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CMCS Informational Bulletin

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SUBJECT: Medical Loss Ratio (MLR) Credibility Adjustments

The Centers for Medicare & Medicaid Services' (CMS) Medicaid managed care final rule[1] adopted standards for the calculation and reporting of a medical loss ratio (MLR) applicable to Medicaid and CHIP managed care contracts, including contracts with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs). In Medicaid managed care contracts that start on or after July 1, 2017, states must include requirements for managed care plans to calculate and report an MLR and related underlying data as described in 42 CFR 438.8(k). CHIP also adopts the Medicaid requirements for calculating and reporting MLRs in 42 CFR 438.8 for CHIP managed care contracts at 42 CFR 457.1203(c) through (f); however, the CHIP requirements go into effect for CHIP managed care contracts as of the state fiscal year beginning on or after July 1, 2018. Medicaid and CHIP managed care plans[2] must submit an MLR report to the state in a timeframe and manner determined by the state, which must be within 12 months of the end of the MLR reporting year.[3]

Included in the MLR standards is a credibility adjustment, described in 42 CFR 438.8(h). The regulations require CMS to publish the credibility adjustment annually, based on the methodology in §438.8(h)(4). The purpose of this Information Bulletin is to publish the credibility adjustment for rating periods beginning July 1, 2017 or later.

Overview of Credibility Adjustments

As discussed in the Medicaid and CHIP managed care proposed[4] and final rules, a managed care plan's actual MLR is dependent on the accuracy of the actuary's assumptions (for example, the characteristics and health status of the enrollees, the intensity and frequency with which its

1 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule, 81 Fed. Reg. 27498 (May 6, 2016); available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

2 For CHIP managed care plans only, 42 CFR 457.1203(e) requires that the description of the reports received from MCOs, PIHPs, and PAHPs under 42 CFR 438.8(k) will be submitted independently, and not with the actuarial certification.

3 This is different than the requirement that capitation rates must be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve an MLR of at least 85 percent as described in §438.4(b)(9). That provision is applicable for managed care contract rating periods that begin on or after July 1, 2019. Information from the MLR reports provided by managed care plans before states are required to set managed care capitation rates to meet targeted MLR thresholds will be useful for purposes of rate setting.

4 Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Notice of Proposed Rule Making, 80 Fed. Reg. 31098 (June 1, 2015); available at: https://www.federalregister.gov/documents/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered.

enrollees will use health care services, and unit cost). All things being equal, it is more likely that the assumptions made by the actuary will be more accurate when a plan insures a larger number of enrollees rather than a smaller number. Similarly, differences between the assumptions and actual experience will likely be smaller when a managed care plan covers more enrollees. Even though the state or the managed care plan estimated in good faith that the combination of the capitation payments and claims would produce an MLR that meets a specific standard (for example, 85 percent), a smaller managed care plan's reported MLR is more likely to vary, and vary more widely, around a targeted standard, due to the disproportionate effect random variations can have on smaller managed care plans. Random variations are less likely to have such large effects on managed care plans with more enrollees.

In alignment with MLR requirements for health plans operating in the private market and Medicare Advantage, the Medicaid and CHIP managed care rule provides a credibility adjustment to account for the potential variation in smaller managed care plans. As defined in 42 CFR 438.8(b), the credibility adjustment is used to account for random statistical variation related to the number of enrollees in a managed care plan. The credibility adjustment categorizes managed care plans into three groups:

- **Fully-credible**: Managed care plans with sufficient claims experience, measured in terms of member months, to calculate an MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. In other words, for managed care plans in this group, it is highly likely that the difference between the actual and target MLR is statistically significant and not due to random variation. Such managed care plans will not receive a credibility adjustment for their MLRs.
- **Partially-credible**: Managed care plans with sufficient claims experience, measured in terms of member months, to calculate an MLR with a reasonable chance that the difference between the actual and target medical loss ratios is statistically significant. In other words, for managed care plans in this group, it is somewhat likely that the difference between the actual and target MLR is statistically significant but such difference could, at least in part, be due to random variation. Such managed care plans will receive a partial credibility adjustment to their calculated MLRs.
- **Non-credible**: Managed care plans with insufficient claims experience, measured in terms of member months, to calculate a reliable MLR. Such plans will not be measured against the MLR standard; managed care plans in this group are presumed to meet or exceed the target MLR standard.

Methodology

The CMS Office of the Actuary (OACT) calculated:

- The minimum number of member months for a managed care plans' MLR to be fully credible;
- The maximum number of member months for a managed care plans' MLR to be non-credible; and
- The number of member months for several partial credibility adjustment factors.

These credibility adjustment factors were developed for two types of Medicaid and CHIP managed care plans that may operate in each state: 1) all managed care plans that provide health care services, except managed care plans that only provide long-term services and supports (referenced as "Standard Plans"); and 2) managed care plans that only provide long-term services and supports. The credibility adjustment factors for both types of plans are shown in Table 1 below. The majority of plans will use the "Standard Plans" credibility adjustment factors, including MCOs that cover long-term services and supports in addition to other services. The only exception will be plans that cover only long-term services and supports and no other services; such plans will use the "LTSS Only Plans" credibility adjustment factors.

Table 1:
Credibility Adjustment for Medicaid and CHIP Managed Care Plans with Rating Periods Beginning July 1, 2017 or Later

Standard Plans Member Months in MLR reporting year	Standard Plans Credibility Adjustment	LTSS Only Plans Member Months in MLR reporting year	LTSS Only Plans Credibility Adjustment
<5,400	Non-credible	<630	Non-credible
5,400	8.4%	630	8.4%
12,000	5.7%	1,000	6.7%
24,000	4.0%	2,000	4.7%
48,000	2.9%	4,000	3.4%
96,000	2.0%	8,000	2.4%
192,000	1.5%	16,000	1.7%
380,000	1.0%	32,000	1.2%
>380,000	Fully credible	45,000	1.0%
		>45,000	Fully credible

The following steps describe the methodology that each managed care plan, separately for each state, shall follow to determine the applicable MLR credibility adjustment factor.

1. The managed care plan shall calculate the number of member months for the MLR reporting year. This shall equal the number of member months calculated and reported pursuant to §438.8(k)(1)(xiii).

2. Determine which set of credibility adjustment factors in Table 1 should be used – the "Standard Plans" or the "LTSS Only Plans." If the managed care plan only provides long-term services and supports (LTSS), then use the "LTSS Only Plans" credibility adjustment factors. Otherwise, the "Standard" table must be used.

3. Using the correct credibility adjustment factors, determine where the plan's enrollment in terms of member months falls in Table 1.

a. If the number of member months is ***less than*** the number of member months corresponding to ***"Non-credible"*** in Table 1, no adjustment to the MLR calculation shall be made, and the MLR calculation shall be determined not credible. (*Reminder: Such plans will not be measured against the MLR standard; managed care plans in this group are presumed to meet or exceed the target MLR standard.*)

b. If the number of member months is ***more than*** the number of member months corresponding to ***"Fully credible"*** in Table 1, no adjustment to the MLR calculation shall be made, and the MLR calculation shall be determined fully credible. The MLR reported may be compared to the MLR standard.

c. If the number of member months is ***between*** the number of member months corresponding to "Non-credible" or "Fully credible" in Table 1, the managed care plan shall calculate a ***partial credibility adjustment***. The partial credibility adjustment shall be calculated as follows:

$$Credibility\ Adjustment = CA_b + \left[\frac{(MM_b - MM)}{(MM_b - MM_a)}\right] \times (CA_a - CA_b)$$

Where:

MM is the number of member-months for a specific managed care plan. This is the number of member months calculated in step 1.

MM_a is the number of member months where *MM* is rounded down to the nearest "Annual Member Months" number in Table 1.

MM_b is the number of member months where *MM* is rounded up to the nearest "Annual Member Months" number in Table 1.

CA_a and CA_b are the credibility adjustment factors found in the applicable table for MM_a and MM_b, respectively.

Round the credibility adjustment factor to the nearest tenth. This credibility adjustment factor shall be added to the plan's calculated MLR.

Examples

Example 1:
In State A, a managed care plan only provides long-term services and supports, and has calculated an MLR of 81.1 percent prior to any credibility adjustment. The plan has 1,475 member months in the MLR reporting year in State A.

The credibility adjustment is calculated as follows for this managed care plan in State A:

The "LTSS Only Plans" factors in Table 1 show the credibility adjustment for a plan with 1,000 member months is 6.7 percent and the credibility adjustment for a plan with 2,000 member months is 4.7 percent. The credibility adjustment is calculated as follows:

$$Partial\ adjustment = 4.7\% + \left[\frac{(2000\text{-}1475)}{(2000\text{-}1000)}\right] \times (6.7\%\text{-}4.7\%) = 5.8\ \%$$

The final MLR including the credibility adjustment is 81.1% + 5.8% = 86.9%.

Example 2:
In State B, a managed care plan provides behavioral health services only and has a calculated MLR of 81.1 percent prior to any credibility adjustment. The managed care plan has 100,000 member months in the MLR reporting year in State B.

The credibility adjustment is calculated as follows for this managed care plan in State B:

The "Standard Plans" factors in Table 1 show the credibility adjustment for a plan with 96,000 member months is 2.0 percent and the credibility adjustment for a plan with 192,000 member months is 1.5 percent. The credibility adjustment is calculated as follows:

$$Partial\ adjustment = 1.5\% + \left[\frac{(192{,}000\text{-}100{,}000)}{(192{,}000\text{-}96{,}000)}\right] \times (2.0\%\text{-}1.5\%) = 2.0\ \%$$

The final MLR including the credibility adjustment is 81.1% + 2.0% = 83.1%.

Example 3:
In State C, a managed care plan provides comprehensive services (for example, acute care and long term services and supports) and has a calculated MLR of 81.1 percent prior to any credibility adjustment. The managed care plan has 400,000 member months in the MLR reporting year in State C.

The credibility adjustment is calculated as follows for this managed care plan in State C:

The "Standard Plans" factors in Table 1 show the plan's MLR is determined to be fully credible, because 400,000 > 380,000. No credibility adjustment is added to the MLR.

The final MLR is 81.1%.

Example 4:
In State D, a managed care plan provides targeted case management services, and has a calculated MLR of 81.1 percent prior to any credibility adjustment. The plan has 400 member months in the MLR reporting year in State D.

The credibility adjustment is calculated as follows for this managed care plan in State D:

The "Standard Plans" factors in Table 1 show the plan's MLR is determined to be non-credible, because 400 < 5,400. This plan will not be measured against the MLR standard; it is presumed to meet or exceed the MLR calculation standard in the regulation.

Technical Assistance

If you have questions or would like to request technical assistance related to credibility adjustments with respect to the MLR standards applicable to Medicaid and CHIP managed care contracts, please send an email to ManagedCareRule@cms.hhs.gov. We look forward to continuing our partnership to deliver on our shared goals of providing high quality, sustainable health care to those who need it most.