2023and subsequent years, the total amount spent on fraud reduction activities (including fraud prevention, fraud detection, and fraud recovery) should be entered at Line 4.8.

Part D federal reinsurance is included in both the MLR numerator and denominator.

LICS and CGDP are excluded from both the MLR numerator and denominator.

MA Rebate amounts used to reduce the Part B premium and MSA Enrollee Deposit amounts are included in both the MLR numerator and denominator.

Adjustments that must be deducted from incurred claims include overpayment recoveries received from providers.

The following amounts must not be included in incurred claims:

1. Non-claims costs, as defined in §§ 422.2401 and 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:
        i. Network development.

ii. Administrative fees.
iii. Claims processing.
iv. Utilization management.

c. Amounts paid, including amounts paid to a provider or pharmacy, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee, such as the following:
    i. Medical record copying costs.
    ii. Attorneys' fees.
    iii. Subrogation vendor fees.
    iv. Bona fide service fees.
    v. Compensation to any of the following:
        1. Paraprofessionals.
        2. Janitors.
        3. Quality assurance analysts.
        4. Administrative supervisors.
        5. Secretaries to medical personnel.
        6. Medical record clerks.

2. Amounts paid to CMS as a remittance under § 422.2410(b) or § 423.2410(b).

Incurred claims for policies issued by one MA organization or Part D sponsor and later assumed by another entity must be included in the MLR calculation of the assuming organization for the entire MLR reporting year during which the policies were assumed and no incurred claims for that contract year must be included in the MLR calculation by the ceding MA organization or Part D sponsor.

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 included in the assuming issuer's MLR calculation and must not be included in the ceding issuer's MLR calculation.

Line 2.1 – Claims incurred only during CY 2023, paid through 9/30/2024

This line is similar to the commercial MLR reporting form Part 2 Line 2.1.

Claim experience should generally be through September 30th following the contract year (e.g., for CY 2023 MLR reporting, claims incurred during CY 2023 paid through 9/30/2024; liability and reserves for claims incurred during CY 2023 calculated as of 9/30/2024).

Line 2.1a – Claims incurred for benefits covered under Parts A & B (incl. supp. benefits that extend, or reduce cost sharing for, A/B benefits)

This line should only include claims incurred for items and services that are covered under Medicare Parts A and B. Claims incurred for MA supplemental benefits that extend coverage of, or reduce cost sharing for, items and services covered under Medicare Parts A and B should be

reported on this Line. Expenditures for additional expenditures for Additional Sessions of Smoking and Tobacco Cessation Counseling (PBP 14c) provided as supplemental benefits should be excluded from this Line and included in Line 2.1b.15.

2.1b – Claims incurred for MA supplemental benefits (excl. supp. benefits that extend or reduce cost sharing for A/B benefits)

Calculated field that is the sum of the amounts reported in Lines 2.1b.1 through 2.1b.17.

For each line, also indicate whether the reported amounts are for only one plan under the contract by selecting "Yes" in the drop-down box. Select "No" if the reported amounts are for multiple plans under the contract offering the benefit.

Expenditures reported in Lines 2.1b.1 through 2.1b.17 are generally expected to relate to the benefits in the service categories in the CY 2023 PBP. Expenditures reported in Lines 2.1b.1 through 2.1b.17 that are not related to the PBP service category or categories specified in the instructions below should be identified in the expense allocation methodology (Worksheet 3 Line 1.2).

Line 2.1b.1 Dental

This line should include all expenditures for Dental benefits provided as supplemental benefits. This includes amounts spent on Preventive Dental (PBP B16a) and Comprehensive Dental (PBP B16b).

Line 2.1b.2 Vision

This line should include all expenditures for Vision benefits provided as supplemental benefits. This includes amounts spent on Eye Exams (PBP B17a) and Eye Wear (PBP B17b).

Line 2.1b.3 Hearing

This line should include all expenditures for Hearing benefits provided as supplemental benefits. This includes Hearing Exams (PBP B18a) and Hearing Aids (B18b).

Line 2.1b.4 Transportation

This line should include all expenditures for Transportation benefits provided as supplemental benefits. (PBP 10b).

Transportation for non-medical needs offered as SSBCI (PBP B13i) should be excluded from this line and reported in Line 2.1b.17.

Line 2.1b.5 Fitness Benefit

This line should include all expenditures for Fitness benefits (PBP B14c) provided as supplemental benefits.

Line 2.1b.6 Worldwide Coverage / Visitor Travel

This line should include all expenditures for Worldwide Emergency/Urgent Coverage (PBP B4c) provided as a supplemental benefit.

Line 2.1b.7 Over the Counter (OTC) Items

This line should include all expenditures for OTC items (PBP B13b) provided as supplemental benefits.

Line 2.1b.8 Remote Access Technologies

This line should include all expenditures for Remote Access Technologies (including Web/Phone based technologies and Nursing Hotline) (PBP B14c) provided as supplemental benefits.

Line 2.1b.9 Meals

This line should include all expenditures for Meal Benefits (B13c) provided as supplemental benefits. Meals (beyond a limited basis) offered as SSBCI (PBP B13i) should be excluded from this line and reported in Line 2.1b.17.

Line 2.1b.10 Routine Foot Care

This line should include all expenditures for Routine Foot Care services (PBP B7f) provided as supplemental benefits. Expenditures for Medicare-covered podiatry services should be excluded from this line and reported in Line 2.1a.

Line 2.1b.11 Acupuncture Treatments

This line should include all expenditures for Acupuncture Treatments (PBP 13a) provided as supplemental benefits.

Line 2.1b.12 Chiropractic Care

This line should include all expenditures for Chiropractic Care services (PBP 7b) provided as supplemental benefits.

Expenditures for Medicare-covered Chiropractic Services (which includes only Manual Manipulation of the Spine to Correct Subluxation) should be excluded from this line and reported in Line 2.1a.

Line 2.1b.13 Personal Emergency Response System (PERS)

This line should include all expenditures for Personal Emergency Response Systems (PBP B14c) provided as supplemental benefits.

Line 2.1b.14 Health Education

This line should include all expenditures for Health Education (PBP 14c) provided as a supplemental benefit.

Line 2.1b.15 Smoking and Tobacco Cessation Counseling

This line should include all expenditures for Additional Sessions of Smoking and Tobacco Cessation Counseling (PBP 14c) provided as supplemental benefits.

Amounts spent on smoking and tobacco cessation counseling sessions up to the number of sessions covered by original Medicare should be excluded from this Line and included in Line 2.1a.

Line 2.1b.16 All Other Primarily Health Related Supplemental Benefits

This line should include all amounts spent on primarily health related supplemental benefits that have not already been reported on Lines 2.1b.1 through 2.1b.15.

Line 2.1b.17 Non-Primarily Health Related SSBCI

This line should include all amounts spent on non-primarily health related items and services that are special supplemental benefits for the chronically ill (SSBCI) (as defined in § 422.102(f)) (PBP B13i).

Line 2.1b.18 Non-Primarily Health Related Benefits- Other

This line should include all amount spent on non-primarily health related items and services that are not included under the non-primarily health related SSBCI category.

Line 2.1b.19 Out-of-network Services (informational only; amount already include in Lines 2.1a through 2.1b.18).

Required data entry; do not leave blank.

Report the amount spent on coverage of out-of-network services as a supplemental benefit. Amounts included in this Line should already be reported in Lines 2.1a or 2.1b.1 through 2.1b.17.

Line 2.1c – Claims incurred for Part D prescription drugs

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

For plan types that are only reporting Part D experience for MLR (such as PDPs and section 1876 cost plans), Line 2.1c should equal the Total calculated in Line 2.7.

This amount should be net/after the application of DIR.

Line 2.2 – Liability and reserves for claims incurred only during CY 2023, calculated as of 9/30/2024

This line is similar to 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 similar to 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 similar to 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 similar to the commercial MLR reporting form Part 2 Line 2.11b.

Line 2.4 – Contingent benefit and lawsuit reserves

This line is similar to 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 – Total

Calculated as the sum of Lines 2.1 through 2.6.

Line 2.7a – Low Income Cost Sharing Subsidy Amount (information only; amount must be excluded from Line 2.1c)

Required data entry; do not leave blank.

Note: This amount must also be excluded from Worksheet 1 Line 1 (Revenue).

Line 2.7b – Direct and Indirect Remuneration (DIR) (informational only; amount must be excluded from Line 2.1c)

Required data entry; do not leave blank.

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

The amount reported should include all direct and indirect remuneration (including discounts, charge backs or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits offered to some or all purchasers) from any source (including

manufacturers, pharmacies, enrollees, or any other person) that would serve to decrease the costs incurred under the Part D plan.

Total net DIR should not be reported as negative unless total net DIR increases the sponsor's drug costs.

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

Required data entries; do not leave blank.

The categories under Line 3 are similar to the categories under Part 1 Line 3 of the commercial MLR reporting form.

Federal and State taxes and assessments and licensing or regulatory fees must be in accordance with the provisions in §§ 422.2420(c)(2) and 423.2420(c)(2).

Total net taxes/fees should not be negative unless total net taxes/fees increase the sponsor's revenue.

The regulations at §§ 422.2420(c)(2)(iv)(B) and 423.2420(c)(2)(iv)(B) provide that a federal income tax-exempt MA organization or Part D sponsor may exclude from the MLR denominator amounts used for community benefit expenditures, up to a limit of either 3 percent of total revenue or the highest premium tax rate in the state for which the MA organization or Part D sponsor is licensed, multiplied by the revenue for the contract.

Line 3.1 Federal taxes and assessments, incurred in CY 2023, deductible from revenue in MLR calculation

Line 3.1a Federal income taxes

Line 3.1b Other Federal Taxes (other than income tax) and assessments

Line 3.2 State insurance, premium and other taxes, incurred in CY 2023, deductible from revenue in MLR calculation

Line 3.2a State income, excise, business, and other taxes

Line 3.2b State premium taxes

Line 3.2c Community benefit expenditures

Line 3.3 Regulatory authority licenses and fees

Line 3.4 Total

Line 3.4a Affordable Care Act section 9010 Fee (informational only; already included in Line 3.1)

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

The categories under Lines 4.1 through 4.5 are similar to the categories under Part 1 Line 4 of the commercial MLR reporting form.

The regulations at §§ 422.2430(a) and 423.2430(a) define the expenditures and activities that improve health care quality and can therefore be reported for MLR purposes. Sections 422.2430(b) and 423.2430(b) identify the excluded expenditures and activities that must not be reported.

In accordance with the provisions in §§ 422.2430 and 423.2430, expenditures that must not be included in quality improving activities include ICD–10 implementation costs in excess of 0.3 percent of total revenue.

Line 4.1 Improve health outcomes

Line 4.2 Activities to prevent hospital readmission

Line 4.3 Improve patient safety and reduce medical errors

Line 4.4 Wellness and health promotion activities

Line 4.5 Health information technology expenses related to improving healthcare quality

Line 4.6 Allowable ICD-10 expenses

Line 4.7 Medication Therapy Management program expenses

Line 4.8 Fraud reduction activities

Line 4.9 Total

Line 5 – Non-Claims Costs

Non-claims costs, as defined in §§ 422.2401 and 423.2401, are those expenses for administrative services that are not—

1. Incurred claims (as provided in §§ 422.2420(b)(2) through (4) and 423.2420(b)(2) through (b)(4));
2. Expenditures on quality improving activities (as provided in §§ 422.2430 and 423.2430);
3. Licensing and regulatory fees (as provided in §§ 422.2420(c)(2)(i) and 423.2420(c)(2)(i));
4. State and Federal taxes and assessments (as provided in §§ 422.2420(c)(2)(ii) and (iii), and 423.2420(c)(2)(ii) and (iii)).

Line 5.1 Cost containment expenses not included in QI expenses in Section 4

Line 5.2 All other claims adjustment expenses

Line 5.3 Direct sales salaries and benefits

Line 5.4 Agents and brokers fees and commissions

Line 5.5 Other taxes

Line 5.5a Taxes and assessments not excl. from revenue (not reported in Line 3)

Line 5.5b Fines and penalties of regulatory authorities (not reported in Line 3.3)

Line 5.6 Other general and administrative expenses

Line 5.7 Total

Line 5.8 Community benefit expend. (informational only; incl. amts reported in 3 & 5)

Line 5.9 ICD-10 implementation exp. (informational only; incl. amts reported in 4 & 5)

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

Additional information can be found in the Reporting Considerations section of these instructions, under the heading “EGWPs”.

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, then leave this field blank.

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 6.1, then enter the percentage used to allocate EGWP costs as Medicare-funded under the contract. Otherwise, leave this field blank. The percentage entered is the ratio of Medicare revenue to total revenue (that is, the percentage that is used to allocate costs as Medicare-funded). Additional information on calculating the Medicare-funded portion of EGWP costs can be found in the Reporting Considerations section of these instructions, under the heading “EGWPs”.

Line 7 – Member Months

Member months should be on a consistent basis with the claims and revenue information (e.g., for CY 2023 MLR reporting, include adjustments generally through September 30, 2024).

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.

Line 8 – Plan-Specific Data

Column (b) Plans offered under the contract in CY 2023

Enter the list of plans offered under the contract in CY 2023, in the format of contract-plan-segment (Hxxxx-xxx-xx, Rxxxx-xxx-xx, Sxxxx-xxx-xx, or Exxxx-xxx-xx). There are rows available to enter up to 150 plans. Do not leave blank rows between plans.

Column (c) CY 2023 Member Months

Enter the member months associated with each plan entered.

Member months entered should be on a consistent basis with the claims information entered in Line 2 (e.g., generally through September 2024).

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) MSA Plan Deductible

Enter the amount of the deductible if the plan is an MSA plan.

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 MLR and remittance must be calculated in accordance with the provisions in §§ 422.2420(a) through (c), and 423.2420(a) through (c).

Line 1 – Medical Loss Ratio Numerator

Line 1.1 – Claims

Calculated field that refers to Worksheet 1 Line 2.7.

Line 1.2 – Improving health care quality expenses

Calculated field that refers to Worksheet 1 Line 4.7.

Line 1.3 – MLR numerator

Calculated field: Worksheet 2 Line 1.1 + Line 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 Line 2.1 minus Line 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.

The PD adjustment factors are utilized for S contracts, contracts where total claims (Worksheet 1 Line 2.7) equal Part D claims (Line 2.1c), and contacts where total revenue (Line 1.10) equals Part D revenue. Otherwise MA adjustment factors are utilized.

Line 3.3 – Base Credibility Adjustment Factor

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 3.4 – MSA Deductible Factor

Linear interpolation calculated based on MSA Plan Deductible (Worksheet 1 Line 8 column (o)). For MA MSA contracts that do not have the same deductible for all plans under the contract, the MSA Deductible Factor is weighted by enrollment in each plan based on member months (Worksheet 1 Line 8 column (c)).

Line 4 – 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: Worksheet 2 Line 3.3 (multiplied by Line 3.4, if applicable)).

Line 4.3 – Adjusted MLR

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

Line 5 – Remittance Calculation

Line 5.1 – Is contract either partially-credible or fully-credible?

“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 2023 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, based on member months.

An MA organization or 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 § 422.2440(d)(1) or § 423.2440(d)(1), respectively.

An MA organization or Part D sponsor may not add a credibility adjustment to a contract's MLR if the contract's experience is fully credible, as defined at § 422.2440(d)(2) or § 423.2440(d)(2), respectively.

For those contract years for which an MA or Part D contract has non-credible experience, as defined at § 422.2440(d)(3) or § 423.2440(d)(3), respectively, sanctions under § 422.2410(b) through (d) or § 423.2410(b) through (d) will not apply.

Section 3: MSA Deductible Factors

MSA deductible factors, based on the deductible that applies to MSA plan members under a contract.

For MA MSA contracts only, the deductible factor serves as a multiplier on the Base Credibility Adjustment in Worksheet 2 Line 3.3. If an MSA contract has multiple MSA plans that have different deductibles, the deductible factor for the contract is calculated as the weighted average of the proportion of enrollees in each MSA plan under the contract.

WORKSHEET 3

Section 1 – Description of Expense Allocation Methods

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. The fields on Worksheet 3 are similar to the fields on Part 6 of the commercial MLR reporting form.

The fields on Worksheet 3 refer to the data entry lines of Worksheet 1.

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.

Note that the fields on Worksheet 3 are limited to 4,000 characters each.

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. The attesting officer must be designated as a CEO, CFO, or COO in the HPMS Basic Contract Management Module.

The language below is used in the electronic attestation module in HPMS:

> CY 2023 MLR Attestation
>
> The officer of this reporting issuer being duly sworn, attests 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.
>
> CEO/CFO/CO

TECHNICAL INSTRUCTIONS

The MLR Report is an Excel workbook that contains macro code and validation logic. The workbook provides the visual interface for the user to enter MLR data for a contract.

Workbook Versions

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

- Working file – a read-write enabled file that allows users to enter data in specified input fields. Users may edit, save, name, and re-name working versions of the MLR workbook.

- Finalized file – a read-only file created by a process called finalization, which modifies the format of the working file to prepare it for submission to CMS. Finalization saves the file using a standard naming convention and populates a "timestamp" within the finalized MLR Report. Note that finalized files remove the macro functionality.

- Backup file – also a read-only file created by the finalization process. The backup file uses the same file name 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. Users can remove the text "backup" from the filename to enable editing of the backup file. As such, backup files enable users to convert backup files back into working files—if needed —for further modification.

Workbook Formatting and Protection

Data entry cells are formatted in yellow. Keyboard users may use the 'Tab' key on the keyboard to cycle through the input cells.

All other cells prevent the user from keying in data. A dialog box alerts the user if the user has selected a protected cell. Cutting and pasting are not recommended, to prevent structural changes to the workbook. Users may copy and paste data into the workbook, and link the workbook to external files.

The MLR Report is password protected. The user may not modify the structure of the workbook. Each data item must be located in its pre-defined cell location for successful processing in 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 the workbook. If a workbook is compromised in this way, you must discard the compromised file, download and complete a new MLR Report.

Workbook Macros

The workbook includes macros that assist the user with data entry, data validation, and workbook finalization.

Finalize MLR

The finalization macro prepares the workbook for submission to CMS. The workbook must be finalized before uploading to HPMS. When the finalization macro is triggered, the following actions are performed:

- Checks any required fields (e.g., Contract Number, Organization Name, and Contact information) that must be entered for finalization to be successful.
- Checks any critical validations of data fields.
- Saves the working file.
- Creates 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.
- Creates a finalized file with a date stamp within the worksheet.

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

Example: H1111MLR-CY2023.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: H1111MLR-CY2023_Backup_2024-12-15-100000.xlsm

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

If additional changes are needed prior to submission (i.e., prior to upload to HPMS), modify the contents of the working file and finalize the file again. The previous finalized file will be overwritten and a new backup file will be created (backup files will not be overwritten as they are time-stamped).

In the instance that the working copy has become corrupted, the backup file may be renamed and used as the working copy. Removing the word 'backup' from the filename of the backup file will convert the file into a working copy that is read-write enabled.

The workbook contains a button that can be used to launch the Finalize macro.

Circle Invalid

This macro function displays red circles around cells that have failed validation. The validations are updated each time the file is saved, and when the "Circle Invalid" macro is run.

For example, the MLR Report workbook cannot be finalized if it contains invalid characters. The invalid characters are < > & { } ;