



U.S. Department of Health and Human Services

# Office of Inspector General

## CMS Has Opportunities To Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios

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September 2022, OEI-03-20-00231





## Why OIG Did This Review

State and Federal expenditures on Medicaid managed care are growing and totaled \$360 billion in 2020, which was 55 percent of total Medicaid expenditures in that year. With its 2016 Medicaid managed care regulations, the Centers for Medicare & Medicaid Services (CMS) chose medical loss ratios (MLRs) as a policy tool to apply across the program to ensure appropriate stewardship of managed care funds. States' oversight of their plans' annual MLR reporting is critical to improve fiscal transparency, monitor costs, and promote high-quality care in Medicaid managed care.

## How OIG Did This Review

We administered an online survey to and requested information from all States with Medicaid managed care plans subject to Federal MLR requirements as of September 1, 2020. Between September 2020 and December 2020, 43 States submitted survey responses and plans' annual MLR reports. We reviewed and summarized States' survey responses and analyzed plans' MLR reports for completeness.

# CMS Has Opportunities To Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios

## Key Takeaways

Although States reported that most Medicaid managed care plans submitted medical loss ratio (MLR) reports, nearly half of plans MLR reports were incomplete. In addition, some States did not review selected MLR data elements for accuracy. These gaps highlight the need for stronger State oversight of MLR reporting.

Managed care has replaced fee-for-service as the predominant payment model in Medicaid. Federal MLR requirements were established to ensure that Medicaid managed care plans spend most of their revenue on services related to the health of their enrollees, thereby limiting the amount that plans can spend on administration and keep as profit.

The Federal MLR is the percentage of premium revenue that a managed care plan spent on covered health care services and quality-improvement activities in a 12-month period. Plans must submit annual MLR reports to

the State with 13 data elements, including the MLR, the data needed to calculate the MLR, and other numeric and descriptive data. In turn, States must take into account plans' calculated MLRs as part of the process for setting plans' future capitation rates. States must set capitation rates so that plans would "reasonably achieve" the Federal MLR standard of at least 85 percent.

## What OIG Found

States reported that most Medicaid managed care plans submitted MLR reports as required. However, we found that 49 percent of the 495 MLR reports reviewed were incomplete. These incomplete MLR reports were missing at least one of seven numeric data elements that are essential to the MLR calculation. This missing data occurred across four of the seven MLR report data elements—non-claims costs; taxes and fees; member months; and quality-improvement activity expenses. Two-thirds of the incomplete MLR reports did not contain fields for plans to even enter amounts for at least one of these data elements.

The data element for non-claims costs, generally defined as plans' expenses for administrative services, accounted for the majority of incomplete MLR reports. Missing data on non-claims costs may reduce transparency on managed care spending and limit States' ability to

ensure that plans are appropriately spending Medicaid dollars on the health of enrollees rather than excessive administrative expenses. Even when the data element for non-claims costs appeared in MLR reports, plans did not report this data in a consistent manner.

States indicated that they review MLR reports for completeness, but few States identified incomplete reports. In addition, although 26 States reported that they review MLR data elements for accuracy for all of their plans, 16 States responded that they did not review the accuracy of selected MLR data elements for all or some of their plans.

### **What OIG Recommends and How the Agency Responded**

We recommend that—to strengthen States’ oversight of MLR reporting and better ensure that plans are using Federal dollars for patient care—CMS (1) design an annual MLR reporting template for States to provide to their Medicaid managed care plans; (2) clarify that States should verify the completeness of their plans’ MLR reports; (3) clarify that States should review their plans’ MLR reports to verify the accuracy of reported data elements; and (4) provide additional guidance to States regarding plans’ reporting of non-claims costs in MLR reports. CMS concurred with all recommendations.

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# BACKGROUND

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## OBJECTIVE

To examine States' oversight of Medicaid managed care plans' compliance with medical loss ratio (MLR) requirements.

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Managed care has replaced fee-for-service as the predominant payment model in Medicaid. State and Federal expenditures on Medicaid managed care are growing and in 2020 totaled \$360 billion, which was 55 percent of total Medicaid expenditures in that year.<sup>1</sup> With its 2016 Medicaid managed care regulations (hereinafter referred to as the 2016 Final Rule), the Centers for Medicare & Medicaid Services (CMS) chose MLRs as a policy tool to apply across the program to ensure appropriate stewardship of managed care funds. Federal MLR requirements were established to ensure that Medicaid managed care plans spend most of their premium revenue on covered health care services and quality-improvement activities, thereby limiting the amount that plans can spend on administration and keep as profit.<sup>2</sup> States' oversight of their plans' annual MLR reporting is critical to improve fiscal transparency, monitor costs, and promote high-quality care in Medicaid managed care.

## Medicaid Managed Care

Medicaid is a complex landscape of State-specific programs that offer health coverage to eligible groups, such as low-income adults, pregnant women, children, and individuals with disabilities. States administer and finance Medicaid using State and Federal funds. States have the flexibility to structure their programs on the basis of their unique needs within Federal regulations. For Medicaid managed care, States contract with and oversee the health plans that operate in the State. States pay these contracted managed care plans a monthly premium, known as a capitation payment, for each enrollee regardless of whether the enrollee uses any covered services each month.

## Medicaid Managed Care MLRs

Managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs), hereinafter collectively referred to as managed care plans, are subject to Federal MLR requirements.<sup>3</sup> CMS directed States to include contract requirements for their Medicaid managed care plans to calculate and report MLRs, beginning on or after July 1, 2017.<sup>4</sup>

The Federal MLR is the percentage of premium revenue that a managed care plan spent on covered health care services and quality-improvement activities in

a 12-month period.<sup>5</sup> CMS requires States to set their managed care plans' capitation rates so that plans would "reasonably achieve" MLRs of at least 85 percent for contracts starting on or after July 1, 2019.<sup>6</sup> As part of the process for setting capitation rates, States must take into account the calculated MLRs that their managed care plans have reported.<sup>7</sup> States have the option to require plans to meet a minimum MLR. If States require this, the minimum MLR must be at least 85 percent.<sup>8</sup> Previous OIG work found that most States established minimum MLRs by September 2020.<sup>9</sup> States that set minimum MLRs also have the option to require plans to repay the State if a plan fails to meet the State-set minimum MLR (hereinafter referred to as a remittance).<sup>10</sup>

Federal regulations further established States' oversight of their plans' MLR reporting by requiring States to annually submit to CMS a summary description of each plan's MLR report.<sup>11</sup> As part of their monitoring of managed care programs, States also must use MLR data to improve their programs' performance.<sup>12</sup> CMS explained in its May 2019 guidance that States must ensure that plans comply with MLR requirements and should routinely audit MLR data and calculations reported by their plans. CMS specified that States should ensure that revenues, expenditures, and other amounts are appropriately identified to distinguish payments for healthcare services or quality-improvement expenses from administrative services, taxes, or other activities.<sup>13</sup>

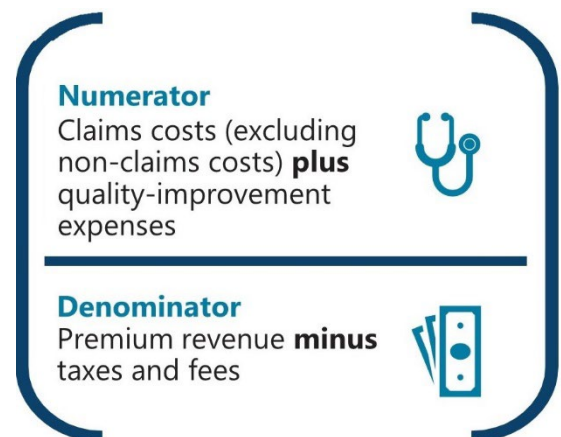
## MLR calculation

The calculated MLR is the percentage of premium revenue that a managed care plan spent on covered health care services and quality-improvement activities in

a 12-month period, as shown in Exhibit 1. Specifically, the MLR numerator is the sum of incurred claims (hereinafter referred to as claims costs) and expenditures on health care quality-improvement activities (hereinafter referred to as quality-improvement expenses).<sup>14, 15</sup> Non-claims costs—generally defined as plans' expenses for administrative services—are excluded from claims costs in the numerator.<sup>16</sup> The MLR denominator is premium revenue minus taxes, licensing fees, and regulatory fees (hereinafter referred to as taxes and fees).<sup>17</sup>

The number of member months is a measure of plan size and is used to determine whether a plan is large enough (i.e., has sufficient claims experience) to

**Exhibit 1: The calculated MLR**



Source: 42 CFR § 438.8.

Note: MLRs for managed long-term services and supports plans smaller than 630 member months and for standard plans smaller than 5,400 member months are considered non-credible and assumed to meet the MLR standard.

calculate a credible MLR and, therefore, be subject to the Federal MLR standard of 85 percent. Small plans are eligible to add credibility adjustments (ranging from 1 to 8.4 percentage points) to their calculated MLRs. If a plan is quite small, the plan’s MLR is considered to be non-credible and assumed to meet or exceed the MLR standard.<sup>18</sup>

## MLR reporting

States must require plans to submit annual MLR reports (hereinafter referred to as MLR reports) to the State within 12 months after the end of the MLR reporting year.<sup>19</sup> Plans must attest to the accuracy of the MLR calculation when submitting the MLR report to the State.<sup>20</sup>

Federal MLR reporting requirements indicate that a plan’s MLR report must contain, at minimum, 13 specific data elements, as shown in Exhibit 2.<sup>21</sup> States may require plans to submit the MLR report in any format, including using a standardized MLR reporting template created by the State. CMS had not provided States a standardized format for the MLR report as of 2020 but may consider developing one in the future.<sup>22</sup>

### Exhibit 2: The 13 data elements required in MLR reports

8 data elements applicable to all plans	4 data elements applicable to some plans	1 data element not yet applicable to any plans
<p><i>To calculate MLR numerator:</i></p> <ul style="list-style-type: none"> <li>• Claims costs</li> <li>• Non-claims costs (to be excluded from claims costs)</li> <li>• Quality-improvement expenses</li> </ul> <p><i>To calculate MLR denominator:</i></p> <ul style="list-style-type: none"> <li>• Premium revenue</li> <li>• Taxes and fees</li> </ul> <p><i>MLR result and other data:</i></p> <ul style="list-style-type: none"> <li>• Calculated MLR</li> <li>• Member months</li> <li>• Comparison with financial audit</li> </ul>	<ul style="list-style-type: none"> <li>• Expense allocation method(s)</li> <li>• Aggregation method</li> <li>• Any credibility adjustment applied</li> <li>• Any remittance owed to the State, if applicable</li> </ul>	<ul style="list-style-type: none"> <li>• Expenditures on activities related to fraud prevention consistent with regulations adopted for the private market at 45 CFR part 158</li> </ul>

Source: OIG review of 42 CFR § 438.8.

Eight of the 13 required data elements are applicable to all managed care plans, 4 are applicable to some plans, and the remaining element is not yet applicable to any plans. There are eight data elements applicable to all plans—seven numeric and one descriptive data element. The numeric data elements include non-claims costs. This data element is defined in Federal MLR regulation as expenses for administrative services that are not for claims; quality improvements; or taxes and fees.<sup>23</sup> The regulation also specifies that non-claims costs should be excluded from claims costs, and lists four non-claims costs, including two types of payments to third-party



vendors.<sup>24</sup> In May 2019 guidance, CMS noted that States must require plans to collect MLR data from their third-party vendors that provide claims adjudication activities to ensure that plans identify and exclude third-party vendors' non-claims costs from the plans' claims costs.<sup>25</sup> For the descriptive data element in this group, plans describe how the information in the MLR report compares with the plan's audited financial report required in Federal regulation (hereinafter referred to as comparison with financial audit).

The data elements applicable to some plans include two numeric (i.e., credibility adjustment, remittance) and two descriptive (i.e., expense allocation method(s), aggregation method) data elements. Plans must complete these data elements depending on the States' MLR requirements or on specific plan characteristics. For example, plans are expected to describe the aggregation method used to combine MLR data for all covered Medicaid eligibility groups. However, as allowed by regulation, States may require separate MLR calculations and reporting for specific populations.<sup>26</sup> Therefore, these States' plans would not have aggregation methods to describe.

The remaining data element in Exhibit 2, expenditures on activities related to fraud prevention, is not yet applicable to any plans. Although specified in the Federal MLR regulations, this data element is not yet part of the MLR calculation.<sup>27</sup> In a technical correction, CMS explained that the reporting requirements for fraud prevention expenses were erroneously finalized in the 2016 Final Rule. The 2020 Final Rule amended fraud prevention expenses to be consistent with private market MLR regulations. Fraud prevention expenses will be added to the Medicaid managed care MLR calculation if and when the private market regulations define these types of expenses.<sup>28</sup>

## Related OIG work

In 2021, OIG issued a data brief that provided a national landscape of the MLRs that plans have achieved. This data brief demonstrated that States that chose to establish minimum MLRs with remittance requirements may recoup millions of Medicaid dollars from plans that failed to meet State-set minimum MLRs.<sup>29</sup> Specifically, OIG found that 92 percent of plans' MLRs met or exceeded the Federal MLR standard of 85 percent. However, 19 plans reported owing \$198 million to States that chose to establish minimum MLRs with remittance requirements.

In 2021, OIG also issued an audit that examined Minnesota's Medicaid managed care plans' MLRs. OIG found that one of eight plans did not achieve an 85-percent MLR. Minnesota could have saved \$82,427 in calendar year 2017 if Minnesota had required this plan to meet a State-set minimum of 85 percent and pay a remittance. However, during the time period of OIG's review, the Federal Medicaid managed care MLR requirements were not yet in effect for this State. OIG did not issue a recommendation because Minnesota incorporated a remittance requirement

beginning calendar year 2018 for plans that do not meet an MLR of at least 85 percent.<sup>30</sup>

From 2015 to 2017, OIG issued a series of seven State-specific audits that determined whether potential Medicaid savings could have been realized if the State had implemented a minimum MLR requirement.<sup>31</sup> These audits covered time periods before CMS incorporated MLRs into the Federal Medicaid regulations. The audits used a hypothetical Medicaid MLR calculation based on a formula similar to the Federal MLR standard for certain private insurers and Medicare Advantage plans. These audits found that five States could have realized savings if they had required an 85-percent minimum MLR and required plans to return money if the minimum MLR was not met.

## Methodology

We requested information from all 51 State Medicaid agencies (including the District of Columbia) regarding their implementation of Federal MLR requirements as of September 1, 2020. All 51 States responded to our request. The 43 States with Medicaid managed care plans subject to Federal MLR requirements as of September 1, 2020, submitted a self-administered online survey and their plans' MLR reports.<sup>32</sup> However, one State had not obtained any of its plans' MLR reports prior to submitting the survey to OIG. As such, this State did not complete the sections of the online survey about reviewing MLR reports for completeness and accuracy. Therefore, the analyses of these sections of the State survey responses reflect only 42 States.

We reviewed and summarized States' responses to the online survey. We calculated frequencies for all numeric and categorical survey responses. Specifically, we determined the number of States that reported including MLR requirements in plans' contracts, and the number of States that said they received complete and accurate MLR reports. We also analyzed survey data to determine whether States reported that they reviewed the accuracy of all eight data elements that are applicable to all plans (i.e., claims costs; non-claims costs; quality-improvement expenses; premium revenue; taxes and fees; calculated MLR; member months; and comparison with financial audit).

We reviewed the completeness of the plans' MLR reports that States submitted to us for review.<sup>33</sup> Specifically, we reviewed 495 MLR reports for the 7 numeric data elements that are applicable to all plans (i.e., claims costs; non-claims costs; quality-improvement expenses; premium revenue; taxes and fees; calculated MLR; and member months). We excluded from this analysis the comparison with the financial audit data element because, even though it is applicable to all plans, it is not required to calculate the MLR. We also excluded from this analysis the data elements that are applicable only to some plans and the fraud prevention expenses data element that is not yet applicable to any plans. We determined whether each of these seven data

elements (1) contained a number; (2) contained a zero or a dash; (3) was blank; or (4) could not be found in the MLR report. We indicated that a data element was not found if the MLR report did not delineate or label a field for plans to enter an amount for that data element.

We determined whether each of the seven numeric data elements was complete. For claims costs, non-claims costs, premium revenue, the calculated MLR, and member months data elements we considered these data elements complete if plans entered amounts greater than zero and did not leave these data elements blank. For the quality-improvement expenses and taxes and fees data elements, we considered each of these data elements complete if plans entered an amount, a zero, or a dash. Plans may not have quality-improvement spending or taxes in an MLR reporting year. Additionally, if we could not find a label or a field for a plan to enter information for a data element, we considered that data element incomplete. Finally, we determined the number of reports that were complete (i.e., reports that included complete data for all seven data elements) or incomplete (i.e., reports that were missing information for one or more of the seven data elements).

## Limitations

We did not independently verify the self-reported information from State Medicaid agencies. We also did not independently verify the data contained in the plans' MLR reports that States submitted to us in response to our information request. However, we reviewed the information for inconsistencies and when we identified them, we followed up with State Medicaid agencies to resolve these inconsistencies.

## Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

# FINDINGS

## States reported that most Medicaid managed care plans submitted MLR reports as required

According to States, most Medicaid managed care plans submitted Federally required MLR reports. As of September 1, 2020, 39 of the 43 States with managed care plans reported receiving all MLR reports from their plans. One State indicated that it had not obtained any of the required MLR reports by September 1, 2020, but noted that it received these reports by the end of 2020. This State granted extensions to plans due to the State's delays with developing an MLR reporting template and the need for plans to update their information systems. For each of the remaining three States, specific types of plans had not yet submitted their MLR reports.

The three States with unsubmitted MLR reports had not taken actions against plans that had not submitted the reports. Two of the States were waiting for specific guidance from CMS for their Medicare-Medicaid plans and the remaining State was reviewing the delays for its small dental and behavioral health plans.

Some States reported challenges with plans submitting MLR reports on time. Four States noted that plans requested extensions to submit MLR reports because of data problems, technical reasons, or the COVID-19 pandemic. To obtain reports not submitted by the deadline, a few States communicated with plans by email or escalated the issue to the plans' management. Appendix A includes additional information about States' deadlines for MLR reports.

All States reported that they have the authority to take actions with their plans if plans do not comply with annual MLR reporting requirements. Most commonly, States indicated that they could require plans to revise and resubmit MLR reports, escalate compliance issues to plan management, and implement corrective actions with their plans. Appendix B contains additional information about other actions States have the authority to take with plans that do not comply with annual MLR reporting requirements.

## States communicated their MLR reporting requirements in plans' contracts, as required, and through policy and guidance documents

States included MLR reporting requirements in plans' contracts, policies, guidance, and through MLR reporting templates. States included these requirements in their Medicaid managed care plan contracts with two exceptions. One State indicated that it incorporates these requirements into only some plans' contracts. Another State noted that its dental plans' contracts do not include a requirement to submit

MLR reports. In accordance with Federal regulations, States must ensure, through plan contracts, that their MCOs, PIHPs, and PAHPs calculate and report MLRs.<sup>34</sup>

Seven States reported challenges with incorporating the MLR requirements into plans' contracts, and a few of them described these challenges. One State explained that MLR requirements were included in the State's MLR reporting template but used minimal language about MLR requirements in plans' contracts. Another State explained it worked with its actuary to develop contract requirements and two States inquired about the availability of draft contract language in their responses.

In addition to including MLR requirements in plans' contracts, 30 States indicated that they developed written policies or procedures regarding plans' submission of MLR reports. States reported providing guidance or information to their plans about MLR reporting requirements by email or regular mail, and through reminders and technical assistance. States also indicated that they developed an annual MLR report template for plans to submit their MLR data. A few of these States indicated that plans submit the MLR reports through an online reporting tool.

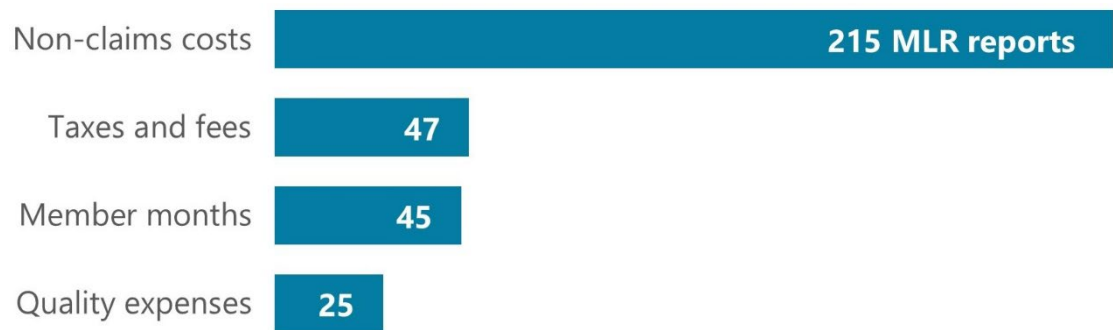
## Nearly half of MLR reports reviewed were incomplete, even though States indicated that they check MLR reports for completeness

### Gaps existed in plans' reporting of four data elements

States received many incomplete MLR reports from their plans.<sup>35</sup> Specifically, 49 percent (244 of 495) of MLR reports reviewed by OIG were missing at least 1 of the 7 numeric data elements applicable to all plans. Plans submitted these reports to 28 different States. Missing data occurred across four MLR report data elements—non-claims costs; taxes and fees; member months; and quality-improvement expenses—as shown in Exhibit 3. Every MLR report in OIG's review contained complete data for the other three numeric data elements: claims costs, premium revenue, and the calculated MLR.

Missing data may prevent plans from calculating accurate MLRs and make it difficult for States to conduct oversight of plans' MLR calculations. Of the 244 MLR reports missing data, most (172) were missing 1 of the 4 data elements. The remaining 72 MLR reports were missing 2 or 3 data elements.

### Exhibit 3: Missing data occurred across four data elements.<sup>a</sup>



Source: OIG analysis of 495 MLR reports with reporting periods ending in 2018 or 2019.

<sup>a</sup>The number of reports do not sum to 244 because incomplete reports could have more than 1 missing data element.

The data element for non-claims costs, generally defined as expenses for administrative services, accounted for the majority of incomplete MLR reports. If a plan fails to exclude non-claims costs from claims costs, as required, the MLR numerator would be inflated. As a result, the calculated MLR would be too high and may erroneously meet the Federal MLR standard of at least 85-percent. The MLR standard is intended to ensure that at least 85 percent of plans' revenue is spent on covered health care services and quality-improvement activities, thereby limiting the amount that plans spend on administrative services.

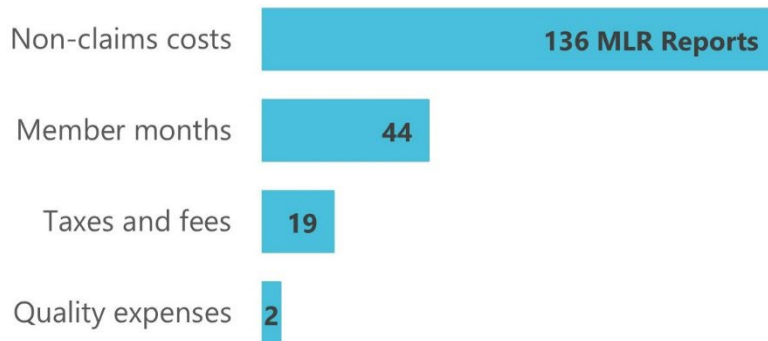
Of the MLR reports that delineated or labelled a field to enter non-claims costs, 79 did not include dollar amounts for the non-claims costs data element. We examined the premium revenue amounts in these reports and identified 24 reports with premium revenue amounts greater than \$500 million, yet the non-claims costs data element was blank or \$0.00. In response to specific questions regarding the non-claims costs data element, CMS explained to OIG that it would be very unusual and unlikely for a plan not to have an amount for non-claims costs in an MLR reporting year.<sup>36</sup>

#### **Federally required data elements did not appear in two-thirds of incomplete MLR reports**

At least one of four data elements (non-claims costs; taxes and fees; member months; quality-improvement expenses) did not appear anywhere in 67 percent (163 of 244) of incomplete MLR reports. In other words, these reports—submitted by plans to 15 States—did not contain fields for plans to even enter amounts for at least one of these data elements.

The non-claims costs data element accounted for the majority of these reports, as shown in Exhibit 4. Of the 215 MLR reports missing non-claims costs, 136 did not delineate fields for plans to enter non-claims cost amounts.

**Exhibit 4: For the four data elements with missing data, many MLR reports had no field for plans to enter these data.**



Source: OIG analysis of 495 MLR reports with reporting periods ending in 2018 or 2019.

Even when the non-claims costs data element appeared in MLR reports, plans did not report it in a consistent manner. Some MLR reports included one line-item and others included many line-items for the non-claims costs data element. In more than two-thirds of these MLR reports, plans used the explicit label “non-claims costs.” However, the remaining MLR reports did not contain a field with this explicit label. Instead, these reports contained fields with a variety of labels such as general phrases about administrative costs and/or some specific phrases including marketing and claims processing/member services.

**States reported that they review MLR reports for completeness, but few States identified incomplete MLR reports**

Forty-two States indicated that they review MLR reports to determine whether they are complete.<sup>37</sup> To ensure completeness, many States responded that they visually review MLR reports to identify missing data elements. Thirty-three States reported that they required plans to submit a self-attestation that MLR reports are complete. States also indicated that they use the State actuary or State data analytics team or hire a third-party contractor to review the reports for completeness. Appendix C includes additional methods States use for ensuring complete MLR reports.

Seven States reported that all or some of their plans did not submit complete MLR reports. A couple of these States indicated that their plans seemed unclear about MLR reporting requirements. Another State explained that it did not include fields in its MLR reporting template for plans to enter some of the MLR data elements specified in Federal MLR regulations. As such, the State had not initially identified these data elements as missing, and therefore, did not take action against the plans. However, upon receipt of OIG’s survey, the State revised its MLR reporting template.

Six of these seven States reported taking actions to address plans that submitted incomplete MLR reports, such as requiring plans to revise and resubmit MLR reports and following up to obtain data elements that had not been submitted. Two of the



six States escalated the issue to the plans' management and one of these two States also amended the plans' contract language and implemented a corrective action plan.

Two States described specific challenges that incomplete MLR reports present. One of them noted that incomplete MLR reports cause delays with the State's analysis of the MLR reports. The other State indicated that incomplete MLR reports require State resources to follow up with plans to obtain corrected reports.

## Sixteen States reported that they did not review all MLR data elements for accuracy, as recommended by CMS

Although many States indicated that they review the accuracy of required MLR data elements, not all States did so. As shown in Exhibit 5, 16 of 42 States<sup>38</sup> indicated that they did not review the accuracy of some of the 8 data elements that are applicable to all plans (i.e., claims costs; non-claims costs; quality-improvement expenses; premium revenue; taxes and fees; the calculated MLR; member months; or the comparison with financial audit). Currently,

CMS recommends, but does not require, that States determine the accuracy of plans' MLR reporting.<sup>39</sup><sup>40</sup> Most commonly, these States did not review the accuracy of the comparison with financial audit; non-claims costs; and taxes and fees data elements. For the comparison with financial audit descriptive data element, a couple of States explained that plans' MLR reports and plans' audited financial reports were not comparable because the audited financial reports covered different timeframes from the MLR reports or included programs other than Medicaid.

Five of the 16 States did not always review at least half of these data elements. One of these States responded that it only reviews the calculated MLR for accuracy. Another State said it reviews the calculated MLR for all plans, but the remaining seven data elements for only some plans. This State explained that it gives the MLR reports from their dental-only plans "a lighter review." A third State reviews only the calculated MLR and member months data elements and explained that it limits its review because the State does not use the MLR calculation to determine whether plans must return funds to the State. A fourth State reviews the claims costs, premium revenue, calculated MLR, and member months data elements, but for only some of its plans, noting that different internal program units reviewed MLR reports for different types of plans. The remaining State indicated it reviews all eight data elements, but only for some of its plans. The State does not review the accuracy of

### Exhibit 5: Sixteen States did not review the accuracy of selected MLR data elements for all or some plans.

States' Review of Data Elements Applicable to All Plans	Number of States
All data elements reviewed for all plans	26
Some data elements not reviewed for all or some plans	16
<b>Total</b>	<b>42</b>

Source: OIG analysis of surveys submitted by States in 2020.



any MLR data from its dental plans because the State does not require dental plans to meet a minimum MLR.

### **States reported that they review MLR data elements for accuracy by comparing them to regulatory language and plans' other financial records**

Most States (34 of 42) reported that they review the accuracy of the numeric MLR data elements that make up the calculated MLR (i.e., claims costs; non-claims costs; quality-improvement expenses; premium revenue; and taxes and fees). Many of these States indicated that they compared these numeric data elements to the description of the data element in the Federal MLR regulation. States also responded that they verify numeric data elements using sources such as plans' prior MLR reports, plans' audited financial reports, and plans' Medicaid claims data. Appendix D provides additional information about other sources States used to verify the accuracy of some of these numeric data elements.

For the calculated MLR data element, 32 States indicated that the reporting template plans use to submit MLR reports contains spreadsheet features to check MLR calculations. Seven States noted that they manually recalculate the MLR to check for accuracy.

For the 3 descriptive data elements (i.e., comparison with financial audit, expense allocation method(s), and aggregation method), 26 States indicated that they reviewed them for accuracy. Some States characterized their reviews of the descriptive data elements in general terms, with phrases like "reviewed for reasonableness" and "validate the accuracy." However, other States described specific strategies for determining the accuracy of the descriptive data elements. For both the comparison with financial audit data element and expense allocation method(s) data element, States indicated that they compared them to plans audited financial reports, recent quarterly financial reports, and prior financial or MLR reports. With respect to the aggregation method data element, four States responded that they use an MLR reporting template that automatically aggregates the MLR data across eligibility groups.

Many States clarified that the review for accuracy of all or some of the numeric and descriptive data elements was conducted by third-party contractors, including accountants and actuaries. For example, 28 States hired a third-party contractor to recalculate the plan's reported MLR. Some States responded that third-party contractors ensure that MLR data are consistent across sources and follow up with plans to request clarification, verification, or additional data.

## Fourteen States found errors within plans' MLR reports and eleven States took actions with plans

Fourteen States reported that they found MLR reports that contained inaccurate numeric or descriptive data for all (2 States) or some (12 States) of their managed care plans. These States indicated that inaccuracies occurred for the premium revenue; claims costs; non-claims costs; taxes and fees; quality-improvement expenses; and member months data elements.

*"Plan submits an incomplete MLR template which translates to incorrect data and calculations"*

**-A State describing a common inaccuracy of MLR reports**

A few States noted that inaccuracies in MLR reports included plans leaving a data element blank, plans entering information on the wrong line of a report, and differences between amounts in the MLR report and the audited financial report.

Many of these States took action when they identified managed care plans that submitted inaccurate data in their MLR reports. Nine States required plans to revise and resubmit the MLR report. Two States explained that the State adjusted plans' MLR reports based on recommendations made by their third-party contractors that review the reports. Five States escalated the issue with inaccurate MLR reports to plans' management. One State implemented a corrective action plan to address the inaccurate data and revised the plan's contract language.

Three States indicated that they had not taken any action with plans that submitted MLR reports that contained inaccurate data. Two of these States had not yet finalized their reviews, and the remaining State noted that the errors it found were minimal and no action was necessary.

## Some States were uncertain about their MLR oversight responsibilities and wanted additional guidance or tools from CMS

Fifteen States responded that CMS's guidance about States' oversight of these reporting requirements, including monitoring MLR reports for completeness and accuracy, were insufficient. For example, three States noted that they had to interpret the Federal MLR regulations and design their own MLR process without clear direction from CMS. One of these States noted that it had trouble finding a point of contact for MLR questions. Another State indicated that it

*"It would be helpful to have insight into CMS's expectation of the activities needed to demonstrate appropriate oversight by [the State]."*

**-A State noting need for additional CMS guidance**

had to confirm plans' MLR calculations without training or guidance from CMS about how to do so.

Some States indicated that assistance from CMS, such as technical assistance and/or tools, would help with MLR oversight. For example, three States requested that CMS provide a standardized MLR reporting template. With respect to automating the

*“Given newer requirement [the State] would appreciate some standardization from CMS [for] how reporting should occur. Such as having a standardized reporting template.”*

**-A State requesting an MLR reporting template**

review of plans' MLR reports, one State expressed the need for an electronic submission platform or software. However, two States explained that their information technology limitations would make it difficult to automate the review of plans' MLR reports. To ensure appropriate MLR oversight, one State suggested CMS provide a best-practices document and another State requested a checklist from CMS that defines MLR reporting expectations and deadlines.

# CONCLUSION AND RECOMMENDATIONS

CMS chose MLRs as a policy tool to apply across the program to ensure appropriate stewardship of Medicaid managed care funds. Federal MLR requirements are intended to ensure that managed care plans spend most of their premium revenue on covered health care services and activities that improve enrollees' quality of care, thereby limiting the dollars plans can spend on administration and keep as profit.

States' oversight of their plans' annual MLR reporting is critical to improve fiscal transparency, monitor costs, and promote high-quality care in Medicaid managed care. States must conduct robust oversight of their plans' MLR reports to effectively leverage the MLR calculation to ensure appropriate Medicaid managed care spending.

Our findings indicate that States succeeded in ensuring that most Medicaid managed care plans submitted their MLR reports to the State as required. However, nearly half of the reports that plans submitted were incomplete, which may present a substantial obstacle to States' oversight efforts and ability to ensure accurate MLRs. Specifically, the data element for non-claims costs, generally defined as plans' expenses for administrative services, accounted for the majority of incomplete MLR reports. Missing data on non-claims costs may reduce transparency into managed care spending and limit States' ability to ensure that plans are appropriately spending Medicaid dollars on the health of enrollees rather than excessive administrative expenses.

Our findings also indicate that data elements were missing from the reporting templates plans use to provide MLR data to States, which may result in incomplete reports. An incomplete reporting template would make it exceedingly difficult for States to identify gaps in plans' reports, and in turn, limit their ability to ensure the accuracy of the reports.

Incomplete and inaccurate MLR reporting may prevent States from verifying the integrity of plans' MLR data and from using accurate MLRs to set plans' future capitation rates, as required. We recommend that—to strengthen States' oversight of plans' MLR reporting and better ensure that plans are using Federal dollars for patient care—CMS:

## **Design an annual MLR reporting template for States to provide to their Medicaid managed care plans**

To ensure that plans report all required MLR data elements, CMS should develop a nationwide MLR reporting template that States could use to collect MLR reports from their plans. This template would delineate fields for plans to report, at minimum, the

data elements specified in Federal MLR regulations. This template would be designed to prevent plans from leaving these data elements blank and would help to ensure the completeness of MLR reporting across all States.

## Clarify that States should verify the completeness of their Medicaid managed care plans' MLR reports

Plans' MLR reports are intended to provide States with financial information they need to oversee Medicaid managed care spending. Complete reports—containing, at minimum, the data elements specified in MLR regulations at 42 CFR § 438.8(k)—are essential to States' oversight of plans' MLR calculations and to fiscal transparency in Medicaid managed care. Current Federal MLR regulations do not explicitly require States to verify the completeness of their plans' MLR reports and CMS guidance to States does not sufficiently detail States' responsibility for ensuring that plans' MLR reports are complete. CMS should clarify to States the importance of verifying the completeness of plans' MLR reports. For example, CMS could:

- emphasize to States the importance of reviewing MLR reports for completeness and following-up with plans that submit incomplete reports;
- organize and publicize periodic conference calls and/or a virtual community of practice for States and CMS to discuss MLR oversight roles and responsibilities, highlight best practices for obtaining complete MLR reports, and share successful methods and strategies for verifying completeness;
- amend Federal MLR regulations to require States to verify that MLR reports are complete and identify in regulation or guidance the actions CMS could take with States that do not verify the completeness of plans' MLR reports.

## Clarify that States should review their Medicaid managed care plans' MLR reports to verify the accuracy of reported data elements

Federal MLR regulations require plans to attest to the accuracy of the MLR calculation when submitting their MLR reports to the State.<sup>41</sup> These regulations do not explicitly require States to review the accuracy of plans' MLR reports, but inaccurate MLRs and underlying data elements cast doubt on the integrity of plans' MLR reporting. CMS should clarify States' oversight responsibilities with respect to the accuracy of the data elements specified in Federal MLR regulations at 42 CFR § 438.8(k). For example, CMS could:

- develop and issue guidance to States that establishes minimum standards for States' reviews of the accuracy of reported MLR data elements;

- organize and publicize periodic conference calls and/or a virtual community of practice for States and CMS to discuss MLR oversight roles and responsibilities, highlight best practices for reviewing MLR data elements for accuracy, and share successful methods and strategies for ensuring accurate reporting;
- amend Federal MLR regulations to require States to review the accuracy of the data elements in plans' MLR reports and identify in regulation or guidance the actions CMS could take with States that do not verify the accuracy of reported MLR data elements.

## **Provide additional guidance to States regarding Medicaid managed care plans' reporting of non-claims costs in MLR reports**

Federal MLR regulations require plans to exclude non-claims costs—generally defined as expenses for administrative services—from claims costs in the MLR numerator to ensure that administrative expenses are not counted as spending on health care services for enrollees.<sup>42</sup> In addition to its May 2019 guidance that plans must exclude third-party vendors' non-claims costs from the plans' claims costs, CMS should provide specific guidance to States to clarify its requirements and expectations for plans' identification and reporting of the non-claims costs data element in MLR reports. Our findings demonstrate that plans are frequently failing to report non-claims costs. Providing specific guidance about the types of administrative expenses that should be considered and reported as non-claims costs for MLR purposes could promote better compliance with this requirement. Clear, specific CMS guidance for the non-claims costs data element could also enhance the transparency of plans' administrative expenses and help to ensure appropriate MLR reporting.

# AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with all of OIG's recommendations and has actions planned for implementation.

In response to our recommendations, CMS stated that it plans to develop a handbook for State oversight of MLR reporting as part of a comprehensive managed care oversight strategy. CMS anticipates that the handbook will include:

- a recommended template for plans' MLR submissions and information on leading MLR oversight practices, in response to our first recommendation;
- information clarifying that States should (1) verify the completeness of their plans' MLR reports and (2) review plans' MLR reports to verify the accuracy of reported data elements, in response to our second and third recommendations; and
- information on the reporting of non-claims costs in MLR reports, in response to our fourth recommendation.

OIG appreciates CMS's planned efforts to improve monitoring and oversight of Medicaid managed care programs and looks forward to reviewing the handbook when it is complete.

Appendix E includes the full text of CMS's comments.

# DETAILED METHODOLOGY

## Data Sources

We requested information from all 51 State Medicaid agencies (including the District of Columbia) regarding their implementation of Federal MLR requirements as of September 1, 2020. All 51 States responded to our request. The 43 States with Medicaid managed care plans subject to Federal MLR requirements as of September 1, 2020, submitted all requested information, which included (1) a self-administered online survey, (2) an accompanying information request, and (3) plans' MLR reports.<sup>43</sup>

### State survey

The online survey included questions about States' oversight of plans' MLR reporting, including whether States included MLR requirements in plans' contracts and received MLR reports from plans, and the extent to which States reviewed the MLR reports for completeness, and accuracy. We also asked States about the challenges they encountered with overseeing MLR requirements.

### Information request

The information request asked States to identify each plan subject to Federal MLR requirements as of September 1, 2020. States provided descriptive information for each plan, including the type of managed care plan and the State-set minimum MLR for the plan, if any.

### Plans' MLR reports

We requested that States provide OIG the MLR report(s) for each Medicaid managed care plan subject to Federal MLR requirements. In total, we reviewed 495 MLR reports submitted by States for reporting periods ending in 2018 or 2019.<sup>44</sup> Our analysis included 293 MLR reports with reporting periods ending in 2018 and 202 MLR reports with reporting periods ending in 2019. States submitted MLR reports for the following types of plans: MCOs; PIHPs; PAHPs; MCOs plus managed long-term services and supports plans (MLTSS); MLTSS-only plans; Medicare-Medicaid plans; behavioral health plans; and dental plans. We did not request from States information about CHIP. However, when States provided MLR reports that contained combined MLR data for Medicaid and CHIP, we included these data in our review.

Federal MLR regulations consider plans' MLRs to be "non-credible" if they have less than 5,400 member months for standard plans and less than 630 member months for MLTSS-only plans.<sup>45</sup> Plans with non-credible MLRs are expected to submit



MLR reports to their States for review.<sup>46</sup> We included in the analysis MLR reports from 11 plans that reported as non-credible.

Four States had plans that were Medicare-Medicaid financial alignment demonstrations. These States, along with CMS, directed these plans to follow either Medicare regulations or a combination of Medicare and Medicaid regulations for MLR requirements. We, therefore, excluded from the analysis 44 plans from these States.

## State Survey Analysis

All 43 States that had plans subject to Federal MLR requirements as of September 1, 2020, submitted responses to the online survey. However, one State did not complete all sections of the survey because the State had not obtained any of its plans' MLR reports prior to submitting the survey to OIG. As such, this State did not complete the sections of the online survey about reviewing MLR reports for completeness and accuracy. Therefore, the analyses of these sections of the State survey responses reflect only 42 States.

We reviewed and summarized States' responses to the online survey. We calculated frequencies for all numeric and categorical survey responses. Specifically, we determined the number of States that reported including MLR requirements in plans' contracts, and the number of States that said they received complete and accurate MLR reports. We also analyzed survey data to determine whether States reported that they reviewed the accuracy of all eight data elements that are applicable to all plans. As noted in the background, 8 of the 13 required MLR data elements are applicable to all plans (i.e., claims costs, non-claims costs; quality-improvement expenses; premium revenue; taxes and fees; calculated MLR; member months; and comparison with financial audit). We excluded from this analysis the remaining five data elements.

For narrative survey responses, we analyzed themes across States and noted unique and informative quotes. We examined States' practices for and challenges with oversight of MLR requirements and reporting.

## Completeness Analysis of Plans' MLR Reports

We reviewed the completeness of plans' 495 MLR reports that States submitted for our review. For the purpose of our completeness analysis, we focused on seven numeric data elements that are applicable to all plans (i.e., claims costs; non-claims costs; quality-improvement expenses; premium revenue; taxes and fees; calculated MLR; and member months). We excluded from this analysis the comparison with financial audit data element because even though it is applicable to all plans, it is not required to calculate the MLR. We also excluded from this analysis the four data elements that are applicable only to some plans and the fraud prevention expenses data element that is not yet applicable to any plans.<sup>47</sup> We determined whether each

of these seven data elements (1) contained a number; (2) contained a zero or a dash; (3) was blank; or (4) could not be found in the MLR report. We indicated that a data element was not found if the MLR report did not delineate or label any field for a plan to enter an amount for a data element.

For the non-claims costs data element, we found that many MLR reports did not delineate or label a field as “non-claims costs.” Instead, some MLR reports contained wording similar to the definition of non-claims costs in the MLR regulation.<sup>48</sup> Some MLR reports contained general phrases about administrative costs and/or specific phrases such as “marketing” and “claims processing and member services.” When an MLR report contained any of this language, we considered the non-claims costs data element as present in the report. Then we determined if the data element contained a non-zero number, a zero, or a dash, or was blank.

We determined whether each of the seven numeric data elements was complete. For claims costs, non-claims costs, premium revenue, the calculated MLR, and member months data elements, we considered these data elements complete if plans entered amounts greater than zero and did not leave these data elements blank. For the quality-improvement expenses and taxes and fees data elements, we considered each of these data elements complete if plans entered an amount, a zero, or a dash. Plans may not have quality-improvement spending or taxes in an MLR reporting year. Additionally, if we could not find a label or field for a plan to enter information for a data element, we considered that data element incomplete. Finally, we determined the number of reports that were complete (i.e., reports that included complete data for all seven data elements) or incomplete (i.e., reports that were missing information for one or more of the seven data elements).

# APPENDICES

## Appendix A: States' Use of Deadlines To Ensure Timely Submission of MLR Reports

Federal regulations require that plans must submit MLR reports to States within 12 months of the end of the MLR reporting year, but do not require States to set a more specific deadline for MLR report submission.<sup>49</sup> However, only 2 of the 43 States did not require plans to submit MLR reports by a specific deadline, as shown in Exhibit A-1. State-set deadlines ranged from 4 months to 18 months after the end of the MLR reporting year for the 36 States that provided a single deadline. Five States responded that they set multiple deadlines. Four of them explained that deadlines differed depending on the plan type and one State had initial and final submission deadlines.

**Exhibit A-1: States set varied deadlines for plans to submit MLR reports.**



Source: OIG analysis of surveys submitted by States in 2020.

## Appendix B: Actions That States Have the Authority To Take If Plans Do Not Comply with MLR Reporting Requirements

All 43 States indicated that they have the authority to take actions with plans that do not comply with MLR reporting requirements. In Exhibit B-1, States identified the actions they take from a list included in the online survey.

### Exhibit B-1: States identified the actions they have the authority to take with their plans.



Source: OIG analysis of surveys submitted by States in 2020.

## Appendix C: States' Methods To Ensure That Plans' MLR Reports Are Complete

Forty-two States indicated that they used at least one of the methods shown in Exhibit C-1 to ensure the completeness of their plans' MLR reports.<sup>50</sup>

### Exhibit C-1: States used several methods to ensure that plans' MLR reports are complete.



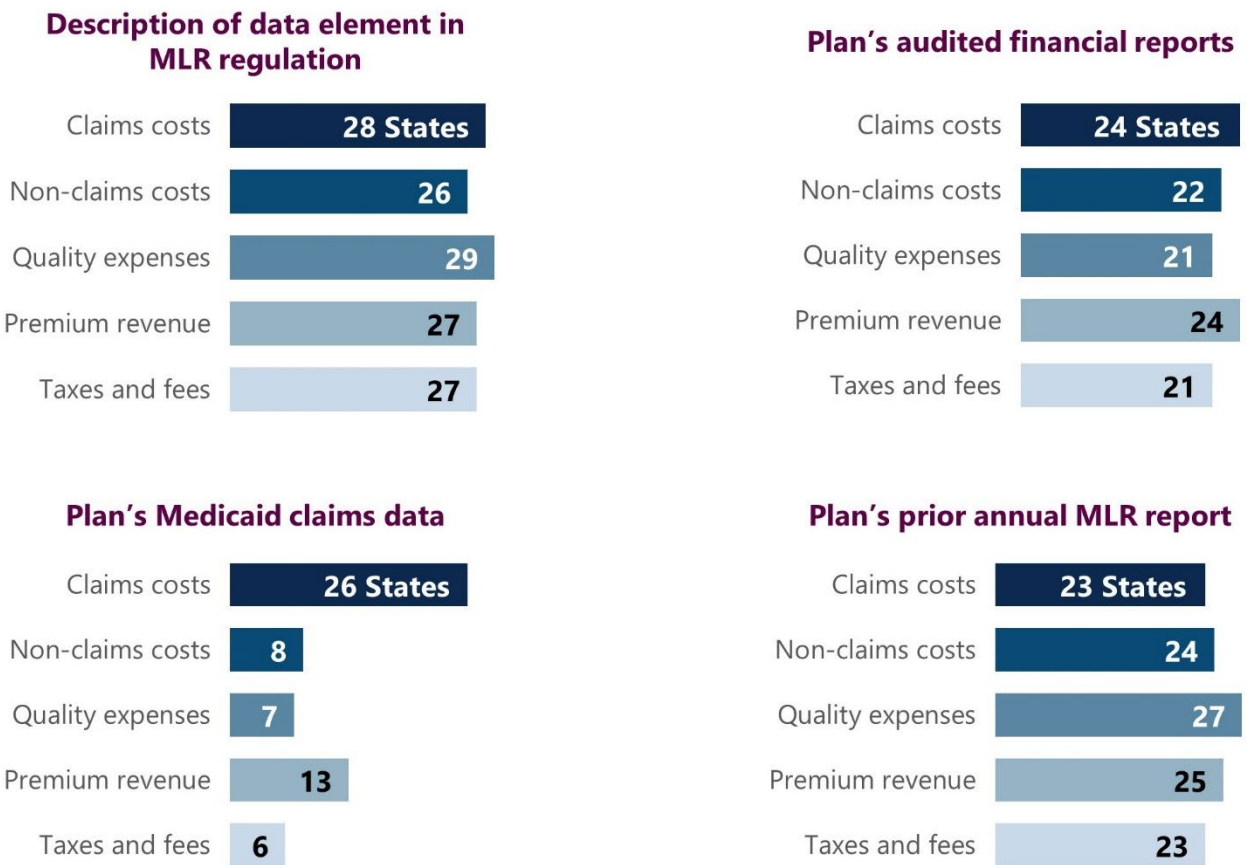
Source: OIG analysis of surveys submitted by States in 2020.

# Appendix D: States' Methods for Verifying the Accuracy of Numeric Data Elements

States used a variety of sources to verify the accuracy of the five data elements that make up the calculated MLR (i.e., claims costs; non-claims costs; quality-improvement expenses; premium revenue; and taxes and fees). States indicated that they compared these data elements to the information and data sources shown in Exhibit D-1.<sup>51</sup> CMS recommends that States should routinely audit the MLR data and calculations reported by their plans.<sup>52</sup>

In addition to the data sources provided in Exhibit D-1, some States provided descriptions of other methods they used to verify the accuracy of certain data elements. Most commonly, these States said that they compare the five numeric MLR data elements to plans' monthly or quarterly financial reports. States also noted that they compare plans' claims costs with encounter data and plans' premium revenues to capitation payment reports. States also explained that they ask plans questions or request more information from plans about each numeric data element, if necessary.

**Exhibit D-1: States used different sources to verify the accuracy of five numeric data elements.**



Source: OIG analysis of surveys submitted by States in 2020.

## Appendix E: Agency Comments

Following this page are the official comments from CMS.

*Administrator*

Washington, DC 20201

**DATE:** August 25, 2022

**TO:** Suzanne Murrin  
Deputy Inspector General  
For Evaluation and Inspections

**FROM:** Chiquita Brooks-LaSure *Chiquita LaS*  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: CMS Has Opportunities to Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios (OEI-03-20-00231)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to partnering with states to help strengthen the monitoring and oversight of Medicaid managed care programs.

The 2016 Medicaid Managed Care Final Rule was the first overhaul of Medicaid managed care regulations in more than a decade.<sup>1</sup> In addition to modernizing how states purchase managed care and enhancing the consumer experience and key consumer protections, the 2016 Final Rule also strengthened the fiscal accountability in Medicaid managed care by adopting a standard for the calculation and reporting of medical loss ratios (MLRs). MLRs are an oversight tool that generally measure how much a managed care plan spends on the provision of covered services compared to the total revenue it receives in capitation payments, i.e., the fixed, prospective, monthly payments plans receive from the state for each person enrolled. The calculation and reporting of MLRs provides states with the information necessary to understand how capitation payments made for people enrolled in Medicaid managed care plans are expended. In addition, the establishment of a common national standard for calculating MLRs allows for comparability across states, facilitates more accurate rate setting, and reduces the administrative burden on managed care plans that operate in multiple states or have multiple product lines.

For contract rating periods starting on or after July 1, 2017, regulations require that Medicaid managed care plans calculate and report their MLR according to the standards laid out in 42 CFR § 438.8, which are similar to those used for calculating MLRs in Medicare Advantage and the private market. Additionally, managed care plans are required to submit to the state an annual MLR report that, at a minimum, must include the 13 data elements outlined in 42 CFR § 438.8(k). The required data elements include both numeric and descriptive items, some of which

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<sup>1</sup> *Federal Register*: "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability"; Final Rule (81 FR 27497) (May 6, 2016).



do not apply to all plan types. Of the 13 total data elements outlined in 42 CFR § 438.8(k), the OIG reviewed plans' MLR reports for completeness of only the seven numeric data elements that were determined to apply to all plans.

CMS has provided states with the flexibility to require their managed care plans to submit the annual report in any format that the state chooses, including using a reporting template created by the state, so long as the report contains the required information outlined in 42 CFR § 438.8(k). Managed care plans are required to submit the annual report in the timeframe established by the state; however, they must be submitted within 12 months after the end of the MLR reporting year. The MLR reporting year varies by state, and is defined in 42 CFR § 438.8(b) as a period of 12 months consistent with the rating period selected by the state. Given that plans were required to begin calculating and reporting their MLRs for rating periods starting on or after July 1, 2017, the first MLR reports were likely not received by states until sometime between July 1, 2018 and June 30, 2019. In their report, the OIG reviewed 293 MLR reports with reporting periods ending in 2018 and 202 MLR reports with reporting periods ending in 2019; which were the first two years in which states and plans were responsible for calculating and reporting MLRs in accordance with the requirements laid out in 42 CFR Part 438. CMS recognizes that the 2016 Final Rule adopted new MLR reporting and oversight requirements for Medicaid managed care, and as such, plans and states may have experienced challenges during the initial years of implementation.

In addition to the requirements for Medicaid managed care plans described above, the regulations at 42 CFR § 438.74(a) require that states annually submit to CMS, along with the rate certification required in 42 CFR § 438.7, a summary description of the MLR report(s) received from their managed care plans. CMS has recently developed a standard format, with instructions, for this required MLR report, and an Excel version of the report is available online.<sup>2</sup> During the development of this report template, CMS consulted with states and other stakeholders on the content and form of the report, and the final report template includes changes made to address comments and concerns from those entities. The Excel template is available for states to use immediately if they choose, and all states submitting rate certification packages on or after October 1, 2022, are required to use the template. Further, CMS is developing a web-based portal through which states will be able to submit several required Medicaid and Children's Health Insurance Program (CHIP) reports, including the MLR report. The web-based forms will collect exactly the same information that is included in the Excel workbook, and CMS will update states when it becomes available.

Since the publication of the 2016 Final Rule, CMS has engaged in numerous activities to support states in their implementation of the MLR requirements. For example, CMS has released several relevant guidance documents, regularly holds conference calls with the Managed Care Technical Assistance Group, and provides direct technical assistance to states as needed. In addition, CMS performs Medicaid MLR reviews in high-risk states to ensure compliance with state and federal MLR reporting requirements. The audit objectives are to determine if plans submitted annual MLR reports to the states in accordance with federal requirements and the annual MLR reporting and minimum MLR remittance calculations for the plans were supported by the underlying data

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<sup>2</sup> CMS, Medicaid and CHIP Managed Care Monitoring and Oversight Tools, 2022, Accessed at: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib07062022.pdf>

and supporting documentation. To accomplish these objectives, CMS reviews MLR remittance submissions and additional supporting documentation provided by the states, including plan's financial reports and additional details to support reported MLR amounts and understand the state's oversight procedures. Finally, CMS has developed Medicaid MLR-specific audit procedures for the 2022 Office of Management and Budget's (OMB) Compliance Supplement, which is a document that identifies important compliance requirements that the federal government expects to be considered by state auditors.<sup>3</sup> The MLR-related procedures in the 2022 Compliance Supplement suggest that, among other things, state auditors verify that the 13 required data elements are included and that the report contains an attestation statement to address accuracy. CMS plans to continue to develop and refine these MLR-specific audit tests and procedures for future releases of the OMB Compliance Supplement.

Over the last decade, CMS has engaged in numerous monitoring and oversight activities for Medicaid managed care programs. While these activities have been effective in assuring state compliance with specific regulatory and statutory requirements, CMS recognizes the need for additional guidance to improve monitoring and oversight, and will continue planned efforts to develop and issue additional tools for states. The OIG's recommendations and CMS's responses are below.

#### **OIG Recommendation**

Design an annual MLR reporting template for States to provide to their Medicaid managed care plans.

#### **CMS Response**

CMS concurs with this recommendation. As part of a comprehensive managed care oversight strategy, CMS plans to develop a handbook for state oversight of MLR reporting. The handbook is anticipated to include a recommended template for plans' MLR submissions as well as information on leading MLR oversight practices.

#### **OIG Recommendation**

Clarify that States should verify the completeness of their Medicaid managed care plans' MLR reports.

#### **CMS Response**

CMS concurs with this recommendation. As noted above, CMS plans to develop a handbook for state oversight of MLR reporting, and will include information clarifying that states should verify the completeness of their Medicaid managed care plans' MLR reports.

#### **OIG Recommendation**

Clarify that States should review their Medicaid managed care plans' MLR reports to verify the accuracy of reported data elements.

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<sup>3</sup> OMB, 2 CFR § Appendix XI to Part 200 - Compliance Supplement, 2022, Accessed at: [https://www.whitehouse.gov/wp-content/uploads/2022/05/2022-Compliance-Supplement\\_PDF\\_Rev\\_05.11.22.pdf](https://www.whitehouse.gov/wp-content/uploads/2022/05/2022-Compliance-Supplement_PDF_Rev_05.11.22.pdf)

**CMS Response**

CMS concurs with this recommendation. As noted above, CMS plans to develop a handbook for state oversight of MLR reporting, and will include information clarifying that states should review their Medicaid managed care plans' MLR reports to verify the accuracy of reported data elements.

**OIG Recommendation**

Provide additional guidance to States regarding Medicaid managed care plans' reporting of non-claims costs in MLR reports.

**CMS Response**

CMS concurs with this recommendation. As noted above, CMS plans to develop a handbook for state oversight of MLR reporting, and will include information on the reporting of non-claims costs in MLR reports.

# ACKNOWLEDGMENTS AND CONTACT

## Acknowledgments

Amy Sernyak served as the team leader for this study. Others in the Office of Evaluation and Inspections who conducted the study include Becky Laster, Craig Diena, and Nancy Molyneaux. Office of Evaluation and Inspections headquarters staff who provided support include Robert Gibbons and Kevin Manley.

This report was prepared under the direction of Linda Ragone, Regional Inspector General for Evaluation and Inspections in the Philadelphia regional office, and Joanna Bisgaier and Edward Burley, Deputy Regional Inspectors General.

## Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at [Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov). OIG reports and other information can be found on the OIG website at [oig.hhs.gov](http://oig.hhs.gov).

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# ENDNOTES

<sup>1</sup> Health Management Associates, *Medicaid Managed Care Spending in 2020*, February 2021. Accessed at <https://www.healthmanagement.com/blog/medicaid-managed-care-spending-in-2020/> on April 22, 2021.

<sup>2</sup> 81 Fed. Reg. 27498, 27521 (May 6, 2016).

<sup>3</sup> 42 CFR § 438.8(a) and CMS, *Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio*, June 2020. Accessed at [https://www.medicaid.gov/federal-policy-guidance/downloads/cib060520\\_new.pdf](https://www.medicaid.gov/federal-policy-guidance/downloads/cib060520_new.pdf) on January 19, 2022. The Federal MLR requirements for managed care plans apply only to risk-based MCOs, PAHPs, and PIHPs, as defined in 42 CFR § 438.2. However, PAHPs that deliver only nonemergency medical transportation are exempted from the MLR requirements. 42 CFR § 438.9.

<sup>4</sup> 42 CFR § 438.8(a).

<sup>5</sup> 42 CFR § 438.8(b), (d)-(f).

<sup>6</sup> 42 CFR § 438.4(b)(9) and 81 Fed. Reg. 27499 (May 6, 2016).

<sup>7</sup> 42 CFR § 438.5(b)(5).

<sup>8</sup> 42 CFR § 438.8(c).

<sup>9</sup> OIG, *Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets*, OEI-03-20-00230, August 2021.

<sup>10</sup> 42 CFR § 438.8(j).

<sup>11</sup> 42 CFR § 438.74(a)(1).

<sup>12</sup> 42 CFR § 438.66(c)(10).

<sup>13</sup> CMS, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 2019. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf> on January 22, 2022.

<sup>14</sup> 42 CFR § 438.8(e)(1)-(3).

<sup>15</sup> The MLR numerator, as defined under 42 CFR § 438.8(e)(1), also includes expenditures for fraud prevention activities. However, expenditures for fraud prevention activities are not yet part of the Medicaid MLR calculation.

<sup>16</sup> As defined under 42 CFR § 438.8(b), non-claims costs mean those expenses for administrative services that are none of the following: incurred claims; expenditures on activities that improve health care quality; or licensing and regulatory fees, or Federal and State taxes.

<sup>17</sup> 42 CFR § 438.8(f)(1)-(3).

<sup>18</sup> 42 CFR §§ 438.8(b) and 438.8(h) and CMS, *Medical Loss Ratio (MLR) Credibility Adjustments*, July 2017. Accessed at <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib073117.pdf> on May 9, 2022.

<sup>19</sup> 42 CFR § 438.8(b) and 438.8(k)(1)-(2).

<sup>20</sup> 42 CFR § 438.8(n).

<sup>21</sup> 42 CFR § 438.8(k).

<sup>22</sup> CMS, *Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio*, June 2020. Accessed at [https://www.medicaid.gov/federal-policy-guidance/downloads/cib060520\\_new.pdf](https://www.medicaid.gov/federal-policy-guidance/downloads/cib060520_new.pdf) on January 19, 2022.

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<sup>23</sup> 42 CFR § 438.8(b).

<sup>24</sup> 42 CFR § 438.8(e)(2)(v)(A)(1)-(4).

<sup>25</sup> CMS, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 2019. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf> on January 22, 2022. Also, under 42 CFR § 438.8(k)(3), managed care plans must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the managed care plan to calculate and validate the accuracy of MLR reporting.

<sup>26</sup> 42 CFR § 438.8(i).

<sup>27</sup> 42 CFR § 438.8(e)(4) and 438.8(k)(1)(iii), and 85 Fed. Reg. 72754, 72792 (November 13, 2020).

<sup>28</sup> 85 Fed. Reg. 72754, 72792 (November 13, 2020).

<sup>29</sup> OIG, [\*Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets\*](#), OEI-03-20-00230, August 2021.

<sup>30</sup> OIG, [\*Minnesota Medicaid Managed Care Entities Used a Majority of Medicaid Funds Received for Medical Expenses and Quality Improvement Activities\*](#), A-05-18-00018, September 2021.

<sup>31</sup> The OIG report numbers and issue dates for the seven audits are [\*The Medicaid Program Could Have Achieved Savings if New York Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act\*](#), A-02-13-01036, October 2015; [\*The Medicaid Program Could Have Achieved Savings if Oregon Had Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act\*](#), A-09-15-02033, April 2016; [\*Review of Massachusetts Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio\*](#), A-01-15-00505, November 2016; [\*Review of South Carolina's Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio\*](#), A-04-16-06191, December 2016; [\*Review of California Medicaid Managed-Care Program Potential Savings With Minimum Medical Loss Ratio\*](#), A-09-15-02025, January 2017; [\*Review of Wisconsin Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio\*](#), A-05-15-00040, June 2017; and [\*Review of Pennsylvania Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio\*](#), A-03-15-00203, July 2017.

<sup>32</sup> Eight States reported that they did not contract with any Medicaid managed care plans subject to Federal MLR requirements as of September 2020. The Federal MLR requirements for managed care plans apply only to risk-based MCOs, PIHPs, and PAHPs as defined in 42 CFR § 438.2. For Vermont, the Federal MLR requirements apply to its single managed care plan, even though it is a non-risk-based PIHP. Therefore, we included Vermont's plan in our analysis.

<sup>33</sup> As part of OIG's information request, we asked States to provide, for each plan, the most recent MLR report that had also been reviewed by the State. If the State had not yet reviewed a plan's most recent MLR report, we requested the prior report. Alternatively, if the State had not yet reviewed any of the plan's MLR reports, we requested the most recent MLR report. This analysis includes 293 MLR reports with reporting periods ending in 2018 and 202 MLR reports with reporting periods ending in 2019.

<sup>34</sup> 42 CFR § 438.8(a).

<sup>35</sup> One State said that its contracted actuary prepares the MLR reports and sends them to its plans for review and feedback.

<sup>36</sup> Information confirmed by CMS staff on November 23, 2020.

<sup>37</sup> This analysis reflects 42 States instead of 43 States. As explained in the Methodology, one State did not complete every question in OIG's survey because the State had not received its plans' MLR reports at the time of OIG's request.

<sup>38</sup> *Ibid.*

<sup>39</sup> Plans are required to submit a comparison of the information in the MLR report with the audited financial report required under 42 CFR § 438.3(m). See 42 CFR § 438.8(k)(1)(xi).

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<sup>40</sup> 81 Fed. Reg. 27498, 27533 (May 6, 2016), and CMS, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 2019. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf> on January 24, 2022.

<sup>41</sup> 42 CFR § 438.8(n).

<sup>42</sup> 42 CFR §§ 438.8(b) and 438.8(e)(2)(v)(A)(1)-(4) and CMS, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 2019. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf> on January 24, 2022.

<sup>43</sup> Eight States reported that they did not contract with any Medicaid managed care plans subject to Federal MLR requirements as of September 2020. The Federal MLR requirements for managed care plans apply only to risk-based MCOs, PIHPs, and PAHPs as defined in 42 CFR § 438.2. For Vermont, the Federal MLR requirements apply to its single managed care plan, even though it is a non-risk-based PIHP. Therefore, we included Vermont's plan in our analysis.

<sup>44</sup> As part of OIG's information request, we asked States to provide, for each plan, the most recent MLR report that had also been reviewed by the State. If the State had not yet reviewed a plan's most recent MLR report, we requested the prior report. Alternatively, if the State had not yet reviewed any of the plan's MLR reports, we requested the most recent MLR report.

<sup>45</sup> 42 CFR § 438.8(h)(3)-(4) and CMS, *Medical Loss Ratio (MLR) Credibility Adjustments*, July 2017. Accessed at <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib073117.pdf> on May 9, 2022.

<sup>46</sup> 81 Fed. Reg. 27498, 27774 (May 6, 2016).

<sup>47</sup> Although specified in the Federal MLR regulations, this data element is not yet part of the MLR calculation. Fraud prevention expenses will be added to the Medicaid managed care MLR calculation if and when the private market regulations define these types of expenses. 42 CFR § 438.8(e)(4) and 438.8(k)(1)(iii), and 85 Fed. Reg. 72754, 72792 (November 13, 2020).

<sup>48</sup> 42 CFR §§ 438.8(b) and 438.8(e)(2)(v)(A)(1)-(4).

<sup>49</sup> 42 CFR § 438.8(k)(2).

<sup>50</sup> This analysis reflects 42 States instead of 43 States. As explained in the Methodology, one State did not complete every question in OIG's survey because the State had not received its plans' MLR reports at the time of OIG's request.

<sup>51</sup> Ibid.

<sup>52</sup> CMS, *Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors*, May 2019. Accessed at <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf> on January 22, 2022.