MINIMUM MEDICAL LOSS RATIO REBATE CALCULATION REPORT INSTRUCTIONS

FOR THE REPORTING PERIOD ENDING DECEMBER 31, 2016

INTRODUCTION

The following definitions and instructions outline the requirements for the Minimum Medical Loss Ratio (MMLR) process that is required by contract for the ACA (Expansion) Population. The Coordinated Care Organizations (CCO) contract includes a provision that requires CCOs to be held to an 80% MMLR for the ACA eligibility categories, and if a lower ratio occurs, then CCOs are required to rebate the difference back to OHA. CCOs are required to submit a form that reports the revenues and costs related to their OHP Line of Business, split out by ACA (Expansion Population) and non-ACA (Non-Expansion Population) eligibility groupings to calculate whether a rebate is required.

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GENERAL DEFINITIONS

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

Expansion Population means Members who are enrolled in the following Rate Categories:

- ACA Ages 19-44, ACA Ages 45-54 and ACA Ages 55-64

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

Member means a client who is enrolled with a Contractor under Contract with OHA.

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

MMLR Standard means an MMLR exceeding 80% for the Expansion Population.

Reporting Period: The Rebate Calculation will be measured for the calendar year period of January 1, 2016 to December 31, 2016. Each Contractor is required to submit a MMLR Calculation Report with accurate data by June 30, 2017 based on data paid through March 31, 2017:

- **Due Date:** June 30, 2017
- **Paid Through Date:** March 31, 2017

REPORT INSTRUCTIONS AND DEFINITIONS BY SECTION

SECTION #1: MEDICAL RELATED REVENUES

1. **Gross Premiums** means Capitation Payments plus Case Rate Revenue. Case Rate Revenue includes any payments made on a case rate basis, including maternity and bariatric case rates. This value should tie to Exhibit L Report L6 OHP.

    a. **Reinsurance/Stop Loss Premiums** means premiums paid/accrued for reinsurance or stop loss insurance but does not include reinsuring all or substantially all of Contractor's risk. This value should tie to Exhibit L Report L6 OHP.

    b. **HRA Payments** means hospital reimbursement adjustment payments. This value should tie to Exhibit L Report L6 OHP.

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

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

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

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

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

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

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

  Include:

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

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

- **State premium taxes.**

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

- **Regulatory authority licenses and fees.**

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

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

2. **Net Premiums** means Gross Premiums reduced by:
   - Reinsurance/Stop Loss Premiums;
   - HRA Payments; and
   - Federal and State Taxes and Licensing or Regulatory Fees.

3. **Other Health Care Related Revenues** means other supplemental revenues received by Contractor.

   Include: Quality Pool payments made by OHA to Contractor.

4. **Total Medical Related Revenues** means the sum of Net Premiums and Other Health Care Related Revenues.

SECTION #2: INCURRED MEDICAL RELATED COSTS

5. **Paid Claims and Non-Claims Costs** means amounts paid through March 31, 2017 that were for services incurred or provided during the Reporting Period. This amount should be reduced by any reinsurance recoveries, Third Party Reimbursement (TPR), Coordination of Benefits (COB), subrogation or similar payments received.

   Include: Claims paid on a fee-for-service basis and payments made for "in-lieu of services" as described in the CMS section 1115 Waiver and as reported on Line 15 of Exhibit L Report L6 OHP.

6. **Unpaid Claim Reserve** means reserves and liabilities established to account for claims incurred during the Reporting Period that were unpaid as of March 31, 2017.

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

7. **Sub-Capitated Payments** means a per member payment on a regular basis made to a sub-capitated provider or vendor that is meant to cover specific services and/or members, and puts the provider/vendor at risk if costs are higher than the total payment received. Sub-capitated payments typically include a factor to cover administrative costs incurred and underwriting gains allowed to the sub-capitated provider or vendor.

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

   Exclude: Non-medical component of sub-capitated payments made to providers/vendors (see separate guidance starting on page 12).

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

   Include: Payments to Participating Providers representing monetary incentive arrangements that reflect priorities which align with the Quality Pool program for achieving the outcome and quality objectives.

9. **Experience Rating Refunds and Reserves for Experience Rating Refunds** includes:

   Experience Rating Refunds means retrospective premium adjustments arising from retrospectively rated contracts, plus any incurred state premium refunds.

   Reserves for Experience Rating Refunds means an estimate of amounts due but unpaid under a retrospectively rated funding arrangement, or due but unpaid for a state premium refund.

   Include: SNRG Settlement Refund.

10. **Change in Contract Reserves** means change during the Reporting Period in reserves that are established which, due to the Gross Premium pricing structure, account for the value of the future benefits at any time exceeding the value of any appropriate future valuation Net Premiums at that time. Contract reserves do not include premium deficiency reserves or reserves for expected MMLR Rebates.

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

12. **Health Care Quality Improvement (QI) Expenses Incurred** includes expenses related to the following:
    - Activities to improve health outcomes
    - Activities to prevent hospital readmission
    - Activities to improve patient safety and reduce medical errors
    - Wellness and health promotion activities
    - Health information technology (HIT) expenses related to improving health care quality
    - Allowable ICD-10 implementation expenses

The next section outlines the definitions of each item above.

13. **Total Incurred Medical Related Costs** means the sum of:
    - Total Incurred Medical Costs; and
    - Health Care Quality Improvement Expenses Incurred.

14. **Minimum Medical Loss Ratio** or **MMLR** means Total Incurred Medical Related Costs, divided by Total Medical Related Revenues.

15. **Rebate** means the dollar amount which, if added to Contractor's Total Incurred Medical Related Costs, would result in an MMLR equal to the MMLR Standard. If MMLR exceeds the MMLR Standard, the Rebate is zero.

LINE 12 – HEALTH CARE QUALITY IMPROVEMENT EXPENSES DEFINITIONS

The information contained in this section outlines the expenses to include and exclude for **Line 12: Health Care Quality Improvement Expenses Incurred** in the MMLR Rebate Calculation Report.

QUALITY IMPROVEMENT ACTIVITIES—GENERAL OVERVIEW

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

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

- Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

QI activities must be primarily designed to:

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

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

- Those that are designed primarily to control or contain costs.
- The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.
- Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from Total Medical Related Revenues included on Line 4.
- Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.
- Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD-10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. §1320d-2, as amended, and ICD-10 implementation costs in excess of 0.3% of Gross Premiums.
- That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
- All retrospective and concurrent utilization review.
- Fraud prevention activities.

- The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.
- Provider credentialing.
- Marketing expenses.
- Costs associated with calculating and administering individual Member incentives.
- That portion of prospective utilization that does not meet the definition of activities that improve health quality.
- Any function or activity not expressly described below, unless otherwise approved by and within the discretion of OHA, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes in this section or otherwise support monitoring, measuring or reporting health care quality improvement.

ACTIVITIES TO IMPROVE HEALTH OUTCOMES

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

- Effective case management, care coordination, and chronic disease management, including through the use of the medical homes model as defined in section 3606 of the Affordable Care Act.
- Accreditation fees by a nationally recognized accrediting entity directly related to quality of care activities included in this section.
- Expenses associated with identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.
- Quality reporting and documentation of care in non-electronic format.

ACTIVITIES TO PREVENT HOSPITAL READMISSION

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

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

- Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

ACTIVITIES TO IMPROVE PATIENT SAFETY AND REDUCE MEDICAL ERRORS

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

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

WELLNESS AND HEALTH PROMOTION ACTIVITIES

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

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

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

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

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

- Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their ''meaningful use'' as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in 45 CFR §158.140;
- Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;
- Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;
- Monitoring, measuring, or reporting clinical effectiveness, including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (e.g., CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law);
- Advancing the ability of Members, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately, and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care – this may include electronic health records accessible by Members and appropriate providers to monitor and document an individual patient's medical history and to support care management;
- Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes;
- Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease; or
- Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

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

ALLOWABLE ICD-10 IMPLEMENTATION EXPENSES

Include: ICD-10 conversion costs incurred in the MLR Reporting Period up to 0.3% of Gross Premiums.

Exclude: ICD-10 maintenance costs, as well as ICD-10 implementation expenses in excess of 0.3% of Gross Premiums.

FREQUENTLY ASKED QUESTIONS

Question 1: How do I allocate a cost between Expansion and Non-Expansion eligibility categories that was not paid based on enrollment? (i.e. incentive payments)?

Answer: OHA recommends using an allocation based on the targeted eligibility categories and include the costs allocated to Expansion Population under that column in the MMLR Calculation Report. Please provide your allocation methodology in the scratch sheet of the template.

Question 2: Can healthcare professional hotline expenses be included in the MMLR Calculation Report?

Answer: Expenses for healthcare professional hotlines should be **excluded** to the extent they do not meet the criteria for **Line 12: Health Care Quality Improvement Expenses** as defined in the previous section.

Question 3: Can expenses for Prospective Utilization Review be included in the MMLR Calculation Report?

Answer: Expenses for prospective Utilization Review should be **excluded** to the extent they do not meet the criteria for **Line 12: Health Care Quality Improvement Expenses** as defined in the previous section; AND the prospective utilization review activities are not conducted in accordance with a program that has been accredited by a recognized accreditation body.

SETTLEMENT GUIDANCE FOR REPORTING SUB-CAPITATION PAYMENTS AS INCURRED MEDICAL RELATED COSTS

INTRODUCTION TO SUB-CAPITATION PAYMENT GUIDANCE

The Oregon Health Authority (OHA) contracts with a 16 different Coordinated Care Organizations (CCOs) that have a variety of different business models to cover members of the Oregon Health Plan (OHP). Many of the CCOs have a mixture of provider contract types and alternative payment methodologies (APMs). A common payment practice is sub-capitation. Sub-capitation is when a CCO distributes a Per-Member rate on a regular basis to a provider or service organization to cover the costs of that member for a specific service, and/or group of members. This APM has demonstrated success across Oregon by putting providers at risk for costs related to specific members, versus a traditional Fee-For-Service (FFS) payment methodology. This has proven to control costs and encouraging preventive services.

OHA is engaged with a variety of settlements with CCOs related to their Medical Loss Ratio (MLR). OHA has decided to limit the requirement of excluding administrative expenses from sub-capitation arrangements in the incurred medical related cost section of the MLR calculation. The goals of this guidance are to:

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

The following document outlines OHA's guidance to CCOs when a settlement is taking place that requires a CCO to identify their incurred medical related costs.

CMS GUIDANCE

OHA reviewed the following CMS Guidance in making its determination:

MLR FOR HEALTH INSURANCE ISSUERS

Under §158.140 (b) (3) Adjustments that must not be included in incurred claims:

(ii) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management. For example, if an issuer contracts with a behavioral health,

chiropractic network, or high technology radiology vendor, or a pharmacy benefit manager, and the vendor reimburses the provider at one amount but bills the issuer a higher amount to cover its network development, utilization management costs, and profits, then the amount that exceeds the reimbursement to the provider must not be included in incurred claims.

(iii) 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. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

MLR FOR MEDICAID MANAGED CARE (PROPOSED RULE) NPRM CMS-2390-P

Under proposed §438.8 (e) (2) (v) Amounts that must be excluded from incurred claims:

(A) (3) Amounts paid, including amounts paid to a health care professional, for professional or administrative services that do not represent compensation or reimbursement for State plan services or services meeting the definition in §438.3(e) and provided to an enrollee.

SUB-CAPITATION PAYMENT DEFINITIONS

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

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

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

SUB-CAPITATION PAYMENT GUIDANCE

CCOs are required to exclude administrative expenses from incurred medical related costs using the following guidance when reporting Sub-capitation Payments in the MMLR Report and other settlements.

GROUP #1: OVER 5% OF NET PREMIUMS

Criteria	Non-medical Exclusion
A sub-capitated entity receives a total of 5% or more of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report)	CCOs are required to only report sub-capitated entities actual incurred medical costs (not to exceed the total amount of the entities sub-capitated payments) and provide detailed financial information of what was included for medical costs and what was excluded for non-medical costs. ***Note**: Consistent with 45 CFR §158.140 (b) (3) (iii) and proposed 42 CFR §438.8 (e) (2) (v), examples of expenses that are not related to providing services are records copying fees, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, etc.*

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

Criteria	Non-medical Exclusion
A sub-capitated entity receives a total of less than 5% or more than 0.5% of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report)	CCOs have two options: A. Exclude a percent* (see next section) of sub-capitated payments related to non-medical costs. B. Report sub-capitated entities actual incurred medical costs (not to exceed the total amount of the entities sub-capitated payments) and provide detailed financial information of what was included for medical costs and what was excluded for non-medical costs.

*PERCENT EXCLUDED FOR GROUP #2, OPTION A

CCOs receive an Administrative load that is a percent of their capitation rates that can vary from year to year. The Administrative load built in the rates distributed during the settlement time period is the same percentage that must be excluded from the Sub-capitated Payments that fall under "Group #2" above if a CCO chooses "Option A". All components of the admin load, including but not limited to, base administrative load, risk contingency, and profit margin, should be excluded.

> *For example, if a sub-capitated entity is paid a total of 3% of a CCO's net revenues and the CCO chooses Option A, then for the 2016 time period, a CCO must exclude the percent by rate category from the sub-capitated payment as administrative expenses when reporting in the MMLR template and other settlements.*

GROUP #3: UNDER 0.5% OF NET PREMIUMS

Criteria	Non-medical Exclusion
A sub-capitated entity receives a total of 0.5% or less of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report)	CCOs do not have to exclude non-medical costs for these sub-capitated entity payments. Include the entire amount of the sub-capitation payments.

FREQUENTLY ASKED QUESTIONS

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

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

Question 2: My CCO has a Sub-capitation Payment contract with a Physician-Hospital Organization (PHO). The PHO then contracts with individual hospitals and physician providers/provider groups.

Payments in total from the CCO to the PHO exceed the 1% threshold, as do the payments made from the PHO to the hospitals, but payments to the individual physician providers are all less than the 1% threshold. What portion of these Sub-capitation Payments need to have the Administrative expenses excluded from incurred medical related costs in the MMLR Report?

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