CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

MEDICAL LOSS RATIO (MLR) DATA FORM FILING INSTRUCTIONS FOR CONTRACT YEAR (CY) 2021

FOR MEDICARE ADVANTAGE ORGANIZATIONS AND PRESCRIPTION DRUG PLAN SPONSORS

As of May 23, 2022

(Revised on August 1, 2022 for a Technical Correction noted on page 4)

OMB Approved # 0938-1232

CMS-10476

OMB expiration date: 01/31/2024

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 36 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 Data Form 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.).

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

All contracts that received Medicare revenue during the contract year must submit an MLR Data Form, 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 Data Form.
- Cost Plans and HCPPs: [2] The MLR Data Form 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 Data Form.
- EGWPs:[3] All EGWPs under the contract must be included in the MLR Data Form. EGWPs are to include costs and revenue only for the Medicare-funded portion of each contract.
- Dual-Eligible Special Needs Plans (D-SNPs): All D-SNPs under the contract must be included in the MLR Data Form. 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 Data Form, 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 Data Form that accounts for revenue, including payment adjustments such as risk adjustment reconciliation amounts.

The MLR Data Form collects the Medicare medical loss ratio (MLR) and remittance amount, if any, or that the contract is non-credible for the applicable year (CY 2021).

These filing instructions apply to the CY 2021 MLR reporting year.

An attestation must be submitted in HPMS for each MLR Data Form.

The submitted MLR Data Forms 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 Data Forms. 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 2021 remittance amount is due to CMS, there will be an adjustment to payment, likely occurring in mid-2023. (Note that a technical correction was made to this sentence on August 1, 2022, to correct the year reference from 2022 to 2023.)

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 and address any data flagged with a "red circle" validation in the MLR Data Form 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 Updates

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.

CMS released a CY 2023 final rule (CMS-4192-F), which was published in the Federal Register on May 9, 2022 (89 FR 27704). That final rule reinstates the detailed MLR reporting requirements for contract year 2023 and thereafter that were in effect for contract years 2014 to 2017. Previously, the regulations required reporting of the underlying data used to calculate and verify the MLR and any remittance amount, such as incurred claims, total revenue, expenditures on quality improving activities, non-claims costs, taxes, and regulatory fees. This final rule also amends MLR reporting for contract year 2023 and thereafter to collect additional details regarding plan expenditures so we can better assess the accuracy of MLR submissions, the value of services being provided to enrollees under MA and Part D plans, and the impacts of recent rule changes that removed limitations on certain expenditures that count toward the 85 percent MLR requirement. The final rule also adopted a clarification of §§ 422.2460 and 423.2460 regarding the correction of errors and omissions in MLR reporting for previous 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.
- The CY 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Programs, and Medicare Cost Plan Program final rule [CMS-4190-F] may be found at

https://www.federalregister.gov/documents/2020/06/02/2020-11342/medicare-program-contract-year-2021-policy-and-technical-changes-to-the-medicare-advantage-program.

- 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. As the Part C and Part D MLR regulations are not identical to the commercial MLR regulations, care should be taken when using the commercial MLR regulations, guidance, instructions and other resources when completing the Medicare Part C and Part D MLR Data Form.
- 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 for covered services, 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 for covered services described at § 422.2420(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 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) that are covered by the MA plan(s) under the contract: 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 any 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.

Note that, as stated in the May 2020 Medicare Advantage/Prescription Drug System (MARx) Payment memo released on April 22, 2020, Section 3709 of the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), enacted on March 27, 2020, suspended sequestration of Medicare programs between May 1, 2020, and December 31, 2020.

The Consolidated Appropriations Act, 2021, enacted December 27, 2020, extended the sequestration suspension through March 31, 2021. H.R. 1868, enacted on April 14, 2021, further extended the sequestration suspension through December 31, 2021.

The Protecting Medicare and American Farmers from Sequester Cuts Act, enacted December 10, 2021, further extended the sequestration suspension through March 31, 2022.

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 2021 MLR Data Forms and subsequently determine if an adjustment to the CY 2021 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 Data Form to CMS, in a timeframe and manner specified by CMS. For CY 2021, 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 Data Forms 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

[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.

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
- 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.

[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.

CY 2021 MLR DATA FORM FIELDS

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

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

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 Data Form finalized

This field is populated with the date when the MLR Data Form 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 Data Form.

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.

Line 6 – Adjusted MLR

Non-credible contracts: For each contract that has non-credible experience, as determined in accordance with §§ 422.2440(d) and 423.2440(d), report that the contract is non-credible. Enter "N/A".

Fully credible and partially credible contracts: For each contract that has fully credible or partially credible experience, as determined in accordance with §§ 422.2440(d) and 423.2440(d), report the Adjusted MLR for the contract. Enter value as a percentage (xx.x%).

The Adjusted MLR should reflect any credibility adjustment applied. Please see the tables below for the credibility factors for MA and Part D contracts, in accordance with §§ 422.2440 and 423.2440.

For contracts other than MSA contracts, the base credibility factor for partially credible experience is determined based on the number of member months for all enrollees under the contract and the factors shown in Table 1 (Table 2 for plans with Part D only experience, such as stand-alone PDPs and Cost Plans). When the number of member months used to determine credibility exactly matches a member month category listed in Table 1 (Table 2 for plans with Part D only experience, such as stand-alone PDPs and Cost Plans), the value associated with that number of member months is the base credibility factor. The base credibility factor for a number of member months between the values shown in Table 1 (Table 2 for plans with Part D only experience, such as stand-alone PDPs and Cost Plans) is determined by linear interpolation.

The credibility adjustment for a partially credible MA MSA contract is the product of the base credibility factor multiplied by the deductible factor. The deductible factor is based on the enrollment-weighted average deductible for all MSA plans under the MA MSA contract, where the deductible for each plan under the contract is weighted by the plan's portion of the total number of member months for all plans under the contract. When the weighted average deductible exactly matches a deductible category listed in Table 3, the value associated with that deductible is the deductible factor. The deductible factor for a weighted average deductible between the values shown in Table 3 is determined by linear interpolation.

Table 1 - Credibility Factors for MA Contracts

Member months	Credibility factor (additional percentage points)
< 2,400	N/A (Non-credible)
2,400	8.4
6,000	5.3
12,000	3.7
24,000	2.6
60,000	1.7
120,000	1.2
180,000	1.0
>180,000	0.0 (Fully credible)

Table 2 - Credibility Factors for Part D Contracts

Member months	Credibility adjustment (additional percentage points)
< 4,800	N/A (Non-credible)
4,800	8.4
12,000	5.3

24,000	3.7
48,000	2.6
120,000	1.7
240,000	1.2
360,000	1.0
> 360,000	0.0 (Fully credible)

Table 3 - Deductible Factors for MA MSA Contracts

Weighted average deductible of contract	Deductible Factor for MA MSA contracts
< $2,500	1.000
$2,500	1.164
$5,000	1.402
$10.000 +	1.736

Line 7 – Remittance Amount

Report the amount of any remittance owed to CMS under §§ 423.2410 and 422.2410. Enter value as a dollar amount ($x.xx).

ADDITIONAL INFORMATION REGARDING MLR CALCULATIONS

On April 2, 2018, CMS issued a final rule [CMS-4182-F] that significantly reduced the amount of MLR data that MA organizations and Part D sponsors submit to CMS on an annual basis. For CY 2021, MA organizations and Part D sponsors are only required to 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(b) and 423.2460(b).

Prior to CY 2018, CMS released a detailed MLR Report template annually. These MLR Report files are available in HPMS and also available at https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/MedicalLossRatio.html. Plan sponsors may continue to use prior years' MLR Report templates to calculate the MLR and remittance, and then enter the results into the CY 2021 MLR Data Form for submission to CMS.

The MLR Report template for contract years prior to 2018 contained detailed categories of revenue and expenses that were used to calculate the MLR and remittance. These categories appeared on the MLR Report template Worksheet 1 and are described below in some detail in the order in which they appeared.

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.

For plans participating in the VBID Model Hospice Benefit Component, see the Reporting Considerations section of these instructions regarding the revenue associated with the VBID Model Hospice Benefit Component.

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. Below is a mapping of CMS reports to the revenue categories of the MLR Report template that was issued for contract years prior to 2018. The following CMS reports are used in this mapping:

- MMDDF = Monthly Membership Detail Data Files
  NOTE for CY 2021 MLR: Payments for contract year 2021, which would include contract year (CY 2021) payment adjustments generally through the last completed quarter prior to the typical MLR reporting timeframe (generally through September 30, 2022 for CY 2021 MLR) and would include payment adjustments for the contract year (CY 2021) risk adjustment reconciliations which appear in the MMR under adjustment reason code 25 for Part C and code 37 for Part D.
  Note that for CY 2021, CMS released an HPMS memo on January 15, 2021 (available at: https://www.cms.gov/hpms-memos-wk-3-january-11-15-2021/hpms-memos-wk-3-january-11-15-2021) that announced that CMS would conduct an Interim Final Risk Score Run and then would conduct a Final Risk Score Run. CMS released an HPMS memo on January 10, 2022 (available at: https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpmshpms-memos-archive/hpms-memos-wk-2-january-10-14) that announced that the CY 2021 Interim Final Risk Adjustment Reconciliation payment adjustments would be run on the typical schedule for reconciliation payment and that CMS will then, later, conduct a final CY 2021 Risk Adjustment Reconciliation. The CY 2021 MLR must reflect these risk adjustment reconciliation payment adjustments even if scheduled for after September 30, 2022[6].
- PRS CTR = Payment Reconciliation System (PRS) Reconciliation Results Report to Plans, Contract Trailer "CTR" version

[6] Note that for contracts that are required to report MLR earlier than the typical timeframe (for contracts that fail to meet the MLR threshold for 2 or more consecutive years), such that the "early filer" MLR submission occurs prior to the final risk adjustment reconciliation, the revenue included as part of the MLR calculation must reflect the projected reconciliation in accordance with §§ 422.2460(c) and 423.2460(c).

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

* Note that any 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 used for contract years prior to 2018 contained 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 (or zero if sequestration is suspended for the entire time period).

Note that the MMDDF amounts do not reflect any sequestration adjustment. The following MMDDF amounts are subject to sequestration when applicable: 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 (LIPSA), 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). Additional information on sequestration can be found in the Reporting Considerations section of this document.

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 2021 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 2021) 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 any sequestration (i.e., "gross" of any sequestration). This information may be used in the development of (CY 2021) 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.

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.

Claims

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

1. Direct claims that the MA organization pays (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 that was 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). If the MLR Report Template is being used to assist in the calculation of MLRs for CY 2021, Lines 2.7a and 2.7b should be left blank. Instead, for CY 2021, the total amount spent on fraud reduction activities (including fraud prevention, fraud detection, and fraud recovery) should be entered under "Line 4 – Health Care Quality Improvement (QI) Expenses Incurred." *See* §§ 422.2430(a)(1)(ii) and (4)(ii) and 423.2430(a)(1)(ii) and (a)(4)(ii).

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.

For plans participating in the VBID Model Hospice Benefit Component, see the Reporting Considerations section of these instructions regarding the expenses associated with the VBID Model Hospice Benefit Component.

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.

Claim experience should generally be through September 30th following the contract year (e.g., for CY 2021 MLR reporting, claims incurred during CY 2021 paid through 9/30/2022; liability and reserves for claims incurred during CY 2021 calculated as of 9/30/2022).

Federal and State Taxes and Licensing or Regulatory Fees

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.

Health Care Quality Improvement (QI) Expenses Incurred

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.

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)).

Member Months

Member months should be on a consistent basis with the claims and revenue information (e.g., for CY 2021 MLR reporting, include adjustments generally through September 30, 2022).

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.

MLR and Remittance Calculations (appeared on MLR Report template Worksheet 2)

MLR Numerator = Claims categories plus Quality Improvement Activities categories

MLR Denominator = Revenue categories minus Taxes & Fees categories

Unadjusted MLR = MLR Numerator divided by MLR Denominator

Credibility Adjustment = a percentage calculated based on contract member months and the published CMS credibility tables for the contract year (either the MA or Part D credibility table, and the MSA deductible factor table)

Adjusted MLR = Unadjusted MLR plus Credibility Adjustment

Medicare MLR Standard = 85.0%

Remittance = (Medicare MLR Standard minus Adjusted MLR) times MLR Denominator for partially credible and fully credible contracts with Adjusted MLR less than the Medicare MLR Standard

ATTESTATION

An attestation must be submitted in the HPMS attestation module to accompany each MLR Data Form 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 2021 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 Data Form 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 Data Form 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/COO

TECHNICAL INSTRUCTIONS

The MLR Data Form 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.

For contract years prior to CY 2018, a separate add-in file (MLRyyyy.xlam) was required to be saved under C:\MLR\MLRyyyy. For contract year 2021, the functionalities/macros of the previous add-in file have now been incorporated into the MLR Data Form workbook.

Workbook Versions

The MLR Data Form 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 Data Form. 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 Data Form 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 Data Form.

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-CY2021.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-CY2021_Backup_2022-11-15-100000.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 workbook cannot be finalized if it contains invalid characters. The invalid characters are < > & { } ;