Topic for Input: Will the proposed federal rules regarding MLR have the same impact on fee-for-service arrangements as with capitation arrangements?

Reimbursement for clinical services provided to enrollees. Generally, the MLR report required by §158.110 must include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy. The report must include claim reserves assocated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the claim portion of lawsuits, and any experience rating refunds paid or received. Remimbursement for clinical services are referred to as incurred claims.

Items that must be Deducted or Excluded from Incurred Claims:

Q. Do providers who are paid on a Fee-For-Service basis include the costs for these administration and quality functions in their bills to plans?

1. Medical records copying costs.
2. Attorneys' fees.
3. Subrogation vendor fees.
4. Compensation to paraprofessionals.
5. Janitors.
6. Quality assurance analysts.
7. Administrative supervisors.
8. Secretaries to medical personal.
9. Medical record clerks.
10. Eligibility and coverage verification.
11. Claims processing.
12. Utilization review.
13. Prescription drug rebates.
14. Overpayment recoveries received from providers.
15. The amount of incentive and bonus payments made to providers.
16. **Amounts paid to third party vendors for secondary network savings.**
17. **Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.**
18. **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.**

The MLR report must include expenditures for activities that improve health care quality. The requirements of the activites the issue must meet are detailed in §158.150.

<u>Quality Improvement Activities Exclusion</u>**s**

19. Quality improvement activities that are designed to primarily control or contain costs.

20. Those quality improvement activities that meet the definition of quality improvement but which were paid for with grant money or other funding separate from premium revenue.
21. 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.
22. Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue.
23. Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services.
24. 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.
24. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.
25. All retrospective and concurrent utilization review.
26. Fraud prevention activities, other than fraud detection/recovery expenses up to the amount recovered that reduces incurred claims.
27. 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.
28. Provider credentialing.
29. Marketing expenses.
30. Costs associated with calculating and administering individual enrollee or employee incentives.
31. That portion of prospective utilization that does not meet the definition of activities that improve health quality.