MEDICAL LOSS RATIO (MLR) MONITORING, REPORTING, AND OVERSIGHT: A TOOLKIT FOR STATES TO ENSURE COMPLETE AND ACCURATE MLR REPORTING

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MEDICAL LOSS RATIO (MLR) MONITORING, REPORTING, AND OVERSIGHT: A TOOLKIT FOR STATES TO ENSURE COMPLETE AND ACCURATE MLR REPORTING

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Section I:

Introduction and Purpose

Risk-based managed care is the predominant delivery system in Medicaid and the Children's Health Insurance Program (CHIP), with 85% of all Medicaid enrollees and 83% of separate CHIP enrollees receiving some or all of their care through a managed care plan (MCP) in 2021.[1,2] In fiscal year (FY) 2022, managed care accounted for more than half of federal and state spending.[3] Due to the growth of Medicaid managed care enrollment and spending, the Centers for Medicare & Medicaid Services (CMS) has increased efforts to strengthen federal and state oversight of Medicaid MCP[4] financial performance to improve fiscal transparency, monitor costs, and ensure value.

Section at a Glance

Aim: Understand the Medicaid managed care MLR and how to use this toolkit

List of figures and exhibits:

- **Figure I.1.** The MLR calculation
- **Exhibit I.1.** Definitions of required MLR reporting elements

A. Why is the medical loss ratio important?

The medical loss ratio (MLR) is a key measure of MCP financial performance. The Medicaid MLR indicates the share of premium revenue that a plan spends on covered health services and activities to improve health care quality. MCPs use the remaining revenue to cover administrative expenses and retain a profit or, a surplus for nonprofit MCPs. MLRs are used as a retrospective tool to assess financial performance by showing the share of Medicaid capitation rates paid to health plans that are spent on incurred claims and health care quality improvement activities (QIA) compared to administrative expenses and profit (or surplus). MLRs may be

Box I.1.

MCPs that **spend a higher proportion of premiums on medical services are viewed as providing better value** to payers and consumers than those that allocate a higher proportion of premiums toward administrative expenses and profit.

[1] https://www.medicaid.gov/sites/default/files/2023-07/2021-medicaid-managed-care-enrollment-report.pdf.

[2] Statistical Enrollment Data System (SEDS) Form 21E, Children Enrolled in Separate CHIP, and Form 64.21E, Children Enrolled in Medicaid Expansion CHIP. Centers for Medicare & Medicaid Services.

[3] https://www.medicaid.gov/state-overviews/scorecard/.

[4] This toolkit uses the term "managed care plan" to refer to all managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs), as defined in 42 CFR 438.2, that hold risk-based contracts with state Medicaid agencies.

used along with other information to assess whether capitation rates were appropriately developed.

Federal Medicaid rules require that states develop actuarially sound managed care capitation rates in such a way that MCPs can "reasonably achieve" an MLR of at least 85% for the rating period (42 CFR §438.4(b)(9)). States must establish a timeline for MCPs to submit annual MLR reports to the state no later than 12 months after the end of the MLR reporting year (42 CFR §438.8(k)(2)). States then review and validate the MCP-reported MLR data and must submit an MLR summary report annually to CMS (42 CFR §438.74(a)(1)). In turn, states and their actuaries use the MCP-reported MLR data to inform the development of actuarially sound prospective capitation rates. Under 42 CFR §438.8(c), State Medicaid agencies can establish minimum MLRs greater than 85% to gain greater value from the premiums paid to MCPs. See **Box I.1**.

Additionally, all states—as part of their managed care financial oversight responsibilities—must conduct or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data, including MLR financial information, submitted by MCPs at least once every three years, as required under 42 CFR §438.602(e).

B. Purpose of the toolkit

This toolkit provides practical information to support states' review, validation, and oversight of their MCPs' annual MLR reporting. States can use the guidance, suggested approaches, and tools provided here to improve the completeness and accuracy of the MCP-reported MLR data in five areas: (1) MLR data collection, (2) MLR data validation, (3) using validated MLR information for state financial monitoring and oversight, (4) reporting guidance for high impact areas such as non-claims costs and expense allocation methodologies, and (5) creating an effective oversight system within the state Medicaid agency. This guide is one in a series of managed care monitoring and oversight toolkits that help states to comply with federal Medicaid managed care regulations and improve monitoring and oversight of MCPs.

1. Organization of the toolkit

This toolkit is organized into seven sections:

- **Section I** describes the background and purpose of the toolkit.
- **Section II** defines requirements for MLR data collection and shares data collection practices that help to ensure complete and accurate MLR reporting from MCPs.
- **Section III** presents steps and methods that states can use to validate MLR information submitted by their MCPs.

- **Section IV** discusses using validated MLR information for state monitoring of MCP financial performance, setting capitation rates, determining if MCPs owe remittances, and contract re-procurement.
- **Section V** provides additional guidance on reporting non-claims costs, expense allocation methodologies, utilization management expenses, services related to health-related social needs (HRSN), MCP incentives, and adjusting premium revenue for community benefit expenditures (CBEs) in MLR reports.
- **Section VI** describes staffing and organizational considerations to create an effective state Medicaid agency oversight structure for MLR data collection, validation, and reporting.
- **Section VII** describes the CMS technical resource for MLR reporting that states can use to collect MLR information from their MCPs.

2. Note on information sources

The information provided in this toolkit comes from several sources. It was informed by interviews with state Medicaid agency staff conducted by CMS in July and August of 2023, as well as documents and resources shared by state Medicaid agency staff.

NOTE: This document contains links to non-United States Government websites. We are providing these links because they contain additional information relevant to the topic(s) discussed in this document or that otherwise may be useful to the reader. We cannot attest to the accuracy of information provided on the cited third-party websites or any other linked third-party site. We are providing these links for reference only; linking to a non-United States Government website does not constitute an endorsement by CMS, HHS, or any of their employees of the sponsors or the information and/or any products presented on the website. Also, please be aware that the privacy protections generally provided by United States Government websites do not apply to third-party sites

C. About the Medicaid managed care MLR

Federal Medicaid standards for calculating the MLR apply to all managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) that hold risk-based contracts with state Medicaid agencies, collectively referred to as MCPs for purposes of this toolkit. CMS first required states to include contract requirements for their MCPs to calculate and report MLRs for contract rating periods starting on or after July 1, 2017 (81 FR 27524). Under 42 CFR §438.8(c), states can elect to set a minimum MLR—which must be at least 85%—and require MCPs to submit a remittance if they do not meet the minimum MLR standard (42 CFR §438.8(j)).

After receiving MLR data from MCPs, states review and validate the data and must annually submit an MLR summary report (42 CFR §438.74(a)(1)) to CMS. States and their actuaries also

review the MLR data MCPs reported when developing actuarially sound prospective capitation rates.

1. How is the MLR calculated?

The MLR is calculated by dividing the MLR numerator, which is the sum of health plan spending on incurred claims (excluding non-claims costs for administrative expenses) and quality improvement activities (QIA) by the MLR denominator, which is premium revenue minus taxes and fees (**Figure I.1**).

Figure I.1. The MLR calculation[5]

Although all of these elements are needed to calculate the MLR, a recent federal review found that nearly half of MCP-reported data were missing at least one of seven data elements necessary to calculate the MLR. These elements include claims costs, non-claims costs (excluded from claims costs), health care QIA expenses, premium revenue, taxes and fees, the calculated MLR, and member months.[6]

2. What are the federal Medicaid MLR reporting requirements?

- **MCPs** are required to submit 12 MLR data elements (listed below) to the state annually according to the state-established timeline which must be no later than 12 months after the end of the MLR reporting year (42 CFR §438.8(k)). MCPs must attest to the accuracy of the MLR calculation. States may use their own reporting template or the plan-to-state

[5] Does not include fraud prevention activities in the numerator. Expenditures for fraud prevention as noted in 42 CFR §438.8(k)(1)(iii) have not been defined by the private market MLR regulations at 45 CFR part 158 and should not be included in the Medicaid MLR.

[6] Office of the Inspector General. "CMS Has Opportunities to Strengthen States' Oversight of their Medicaid Managed Care Plans' Reporting of Medical Loss Ratios." U.S. Department of Health and Human Services, September 2022. https://oig.hhs.gov/oei/reports/OEI-03-20-00231.pdf.

MLR technical resource that CMS developed (see Section II. MLR Data Collection and Section VII. Using the CMS Technical Resource for MLR Reporting for more information).

- **State Medicaid agencies** must review and validate MCP-reported MLR data. After reviewing and validating the data, states must submit an MLR summary report with their rate certifications (42 CFR §438.74(a)) to CMS. The summary report must include the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed (if applicable) for each MCP for the MLR reporting year. The state must include MLR reports for all MCPs in its summary report to CMS, including those that report non-credible MLRs.

3. What are the MLR elements that MCPs must report to the state?

MCPs must submit 12 required MLR data elements to the state under the state's established timeline. The state's timeline must be within 12 months after the end of the MLR reporting year (42 CFR §438.8(k)). Exhibit I.1 defines the 12 MLR data elements.

Section II. MLR data collection provides detailed guidance on the MLR data elements.

Exhibit I.1. Definitions of required MLR reporting elements

1. **Incurred claims.** (42 CFR §438.8(e)(2)) These are amounts paid to providers for providing Medicaid-covered services to enrollees and include:
   - Direct claims that the MCP paid to providers for services or supplies covered under the contract and services meeting the requirements of 42 CFR §438.3(e) provided to enrollees (42 CFR §438.8(e)(2)(I)(A)).
   - Unpaid claims liabilities for the MLR reporting year, including claims reported that are in the process of being adjusted or claims incurred but not reported (42 CFR §438.8(e)(2)(i)(B)).
   - Withholds from payments made to network providers (42 CFR §438.8(e)(2)(i)(C)).
   - Claims that are recoverable for anticipated coordination of benefits (42 CFR §438.8(e)(2)(i)(D)).
   - Claims payment recoveries received as a result of subrogation (42 CFR §438.8(e)(2)(i)(E)).
   - Incurred, but not reported claims based on past experience, and modified to reflect current conditions, such as changes in exposure or claim frequency or severity (42 CFR §438.8(e)(2)(i)(F)).
   - Changes in other claims-related reserves (42 CFR §438.8(e)(2)(i)(G)).
   - Reserves for contingent benefits and the medical claim portion of lawsuits (42 CFR §438.8(e)(2)(i)(H)).
   - The amount of incentive and bonus payments made, or expected to be made, to network providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers (42 CFR §438.8(e)(2)(iii)(A)).
   - The amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses (42 CFR §438.8(e)(2)(iii)(B)).
   - The amount of payments made to providers under state directed payments (SDPs) described in 42 CFR §438.6(c) (42 CFR §438.8(e)(2)(iii)(C)).
   - Net payments related to state mandated solvency funds (42 CFR §438.8(e)(2)(iv)).

   The following amounts must be deducted from incurred claims:
   - Overpayment recoveries received from network providers (42 CFR §438.8(e)(2)(ii)(A)).
   - Prescription drug rebates received and accrued (42 CFR §438.8(e)(2)(ii)(B)).
   - Net receipts related to state mandated solvency funds (42 CFR §438.8(e)(2)(iv)).

   Incurred claims exclude:
   - Non-claims costs (42 CFR §438.8(e)(2)(v)(A)) as defined in 42 CFR §438.8(b).
   - Amounts paid to the state as remittance (42 CFR §438.8(b)).
   - Amounts paid to network providers as pass-through payments under 42 CFR §438.6(d) (42 CFR §438.8(e)(2)(v)(C)).

Exhibit I.1. Definitions of required MLR reporting elements

2. **Health care QIA.** (42 CFR §438.8(e)(3)) See expanded definition at 45 CFR §158.150. These are activities designed to:
   - Improve health care quality (45 CFR §158.150(b)(1)(i)).
   - Increase the likelihood of desired health outcomes in ways that can be objectively measured and can produce verifiable results and achievements (45 CFR §158.150(b)(1)(ii)).
   - Be directed toward individual enrollees or incurred for the benefit of the specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees (45 CFR §158.150(b)(1)(iii)).
   - Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies, or other nationally recognized health care quality organizations (45 CFR §158.150(b)(1)(iv)).
   - Primarily: (1) improve health outcomes, (2) prevent hospital readmissions, (3) improve patient safety, reduce medical errors, and lower infection and mortality rates, (4) implement, promote, and increase health and wellness activities, and/or (5) enhance the use of health care data (45 CFR §§158.150(b)(2)(i)-(v)).
3. **Non-claims costs.** (42 CFR §438.8(b)) Expenses for administrative services that are not: included claims, expenditures on activities that improve health care quality, or licensing and regulatory fees, or Federal and State taxes. Non-claims costs include, but are not limited to:
   - Amounts paid to third party vendors for secondary network savings (42 CFR §438.8(e)(2)(v)(A)(*1*)).
   - Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management (42 CFR §438.8(e)(2)(v)(A)(*2*)).
   - Amounts paid, including those paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for state plan services or services meeting the definition in 42 CFR §438.3(e) and provided to an enrollee (42 CFR §438.8(e)(2)(v)(A)(*3*)).
   - Fines and penalties assessed by regulatory authorities (42 CFR §438.8(e)(2)(v)(A)(*4*)).
4. **Premium revenue.** (42 CFR §438.8(f)(2)) Includes the following for the MLR reporting year:
   - State capitation payments to the MCP for all enrollees under a risk contract approved under 42 CFR §438.3(a), excluding pass-through payments as defined under 42 CFR §438.6(d) (42 CFR §438.8(f)(2)(i)).
   - State-developed, one-time payments for specific life events of enrollees (42 CFR §438.8(f)(2)(ii)).
   - Withhold arrangements developed in accordance with 42 CFR §438.6(b)(3) (42 CFR §438.8(f)(2)(iii)).
   - Unpaid cost-sharing amounts that the MCP could have collected from enrollees under the contract, except those amounts the MCP can show it made a reasonable, but unsuccessful, effort to collect (42 CFR §438.8(f)(2)(iv)).
   - All changes to unearned premium reserves (42 CFR §438.8(f)(2)(v)).
   - Net payments or receipts related to risk sharing mechanisms developed in accordance with 42 CFR §§438.5 or 438.6 (42 CFR §438.8(f)(2)(vi)).
   - Payments to the MCO, PIHP, or PAHP for expenditures under SDPs defined in 42 CFR §438.6(c) (42 CFR §438.8(f)(2)(vii)).

Exhibit I.1. Definitions of required MLR reporting elements

5. **Federal, state, and local taxes and licensing and regulatory fees.** (42 CFR §438.8(f)(3)) Includes the following for the MLR reporting year:
   - Statutory assessments to defray the operating expenses of any state or federal department (42 CFR §438.8(f)(3)(i)).
   - Examination fees in lieu of premium taxes as specified by state law (42 CFR §438.8(f)(3)(ii)).
   - Federal taxes and assessments allocated to MCPs, excluding federal income taxes on investment income and capital gains and federal employment taxes (42 CFR §438.8(f)(3)(iii)).
   - State and local taxes and assessments including: (1) any industry-wide or subset assessments (other than surcharges on specific claims) paid to the state or locality directly; (2) guaranty fund assessments; (3) assessments of state or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by state; (4) state or locality income, excise, and business taxes other than premium taxes and state employment and similar taxes and assessments; and (5) state or locality premium taxes plus state or locality taxes based on reserves, if in lieu of premium taxes (42 CFR §438.8(f)(3)(iv)).
   - For MCPs that are exempt from federal income taxes, CBEs as defined in 45 CFR §158.162(c), which are limited to the highest of either: (1) 3% of earned premium or (2) the highest premium tax rate in the state for which the report is being submitted, multiplied by the MCP's earned premium in the state (42 CFR §438.8(f)(3)(v)).
6. **Allocation of expenses.** As required by 42 CFR §438.8(k)(1)(vii), the MCP's description of the method(s) used to allocate expenses must include incurred claims, QIA expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs, as described at 45 CFR §158.170(b). Each expense must 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 populations, or contracts other than those being reported, must be reported on a pro rata basis (42 CFR §438.8(g)).
7. **Credibility adjustment.** (42 CFR §438.8(b)) An adjustment to the MLR to account for a difference between the actual and target MLRs that may be due to random statistical variation. For more information, see the 2017 CMCS Informational Bulletin (CIB) that provides additional guidance on the credibility adjustment, methodology, and examples.[7]

   Full credibility
   - *Full credibility* means a standard for which the MCP's experience is determined to be sufficient (that is, a plan large enough with sufficient claims experience) for the calculation of an MLR with a minimal chance that the difference between the actual and target MLR is not statistically significant. An MCP that is fully credible will not receive a credibility adjustment to its MLR (42 CFR §438.8(b)).
   - *Partial credibility* means a standard for which the MCP's experience is determined to be sufficient for the calculation of a MLR but with a non-negligible chance that the difference between the actual and target MLR is statistically significant. An MCP that has partially credible claims experience will receive a credibility adjustment to its MLR (42 CFR §438.8(b)).
   - *No credibility* means a standard for which the MCP's experience is determined to be insufficient for the calculation of an MLR. An MCP that has non-credible claims experience will not be measured against any MLR requirements (42 CFR §438.8(b)).

[7] Centers for Medicare & Medicaid Services. "CMCS Informational Bulletin: Medical Loss Ratio (MLR) Credibility Adjustments." July 31, 2017. https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf.

Exhibit I.1. Definitions of required MLR reporting elements

8. **The calculated MLR.** (42 CFR §438.8(d)) Ratio of the numerator (sum of incurred claims and plan expenses for QIA) to the denominator (premium revenue minus the plan's federal, state, and local taxes and regulatory fees). An MLR may be increased by a credibility adjustment.
9. **Remittance.** (42 CFR §438.8(j)) A payment an MCP makes to the state if the MCP fails to meet the MLR standard. States have the discretion to require remittances from MCPs.
10. **Comparison to audited financial statements.** (42 CFR §438.8(k)(1)(xi)) The MLR report must include a comparison of the information reported under 42 CFR §438.8(k) with the audited financial statements required under 42 CFR §438.3(m). These audited financial statements must be specific to the Medicaid contract and submitted on an annual basis. The audit must be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
11. **Aggregation method.** (42 CFR §438.8(k)(1)(xii)) The methodology MCPs use to aggregate data for all Medicaid eligibility groups covered under the contract with the state unless the state requires separate reporting and a separate MLR calculation for specific populations.
12. **The number of member months.** (42 CFR §438.8(k)(1)(xiii)) The total number of months an enrollee or a group of enrollees is covered by an MCP for the MLR reporting period. Used to determine if an MCP is large enough (that is, has sufficient claims experience) to calculate a credible MLR.

Section II:

MLR Data Collection

Regulatory requirements for MLR reporting at 42 CFR §438.8 provide a foundation for states' collection of MLR data. In addition to complying with minimum requirements for MLR data collection and reporting, states should also consider and can choose to implement additional standards and practices that promote MCP submission of complete and accurate MLR data. This section describes how states can optimize their oversight responsibilities with respect to the accuracy of MLR data elements, calculation, and reporting.

Section at a Glance

Aim: Understand the MLR data collection requirements and practices that encourage complete and accurate MLR reporting from MCPs.

List of exhibits, figures, and tables:

- **Exhibit II.1.** Summary of contents from the Arizona Health Care Cost Containment System (AHCCCS) Financial Reporting Guide
- **Exhibit II.2.** Summary of contents from the Maryland Medicaid MCO MLR Reporting Instructions Companion Guide
- **Exhibit II.3.** Annual review of MLR reporting guidance and templates
- **Figure II.1.** Communication strategies for working collaboratively with MCPs
- **Appendix Table II.1.** MLR elements and submission requirement excerpts from MCP contracts
- **Appendix Table II.2** Example summary report comparing MCPs' MLR data

A. Minimum regulatory requirements

- States must include MLR calculation and reporting requirements in their contracts with MCOs, PIHPs, and PAHPs (42 CFR §438.8(a)).
- The MLR must be calculated and reported by the MCPs for each MLR reporting year (42 CFR §438.8(a)).
- MCPs must submit the MLR report within a timeframe and format specified by the state, which must be within 12 months of the end of the MLR reporting year (42 CFR §438.8(k)(2)). MCPs with non-credible MLRs are *not* exempt from the reporting requirement.[8]
- MCPs are required to attest to the accuracy of the MLR calculation when submitting MLR reports to the state (42 CFR §438.8(n)).

[8] States may exempt an MCP from MLR reporting requirements in its first year of operation within the state, per 42 CFR §438.8(l). These MCPs must comply with MLR reporting requirements in subsequent years, even if the first year was not a full 12 months.

B. Standards and practices that promote complete and accurate MLR reporting

1. Set clear expectations by establishing MLR report content, format, and submission requirement language in MCP contracts.

Contracts should set clear expectations for the MLR data and reports MCPs are required to submit to the state. Contracts with MCPs should include the requirements for MLR calculation and reporting as noted in 42 CFR §438.8. However, contract language that is limited to a restatement of the federal regulations in 42 CFR §438.8 is likely insufficient to promote reporting completeness and accuracy (that is, only listing the MLR requirement, components of the MLR numerator and denominator, and reporting requirements). State officials detailing MLR reporting requirements in contracts should, at a minimum, take the steps listed below (see Appendix Table II.1 for excerpts from managed care contracts that cover these elements):

- **Describe the data elements that MCPs must submit.** There are 12 required data elements for MLR reporting (42 CFR §438.8(k)) that states should describe in the contract.[9,10] See Exhibit I.1 for definitions of the following terms:
  - *Total incurred claims* (§§438.8(k)(1)(i) and 438.8(e)(2)).
  - *Expenditures on quality improvement activities* (§§438.8(k)(1)(ii), 438.8(e)(3), 45 CFR §§158.150 and 151) including expenditures on external quality review described in 42 CFR §438.358(b)-(c).
  - *Non-claims costs* (§§438.8(k)(1)(iv), 438.8(b), and 438.8(e)(2)(v)(A)). See **Box II.1.**
  - *Premium revenue* (§§438.8(k)(1)(v) and 438.8(f)(2)).

Box II.1.

Non-claims costs—defined as expenses for administrative services—are often missing from MCP MLR reports. Non-claims costs must be excluded from claims costs in the MLR numerator so that administrative expenses are not counted as spending on health care services for enrollees (42 CFR §438.8(e)(2)(v)). Non-claims costs include, but are not limited to, the following administrative costs:

- Amounts paid to third party vendors for secondary network savings,
- Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management,
- Amounts paid to a provider for professional or administrative services that do not represent compensation or reimbursement for state MCP services or services meeting the definition in §438.3(e) and provided to an enrollee,
- Fines and penalties assessed by regulatory authorities.

States should specify additional types of non-claims costs to ensure the amounts are excluded from incurred claims and to provide an additional data source for actuaries to reference when developing administrative margins.

See **Section VII. Using the MLR Technical Resource** for more information.

[9] Note that expenditures for fraud prevention as noted in 42 CFR §438.8(k)(1)(iii) have not been defined by the private market MLR regulations at 45 CFR part 158 and should not be included in the Medicaid MLR.

[10] Note that guidance for data validation of some of these elements and sub-elements (e.g., non-claims costs, expense allocation methods, provider incentives) is provided in more detail in the Section III: MLR Data Validation section.

- *Taxes, licensing and regulatory fees* (§§438.8(k)(1)(vi) and 438.8(f)(3)).
- *Methodology(ies) for allocation of expenditures, which must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR §158.170(b)* (§§438.8(k)(1)(vii) and 438.8(g)). See **Box II.2**
- *Any credibility adjustment* applied (§§438.8(k)(1)(viii), 438.8(b), and 438.8(h)).
- *The calculated MLR* (§§438.8(k)(1)(ix) and 438.8(d)).
- *Any remittance owed* to the state, if applicable (§§438.8(k)(1)(x) and 438.8(j)).
- *A comparison of the information (reported in §438.8(k)) with the audited financial report* (§§438.8(k)(1)(xi) and 438.3(m)).
- *A description of the aggregation method* (§§438.8(k)(1)(xii) and 438.8(i)).
- *The number of member months* (§§438.8(k)(1)(xiii) and 438.8(b)[11].

- **Describe the MLR calculation inclusions and exclusions.** Contracts should reference the definitions of the MLR components at 42 CFR §438.8(e) and (f), which describe the types of expenditures that must be included and excluded from the MLR numerator and denominator, respectively (see Exhibit I.1).
- **Link provider bonus or incentive payments to quality or performance metrics.** For a provider bonus or incentive arrangement to be included in the MLR numerator, the payment must require providers to meet clearly defined, objectively measurable, and well-documented clinical or quality improvement standards (42 CFR §438.8(e)(2)(iii)(A)). Contracts should define and link quality or performance metrics that the provider must meet to receive the incentive payment. They should also include a defined performance period tied to the applicable MLR reporting period and specify dollar amounts or a percentage of a verifiable dollar amount that can be linked to the successful completion or achievement of the quality or performance metrics and date of payment (89 FR 41130).
- **Establish time periods for payment of provider bonuses or incentives.** States should specify the timeframe within which incentive payments are paid to providers to prevent MCPs from accruing large provider incentives that are paid long after the annual MLR

Box II.2.

MCPs often fail to report the methods used to allocate expenses. The expense allocation and expense allocation methodology must be included in MCP MLR reports (42 CFR §438.8(g)). This includes a detailed description of the methods used to allocate expenses to each expense category, including incurred claims, quality improvement expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs as described in 45 CFR §158.170(b).

[11] Note that guidance for data validation of some of these elements and sub-elements (e.g., non-claims costs, expense allocation methods, provider incentives) is provided in more detail in the Section III: MLR Data Validation section.

submission and audit. The accruals can be significantly different than the actual amounts paid.

- **Specify that QIA should exclude administrative costs.** Only expenses that are directly related to health care QIA can be included in the MLR numerator (42 CFR §438.8(e)(3)). This clarification in the 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (89 FR 41130) aligns MLR QIA reporting requirements with the private market requirements at 45 CFR §458.150(a).
- **Describe data collection requirements for third-party vendors in a subcontracted arrangement.** Under 42 CFR §438.8(k)(3), MCPs must require any third-party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the MCP to calculate and validate the accuracy of MLR reporting. States must ensure that revenues, expenditures, and amounts in the MLR are appropriately identified and classified for each MCP, including when an MCP uses a third-party vendor for specific activities such as claims adjudication. In a CIB published May 15, 2019, CMS clarified that expenditures reported in the MLR under these subcontractor arrangements, including claims adjudication and benefit management, must exclude non-claims costs, and that applicable third-party vendors must provide all underlying data associated with MLR reporting to the MCP.
- **MCPs that subcontract with vendors for other MCP functions, such as QIA, must also exclude the vendor's indirect costs when reporting these expenditures in the MLR.** Vendors entering into subcontracted arrangements for performance of QIA functions must report subcontractor expenses that support the actual QIA expense to the MCP, which is primarily salaries and benefits of vendor employees performing the QIA activities. Vendor's indirect costs and profit cannot be reported as a QIA expense as QIA expenditures must exclude indirect costs and profit under 42 CFR §438.8(e)(3).
- **Describe MLR reporting requirements related to oversight of SDPs.** As part of the changes in the 2024 Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (89 FR 41119), CMS codified its policy that MCPs must include SDPs made to providers in the MLR numerator as incurred claims (42 CFR §438.8(e)(2)(iii)(C)), and the SDP revenue in the MLR denominator as premium revenue (42 CFR §438.8(f)(2)(vii)). All SDP arrangements, including those that do not require written CMS approval under 42 CFR §438.6(c)(2)(i), must be reported as payments in the MLR numerator and revenue in the MLR denominator.[12] SDPs that are paid to MCPs based on separate payment terms must also be included as MCP revenue within the MLR denominator until the rating period in which separate payment terms are no longer applicable. States should consider

[12] SDPs in the MLR numerator and SDP revenue in the MLR denominator may not necessarily be equal. SDPs made to providers are tied to actual utilization, which may differ from the utilization assumptions that factor into the SDPs provided to the MCPs.

integrating MCPs' SDP reporting with the MLR reporting process as part of their monitoring and oversight of SDPs.

- **Reference annual audited financial report requirement and its relation to the MLR.** Under 42 CFR §438.8(k)(1)(xi), MCPs must compare the MLR components to the annual audited financial report required under §438.3(m). Therefore, states should connect MLR reporting to MCPs' compliance with the submission of the annual financial report. States should also specify in the contract that the annual financial report must be specific to the Medicaid contract, audited, and comply with generally accepted accounting principles as noted at §438.3(m).
- **Establish MLR report submission format and decide how to communicate reporting requirements.** States should specify the report format and submission method that they require MCPs to use. States should consider developing templates and/or online reporting tools for MCPs' MLR reports. Some states include very detailed requirements in their contracts. However, states may prefer more general contract language to enable flexibility to account for changes to reporting format and submission methods over the course of the contract. In these instances, the state could develop guidance and/or MLR reporting templates or manuals. Manuals allow states to provide more detailed descriptions of reporting elements, example reports, and more frequent updates to requirements without having to formally amend the contract. We discuss MLR companion manuals and guidance for MCPs in more detail in Step 3. Develop additional reporting guidance for MCPs' submission of MLR reports to states.
- **Establish MLR report frequency, submission timelines, and claims runout requirements.** At a minimum, MLR reporting is an annual requirement; under 42 CFR §438.8(k)(2), MCPs must submit the report to the state within 12 months from the end of the reporting period. Some states, such as Mississippi and Arizona, require MCPs to comply with a quarterly MLR reporting process in addition to annual reports.

  The submission timelines should specify the number of months of claims runout after the end of the reporting period. In determining the appropriate number of months of claims runout, states should incorporate ample time after the end of the runout period for MCPs to prepare their MLR reporting to comply with the submission requirements in federal regulation. A longer runout period ordinarily reduces the risk of inaccurate estimates for incurred but not reported claim costs as fewer claims would be outstanding. However, many MCPs have timely provider claim submission requirements that can reduce the need for longer runout periods. The number of months for the MLR claims runout should align with the runout periods for the reconciliation of any risk mitigation arrangements. This alignment will ensure that the risk mitigation reconciliation results are appropriately included in the MLR calculation and that the underlying data elements of the MLR are uniform.

- **Describe the resubmission requirements.** States should indicate requirements for incorporating retroactive eligibility payments and/or capitation rate adjustments after MCPs submit their MLR report. States may also consider establishing a timeline for MCPs to resubmit MLR reports. The resubmission process should also account for adjustments that are material to the MLR and to minimize MLR report "churn" by MCPs. States with remittance requirements may have lower thresholds for MLR adjustments than those without remittance requirements. In addition, states may want to base adjustment thresholds on how close the MCP is to meeting the minimum MLR requirement.
- **Include conditions and timelines for requiring MCPs to submit a remittance to the state.** If a state imposes a remittance requirement on MCPs, states should describe the process and timeline MCPs should follow to pay a remittance to the state for failure to meet the MLR standard.
- **Describe additional monitoring, penalties, or sanctions for failure to submit information, data inaccuracies, and/or incomplete data.** Although MCPs must attest to the accuracy of their MLR reports, states can also impose enhanced monitoring or sanctions for repeated late submissions, inaccuracies, and/or incomplete reports. States may require MCPs to revise and resubmit MLR reports within a specified time frame, implement corrective actions with MCPs, or impose financial sanctions. Appendix II.1 provides example language around submission requirements and sanctions.
- **Maintenance of records.** Similar to the audited financial report requirement, the state should reiterate the MCP and subcontractor recordkeeping requirements described at

Exhibit II.1. Summary of contents from the Arizona Health Care Cost Containment System (AHCCCS) Financial Reporting Guide

The AHCCCS Financial Reporting companion guide describes all financial reporting and procedural requirements between AHCCCS and its contracted MCPs, which includes MLR reporting requirements. Contents include:

Definitions of Terms

1.00 General Information

- 1.01 Purpose and Objective of the Guide
- 1.02 Effective Dates and Reporting Time Frames
- 1.03 Sanctions

2.00 Financial Reporting Requirements

- Table representing all financial reporting requirements and due dates, including MLR reporting, which is integrated into the state's Financial Statement Template Audit Report

3.00 Instructions for Completion of Quarterly and Annual Reporting

- 3.01 General Instructions
- 3.02 Certification Statement
- 3.03 Financial Statement Reporting Template Audit Report
- 3.04 Balance Sheet (Statement of Net Assets – Governmental Entities)
- 3.05 Income Statement
- 3.06 Footnote Disclosure Requirements

4.00 Supplemental Reports

- 4.01–4.18 Other Supplemental Reports
- 4.19 Medical Loss Ratio Report

5.00 Accounting and Reporting Issues

6.00 Appendices

42 CFR §438.3(u) in the contract, which specifies the time period for MLR report recordkeeping.

2. Develop and use a plan-to-state MLR reporting template or web-based reporting tool to encourage complete and accurate data reporting.

CMS recommends that states provide MCPs with a standardized template for MLR report submission. States have flexibility in developing the format of a template, including the level of detailed reporting required from MCPs. CMS has developed a standardized technical resource states can use (see Section VII) that includes all MLR data elements specified in federal MLR regulations as well as additional detail to assist states in validating the MLR percentage.

3. Develop additional reporting guidance for MCPs' submission of MLR reports to states.

To provide complete and accurate data, MCPs must have a clear understanding of what the state requires in MLR report submissions. The first place to specify requirements is in the contract between the state and MCP (see Step 1. Set clear expectations by establishing MLR report content, format, and submission requirement language in MCP contracts). Using standalone companion guides or detailed guidance integrated into an MLR template can provide an added level of detail beyond what is included in contracts and may eliminate the need for periodic contract amendments to address MLR reporting changes. If using a companion guide, the contract between the state and MCP should specify that the MCP is required to follow the guide to ensure compliance with the financial statement and MLR submission requirements. If the state has MLR submission contract language, but the

Exhibit II.2. Summary of contents from the Maryland Medicaid MCO MLR Reporting Instructions Companion Guide

The Maryland MCO MLR Reporting Instructions companion guide provides additional guidance to its MCPs on MLR reporting and the components of the MLR calculation. The contents of the guide include:

Overview

Timing and Form of Report

Maintenance of Records

MLR Components

General Requirements

- Incurred Claims
  - Inclusions
    - Incentive and Provider Payments
    - Qualified Direct Fraud Recovery Expenses
    - Other Self-Inclusions
  - Deductions
- Pharmacy Benefit Manager (PBM) Spread Pricing
- QIA Expenses
- Exclusions to QIA
- Expenditures Related to Program Integrity Requirements
- Non-Claims Costs
- Premium Revenue
  - Deductions
    - Health Insurer Fee
    - Premium Tax Component of Reported Revenue
    - Other Taxes, Licensing, and Regulatory Fees
- The Calculated MLR Percentage (Before Credibility Adjustment)
  - Credibility Adjustment
  - The Calculated MLR Percentage (After Credibility Adjustment)
  - MLR Requirements
  - Remittance Owed to the State
- Member Months

submitted MLR reports and/or data are substandard, the state should consider developing additional reporting guidance. **Exhibits II.1–2** suggest content to include when developing MLR reporting guidance to MCPs.

To provide more flexibility for data collection over time, Arizona uses a companion guide (**Exhibit II.1**) which encompasses all financial reporting requirements for MCPs. Maryland's reporting guide (**Exhibit II.2**) is a stand-alone document for MLR. Both guides provide additional detail beyond the contract language for MLR reporting; the guides include timelines, submission format, and descriptions of the required data elements for the calculation of the MLR numerator and denominator.

4. Develop MLR accuracy attestation language for MCPs to submit with MLR reports.

Plans must attest to the accuracy of the MLR calculation as required at 42 CFR §438.8(n). States must require MCPs to submit a self-attestation of the accuracy of the MLR calculation when they submit the MLR report. To facilitate this, states can provide a standalone attestation document or include the attestation in the template as a separate tab. As discussed in Step 1. Set clear expectations by establishing MLR report content, format, and submission requirement language in MCP contracts, states should also include the attestation requirement in MCP contracts. Appendix Table II.1 includes (1) example language for MCP attestation with signature lines and dates for both the MCP's chief executive officer and chief financial officer signatures and (2) excerpts from states' contracts with MCPs that have the attestation requirement.

5. Regularly communicate with MCPs to review MLR reporting requirements, submission timing, and data patterns over time.

Establishing regular and open communication between state staff and MCPs provides (1) an opportunity to develop shared understanding on data quality standards, (2) a forum for resolving problems in data collection and reporting, and (3) the space to provide feedback on potential updates to reporting policies and procedures. It is also an opportunity to establish rapport between the state and MCPs. Communication can range from informal check-ins to regular formal meetings with MCPs.

Box II.3.

Mississippi reaches out to MCPs to clarify MLR reporting discrepancies. In addition, the state conducts monthly meetings with the individual finance teams of their MCPs to review specific changes in reporting. The state also holds ad-hoc meetings to discuss variances in MLR reports.

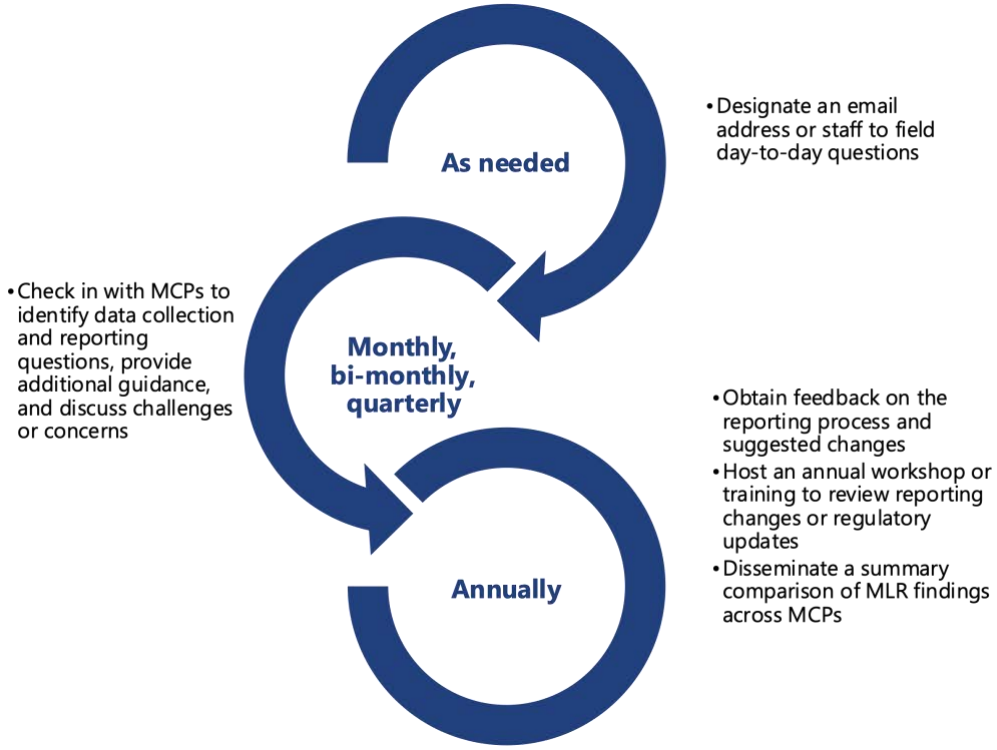
Figure II.1 illustrates the communication cadence and modes states can establish with their MCPs.

- **Ad hoc or as needed communications.** States can implement an email help desk with a standard email address to triage ad hoc questions.

- **Monthly, bi-monthly, or quarterly communications.** Some states designate state staff to review MCPs' monthly or quarterly reporting templates and follow up with MCPs if necessary. For example, Arizona reviews MLRs and financial reporting templates at quarterly internal meetings and follows up with MCPs on areas where MCP staff may need additional assistance. Maryland discusses financial reporting issues with MCPs at monthly rate-setting meetings between February and August. Maryland also holds a monthly MCO liaison meeting, which provides another opportunity to raise specific concerns with MCPs.
- **Annual Communications.** Annual communications with plans can range from trainings and workshops on upcoming reporting changes, to the dissemination and discussion of summary MLR report findings. These communications can also include regular monitoring of plan performance and working with non-compliant plans before escalating to penalties or sanctions. For example, Mississippi provides summary reports comparing MCPs' MLR data, which tend to engage plans.

Arizona holds an annual workshop with MCPs and requires the attendance of MCP CFOs and a state Medicaid staff member noted: "The workshops have been helpful as [the MCPs] have a different perspective and sometimes [the state] misses things . . . the annual workshop has been a great tool."

Figure II.1. Communication strategies for working collaboratively with MCPs



6. Conduct an annual review of MLR reporting guidance and template to identify suggestions for process improvements and updates from auditors, financial analysts, actuaries, and CMS.

To provide clear guidance to MCPs, states should establish a review process of their MLR reporting template and procedures to identify any suggestions, clarifications, and regulatory updates that will further bolster MCPs' submission of complete and accurate data. The review process can range from a less structured review that identifies clarifications or changes throughout the year to a formal annual review. Regardless of the type of review, the state should incorporate suggestions from their actuaries and auditors and communicate all reporting changes to MCPs early in the rating period. **Exhibit II.3** describes best practices for states' annual review of reporting guidance. **Exhibit III.2** describes California's annual reporting review process including the timing of communicating updates to MCPs.

Exhibit II.3. Annual review of MLR reporting guidance and templates

On an annual basis, CMS recommends that states:

- Request suggestions on the existing template, companion guidance, and procedures from auditors, financial analysts, and/or actuaries.
- Identify common trouble spots in MCP MLR report submissions that need additional detail or clarification.
- Review the CMS regulations and the CMS technical resource for plan-to-state MLR reporting for updates.
- Review and prioritize the list of suggested changes and determine if any changes can be made later based on feasibility and need.
- Communicate the changes to MCPs within a reasonable timeframe. For example, Mississippi schedules meetings with its MCPs after finalizing changes to the template and guidance from their auditor.

Section III:

MLR Data Validation

State Medicaid agencies need complete and accurate MLR information to oversee MCP financial performance and review the accuracy of capitation rate setting. In addition, states must ensure that MCPs comply with federal MLR requirements to fulfill their responsibility to submit accurate MLR summary information to CMS. A 2022 HHS OIG study found that some states were unsure about their responsibilities in verifying the completeness and accuracy of MLR data.[13] This section explains how states can validate the completeness and accuracy of the MLR information their MCPs submit.

Section at a Glance

Aim: Describe the three steps that states can use to implement data validation processes for MLR information submitted by their MCPs.

List of exhibits and tables:

- **Exhibit III.1.** MLR audits
- **Exhibit III.2.** California's MLR information collection, validation, and reporting timeline
- **Exhibit III.3.** Arizona's MLR and financial reporting template
- **Exhibit III.4.** How California validates MLR information using rate development data
- **Appendix Tables III.1 – III.5.** Example tables for validating MLR information

A. Minimum regulatory requirements

Federal regulations require that:

- MCPs submit MLR information to states on an annual basis as required under 42 CFR §438.8(k). This information includes total incurred claims, QIA expenses, premium revenue, a comparison of the MLR information submitted by the MCP with the MCP's audited financial report required under 42 CFR §438.3(m), and other elements.
- States monitor the performance of their managed care programs and MCPs as required under 42 CFR §§438.66(a) and (b). Among other topics, states must assess MCP financial performance along with MLR reporting (42 CFR §438.66(b)(5)). This includes reviewing and validating the information provided in MCP MLR reports.
- States conduct or contract for an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data (including MLR information) submitted by MCPs at least once every three years, as required under 42 CFR §438.602(e).

[13] Office of the Inspector General. "CMS Has Opportunities to Strengthen States' Oversight of their Medicaid Managed Care Plans' Reporting of Medical Loss Ratios." U.S. Department of Health and Human Services, September 2022. https://oig.hhs.gov/documents/evaluation/2814/OEI-03-20-00231-Complete%20Report.pdf.

B. Steps for validating MLR information submitted by MCPs

To ensure compliance with federal MLR reporting requirements set forth at 42 CFR §438.8(a), states are responsible for reviewing MLR submissions for completeness and validating the accuracy of the information MCPs provide. The requirement to review and validate MLR information is part of the state's monitoring system specified in federal regulation at 42 CFR 438.66(b)(5). States can use a three-step process to validate the completeness and accuracy of the MLR information submitted by their MCPs:

- Determine the state's MLR data completeness review and validation approach, including staffing, timeline, and MCP engagement.
- Select and implement specific MLR validation methods.
- Act on validation results.

The remainder of this section provides additional detail and examples for each step.

Step 1. Determine the state's MLR data validation approach, timeline for validation activities, and the plan to engage with MCPs, auditors, and actuaries.

Determine the state's validation approach. The first step is to determine what methods the state will use to validate the data and identify staff to complete the validation activities. Examples of these activities include assessing whether the MLR information MCPs submitted is complete and contains valid values, as well as validating MLR information using MCP financial data. As a best practice, MLR information should be validated in as many ways as practicable considering the state's resources, the availability of MCP financial oversight staff, and the capabilities of those staff when making these decisions. See Section VI: Staffing and Organizational Considerations. In general, states can implement one of two tracks:

1. States with smaller state-employed financial oversight teams can implement basic validation checks, such as (1) assessing whether the MLR information reported by MCPs is complete and uses valid values, and (2) verifying that the MCPs' reported MLR is calculated correctly. See methods two and three in Step 2. These states can also engage auditors to perform more advanced validation steps, such as comparing MLR information MCPs reported to MCP financial data and other resources to verify that MCP-MLR information is complete and accurate. Many of these states require MCPs to undergo annual formal audits of MLR reports, including submitting claims and payment data to auditors.
2. States with larger state-employed financial oversight teams who have MLR expertise and experience with MLR validation data sources —such as MCP financial data and capitation rate development information — can consider using many of the methods detailed in Step 2 to oversee MCP financial performance and validate MLR information. These states

must also undertake periodic independent audits but may use a two- or three-year audit cycle rather than an annual cycle.

In either track, states can engage auditors, actuaries, or contractors to supplement their in-house agency staff when needed. For example, state staff may be able to perform basic validation methods and partner with auditors, financial analysts and/or actuaries to incorporate more advanced validation methods. In addition to using a baseline set of validation methods, states can add customized validation processes for MCPs with past MLR reporting problems.

Regardless of the state's MLR validation approach, states must conduct or contract for an independent audit of financial data, including MLR information, and encounter data submitted by MCPs at least once every three years, as required under 42 CFR §438.602(e).[14] **Exhibit III.1** provides more information on MLR audits.

Exhibit III.1. MLR audits

At least once every three years, states should conduct or contract for independent audits of MCP MLR information with professionals who have expertise in Medicaid managed care MLR and financing as well as the sources for validating MLR information. These audits should follow generally accepted auditing standards. To provide timely information, the audit should take place as soon as practicable, after MLR information is available to the state, and following the end of the final MLR reporting period(s) included in the audit. Components of these audits include, but are not limited to:

- A comparison of MLR information to audited MCP financial statements required at 42 CFR §438.8(m).
- A comparison of MLR information to capitation disbursements and rate setting data.
- A comparison of the MCP's current year MLR information to prior year information.
- A review of the MCP's MLR expense allocation methodology across lines of business to ensure that MCPs are using methods in compliance with 42 CFR §438.8(g) and that are expected to yield accurate results.
- A sampling of financial records to ensure that the MCP assigned expenses to expense categories correctly. For example, this includes (1) distinguishing amounts that the MCP actually paid for benefits or activities that improve health care quality and which amounts were for administrative services, taxes, or other activities, and (2) ensuring that the MCP assigned expenses to the correct MLR expense categories.

Step 2 provides more details on why states may decide to implement each of these methods, what information they yield, and how to complete them.

Set a timeline for validation activities. States should set clear and timely submission and validation schedules with MCPs and state staff that complete MLR reporting and validation activities. As required under 42 CFR §438.8(k)(2), MCPs must submit MLR information to the state in a timeframe and manner determined by the state; the timeframe must be within 12 months of the end of the MLR reporting year, and states can set more stringent timelines.

[14] For more information about audits of encounter data, see State Toolkit for Validating and Auditing Managed Care Encounter Data available from: https://www.medicaid.gov/medicaid/managed-care/downloads/mmce-data-valdtn-tolkit.pdf.

Once MCPs submit MLR information to the state, states need to validate that information in a timely manner to fulfill their annual summary MLR reporting responsibilities under 42 CFR §438.74(a). When setting these timelines, states should balance the breadth and complexity of their validation methods with the need to provide timely, actionable data to improve MCP MLR reporting performance and support the state's policy objectives. For example, states could perform basic validation immediately after receiving MLR information from MCPs to support state summary reporting and rate setting activities and follow-up with more advanced methods. **Exhibit III.2** describes how California's validation activities fit in with the state's overall MLR timeline.

Exhibit III.2. California's MLR information collection, validation, and reporting timeline

California uses a two-year cycle to update its MLR reporting template, collect information from MCPs, validate that information, and submit summary MLR reports to CMS.

Year 1:

- In quarters one through three, the state updates its MLR template and instructions to incorporate CMS guidance and any state-specific items that need to be addressed from prior years.
- In quarter four, MCPs submit completed templates for the prior year's MLR reporting period.

Year 2:

- In quarters one through three, the state reviews and validates MCPs' MLR information. First, the state verifies that MCP reporting packages are complete and notifies MCPs of any additional documents they need to submit. Next, the state organizes the MLR information for review and validation. During the validation process, the state identifies outliers, compares MLR information across MCPs with similar populations, and completes other validation methods. State staff contact MCPs to resolve outliers, unexpected results, and other issues. MCPs submit revised MLR reports to the state as required.
- In quarter four, the state completes and submits its MLR summary report to CMS and includes the report in its capitation rate certification submission.

Engage with MCPs, auditors, and actuaries. State Medicaid agency staff who oversee MCP MLR reporting should develop and implement a plan for engaging with MCPs, auditors, and actuaries. First, states can collect suggestions and input from their auditors and actuaries throughout the MLR reporting and validation cycle. For example, states can collect suggestions on improving their MLR reporting templates. Second, states should communicate with MCPs throughout the MLR reporting and validation process to help MCPs understand changes in reporting requirements, how to report MLR information to the state in a timely manner, and resolve issues discovered during the process. See Section II: MLR Data Collection for more information.

Step 2. Select and implement specific MLR validation methods

This section describes six methods that states can use to validate the completeness and accuracy of MCP MLR information. States may select a combination of these methods based

on the validation approach the state selects in Step 1, considering the staffing resources, the capabilities of those staff, and the role of auditors, financial analysts, and actuaries. States can move to each method using the links below:

- **Method 1.** Build validation checks into the template that MCPs use to report MLR information to the state.
- **Method 2.** Assess whether the MLR information MCPs reported is complete and uses valid values.
- **Method 3.** Compare the MCP's MLR information to the MCP's financial data.
- **Method 4.** Compare the MCP's MLR information to state reports of capitation payments made to MCPs and rate setting data.
- **Method 5.** Review trends in MCP MLR reporting and compare statistics across MCPs in a program.
- **Method 6.** Validate high-risk program integrity areas, including the MCP's reported total incurred claims, non-claims costs, provider incentives, and QIA.

Method 1. Build validation checks into the template that MCPs use to report MLR information to the state.

MCPs are required to report MLR information to the state in a manner determined by the state. See 42 CFR §438.8(k)(2). This information includes total incurred claims, QIA expenses, premium revenue, and other data. CMS developed a **technical resource for plan-to-state MLR reporting** (see Section VII) that states can consider requiring MCPs to use when reporting this information; states can also develop their own reporting templates. States may choose to develop their own templates to integrate MLR and financial data reporting, or to implement features (such as detailed worksheets) that help ensure MCPs submit complete and accurate MLR information to the state. Regardless of the template format, states should ensure at a minimum that MCPs report the required elements included in the **MLR reporting technical resource**. States can also build the following features and information into their templates to help ensure that MCPs submit complete and accurate MLR information:

- Error flags to identify when the MCP has not entered information in all the required fields in the template. This helps to ensure that the information the MCP submits is complete.
- Accuracy checks that automatically flag when MCPs enter potentially inaccurate information in their MLR templates. This includes, for instance, requiring MCPs to enter comparable amounts from MCP financial statements and automatically flagging when those amounts do not match the MCP's MLR information.
- A calculated field for the MCP's MLR based on the MLR numerator and denominator information the MCP entered.

- Detailed line items for various MLR expense categories (for example, QIA), which enable the state to gather information on different types of expenses and compare those to other resources such as MCP financial reports.
- Crosswalks to MCP-submitted expense account numbers for each MLR expense type to assist the state when comparing financial reports and MLR information.
- Detailed definitions for each line item to provide transparency and help ensure that the MCP enters MLR information in the correct fields.
- Pre-populated MCP financial data that the state previously reviewed and validated. By pre-populating its templates with this information, a state can streamline its comparison of an MCP's MLR information against the MCP's financial data.

Exhibit III.3 details an MLR information template that Arizona uses.

Exhibit III.3. Arizona's MLR and financial reporting template

Arizona uses an Excel-based quarterly financial reporting template in which MCPs submit MLR information and other MCP financial information:

- The first MLR tab collects MLR information, such as the MCP's premium revenue, taxes, licensing, and regulatory fees, incurred claims expenses, non-claims expenses, QIA expenses, and other required MLR information. This tab also collects the MCP's expense allocation methods.
- The second MLR tab serves as a first-level tool for validating MLR information by indicating if the MCP reported erroneous MLR information based on a comparison to other financial information that the MCP reported in the template.
- State staff review each line of MLR information to verify that it ties to the financial information the MCP reported, and staff can request MCPs to resubmit the template to correct issues. By identifying errors, this tab also helps educate MCP staff on common issues that they can correct before submitting MLR information to the state.

Method 2. Assess whether the MLR information reported by MCPs is complete and uses valid values.

After receiving MLR information from MCPs, states should assess whether that information is complete and valid by reviewing automated validation check results (detailed in Method 1) and comparing the information MCPs submitted to the MLR elements required under 42 CFR §438.8(k). For the comparison, the state can utilize data dictionaries, or the reporting instructions used in its MCP to state MLR reporting processes as well as guides the state developed for its staff when reviewing MLR information. This method is useful for states that would like to efficiently assess MLR information for potential errors before advancing to more advanced methods, such as comparing MCP MLR information to financial data and other sources, as described in Methods 3 through 6. However, states should not rely solely on these initial validation checks because they do not compare MLR information to other data sources and cannot help states identify potential discrepancies between the MLR and other financial data that MCPs report.

For the initial data validation, the state should compare the MLR information provided by the MCP to the 12 required elements under 42 CFR §438.8(k) (see Exhibit I.1 for definitions of key MLR elements) and ensure that the MCP reported complete information. This includes ensuring that the MCP reported total incurred claims, QIA expenses, non-claims expenses, premium revenue, and each of the other required elements as well as any additional elements that the state requires MCPs to report.

Second, the state should review this information for likely errors to help ensure that the MCP reported valid information. For example:

- Alphabetic text in numeric fields.
- Repeated values in different fields.
- A total MLR numerator that does not equal total incurred claims plus QIA expenses and provider incentive payments.
- A total MLR denominator that does not equal premium revenue minus taxes and fees.
- An MLR denominator that is greater than premium revenue.
- An unexpected reported MLR considering the financial communications between the MCP and the state during the MLR reporting year.
- An MLR value outside of the typical MLR range (for example, above 110% or below 70%).
- An unexpected MLR remittance considering the MCP's reported MLR and the state's minimum MLR requirement (if the state requires MCPs to meet a minimum MLR). For example, this could include an MCP reporting no remittance owed when the MCP reports an MLR below the state's minimum MLR requirement.

The automated validation checks detailed in Method 1 can reduce some of the state's effort in this step. For example, many states use templates that automatically calculate the MCP's MLR. These checks can help flag when MCPs enter incomplete information and/or likely erroneous values, and MCPs can correct these issues before submitting their MLR reports.

Method 3. Compare the MCP's MLR information to the MCP's financial data.

States use MCP financial data to oversee the financial performance and solvency of their MCPs. They can also use these data to validate the MLR information submitted by their MCPs. Depending on the financial data that the state receives from MCPs, this method can be useful for validating MLR information because financial data can provide a secondary source of information for most MLR line items. For example, although capitation payment reports generated by the state may only be useful for validating premium revenue and member months, states at a minimum should be able to validate total incurred claims, non-claims expenses, premium revenue, taxes and fees, and member months (if included) using MCP financial data. There are two types of data that states can use:

- As required under 42 CFR §438.3(m), MCPs must submit audited financial reports specific to their Medicaid contracts with the state on an annual basis.
- In addition to annual audited financial reports, states can require MCPs to submit periodic (such as quarterly or monthly) financial statements. The content, level of detail, and cadence of these financial statements varies across states. States that require MCPs to submit highly detailed financial statements that are customized for Medicaid MCP financial performance and align with the MLR information offer a strong source of data to validate MLR information.

Tips for when financial reports and MLR reporting periods align. States can validate MLR information using MCP financial information by comparing the total incurred claims that MCPs report in their MLR information to the total incurred claims that MCPs report in their financial data for the same rating period. The state can replicate this approach for non-claims expenses, premium revenue, and taxes and fees. Because the MCP produces both its financial statements and reports and its MLR information, a state can reasonably expect that comparable information should match or be very close to each other for a particular rating period. For example, as noted above, Arizona reviews each line item in an MCP's MLR information to verify that it matches the reported financial information. The template crosswalks each line item of MLR information to one or more account numbers in the financial reporting worksheet; this crosswalk helps state staff compare the two sources.

Appendix III, Table III.1 shows how a state can structure a table that compares an MCP's MLR information to the MCP's annual audited financial report. To assist MCPs in meeting the requirement in 42 CFR §438.8(k)(1)(xi), the state can include this comparison in its MCP reporting template detailed in Method 1 above. The example data in the table show discrepancies that the state may consider investigating if those discrepancies are not explained by data lag, data runout, or reporting period issues.

Tips for when financial reports and MLR reporting periods do not align. States with unaligned reporting timelines (for example, a state with an MLR reporting year that is based on the state fiscal year and audited financial reports based on the calendar year) can still use MCP financial data to validate MCP MLR information. For example:

- Financial reports that use a different time period than MLR reports. States that receive annual audited financial reports from MCPs with time periods that do not align with the time period of the MLR reporting period under analysis can gather (or require their MCPs to report) pro-rated line items from those financial reports. After gathering and summing those pro-rated amounts, the state can proceed with validation. For instance, if the state's MLR reporting year begins on July 1 and MCP financial reports are on a calendar year basis, the state can gather pro-rated line items for July 1 to December 31 and January 1 to June 30 from the MCPs' financial reports, sum pro-rated amounts for each line item, and proceed with validation.

- Quarterly amounts that sum to annual amounts. States that receive quarterly or monthly financial statements from MCPs that align with comparable timeframes in the state's MLR reporting period (for instance, quarterly financial statements beginning on January 1 of each year and an MLR reporting period that begins on July 1 of each year) can sum line items from the appropriate periods for those quarterly financial statements and proceed with validation. In this example, that could include summing financial amounts for the third and fourth quarters of Year 1 and the first and second quarters of Year 2 to compare to the annual MLR reporting period.
- Mississippi uses an "annual financial reconciliation statement" tab in its annual MLR report submitted by MCPs to identify per member per month (PMPM) and percentage differences (such as the percent of premium revenue spent on non-claims expenses) between an MCP's MLR information and its audited financial report. Material differences in these figures can indicate potential reporting errors by MCPs.
- Although Virginia's MLR information and MCP financial statements use different incurred but not reported (IBNR) runout periods, state staff still compare information in these reports to assess whether the MLR information is within a reasonable margin of the information on the MCP's financial reports.

Method 4. Compare the MCP's MLR information to capitation payment reports and rate setting data.

In addition to using MCPs' financial data, states may choose to use state reports of capitation payments made to MCPs and rate setting data to validate MCPs' MLR information. This method is useful for states that identify the need for additional MLR validation, such as after discovering completeness and accuracy issues when validating MLR information using MCP financial data.

Box III.1.

More information on the Medicaid managed care rate setting process and what data states use to develop rates is available on Medicaid.gov, Rate Review and Rate Guides.

First, states must document the capitation payments that they make to MCPs based on MCP enrollment and the final capitation rates developed through the rate setting process. Using these capitation payment reports, states should validate the MLR premium revenue and member months that MCPs report. If the state captures other aligned information in MCP MLR reporting and capitation payment reports, such as capitation withholds earned back by MCPs, settlement payments from risk-sharing arrangements, and SDPs paid under separate payment terms, the state should also validate these items. For example, California uses its Capitation Payment Management System (CAPMAN) to calculate monthly capitation payment amounts for the state's MCPs and compares CAPMAN data to the MLR information that MCPs report. Specifically, the state compares capitation payments, SDPs, capitation withholds earned back

by MCPs, risk sharing arrangement settlements, taxes and fees, and other items across CAPMAN data and MCPs' MLR information.

Second, actuaries gather detailed financial data from MCPs using rate development templates (RDTs) to inform the rate setting process. **Exhibit III.4** describes how California uses data from its RDT to validate MLR information reported by MCPs.

At a minimum, states should be able use these data to validate the total incurred claims, premium revenue, taxes and fees, and member months that MCPs report through MLR information. If the state captures aligned non-claims expenses in MLR information and rate development data, the state can validate non-claims expenses as well.

Exhibit III.4. How California validates MLR information using rate development data

California uses an RDT in which MCPs annually report expenses (including incurred claims and non-claims expenses), utilization, and other information to support the state's rate setting process. The state uses expenses reported in the RDTs to validate expenses reported through MLR by identifying variances between the expenses (including incurred claims and non-claims expenses) reported in RDTs and those expenses reported in MLR information. The RDT and MLR information are comparable because they use the same reporting period, runout period, and IBNR rules. Because MCPs produce the expense information that they report in the RDT and through MLR reporting, the state can reasonably expect that these expenses should match for a particular rating period.

Appendix III, Tables III.2 and III.3 show how states can validate MLR information submitted by MCPs using capitation payment reports and rate development data.

Method 5. Review trends in MCP MLR reporting and compare statistics across MCPs in a program.

In addition to using a combination of the methods detailed above, states can compare MLR information from MCPs to previously submitted MLR information (for example, for prior quarters or years). This method enables the state to identify potential outliers and assess the reasonableness of MCP MLR information. Specifically, states can track total incurred claims, QIA expenses, non-claims expenses (both aggregated and separated by type of non-claims expenses) as well as other elements, over time for unexpected material changes that are not explained by changes in the MCP or program. To help make the analysis comparable over time, states can calculate ratios and PMPM amounts across elements, such as tracking the ratio of premium revenue spent on non-claims costs (that is, the administrative cost ratio) and claims expenses PMPM. Mississippi monitors the percentage of premium revenue spent on QIA expenses over time. Using this method, an unexpected increase in QIA expenses may indicate that the MCP assigned ineligible administrative expenses to that category. Appendix III, Table III.4 shows how a state might consider organizing information for this analysis.

States can also perform this analysis across MCPs in the same program. For example, Mississippi staff enter MLR information submitted by MCPs into a summary spreadsheet and analyze the information using incurred claims PMPM and ratios of health care QIA expenses and non-claims expenses to premium revenue. As another example, when California discovers outliers or other variances, the state compares MCPs' data within a particular county. Because the MCPs generally contract with the same providers, the state does not expect to see significant variances across MCPs in each county. When performing this analysis, states should account for factors such as the MCP's enrollment size, its regional and/or national footprint, and the length of time that the MCP has operated in the program. Appendix III, Table III.5 displays how a state might consider organizing this analysis.

Method 6. Review high-risk program integrity areas including the MCP's reported total incurred claims, non-claims costs, provider incentives, and QIA.

Validate total incurred claims. As explained in the introduction, total incurred claims are included in the MLR numerator and are critical for determining an accurate MLR. To validate incurred claims, states can (1) review the guidelines that MCPs use to assign expenses to the incurred claims line item and (2) sample MCP financial records to verify that MCPs only included allowed expenses in the incurred claims line item. This method is useful for states to periodically ensure that MCPs only include valid expenses in their incurred claims. It is also useful for states needing to investigate further after discovering potential completeness and accuracy issues in incurred claims.

States can require MCPs to report the guidelines they used to assign expenses to the incurred claims line item and verify that these guidelines comply with regulations at 42 CFR §438.8(e)(2). These regulations detail what MCPs must and must not include in the incurred claims line item. For example, incurred claims include direct claims that MCPs pay to providers, unpaid claims liabilities for the MLR reporting year, withholds from payments made to providers, recoverable claims for anticipated coordination of benefits, and other expenses. In addition, MCPs must exclude non-claims expenses such as those paid to third party vendors for network development, administrative fees, claims processes, and utilization management from incurred claims. In a CIB published May 15, 2019, CMS provides additional details on what MCPs must and must not include in their incurred claims, particularly when a MCP uses a third-party vendor in a subcontracted arrangement.

Box III.2.

Validating the expenses that MCPs assign to the claims expenses line item is closely related to validating (1) which expenses MCPs assign to the non-claims expenses line item and (2) MCPs' expense allocation methodologies.

More information to help state staff understand and validate non-claims expenses and the methodologies that MCPs use to allocate expenses is available in **Section V: MLR reporting guidance for key areas**.

States can sample the financial records that MCPs used to generate their total incurred claims line item to validate that MCPs only included allowed expenses. This process involves

verifying that none of the sampled financial records include non-claims expenses such as expenses paid to third party vendors for network development, administrative fees, claims processes, and utilization management.

Validate non-claims costs. States can use the same steps to validate non-claims expenses submitted by MCPs: (1) require MCPs to assign non-claims costs to the list of administrative expenses described in Section V: MLR Reporting Guidance for Key Areas; (2) reconcile the MLR report to the financial statement by comparing the administrative expenses MCPs report in their MLR report, and compare the sum of incurred claims, QIA, taxes, and non-claims to the total expenses per the financial statements to ensure all costs, including non-claims, are reported on the MLR; and (3) sample the financial records that MCPs used to generate their total incurred claims line item to validate that MCPs did not include unallowable expenses. The absence of unallowable, non-claims expenses in the incurred claims line items helps to validate that these items are properly classified under non-claims expenses.

Validate provider incentives and QIA expenses. In addition to validating total incurred claims, states should also validate MCPs' provider incentives and QIA expenses to ensure that MCPs only report allowable expenses in the MLR numerator. Like validating total incurred claims, states can (1) review the guidelines that MCPs use to assign expenses to the provider incentives and QIA line items and (2) sample MCP financial records to verify that MCPs only included allowed expenses in these line items.

States can require MCPs to report the guidelines they used to assign expenses to the provider incentives and QIA expenses line items and verify that these guidelines comply with regulations at 42 CFR §438.3(i) as well as §438.8(e)(2) and (3). These regulations define allowable incentive and QIA expenses. For example, provider incentives include bonuses, capitation payments, and withholds returned to providers, and these incentives must not function as an inducement to reduce or limit medically necessary services. For a provider incentive to be included in the MLR numerator, the provider bonus or incentive arrangement must require providers to meet clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards to receive the bonus or incentive payment (89 FR 41128). As another example, expenses must be in one of the following three categories to qualify as QIA expenses:

- A QIA activity under 42 CFR §158.150 must be primarily designed to improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline (42 CFR §158.150(b)(2)(i)), prevent hospital readmissions through a comprehensive program for hospital discharge (42 CFR §158.150(b)(2)(ii)), improve patient safety, reduce medical errors, and lower infection and mortality rates (42 CFR §158.150(b)(2)(iii)), and implement, promote, and increase wellness and health activities (42 CFR §158.150(b)(2)(iv)).

- An MCP activity that is related to mandatory and optional external quality review (EQR)activities as described at 42 CFR §438.358(b) and (c), such as participating in EQR review.
- An expenditure that is related to Health Information Technology and meaningful use, as described in regulations at 45 CFR §158.151. This includes making incentive payments to providers for the adoption of certified electronic health record technologies, implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by providers, providing technical assistance to support adoption and meaningful use of certified electronic health records technologies, and other activities.

States can also sample the financial records that MCPs used to generate their provider incentives and QIA expenses line items to validate that MCPs only included allowed expenses in these line items. Regulations at 42 CFR §§438.3(i) as well as 438.8(e)(2) and (3) provide details on what qualifies as provider incentives and QIA expenses.

Step 3. Act on validation results

As noted above, states and MCPs should regularly communicate during the MLR reporting process so that MCPs can ask questions about timelines and data specifications and troubleshoot difficulties. In addition, states should determine the process for correcting and using MLR information submitted by MCPs. For example, states can:

- Ask MCPs questions to clarify their MLR information, inform MCPs of validation results, and provide recommendations to MCPs to improve their future MLR reporting.
- Require MCPs to resubmit their MLR information if they did not submit all information required under 42 CFR §438.8(k), such as non-claims expenses, and additional information the state requires.
- Require that MCPs explain potential accuracy issues, such as discrepancies between MCP MLR information and financial data.
- Consult with the state's rate setting team, auditors, and other professionals who support the state's financial oversight activities as needed to help resolve issues identified during the validation process.
- Deliver validated MLR information to the state's rate setting team, auditors, and other professionals who support the state's financial oversight activities.
- Implement additional audits or validation methods for MCPs with persistent or significant problems with completeness and accuracy in reported MLR information.
- Review contracts with MCPs to identify enforcement options for MCPs with persistent and significant problems with completeness and accuracy in reported MLR information.

Section IV:

Making Use of Validated MLR Information

Validated MLR data are essential to state monitoring of MCPs' costs and holding them accountable for spending sufficient Medicaid funds on services for enrollees and activities to improve the quality of care. States can also use validated MLR data to inform development of accurate capitation rates, identify the need for additional data analysis for certain areas of MCP operations and policy, and inform procurement decisions and contractual requirements.

Section at a Glance

Aim: Provide states with suggestions for using validated MLR data, including monitoring of MCP financial performance and plan operations, setting capitation rates, and contract re-procurement

List of tables:

Appendix Table IV.1. Example MLR metrics for state leadership

A. Monitor plan financial performance

States can use MLR information to develop other financial performance metrics to paint a picture of overall MCP financial health and performance. This is done by breaking down MCP revenue into medical loss, administrative loss, and profit. States can use data from the MLR report to calculate additional financial benchmarks, including the administrative loss ratio (ALR) and profit or operating margin. The ALR measures the amount of revenue spent on administrative expenses. The profit margin (or operating margin) indicates financial gain or loss. States can monitor plan financial performance by comparing MCP financial benchmarks over time. When states review trends in financial benchmarks, they can identify large variances over time and are better able to assess the reasonableness of MCPs' financial performance. See Section III, Step 2, Method 5 for more information on reviewing trends in MCP MLR reporting).

Provide information to state Medicaid leadership

As part of the MLR reporting process, state staff should consider how to communicate plan financial performance to Medicaid and other state leadership. States may consider providing the Medicaid agency chief financial officer (CFO), state Medicaid director, cabinet secretary and Governor's office with summary reports based on annual MLR reporting, including a review of remittances, if applicable. For example, Arizona provides scorecard metrics to the governor's office showing how MCPs are meeting MLR standards (Appendix IV.1). Staff also provide quarterly metrics to the state Medicaid director showing whether the MCP is meeting

the standard with MLR percentages by MCP and program. This example includes results for long term services and supports (LTSS), traditional Medicaid, and a separate CHIP.

B. Set accurate capitation rates

Federal regulation (42 CFR §438.4(b)(9)) requires that states develop managed care capitation rates in such a way that the MCPs can reasonably achieve an MLR of at least 85% for the rating period. Actuaries review MCP-reported MLR data from previous years as part of the development of actuarially sound prospective capitation rates. Actuaries can use audited MLR data to review the differences between the previously projected MLR and actual MLR results and use this to inform rate development. Additionally, by reviewing the MLR reports during rate development, the state protects against the possibility that capitation rates are set too low, which could affect provider participation, enrollees' access to health care services, the quality of care, and the viability of Medicaid MCPs in the market.

Several states interviewed for this toolkit noted that MLR data is an important tool to inform the rate development process. States can aggregate MLR data to calculate statewide statistics, such as averages, to use in the analysis of capitation rates. States can also review year-over-year data for trends, which helps spot outliers among MLRs. These statistics and trends give the state a frame of reference for setting reasonable thresholds for its plans. For example, in Mississippi, MLR data is a key source in reviewing the allowable costs and subsequent percentages for medical benefits, premium tax, and administrative margin, as part of the overall rate setting process. The aggregated data provide the state with benchmarks to help them understand if the actuary's calculated administrative percentage and medical target seem reasonable. Additionally, Mississippi reviews MLR percentages over time by plan and by quarter, year-to-year, to track historical trends. MCPs have access to the trend data, and the state can also see what may need to be adjusted in rate setting.

C. Act as a bellwether for additional analyses of MCP operations or policies

States can use the MLR as an indicator of cases where an MCP's operations and/or policies may warrant additional analysis or scrutiny. Three areas in which the MLR can act as a bellwether for follow-up analysis are: (1) risk adjustment accuracy, (2) adequacy of the provider network, and (3) use of risk corridors.

- **Accuracy of risk adjustment.** States can use the MLR to identify the need for more extensive data review that could indicate adverse selection and/or systematic denial of costly benefits by MCPs. If plans are experiencing adverse selection, the state may need to implement a risk adjustment methodology or change the current one. MLRs that are consistently lower than expected can signal the need to implement risk adjustment strategies and/or closely review prior authorization and claim denials.

- **Provider network adequacy.** States may use the MLR as a signal of potential issues with the adequacy of the MCP's provider network. A consistently low MLR may indicate the need for additional analysis to determine whether the MCP's provider network allows sufficient access to health care services for its enrollees.
- **Risk corridors.** States can use MLR data to determine whether MCP financial performance has stabilized and that risk corridors are no longer necessary.[15] For example, Maryland implemented a risk corridor in 2020 to protect the state and MCPs from COVID-19 related uncertainty in enrollment and utilization levels. The state's review of deviations in the MCPs' actual MLRs compared to the target MLRs triggered sharing of gains and losses between Maryland and its plans. The ability to review MLR data trends over time informed Maryland's decision to discontinue the risk corridor in 2023.

D. Inform the MCP procurement process or contractual requirements

As financial performance standards, states can use MLR data as part of Medicaid managed care procurement to inform (1) competitive procurement or re-procurement standards, and (2) contractual MLR data reporting requirements that MCPs must meet:

- As part of the procurement process, states can require new bidders to submit validated Medicaid MLR information from other states in which they currently operate as part of the state's review of plan qualifications and performance against selected metrics. The state may also consider incorporating MLRs for recompeting MCPs into the procurement process.
- States can add contractual requirements that (1) set MLR data quality standards and (2) provide for penalties and/or corrective action plans (CAPs) if MLR data are consistently late, inaccurate, or incomplete.
  - *MLR data quality standards.* If state staff continue to see repeated errors in MCP MLR reporting, the state may consider establishing data quality standards and require MCPs to correct errors before the state accepts MLR data.
  - *Penalties or sanctions.* States may set penalties or implement sanctions to address repeated late, noncompliant, or deficient MLR reporting. If MLR reporting is repeatedly deficient, states may also require MCPs to develop CAPs.

[15] Note that CMS may require risk mitigation mechanisms for new Medicaid managed care programs and/or populations to remain in place until sufficient claims experience is available for rate setting. See the Medicaid Managed Care Rate Development Guide available from: https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html.

Section V:

MLR Reporting Guidance for Key Areas

CMS is providing additional guidance to clarify MCP reporting in six high impact areas: (1) non-claims costs, (2) expense allocation and methods used to allocate expenses, (3) utilization management expenses, (4) services related to health-related social needs (HRSNs), (5) MCP incentives, and (6) adjusting premium revenue for CBEs.

Section at a Glance

Aim: Provide additional guidance and expectations for MCP identification, reporting, and validation of:

- Non-claims costs.
- Expense allocation methodology.
- Utilization management expenses.
- Services related to HRSNs.
- MCP incentives.
- Adjusting premium revenue for CBEs.

List of exhibits:

- **Exhibit V.1.** Description of methods used to allocate expenses

A. Clarify MCP reporting of non-claims costs

Non-claims costs—defined as expenses for administrative services—are often missing from MCP MLR reports.[16] Unreported non-claims costs limit states' abilities to monitor that MCPs are properly excluding administrative expenses from spending on health care services for enrollees. It is important that states review MCP administrative expenses even though non-claims costs are not a required line item in the annual MLR summary report states submit to CMS. Specifying the non-claims costs with the level of detail in the line items described below helps states validate the accuracy of the reported MLR numerator and helps actuaries set the non-benefit administrative load for capitation rate setting.

Non-claims costs should include the categories specified in the Medicaid managed care MLR regulation at 42 CFR §438.8(e)(2)(v)(A), reflect the categories specified in the private market regulation at 45 CFR §158.160, and include administrative costs excluded from QIA at §158.150(c). Reported non-claims costs should include the following expenses:

Box V.1. What are non-claims costs?

Non-claims costs are administrative expenses that are not incurred claims, health care QIA expenses, licensing and regulatory fees, or federal and state taxes (42 CFR §§438.8(b), 438.8(e)(2), 438.8(e)(3), 438.8(f)(3)). Federal Medicaid rules require that non-claims costs must be excluded from incurred claims in the MLR numerator so that administrative expenses are not included as spending on health care services for enrollees (§438.8(e)(2)(v)(A)).

[16] Office of the Inspector General. "CMS Has Opportunities to Strengthen States' Oversight of their Medicaid Managed Care Plans' Reporting of Medical Loss Ratios." September 2022. https://oig.hhs.gov/documents/evaluation/2814/OEI-03-20-00231-Complete%20Report.pdf.

- Amounts paid to third party vendors for secondary network savings. (42 CFR §438.8(e)(2)(v)(A)(*1*)) These are payments made by one MCP to another vendor to purchase their network to serve as a contracted, out-of-network provider to avoid single-case agreements with those providers, which results in saving on out-of-network service costs (81 FR 27527).
- Amounts paid to vendors or providers for network development, administrative fees, claims processing, and utilization management. (42 CFR §438.8(e)(2)(v)(A)(*2*))
- Amounts paid, including those paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for state plan services or services meeting the definition of 42 CFR §438.3(e) and provided to an enrollee. (42 CFR §438.8(e)(2)(v)(A)(*3*))
- Cost containment expenses. (45 CFR §§158.160(b)(2)(i)) and 158.150(c)(1))
- All other claims adjustment expenses. (45 CFR §158.160(b)(2)(ii))
- Pharmacy benefit manager (PBM) and pharmacy benefit administrator (PBA) expenses not allowable as incurred claims. When an MCP subcontracts with a PBM or a PBA to administer the Medicaid-covered outpatient drug benefit, —but does not provide any of the Medicaid-covered drugs directly to enrollees through its own employees— the costs paid to the PBM or PBA for administrative functions cannot be included as incurred claims. These administrative costs include any difference between the amount the MCP pays the PBM or PBA and the amount the PBM or PBA pays to the pharmacies, which includes spread pricing, transaction fees, network fees, and claw-backs for arrangements such as global effective rate guarantees.[17] In addition, prescription drug rebates received and accrued must be deducted from incurred claims regardless of (1) the source of the rebate, and (2) who retains the rebate (the MCP or the third-party vendor).[18] Amounts related to the reduction of incurred claims costs for rebates retained by the PBM or PBA can be included in non-claims costs.
- Salaries and benefits, excluding amounts reported in QIA expenses. (45 CFR §158.160(b)(2)(iii))
- Depreciation. (45 CFR §158.160(b)(2)(v))
- Fees, such as bank service charges. (45 CFR §158.160(b)(2)(v))
- Insurance. (45 CFR §158.160(b)(2)(v))
- Interest expense. (45 CFR §158.160(b)(2)(v))
- Office supplies and equipment. (45 CFR §158.160(b)(2)(v))

[17] For a description of "spread pricing", see: https://www.cms.gov/newsroom/press-releases/cms-issues-new-guidance-addressing-spread-pricing-medicaid-ensures-pharmacy-benefit-managers-are-not.

[18] Centers for Medicare & Medicaid Services. "CMCS Informational Bulletin: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors." May 15, 2019. https://www.medicaid.gov/federal-policy-guidance/downloads/cib051519.pdf.

- Professional and outside services. (45 CFR §158.160(b)(2)(v))
- Repairs and maintenance. (45 CFR §158.160(b)(2)(v))
- Travel. (45 CFR §158.160(b)(2)(v))
- Indirect expenses for QIA. QIA expenses not directly related to QIA must be reported as non-claims costs. Examples of these expenses include office space, equipment, and information technology infrastructure. (45 CFR §158.150(a))
- Taxes and assessments, excluding amounts reported as federal and state taxes and licensing or regulatory fees required under 42 CFR §438.8(f)(3). (45 CFR §158.160(b)(2)(v))
- Fines and penalties by regulatory authorities. (42 CFR §438.8(e)(2)(v)(A)(*4*))
- Federal and state employment taxes and assessments, excluding amounts reported in QIA expenses required under 42 CFR §438.8(e)(3). (45 CFR §158.160(b)(2)(iii))
- Other administrative expense. (45 CFR §158.160(b)(2)(v))

Reported non-claims expenses should also include the following additional non-claims expense items that are generally not included in the administrative load for capitation rate setting. These items should be reported in non-claims on separate lines so the costs can easily be excluded for rate setting purposes. They include:

- Lobbying expenses.
- Marketing, advertising, and public relations expenses.
- Entertainment and alcoholic beverages.
- Contributions and donations.

States should specify additional types of non-claims costs to ensure the amounts are excluded from incurred claims and ensure administrative margins are properly set in capitation rate setting. CMS recommends that managed care contracts also provide information on costs that are unallowable for capitation rate setting.

B. Enhanced expense allocation reporting

A recent CMS state-level Medicaid MLR review[19] noted that MCPs' MLR reports to states lacked information on expense allocation. CMS determined that several plans operated in multiple markets—for example, Medicaid and Medicare Advantage—and failed to adequately describe how certain costs that may apply across multiple lines of business were allocated to the Medicaid line of business. This lack of transparency may make it impossible for a state to determine if the MCP's allocation of the applicable expenses to the Medicaid line of business was reasonable. For example, if an MCP operating in multiple markets does not provide

[19] Centers for Medicare & Medicaid Services, Center for Program Integrity. "Oregon Medicaid Managed Care Medical Loss Ratio Audit. Audit Period: Calendar Year 2019 Reporting Period. Final Report." March 2023. https://www.cms.gov/files/document/oregon-medicaid-managed-care-medical-loss-ratio-report.pdf.

information on how QIA expenses were allocated to the Medicaid MLR, the state will be unable to determine if the MLR numerator is accurately reported or inappropriately inflated.

The expense allocation and methodology must be included in MCP MLR reports (42 CFR §§438.8(g) and 438.8(k)(1)(vii)) and must reflect the same information required under the private market regulation at 45 CFR §158.170(b). The report should contain a detailed description of the methods used to allocate expenses, including incurred claims, QIA expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs as described in 45 CFR §158.170(b). See **Exhibit V.1**. The enhanced reporting will provide states more detailed information to ensure the appropriateness of MCPs' expense allocation (89 FR 41133). See Section VII. Using the CMS Technical Resource for MLR Reporting for more information.

Exhibit V.1. Description of methods used to allocate expenses (42 CFR §438.8(k)(1)(vii))

The MLR report must include a detailed description of each expense element, including how each expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated (45 CFR §158.170(b)).

- Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented as incurred claims, QIA, federal and state taxes and licensing or regulatory fees, and other non-claims costs will generally be the most accurate method. If a specific identification is not feasible, issuers should explain why they believe a more accurate result will be gained from allocating expenses based on pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.
- Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.
- Any basis adopted to apportion expenses must be one that is expected to yield the most accurate results and may be based on special studies of employee activities, salary ratios, premium ratios, or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

C. Clarify reporting of reinsurance arrangements in MLR

Under 42 CFR §438.8(f)(2)(vi), MCPs are required to report the results of risk sharing arrangements in the MLR denominator as an adjustment to premium revenue. Per 42 CFR §438.6(b)(1), risk sharing mechanisms such as reinsurance, risk corridors, or stop-loss limits must be described in the contract. Some states require by statute or as a state contract stipulation that Medicaid MCPs purchase reinsurance. For states that require MCPs to purchase reinsurance, MCPs should adjust premium revenue in the MLR denominator by the net payments or receipts related to reinsurance arrangements. This premium adjustment for reinsurance was described in the 2016 managed care final rule (81 FR 27528). When reinsurance is required by statute or the MCP contract, the MLR denominator adjustment

would apply to both commercial reinsurance and state-based reinsurance programs. If reinsurance is not required by statute or the MCP contract, then net payments or receipts related to reinsurance arrangements (either commercial or state-based programs) would be reported as non-claims costs.

D. Clarify utilization management expenses in MLR

Certain utilization management activities are designed to contain costs rather than improve quality. As noted above, utilization management expenditures primarily designed to contain costs should be reported as non-claims costs. As described at 42 CFR §438.8(e)(3)(i), QIAs cannot include any prospective, concurrent, or retrospective utilization management costs that do not meet the definition of QIA in 45 CFR §158.150. **States must monitor all managed care programs per 42 CFR §438.66—including the QIA expenditures reported by MCPs—to determine if any of the reported expenditures have the primary goal of cost containment and should be excluded from the MLR numerator.** States should also ensure that where MCPs report all expenses from any given cost center as QIA, to the extent the cost center also performs non-QIA functions, only those qualifying expenses are included in the numerator. In such cases, the state should ensure that the MCP provides the state with documentation, such as time studies, showing how it determined the portion of time that staff expended on QIA programs versus non-QIA programs (89 FR 41131).

E. Clarify services related to HRSN expense reporting in MLR

CMS guidance on including expenses for activities to address social determinants of health (SDOH) in MLR is also relevant for HRSN expenses.[20] CMS clarified in the 2016 final rule (81 FR 27537) that services approved under a waiver (for example, sections 1915(b)(3), 1915(c), or 1115 of the Social Security Act) are considered state plan services for purposes of MLR requirements and are encompassed in the reference to state plan services in 42 CFR §438.3(c). **Therefore, if services to address SDOH are approved under these waiver authorities for the state Medicaid program, and the services are included in the managed care contract, then the covered services must be incorporated in the numerator of the MCP's MLR.**

Box V.3. SDOH activity examples:

CMS encourages states and MCPs to review the original guidance (SHO# 21-001, RE: Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)) as it contains many examples of activities that address SDOH.

Additionally, states may develop and implement specific MCP procurement and contracting strategies to incentivize care coordination across medical and nonmedical contexts, including to address SDOH. **If MCPs implement SDOH activities that meet the requirements in 45**

[20] Centers for Medicare & Medicaid Services. "SHO# 21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH)." January 7, 2021. https://www.medicaid.gov/federal-policy-guidance/downloads/sho21001.pdf.

CFR §158.150(b) and are not excluded under §158.150(c), MCPs may include the costs associated with these activities in the numerator of the MLR as activities that improve health care quality under 42 CFR §438.8(e)(3).

Under the 2016 final rule (81 FR 27526), CMS also clarified **that all services under 42 CFR §438.3(e), including approved in lieu of services and settings (ILOS) at §438.3(e)(2), can be considered as incurred claims in the MLR numerator.** Under §438.3(e)(1), an MCP may voluntarily cover services that are in addition to those covered under the state plan for enrollees. These services are often referred to as value-added services, and those costs may not be included in the capitation rate. However, as outlined in the 2016 final rule (81 FR 27526), value-added services can be considered as incurred claims in the numerator for the purposes of the MLR calculation if the services are activities that improve health care quality under 45 CFR §158.150 and are not excluded under §158.150(c). CMS also provided this information in the preamble to the 2024 managed care final rule (89 FR 41133).

F. Clarify exclusion of MCP incentives from the MLR calculation

Incentive arrangements between states and MCPs in accordance with 42 CFR §438.6(b)(2) cannot be included in the MLR calculation as these payments are in addition to the capitation payments received under the contract. See the 2016 final rule, 81 FR 27530. With an incentive arrangement, an MCP may receive additional funds over and above the capitation rates for meeting targets specified in the contract and rate certification as defined in 42 CFR §438.6(a); it is not considered part of the capitation payments and cannot be treated as such.

G. Clarify adjusting premium revenue for CBEs

The Medicaid MLR regulations specify that only those MCPs that are exempt from federal income taxes can adjust premium revenue for CBEs within specific limits. MCPs that are not exempt from federal income taxes do not have the option to report CBEs in the MLR denominator but may include CBEs as non-claims costs. CBEs are expenditures for activities that seek to improve access to health services, enhance public health, and relieve government burden. Expenditures that do not meet the definition of CBEs in 45 CFR §158.162(c) should not be allowed.

CBEs include any of the following activities that:

- Are available broadly to the public and serve low-income consumers.
- Reduce geographic, financial, or cultural barriers to accessing health services, and if they ceased to exist, would result in access problems (for example, longer wait times or increased travel distances).

- Address federal, state, or local public health priorities such as advancing health care knowledge through education or research that benefits the public.
- Leverage or enhance public health department activities such as childhood immunization efforts.
- Otherwise would become the responsibility of government or another tax-exempt organization.

There are two methods for determining the limits to the premium adjustment from CBEs described at 42 CFR §438.8(f)(3)(v). CBEs made by an eligible MCO, PIHP, or PAHP are limited to the higher of either:

- Three percent of earned premium, or
- The highest premium tax rate in the state for which the report is being submitted, multiplied by the MCO's, PIHP's, or PAHP's earned premium in the State.

Section VI:

Staffing and Organizational Considerations

States should bring together an appropriate combination of staff with the skills and knowledge to collect, validate, and report MLR data. Although staffing resources will vary by state, staff review and reporting of MLR data will typically be integrated with other Medicaid managed care financial reporting, monitoring, and oversight responsibilities.

To create an effective staff structure for MLR data collection, validation, and reporting, states should consider the availability, skills, and knowledge capabilities of their MCP financial oversight staff. This section describes the range of skills, expertise, and capabilities necessary for the staff at a state Medicaid agency or contracted vendor(s) who have financial monitoring and oversight responsibilities, including oversight of MLR reporting.

Section at a Glance

Aim: Create an effective staff structure for MLR data collection, validation, and reporting. Assess staff skills and knowledge areas and identify staffing gaps.

List of figures and tables:

- **Figure VI.1.** MLR staffing approaches
- **Appendix Table VI.1.** Excerpts on major responsibilities from state job descriptions for financial monitoring and oversight staff
- **Appendix Table VI.2.** Details on required knowledge and skills from state job descriptions for financial monitoring and oversight staff

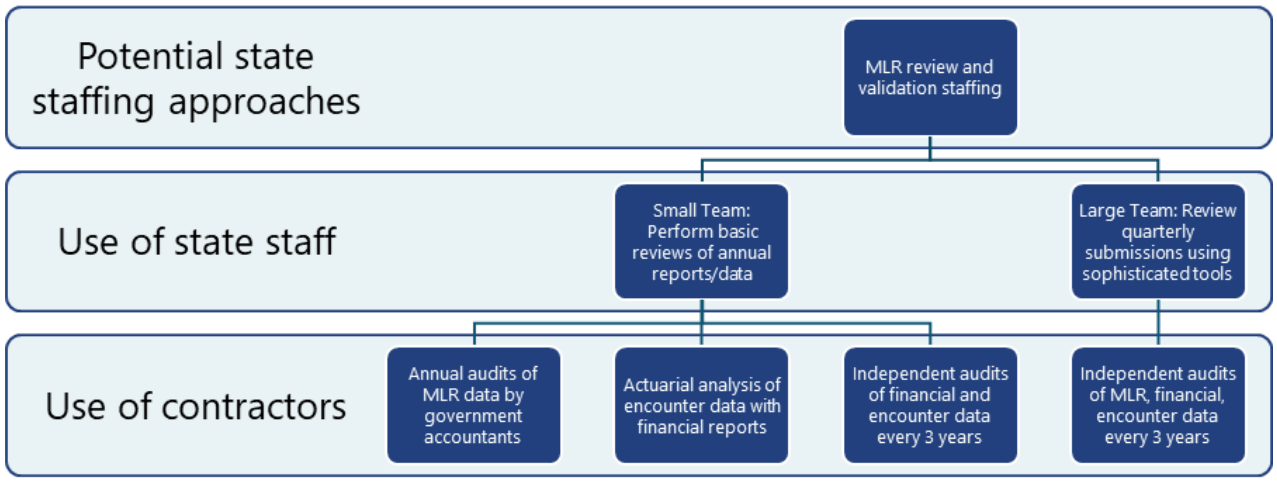
A. Building a team of skilled financial oversight staff

There are four steps states can consider when building a team and determining staffing needs.

1. Determine the staffing approach.

The first step in building a skilled team is to determine available staffing resources. See **Figure VI.1**. Whether a state has a smaller or larger state-employed financial oversight team will likely impact the staff involved with the state's MLR data validation approach. See Section III: MLR Data Validation and the decision to supplement in-house staff with vendors. See Step 3. Consider using vendors to supplement state staff capabilities. How states choose to assemble their teams will also depend on how a state Medicaid agency organizes its financial oversight and reporting offices, divisions, or units, as well as the size of the Medicaid managed care program(s), number of MCPs, and subcontractors.

Figure VI.1. MLR staffing approaches



Based on CMS state interviews, at a minimum, states should consider having approximately three full-time staff who support MLR and other managed care financial reporting. These include at least two experienced individuals who can provide financial oversight of MCPs and work with contractors responsible for auditing. States that intend to perform extensive MLR data validation in-house will likely need additional staff. For example, Arizona employs one financial analyst or consultant per two to three of its MCOs to analyze quarterly and annual financial reports, including MLRs. Virginia employs two financial analysts, one for each of its programs, who are supervised by the managed care rate setting manager. These staff are supported by a division director.

2. Assess skills and knowledge areas.

The second step in building an effective team is to ensure state and vendor staff have the skills and capabilities to analyze MLR and broader managed care financial reporting, including the integration of these two areas. When recruiting for financial monitoring and oversight staff, states mentioned that successful candidates have the following key characteristics: a background in accounting, financial reporting, and analysis of provider payment; an understanding of financial statements; and a background in data collection and analysis. The following skills and knowledge areas are important for both managerial and line staff working with MLR and other financial data reported by MCPs. See **Box VI.1**.

Box VI.1.

In sourcing candidates for MLR work, **California** identified candidates that had a policy background to interpret state and federal regulations and the ability to translate these requirements into financial reporting documents, instructions, and state All Plan Letters (APLs) provided to stakeholders.

The state used its experience and understanding of the analytic reviews required of MLR data for adult expansion Medicaid to inform its staff search.

In **Arizona**, staff responsible for MLR reporting have financial and accounting backgrounds; most have a bachelor's degree in accounting.

Skills and knowledge areas

- **Data collection and data analysis:**
  - Ability to collect, organize, monitor, and analyze financial data reported by MCPs, including analyzing comparative data from different sources. For example, MLR reporting and financial statements submitted by MCPs
  - Ability to perform quantitative data analysis. For example, compare MCP MLR information to MCP financial statements).
- **Written and verbal communications:**
  - Ability to develop clear and user-friendly manuals, guidance, and other technical documents and make revisions based on regulations, policy, and other programmatic changes.
  - Ability to work with MCP staff on financial data reporting submissions, questions, and to troubleshoot issues.
  - Ability to work with consultants, such as auditors, financial consultants, and actuaries, on tasks related to required financial and MLR reporting.
- **Payment:**
  - Knowledge of financial analysis and reporting methods, accounting practices and standards, and cost reports.
  - Knowledge of managed care capitation rate setting and provider reimbursement.
  - Knowledge of health care claims processing and incurred claims analysis.
- **State and federal managed care policy and standards:**
  - Understanding of financial oversight, monitoring, and reporting requirements and ability to interpret federal and state laws, regulations, and guidance regarding Medicaid managed care.
  - Ability to translate updates and changes from regulations and guidance to existing financial oversight and monitoring processes and procedures.
- **Contracts:**
  - Understanding of reporting and monitoring requirements in managed care contracts.

Appendices VI.1 and VI.2 feature excerpts of major responsibilities and required knowledge and skills from job descriptions for analyst-level employees tasked with managed care financial oversight and monitoring.

3. Consider using vendors to supplement state staff capabilities.

States can use vendor staff to supplement state staff bandwidth and/or skills. Vendors, such as financial consultants and actuaries, can assist state staff by verifying the completeness and accuracy of MLR reporting. See **Box VI.2**. For example, states with smaller state-employed financial oversight teams may solicit assistance from financial consultants, auditors, or actuaries to (1) help verify that MCPs' reported MLRs are calculated correctly and (2) compare the MLR data to the annual audited financial report and/or capitation rate information. See Section III for more information on MLR data validation approaches. Additionally, all states—as part of their managed care financial oversight responsibilities—must conduct or contract for an independent, periodic audit of the accuracy, truthfulness, and completeness of the encounter and financial data, including MLR financial information, submitted by MCPs at least once every three years, as required under 42 CFR §438.602(e). These audits are typically conducted by certified public accountants (CPAs).

Box VI.2.

California works in tandem with an external actuary to review MLR submissions for completeness and accuracy. Specifically, the actuary:

- Updates the MLR reporting guidance and template as needed.
- Verifies that each MCP's reporting package is complete and notifies MCPs of any additional documents they need to submit.
- Organizes the MLR data from all MCPs for review and comparison.
- Supports data validation on the MLR numerator, non-claims costs, and allocation methodologies.
- Identifies outliers or concerns by comparing data to MCPs with similar populations and MCP types, checks parity of tax expenses between non-profit and for-profit entities, and confirms that MCPs excluded pass-through payments.

State staff review and analyze revenue data for the service period to validate the capitation payments reported in the denominator and follow-up with MCPs on outliers, unexpected results, and classification issues. The CFO signs off on final MLR determinations.

Section VII:

Using the CMS Technical Resource for Plan-to-State MLR Reporting

To help states improve their MLR data collection and validation processes, CMS created a technical resource that states can use to collect MLR information from MCPs pursuant to 42 CFR §438.8(k)(1). States may use this resource, included in Appendix VII of this toolkit, to modify the current MLR data collection tool that is provided to MCPs. After release of this toolkit, CMS will release a Microsoft Excel template that includes the reporting items in the technical resource as well as formulas and links from supplemental worksheets. The Excel template will be available on Medicaid.gov. States may use their discretion in deciding whether to adopt the CMS technical resource or use an alternative template for MCPs to report MLR information to the state.

Section at a Glance

Aim: Introduce the CMS technical resource for plan-to-state MLR reporting and explain how states can implement the resource

List of tables:

- **Appendix Tables VII.1 – VII.8.** CMS technical resource for plan-to-state MLR reporting

It is important to note that CMS' technical resource does not include the most extensive set of items that states can use for MLR reporting from MCPs. However, it includes line items and supplementary reporting worksheets beyond the minimum set of items required in 42 CFR §438.8(k)(1). States currently using templates with more extensive lists of reporting items than CMS' technical resource may continue to use their existing templates. States using a template with fewer reporting items than CMS' technical resource may continue to use their existing templates, provided they include all the required reporting items under 42 CFR §438.8(k)(1). However, by not aligning their reporting templates with CMS' technical resource, these states may not have sufficient information to validate the MLR information received from MCPs.

A. Implementing the CMS technical resource for plan-to-state MLR reporting

States with established MLR reporting templates and managed care programs should consider review and potential revisions of existing templates and instructions based on the content and data components included in the CMS technical resource and instructions. CMS recommends implementing new or revised MLR data reporting tools and/or instructions at the start of a rating period, or soon after the rating period begins, rather than in the middle

of a rating period. Contract language should be reviewed before implementing revisions to ensure the MLR data collection process and tools are clearly indicated in current contracts.

States with long-standing, established Medicaid managed care programs may have developed a process for providing an MLR reporting template and instructions to the MCPs; they can use the same process using the CMS technical resource. However, if a state is implementing a new managed care program and does not yet have an established procedure for disseminating the new MLR technical resource to MCPs, states should consider methods that include version controls to ensure proper MLR reporting. Many states post the latest reporting template and instructions on a website and direct MCPs to download the latest version of the template and instructions each reporting year.

Box VII.1.

States implementing the CMS technical resource should follow these guidelines:

- Consider whether to adopt the CMS technical resource, or modify an existing template based on CMS' technical resource.
- Determine how the technical resource will be distributed to MCPs.
- Train MCPs on how to use the technical resource for MLR reporting.

For states with established Medicaid managed care programs that are substantially modifying or replacing previous MLR reporting templates with the CMS technical resource, CMS recommends providing MCPs with a comparison or "crosswalk" of the previous template with the CMS technical resource. The crosswalk should detail how to provide previously reported MLR information on the revised state template. States should provide in-depth training on how to include new information that was not previously requested. For example, if a state's previous MLR reporting template did not request a detailed breakout of incurred claims, the state should provide training on the new line items and explain why they are needed.

B. Release of the CMS technical resource in a Microsoft Excel template

When CMS releases the technical resource adapted as a template in Microsoft Excel, it will provide states with the flexibility to adapt to their unique Medicaid managed care program needs. Various elements of the Excel template will be customizable for state needs, including capturing data for specific eligibility groups, collecting net payments or receipts related to the state's various risk sharing arrangements, SDPs, and targeted non-claims costs. The template will capture the requirements in 42 CFR §438.8(k) that states must comply with by providing tabs to collect detailed methodologies for allocation of expenditures and comparisons of the MLR information to the audited financial report.

The first step in implementing the Excel template will involve customizing it for state specifications based on the state's Medicaid managed care contract and program requirements. This includes defining the MLR reporting period and runout date and customizing the MLR attestation language.

C. Supporting MCPs after template implementation

MCPs may need technical support or have questions regarding the technical resource. CMS recommends ensuring state personnel are knowledgeable about both the CMS technical resource and the federal policy and guidance that are the basis for the CMS technical resource's structure and content, as well as state-specific contractual requirements that may impact MLR reporting. Knowledgeable state staff can answer technical and policy questions from MCPs.

Box VII.2.

Follow-ups for implementing and using the CMS technical resource for plan-to-state MLR reporting:

- Validate all MLR data received from MCPs.
- Expect release of the MLR reporting template in Microsoft Excel form.
- Keep an eye out as CMS releases future versions of the template reflecting regulatory or guidance changes.

States are responsible for reviewing the completeness and validating submitted MLR data; states may contract with a qualified auditor or other vendor to validate the data. See Section III for recommended validation procedures. States should also use validated MLR data to monitor financial performance of plans and to inform rate setting. Refer to Section IV for recommended methods for monitoring financial performance of plans and informing rate setting.

CMS may release updated versions of the CMS technical resource to account for regulatory changes or guidance changes. CMS will notify states in advance of planned reporting template changes to give states sufficient time to modify templates and instructions to MCPs.

Appendix I.

Appendix I intentionally left blank: Section I does not include an appendix.

Appendix II. MLR Data Collection

Appendix Table II.1. MLR reporting requirements excerpts from MCP contracts, including high-risk program integrity areas

Disclaimers: (1) Please contact the state's managed care analyst from the Division of Managed Care Operations (DMCO) for questions and technical assistance about MLR contract language; (2) Excerpts in Appendix Table II.1 come directly from state contracts with MCPs that CMS has reviewed and approved in the past; (3) Each state must evaluate the examples and consult with its legal staff about the applicably and appropriateness for use by the state.

Appendix Table II.1. MLR reporting requirements excerpts from MCP contracts, including high-risk program integrity areas

Contract element	Excerpts from MCP contracts
Provider incentives and bonus payments based on performance metrics	• "Expenditures that must be included in incurred claims include: a. The amount of incentive and bonus payments made, or expected to be made to Network Providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section B.3.a."*
Activities that improve health care quality—general requirements	• "Activities that improve health care quality must be in one of the following categories: (a) Contractor's activity that meets the requirements of 45 CFR §158.150(b) and is not excluded under 45 CFR §158.150(c); (b) Contractor's activity related to any External Quality Review-related activity as described in 42 CFR §438.358(b) and (c); or (c) Any Contractor expenditure that is related to Health Information Technology (HIT) and meaningful use, meets the requirements placed on issuers set forth in 45 CFR §158.151, and is not considered incurred claims, as defined in this provision. Contractor's expenditures on activities related to Fraud prevention as described in 45 CFR Part 158, and not including expenses for Fraud reduction efforts." *Source: CA Medi-Cal Managed Care Plans, Primary Operations Contract Sample, 1.2.5(C)(2)(a)-(c).* • "General Requirements. The MLR Report may include expenditures for activities that improve health care quality, as described in this section. The expenditures must be directly related to activities that improve healthcare quality and meet the following requirements: a. An activity that meets the requirements of 45 CFR §158.150(b) and is not excluded under 45 CFR §158.150(c). b. An activity related to any EQR-related activity as described in 42 CFR §438.358(b) and (c). c. Any expenditure that is related to Health Information Technology and meaningful use, meets the requirements placed on issuers found in 45 CFR 158.151, and is not considered incurred claims. *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section C.1."*

Contract element	Excerpts from MCP contracts
Activities that improve health care quality—activity requirements	• "Activity Requirements. Activities conducted by the Contractor to improve quality must meet the following requirements: a. The activity must be designed to: i. Improve health quality; ii. Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements; iii. Be directed toward individual Members or incurred for the benefit of specified segments of Members or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-Members;

Contract element	Excerpts from MCP contracts
Activities that improve health care quality—activity requirements *(cont'd.)*	iv. Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations; v. Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations. Examples include the direct interaction of the Contractor (including those services delegated by Subcontract for which the Contractor retains ultimate responsibility under the terms of the Contract with the Division) with Providers and the Member or the Member's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as: (a) Effective Care Management, Care Coordination, chronic disease management, and medication and care compliance initiatives including through the use of the Medical Homes model as defined in the section 3502 of PPACA; (b) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine; (c) Quality reporting and documentation of care in non- electronic format; (d) Health information technology to support these activities; vi. Accreditation fees directly related to quality of care activities; vii. Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD-10 as the standard medical data code set, implementing ICD-10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C.1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in §158.130. viii. Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include: (a) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital; (b) Patient-centered education and counseling; (c) Personalized post-discharge reinforcement and counseling by an appropriate health care professional; (d) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission; and, (e) Health information technology to support these activities. ix. Improve patient safety, reduce medical errors, and lower infection and mortality rates. Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include: (a) The appropriate identification and use of best clinical practices to avoid harm; (b) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns; (c) Activities to lower the risk of facility-acquired infections; (d) Prospective prescription drug utilization review aimed at identifying potential adverse drug interactions; (e) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors; and health information technology to support these activities. x. Implement, promote, and increase wellness and health activities. Examples of activities primarily designed to implement, promote, and increase wellness and health include, but are not limited to: (a) Wellness assessments (b) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements (c) Coaching programs designed to educate individuals on clinically effective methods for dealing with a specific chronic disease or condition;

Contract element	Excerpts from MCP contracts
Activities that improve health care quality—activity requirements *(cont'd.)*	(d) Public health education campaigns that are performed in conjunction with state or local health departments; Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS (Public Health Service) Act; (e) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities; (f) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and (g) Health information technology to support these activities. xi. Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with 45 CFR §158.151." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section C.2"*
Exclusions from activities that improve health care quality	• "Exclusions. Expenditures and activities that must not be included in quality improving activities are: a. Those that are designed primarily to control or contain costs; b. The pro rata shares of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans; c. Those which otherwise meet the definitions for quality improvement activities, but which were paid for with grant money or other funding separate from premium revenue; d. Those activities that can be billed or allocated by a Provider for care delivery and which are, therefore, reimbursed as clinical services; e. Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD- 10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended; f. That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality; g. All retrospective and concurrent utilization review; h. Fraud prevention activities; i. The cost of developing and executing Provider contracts and fees associated with establishing or managing a Provider Network, including fees paid to a vendor for the same reason; j. Provider credentialing; k. Marketing expenses; l. Costs associated with calculating and administering individual Member or employee incentives; m. That portion of prospective utilization that does not meet the definition of activities that improve health quality; n. Any cost that is not directly applicable to providing measurable quality improving activities such as corporate administrative allocations, amounts exceeding actual cost of providing service, or other overhead expenses that do not directly support the healthcare quality initiative; o. State and federal taxes, licensing and regulatory fees; and p. Any function or activity not expressly included in paragraph one (1) or two (2) of this section, unless otherwise approved by and within the discretion of the Division, upon adequate showing by the Contractor that the activity's costs support the definitions and purposes described above or otherwise support monitoring, measuring or reporting health care quality improvement. Note: The Contractor must also possess documentation for the source expense, methodology for determining how the expense meets the above definition of an expense that improves healthcare quality improvement, the allocation methodology and statistics utilized for any allocation. Note: DOM has adopted the definitions and guidelines provided in the Patient Protection and Affordable Care Act, 45 CFR Parts 144, 147, 153, 155, 156, and 158 as recorded in the Federal Register, Vol. 87, No. 88, issued on May 6, 2022. Qualifying direct quality improvement activity (QIA) expense is limited to the QIA portion of salaries and benefits for employees directly performing QIA functions for inclusion in the MLR calculation. Expenses for items such as office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives,

Contract element	Excerpts from MCP contracts
Exclusions from activities that improve health care quality *(cont'd.)*	equipment, computer and telephone usage, travel and entertainment, company parties and retreats, IT infrastructure and systems, and software licenses do not qualify as direct QIA expense. Please reference the guidance provided in PPACA regulation, as well as the remainder of this section when determining reportable QIA expense." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section C.3."*
Non-claims costs	• "F. 1. Non-Claims Costs. 1. General Requirements. The MLR Report must include non-claims costs, which are those expenses for administrative services that are not: incurred claims (as defined in section B, Reimbursement for Clinical Services Provided to Members), expenditures for activities that improve health care quality (as defined in section C, Activities that Improve Health Care Quality) or licensing and regulatory fees or Federal and State taxes (as defined in section L, Formula for Calculating Medical Loss Ratio). 2. Non-Claims Costs Other. The MLR Report must include any expenses for administrative services that do not constitute adjustments to capitation payments for clinical services to Members, or expenditures on quality improvement activities as defined above. Expenses for administrative services include the following: a. Cost-containment expenses not included as an expenditure related to a qualifying quality activity; b. Loss adjustment expenses not classified as a cost containment expense; c. Workforce salaries and benefits; d. General and administrative expenses; and e. Community benefit expenditures. Revenue and expenses for administrative services should exclude the Health Insurer Tax, any allocation for premium taxes and any other revenue based assessments. 3. Expenses Not Allowable as Non-Claims Costs. The following expenses are not allowable to be included in non-claims costs or for consideration by the Division's actuaries for capitation rate setting purposes: a. Charitable contributions made by Contractor; b. Any penalties or fines assessed against Contractor; c. Any indirect marketing or advertising expenses of the Contractor, including but not limited to costs to promote the managed care plan, costs of facilities used for special events, and costs of displays, demonstrations, donations, and promotional items such as memorabilia, models, gifts, and souvenirs. The Division may classify an item listed in this clause as an allowable administrative expense for rate-setting purposes, if the Division determines that the expense is incidental to an activity related to state public health care programs that is an allowable cost for purposes of rate setting; d. Any lobbying and political activities, events, or contributions; e. Administrative expenses related to the provision of services not covered under any state MCP or waiver; f. Alcoholic beverages; g. Memberships in any social, dining, or country club or organization; h. Entertainment, including amusement, diversion, and social activities, and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities; i. Bad Debts of the Contractor; j. Liquidated Damages paid to the Division, the State, or any other entity; k. Capital Expenditures-Expenditures for items requiring capitalization are unallowable (depreciation of these capital expenditures, and maintenance expenses, in accordance with GAAP, are allowable); l. Abnormal or mass severance pay where payments of salaries and wages or any benefit arrangements exceed two months of compensation; m. Cost of unallowable financing expenses (interest, bond issuance, bond discounts, etc.) as determined by applying the principles included in CMS Publication 15.1 Chapter 2, interest expense; n. Defense and Prosecution (of criminal proceedings, civil proceedings, and claims are generally unallowable). Exceptions are costs relating to Contractors' obligation to identify, investigate, or pursue recoveries relating to suspected Fraud, Waste, or Abuse of providers or Subcontractors and the reasonable legal costs related to subrogation, third party recoveries and provider credentialing matters, if incurred directly in administration of the Contract;

Contract element	Excerpts from MCP contracts
Non-claims costs *(cont'd.)*	o. Income Taxes (Federal, state, and local taxes) and State Franchise Taxes - (Other taxes are generally allowable); p. Investment Management Costs; q. Proposal Costs; r. Rebates and Profit Sharing (profit sharing or rebate arrangements between the Contractor and a Subcontractor resulting in fees or assessments which are not tied to specifically identified services that directly benefit the Contract are unallowable unless specifically allowed by Contract. This fee effectively becomes a form of profit payment or rebate); s. Royalty Agreements (associated fees, payments, expenses, and premiums); t. Losses in excess of the remaining depreciable basis for the disposition of depreciable property; u. Costs in excess of what a reasonable or prudent buyer would pay for goods or services. For the purposes of this subsection, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits. Charitable contributions under clause (a) include payments for or to any organization or entity selected by the Contractor that is operated for charitable, educational, political, religious, or scientific purposes that are not related to medical and administrative services covered under and state plan." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section F.*
Allocation of expenses	• "H.1. General Requirements. Each expense must be reported 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 populations, or contracts other than those being reported, must be reported on a pro rata basis." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section H.* • "Pursuant to 42 CFR §438.8, when reporting expenses the Contractor must ensure that each expense must be included under only one (1) type of expense, unless a portion of the expense fits under the definition of, or criteria for, one (1) type of expense and the remainder fits into a different type of expense, in which case the expense must be prorated between types of expenses. In accordance with 42 CFR §438.8, expense allocation must be based on a generally accepted accounting method that is expected to yield the most accurate results. The MLR must reflect the following, if applicable: 1. Expenditures that benefit multiple contracts or populations (such as Medicaid Expansion and non-Expansion), or contracts other than those being reported, must be reported on a pro rata basis, per 42 CFR §438.8(g)(1)(ii); 2. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the contract and/or population incurring the expense, per 42 CFR §438.8(g)(2)(ii); and 3. Expenses that relate solely to the operation of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to the other entities, per 42 CFR §438.8(g)(2)(iii)." *Source: VA MLR Sample Contract Language.*
Description of methods used to allocate expenses	• "I.1. General Requirements. The report required must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, and other non-claims costs resulting from Contractor activities in Mississippi. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated. a. Allocation to each category must be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the Contractor must provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses; b. Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense; and,

Contract element	Excerpts from MCP contracts
Description of methods used to allocate expenses *(cont'd.)*	c. Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios, Capitation Payment ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section I.*
Data aggregation	• "Contractor must aggregate data by Potential Member groups as defined in this Contract, or as otherwise directed by DHCS. This may require separate reporting and MLR calculations for specific populations." *Source: CA Medi-Cal Managed Care Plans, Primary Operations Contract Sample, 1.2.5(G).*
MLR exemption language	• "Contractor may be excluded from the requirements in this Provision in the first MLR Reporting Year of its operation. Contractor then must comply with these requirements beginning with the next MLR Reporting Year in which it contracts with DHCS, even if the first MLR Reporting Year was not a full 12 months." *Source: CA Medi-Cal Managed Care Plans, Primary Operations Contract Sample, 1.2.5(I).*
State directed payments	• "The MLR Report will include all state directed payments paid pursuant to 42 CFR §438.6(c) to include payments received by the Contractor reported as Capitation Revenue on the MLR Report for dates of service within the Rating Period, including any adjustments." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section G.*
MLR report submission frequency, timelines, and requirements	• "Pursuant to 42 CFR §438.8, the Contractor is required to submit a report annually that includes information for each MLR reporting year for both Base Medicaid Members as well as Medicaid Expansion Members. The Contractor must submit to the Department, in the form and manner prescribed by the Department, the necessary data to calculate and verify the MLR within nine (9) months of the end of the reporting year. The MLR reporting year must be the contract year." *Source: VA MLR Sample Contract Language.*
Claims runout requirements	• "A run-out period of 180 days is required for the first annual MLR report. For the quarterly report, use the state fiscal year-to-date information with the 30-day run-out period. The report for each MLR Reporting Year must be submitted to the Division by April 1st of the year following the end of an MLR Reporting Year. The report for each MLR Reporting Quarter must be submitted to the Division by the sixtieth (60th) calendar day following the end of the MLR Reporting Quarter." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements.*
Complying with annual financial report and audit	• "Financial Reports: The Contractor shall provide clarification of accounting issues found in financial reports identified by AHCCCS upon request and provide annual financial reports audited by an independent Certified Public Accountant prepared in accordance with Generally Accepted Auditing Standards (GAAS) and the Cost Allocation Plan. The Contractor shall have the annual Supplemental Reports audited and signed by an independent Certified Public Accountant [42 CFR §438.3(m)] . . .The Contractor shall submit a Medical Loss Ratio (MLR Report in compliance with 42 CFR §457.1203 and 42 CFR §438.8 . . . All components of the calculation should include annual audit adjustments and true up of any estimates to present on an incurred date of service basis . . . For additional information refer to the AHCCCS Financial Reporting Guide." *Source: AZ Sample Contract, Section D. Program Requirements, 47. Financial Reporting and Viability Standards.*
Incorporating retroactive capitation rate adjustment after MLR report submission	• "Any retroactive changes to capitation rates after the Contract year end will need to be incorporated into the MLR calculation. If the retroactive capitation rate adjustment occurs after the MLR report has been submitted to AHCCCS, a new report incorporating the change will be required to be submitted within 30 days of the capitation rate adjustment payment by AHCCCS. For additional information refer to the AHCCCS Financial Reporting Guide." *Source: AZ Sample Contract, Section D. Program Requirements, 47. Financial Reporting and Viability Standards.* • "In any instance where there is a retroactive change to the Capitation Payments for a MLR Reporting Year and the MLR report has already been submitted to DHCS, Contractor must re-calculate the MLR for all MLR Reporting Years affected by the change and submit a new report meeting the reporting requirements in this Provision." *Source: CA Medi-Cal Managed Care Plans, Primary Operations Contract Sample.*

Contract element	Excerpts from MCP contracts
Incorporating retroactive capitation rate adjustment after MLR report submission *(cont'd.)*	• "Recalculation of MLR. In any instance where the Division makes a retroactive change to the Capitation Payments for an MLR Reporting Year where the MLR Report has already been submitted to the Division, Contractor must recalculate the MLR for all MLR Reporting Years affected by the change and submit a new MLR Report meeting the requirements of this section. Refer to 42 CFR §438.8(m). Any recalculated MLR Report identified in this section must be provided to the Division no later than sixty (60) days after the reported retroactive change has been provided to the Division." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements.*
File format	• "The report for each MLR Reporting Year must be submitted to the Division . . . in a format and in the manner prescribed by the Division. The report for each MLR Reporting Quarter must be submitted to the Division . . . in a format and in the manner prescribed by the Division." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements.*
Subcontractors/third party vendors	• "For rating periods during which the State mandates a minimum MLR remittance in accordance with 42 CFR §438.8(j), Contractor shall impose equivalent MLR reporting and remittance requirements on Fully Delegated Subcontractors, Partially Delegated Subcontractors, Downstream Fully Delegated Subcontractors, and Downstream Partially Delegated Subcontractors . . . Contractor must, in compliance with 42 CFR §438.230(c)(1), require all Subcontractors and Downstream Subcontractors to comply with the MLR reporting responsibilities in this Section, including the requirement to distinguish which amounts are actually paid for benefits, or activities that improve health care quality, and which amounts were actually paid for administrative services, taxes, or other activities in accordance with the CMCS Informational Bulletin published May 15, 2019 with the subject "Medical Loss Ratio Requirements Related to Third-Party Vendors." Payments to a Subcontractor or Downstream Subcontractor that are not the amount actually paid to a Provider or supplier for furnishing Covered Services must not be included in incurred claims." *Source: CA Medi-Cal Managed Care Plans, Primary Operations Contract Sample, 1.2.5 and 1.2.5(A)(2) Medical Loss Ratio (MLR).* • "Third party subcontractors. Third party Subcontractors or vendors providing claims adjudication activity services to enrollees are required to supply all underlying data to the Contractor within 180 days of the end of the MLR reporting period or within 30 days of such data being requested by the Contractor in accordance with the requirements of 42 CFR §438.8(k)(3). The Contractor should validate the cost allocation reported by third parties to ensure the MLR accurately reflects the breakdown of amounts paid to the vendor between incurred claims, activities to improve health care quality, and non-claims cost. – Sub-Capitated Vendors. The Contractor must report to the Division the total expenses incurred by the third party vendor for clinical services provided to members, activities that improve health care quality, activities related to external quality review, expenditures related to Health Information Technology and Meaningful Use Requirements, and non-claims cost incurred by the sub-capitated vendors. The sub-capitated payments should be adjusted to reflect the aforementioned expenses to the third party. When the sub-capitation payments to the third party vendor exceed third party vendor's actual costs, the excess (profit margin), should be considered administrative non-claim costs from non-related vendors. When these transactions occur between related parties, there must be justification that these higher costs are consistent with prudent management and fiscal soundness policies to be included as allowable administrative non-claim costs. Refer to Medicare Final Rule 42 CFR §422.516(b). Management Fee Arrangement. The Contractor is encouraged to report to the Division the total expenses incurred by the management organization for the MCP. These costs should be adjusted for any non-allowable activities. In the absence of specific State guidance, the Contractor should refer to other Federal regulations concerning the identification of non- allowable costs." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section J(1-2).* • "In accordance with 42 CFR §438.8(k)(3), the Contractor must require any third party vendor providing claims adjudication activities to provide all underlying data associated with MLR reporting to the Contractor within one hundred and (180) days of the end of the MLR reporting year or within thirty (30) days of being requested by the Contractor, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting. Reporting specifications will be included in the Cardinal Care Technical Manual and the Contractor must attest to the accuracy of the calculation of the MLR in accordance with the MLR standards when submitting required MLR reports." *Source: VA MLR Sample Contract Language.*

Contract element	Excerpts from MCP contracts
Remittance	• [Note: MS sets its minimum MLR at 87.5 percent] "If the MLR (cost for health care benefits and services and specified quality expenditures) is less than eighty-seven and one-half percent (87.5%), the Contractor shall refund the Division the difference no later than the tenth (10th) business day of May following the end of the MLR Reporting Year. Any unpaid balances after the tenth (10th) business day of May shall be subject to interest of ten percent (10%) per annum." *Source: MSCAN CCO Contract, Section 13.G, Medical Loss Ratio.* • "To provide a remittance for an MLR reporting year if the MLR for that MLR reporting year does not meet the minimum MLR standard of 85 percent . . .To acknowledge the right to repeal a remittance being due to the Department within 30 days of notice, and that filing the appeal does not stay the obligation to remit the amount owed to the Department." *Source: MD MCO Agreement 2023, MLR Reporting and Remittance Requirements.*
Additional monitoring or sanctions for failure to submit, data inaccuracies, and/or incomplete data	• "Sanctions may be imposed if the Contractor does not meet [the stated] financial viability standards [that include MLR]. AHCCCS will take into account the Contractor's unique programs for managing care and improving the health status of members when analyzing medical loss and administrative ratio results. However, if a critical combination of the financial viability standards is not met, or if the Contractor's experience differs significantly from other Contractors, additional monitoring, such as monthly reporting, may be required." *Source: AZ Sample Contract, Section D. Program Requirements, 47. Financial Reporting and Viability Standards).*
Maintenance of records	• "Contractor must maintain and retain, and require Subcontractors to retain, as applicable, for a period of no less than ten (10) years, in accordance with 42 CFR §438.3(u), and make available to the Division upon request the data used to allocate expenses reported, together with all supporting information required to determine that the methods identified and reported as required under this Exhibit C [MLR Reporting Requirements] were accurately implemented in preparing the MLR Report." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements, Section K.*
Attestation requirement	• "Contractor must attest to the accuracy of the calculation of the MLR in accordance with the requirements of 42 CFR §438.8(n) when submitting reports required under this section." *Source: MS MSCAN Exhibit C - SFY 24 Medical Loss Ratio (MLR) Requirements.* • "[The Contractor is required] To provide to the Department a completed MLR Reporting Template, including the MCO attestation and any additional documentation supporting the MLR reporting template (Appendix G), in accordance with 42 CFR §438.8, by November 15th of the calendar year following the MLR reporting year." *Source: MD MCO Agreement 2023, MLR Reporting and Remittance Requirements.*
MCP attestation statement when submitting MLR reports to the state	• "I hereby attest that the Medical Loss Ratio (MLR) report provided, consistent with 42 §CFR 438.8, herein is accurate, complete, and truthful. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the report may be prosecuted under the applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the entity already participates, a termination of a Contractor's agreement or contract with the Arizona Health Care Cost Containment System. Failure to sign this Certification Statement, either by written or electronic signature, will result in AHCCCS' non-acceptance of the attached MLR report." *Source: AZ Medical Loss Ratio Annual Attestation Statement.* • "Consistent with 42 CFR §§438.8(n) and 438.606, the officers of this reporting issuer being duly sworn, each attest that he/she is the described officer of the reporting issuer, and that this MLR Report, the Company/Issuer Associations, and any supplemental submission that the issuer includes are full and true statements of all the elements included therein for the MLR reporting year, and that the MLR Report has been completed in accordance with the State's reporting instructions, according to the best of his/her information, knowledge and belief." *Source: CA CY 2021 Mainstream Annual Medi-Cal MLR Reporting Template; VA MLR Reporting Tool.*

Appendix Table II.2. Example summary report comparing MCPs' MLR data

Instructions: This example table shows how states can develop summary reports comparing MCPs' MLR data after the state has validated MCP MLR data. Starting from the left, the "MLR report quarter" lists the quarter and year, starting with quarter 3 (July 1, 2023 – September 30, 2023). For each quarter, state staff can enter each MCP's MLR as reported in the quarterly financial statement. The "total" column for each quarter reflects the weighted average of the MCPs according to the MLR denominator of each plan. For the Q3 2023 report, the weighted average of MCP 1's Q3 MLR of 88.2% and MCP 2's Q3 MLR of 86.3% is 87.2%. The "total" column for the full state fiscal year reflects the weighted average of the respective plan or total in each quarter. For example, for the Q2 2024 report, the weighted average of MCP 1's quarterly MLRs of 90.2%, 83.7%, 93.3% and 82.8% is equal to 87.3%). The SFY total columns on the right side of the chart show the running total MLR percentage as quarterly financial statements including increasingly complete information as the fiscal year progresses.

By building this table in Excel, the state can add additional MCPs and input formulas to pull the quarterly MLR data from quarterly financial reports and the annual audited financial report.

Appendix Table II.2. Example summary report comparing MCP's MLR data

Quarterly financial statement submission	MLR for period: Q3 Year (e.g., 2023)			MLR for period: Q4 Year (e.g., 2023)			MLR for period: Q1 Year (e.g., 2024)			MLR for period: Q2 Year (e.g., 2024)			Cumulative MLR for period: SFY 2023 (e.g., July 1, 2023 – June 30, 2024)		
	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total
Q3 2023	88.2%	86.3%	87.2%										88.2%	86.3%	87.2%
Q4 2023	88.2%	84.2%	86.2%	88.3%	87.1%	87.7%							88.2%	85.6%	86.9%
Q1 2024	87.4%	83.3%	85.3%	85.3%	89.0%	87.1%	91.3%	86.6%	88.9%				87.9%	86.3%	87.1%
Q2 2024	90.2%	84.5%	87.3%	85.4%	87.4%	86.4%	93.3%	83.7%	88.3%	82.8%	90.2%	86.4%	87.8%	86.4%	87.1%
MLR numerator (millions)															
Q3 2023	82.0	82.0	164.0										82.0	82.0	164.0
Q4 2023	82.0	80.0	162.0	83.0	81.0	164.0							165.0	161.0	326.0
Q1 2024	83.0	80.0	163.0	81.0	81.0	162.0	84.0	84.0	168.0				248.0	245.0	493.0
Q2 2024	83.0	82.0	165.0	82.0	83.0	165.0	84.0	82.0	166.0	82.0	83.0	165.0	331.0	330.0	661.0

Quarterly financial statement submission	MLR for period: Q3 Year (e.g., 2023)			MLR for period: Q4 Year (e.g., 2023)			MLR for period: Q1 Year (e.g., 2024)			MLR for period: Q2 Year (e.g., 2024)			Cumulative MLR for period: SFY 2023 (e.g., July 1, 2023 – June 30, 2024)		
	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total	MCP 1	MCP 2	Total
MLR denominator (millions)															
Q3 2023	93.0	95.0	188.0										93.0	95.0	188.0
Q4 2023	93.0	95.0	188.0	94.0	93.0	187.0							187.0	188.0	375.0
Q1 2024	95.0	96.0	191.0	95.0	91.0	186.0	92.0	97.0	189.0				282.0	284.0	566.0
Q2 2024	92.0	97.0	189.0	96.0	95.0	191.0	90.0	98.0	188.0	99.0	92.0	191.0	377.0	382.0	759.0

Appendix III. MLR Data Validation

Appendix Tables III.1–III.5 show how states can validate MLR information using annual audited financial reports, capitation payment reports, rate development data, as well as by comparing various MLR statistics over time and across MCPs. Each table contains instructions and example data to illustrate how to complete it.

Appendix Table III.1. Example table for validating MLR information using MCPs' annual audited financial reports

Instructions: This example table shows how states can validate MLR information using MCPs' annual audited financial reports. Starting from the left, the "MLR element" column lists MLR elements that states should be able to validate using these reports. Specifically, states should be able to validate incurred claims expenses, non-claims expenses, premium revenue, taxes and fees, and member months, if included in a MCP's reports. In the "MLR information" and "financial report" columns, enter values reported by the MCP for each MLR element. The state can manually calculate numeric differences and percent differences in the following two columns. By building this table in Excel, the state can input formulas to calculate those differences. The state can add analysis columns of interest, such as per member per month (PMPM) differences between each source. If the state finds discrepancies during the analysis, such as discrepancies in total incurred claims, non-claims expenses, and premium revenue like in the example data below, the state should work with the MCP to understand and resolve those discrepancies. Finally, the table is for two MCPs, and the state can add rows for each MCP it contracts with.

Appendix Table III.1. Example table for validating MLR information using MCPs' annual audited financial reports

MLR element	MLR information (A)	Financial report (B)	Numeric difference (A) – (B)	Percent difference [(A) – (B)]/(B)*100	[Enter additional analysis columns of interest]
Plan A					
Total incurred claims	$9,250,000	$9,000,000	$250,000	2.8%	[enter value]
Non-claims expenses	$450,000	$480,000	$(30,000)	(6.3)%	[enter value]
Premium revenue	$10,400,000	$10,600,000	$200,000	(1.9)%	[enter value]
Taxes, licensing and regulatory fees	$400,000	$400,000	$0	0.0%	[enter value]
Member months	20,000	20,000	0	0.0%	[enter value]

MLR element	MLR information (A)	Financial report (B)	Numeric difference (A) – (B)	Percent difference [(A) – (B)]/(B)*100	[Enter additional analysis columns of interest]
Plan B					
[Repeat elements for each MCP]	[enter value]	[enter value]	[enter value]	[enter value]	[enter value]

Appendix Table III.2. Example table for validating MLR information using capitation payment reports

Instructions: This example table shows how states can validate MLR information using capitation payment reports. States should, at a minimum, be able to validate premium revenue and member months using these reports. If the state captures other aligned information in its MLR information and capitation payment reports, such as capitation withholds earned back by the MCP, settlement payments from risk-sharing arrangements, and/or state directed payments paid under separate payment terms, the state can validate these items as well. In the 'MLR information' and 'capitation payment report' columns, enter values for each MLR element. The state can manually calculate numeric differences and percent differences in the following two columns. By building this table in Excel, the state can input formulas to calculate those differences. The state can add analysis columns of interest, such as PMPM differences between each source. If the state finds discrepancies during the analysis, such as discrepancies in premium revenue like in the example data below, the state should work with the MCP to understand and resolve those discrepancies. Finally, the table is for two MCPs, and the state can add rows for each MCP it contracts with.

Appendix Table III.2. Example table for validating MLR information using capitation payment reports

MLR element	MLR information (A)	Capitation payment report (B)	Numeric difference (A) – (B)	Percent difference [(A) – (B)]/(B)*100	[Enter additional analysis columns of interest]
Plan A					
Premium revenue	$10,400,000	$10,600,000	$(200,000)	(1.9)%	[enter value]
Member months	20,000	20,000	0	0.0%	[enter value]
[Enter additional MLR elements that the state can validate using capitation payment report data]	[enter value]	[enter value]	[enter value]	[enter value]	[enter value]
Plan B					
[Repeat elements for each MCP]	[enter value]	[enter value]	[enter value]	[enter value]	[enter value]

Appendix Table III.3. Example table for validating MLR information using rate development data

Instructions: This example table shows how states can validate MLR information using rate development data. Starting from the left, the "MLR element" column lists MLR elements that states should be able to validate using rate development data. Specifically, states should at a minimum be able to validate incurred claims, taxes and fees, premium revenue, and member months using these data. If the state captures aligned non-claims information in MLR information and rate development data, the state can validate non-claims expenses using rate development data as well. In the "MLR information" and "rate development data" columns, enter values for each MLR element. The state can manually calculate numeric differences and percent differences in the following two columns. By building this table in Excel, the state can input formulas to calculate those differences. The state can add analysis columns of interest, such as PMPM differences between each source. If the state finds discrepancies during the analysis, such as discrepancies in total incurred claims and premium revenue like in the example data below, the state should work with the MCP to understand and resolve those discrepancies. Finally, the table is for two MCPs, and the state can add rows for each MCP it contracts with.

Appendix Table III.3. Example table for validating MLR information using rate development data

MLR element	MLR information (A)	Rate development data (B)	Numeric difference (A) – (B)	Percent difference [(A) – (B)]/(B)*100	[Enter additional analysis columns of interest]
Plan A					
Total incurred claims	$9,250,000	$9,000,000	$250,000	2.8%	[enter value]
Taxes, licensing and regulatory fees	$400,000	$400,000	$0	0.0%	[enter value]
Premium revenue	$10,400,000	$10,600,000	$(200,000)	(1.9)%	[enter value]
Member months	20,000	20,000	0	0.0%	[enter value]
[Enter additional MLR elements that the state can validate using rate development data]	[enter value]	[enter value]	[enter value]	[enter value]	[enter value]
Plan B					
[Repeat elements for each MCP]	[enter value]	[enter value]	[enter value]	[enter value]	[enter value]

Appendix Table III.4. Example table for comparing MLR statistics over time

Instructions: This example table shows how states can validate an MCP's MLR information by comparing statistics over time to identify potential outliers. For example, states can compare QIA expenses PMPM as well as QIA expenses as a percent of premium revenue over time, where unexpected/unexplained differences could indicate MLR reporting accuracy issues. In the "percent change" column, enter the percent change from the first reporting period to the second reporting period. By building this table in Excel, the state can use formulas to calculate the statistics. The state can add (1) columns for additional reporting periods and (2) rows for additional MLR elements (including sub elements, such as pharmacy rebates and provider incentives) and statistics of interest to the state. If the state finds significant changes during its analysis, such as the changes in QIA expenses and non-claims expenses in the example data below, the state should work with the MCP to understand and validate those changes. Finally, the table is for one MCP, and the state can repeat the table for each MCP it contracts with.

Appendix Table III.4. Example table for comparing MLR statistics over time

MLR element	Reporting period one (G)	Reporting period two (H)	Percent change [(H) - (G)]/(G)*100
Member months (A)	20,000	22,000	10.0%
Premium revenue (B)	$10,400,000	$11,440,000	10.0%
Premium revenue PMPM (B)/(A)	$520.00	$520.00	0.0%
Total incurred claims (C)	$9,250,000	$9,900,000	7.0%
Total incurred claims expenses PMPM (C)/(A)	$462.50	$450.00	(2.7)%
Total incurred claims expenses as a percent of premium revenue (C)/(B)	88.9%	86.5%	(2.7)%
QIA expenses (D)	$160,000	$320,000	100.0%
QIA expenses PMPM (D)/(A)	$8.00	$14.55	81.8%
QIA expenses as a percent of premium revenue (D)/(B)	1.5%	2.8%	86.7%
Non-claims expenses (E)	$390,000	$480,000	23.1%
Non-claims expenses PMPM (E)/(A)	$19.50	$21.82	11.8%
Non-claims expenses as a percent of premium revenue (E)/(B)	3.8%	4.2%	10.5%

MLR element	Reporting period one (G)	Reporting period two (H)	Percent change [(H) - (G)]/(G)*100
Taxes, licensing and regulatory fees (F)	$400,000	$400,000	0.0%
Taxes, licensing and regulatory fees PMPM (F)/(A)	$20.00	$18.18	(9.1)%
Taxes, licensing and regulatory fees as a percent of premium revenue (F)/(B)	3.8%	3.5%	(7.9)%
[Enter rows for additional MLR elements and statistics of interest to the state]	[enter value]	[enter value]	[enter value]

Appendix Table III.5. Example table for comparing MLR statistics across MCPs in a program

Instructions: This example table shows how states can validate MLR information across MCPs in a program using various statistics to identify outliers. Starting from the left, the "MLR element" column lists MLR elements and statistics that the state can compare across MCPs. For example, states can compare total incurred claims PMPM and incurred claims as a percent of premium revenue across MCPs. In the "Plan A" and "Plan B" columns, enter information for each MCP. By building this table in Excel, the state can use formulas to calculate the statistics. The state can add (1) columns for additional MCPs and (2) rows for additional MLR elements (including sub elements, such as pharmacy rebates and provider incentives) and statistics of interest to the state. If the state finds significant differences across MCPs during its analysis, such as the differences in QIA expenses in the example data below, the state should work with its MCPs to understand and validate those differences.

Appendix Table III.5. Example table for comparing MLR statistics across MCPs in a program

MLR element	Plan A	Plan B	[Enter columns for additional MCPs]
Member months (A)	20,000	22,000	[enter value]
Premium revenue (B)	$10,400,000	$10,400,000	[enter value]
Premium revenue PMPM (B)/(A)	$520.00	$472.73	[enter value]
Total incurred claims (C)	$9,250,000	$9,000,000	[enter value]
Total incurred claims expenses PMPM (C)/(A)	$462.50	$409.09	[enter value]
Total incurred claims expenses as a percent of premium revenue (C)/(B)	88.9%	86.5%	[enter value]

MLR element	Plan A	Plan B	[Enter columns for additional MCPs]
QIA expenses (D)	$160,000	$320,000	[enter value]
QIA expenses PMPM (D)/(A)	$8.00	$14.55	[enter value]
QIA expenses as a percent of premium revenue (D)/(B)	1.5%	3.1%	[enter value]
Non-claims expenses (E)	$390,000	$480,000	[enter value]
Non-claims expenses PMPM (E)/(A)	$19.50	$21.82	[enter value]
Non-claims expenses as a percent of premium revenue (E)/(B)	3.8%	4.6%	[enter value]
Taxes, licensing and regulatory fees (F)	$400,000	$400,000	[enter value]
Taxes, licensing and regulatory fees PMPM (F)/(A)	$20.00	$18.18	[enter value]
Taxes, licensing and regulatory fees as a percent of premium revenue (F)/(B)	3.8%	3.8%	[enter value]
[Enter rows for additional MLR elements and statistics of interest to the state]	[enter value]	[enter value]	[enter value]

Appendix IV. Making Use of Validated MLR Information

Appendix Table IV.1. Example "scorecard" of MCP MLR metrics provided to state leadership

Appendix Table IV.1. Example "scorecard" of MCP MLR metrics provided to state leadership

MLR element	Metric title	Update frequency	Data availability	July 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	April 2024	May 2024	June 2024
Plan name	MLR	Quarterly	One-quarter lag in reporting		96.0%			93.7%			94.0%				
	ALR	Quarterly	One-quarter lag in reporting		8.1%			8.4%			8.1%				
[Repeat for each MCP]															

Appendix V.

Appendix V intentionally left blank: Section V does not include an appendix.

Appendix VI. Staffing and Organizational Considerations

Appendices Tables VI.1 and VI.2. Major responsibilities and required knowledge and skills for financial monitoring and oversight staff

Disclaimer: These examples are provided for informational purposes to illustrate different state approaches to addressing financial oversight responsibilities. Each state must consider its own needs and resources in identifying the appropriate staff to fulfill the state's monitoring and oversight obligations.

Appendix Table VI.1. Excerpts on major responsibilities from state job descriptions for financial monitoring and oversight staff

State	Arizona	California	Virginia
Job title	**Health Care Financial Consultant**	**Associate Governmental Program Analyst**	**Health Care Reimbursement Analyst**
Major responsibilities	• Assist with capitation rate development for one or more managed care programs. Duties include preparing financial and encounter data, directed payments and rates and reimbursement data, as well as data modeling and analysis to support the signing actuaries for the managed care programs. • Assist with reviewing the accuracy of information from other reporting departments, as well as reviewing other managed care programs for quality control purposes, including verifying source data, accuracy of formulas, documentation of assumptions and methodologies, and capitation rate certification review to identify errors or concerns, and make recommendations for corrections. • Research, collect, analyze, document, and present complex data, including financial data and analysis. • Gain familiarity with policies/laws/regulations and review revisions to the same for impacts to AHCCCS programs, implement process improvements as appropriate. • Assist with preparation of data supplement items, keeping and tracking a timeline of deliverables, updating reports, and submitting items to be posted to the AHCCCS website for Capitation Rate Certifications, RFPs, and other projects.	• Analyze health care policy and standards including, but not limited to state statute or legislation, federal regulations or guidance, contractual requirements, industry standards and principles, and the implementation, monitoring, and evaluation of MLR requirements for impacts on the Medi-Cal managed care delivery system. • Collect, analyze, and review historical and current cost and utilization, and other data from both managed care plans and subcontractors for the purposes of required financial and MLR reporting. Develop summary reports based on completeness and reasonableness review findings. • Communicate directly with plans and providers to discuss data reporting requirements and deficiencies. • Monitor, log, triage, and develop responses to plan and subcontractor inquiries regarding DHCS' review of financial and MLR reporting, inquiries regarding incentive payments, capitated payments, and rate adjustments. • Perform analyses related to plan and subcontractors' financial and MLR reporting, Medi-Cal managed care incentive payments, supplemental payment programs, capitation rates, and rate setting. • Maintain the accuracy and integrity of the data used by plan s and subcontractors to calculate MLRs, and the data used to calculate and implement Medi-Cal incentive payments, supplemental payments, and capitation rates in compliance with contractual and state and federal regulatory requirements.	• Develop complex and highly technical payment policy analysis for Medicaid and other programs administered by the Department of Medical Assistance Services. • Collect and maintain data submitted by MCOs for program rate setting. • Articulate reimbursement methodologies accurately and coherently to agency management, state policy-makers, and other interested parties as directed by the reimbursement manager or division director and in both oral and written form. This includes developing contract language for inclusion in managed care contracts and the review of contract language pertaining to reimbursement as requested by other interested parties within DMAS. • Ensure capitation rates are loaded correctly into payment system and match written MCO contract. • Verify submission of rate certifications to CMS and ensure that questions posed by CMS are responded to accurately and timely. • Collect and review quarterly financial statements of Medallion 4.0 MCOs filed with BOI. Update financial reports summary spreadsheet quarterly. Prepare quarterly financial status memos. Correspond with MCOs on discrepancies between reported financial data and encounter data summaries. Responsible for maintaining and supporting reimbursement under the Rx Reinsurance program, Performance Incentive Award program and the health insurance providers fee PF tax. Responsible for oversight of MLR and Underwriting Gain.

State	Arizona	California	Virginia
Job title	**Health Care Financial Consultant**	**Associate Governmental Program Analyst**	**Health Care Reimbursement Analyst**
Major responsibilities *(cont'd.)*	• Communicate with internal and external stakeholders, including follow-up communication on a normal basis.	• Work with other professional staff to examine financial reports, analyze fiscal information and transactions, and review applicable financial and utilization data, and maintains ongoing records of contract, financial, policy, and other documents. • Consult with staff internal and external [to the Division] to obtain and share pertinent information, discuss options and alternatives, and arrive at recommendations to project leads, management, internal and external actuaries, and health plans concerning MLR standards and reporting. • Interpret and analyze the implications of enacted and proposed legislation on Medi-Cal managed care program costs and rate development and develop legislative bill analyses that describe the program and fiscal impacts of proposed legislative changes.	• Support the development of and response to regulatory initiatives affecting provider reimbursement. Provides timely written products addressing legislative and regulatory initiatives related to Medicaid rate setting. Develops written work products representing a comprehensive analysis of necessary regulatory and State Plan amendments to achieve the desired goal of Agency management, the Administration, or the Legislature.

Appendix Table VI.2. Details on required knowledge and skills from state job descriptions for financial monitoring and oversight staff

State	Arizona	Virginia
Job title	**Health Care Financial Consultant**	**Health Care Reimbursement Analyst**
Required knowledge	• Financial analysis principles. • Accounting and financial reporting. • Administrative policies and procedures. • Health care industry and delivery systems, preferably Medicaid managed care. • Audits or reconciliation. • Data Warehouse or claims and encounter analysis. • Statistical methods. • Analytical terminology. • Health care terminology. • Google, Microsoft Office, Word, Excel, PowerPoint and other comparable software programs. • Cognos (preferred).	• Health care claims processing and incurred claims analysis. Knowledge of the principals of managed care capitation rate setting a plus. • Financial analysis and reporting methods, with knowledge of accounting standards and cost reports a plus. • Medicaid and Medicaid VAMMIS system a plus. • Public policy analysis, its development and interpretation, with specific focus on health policy issues preferred. • Demonstrated skill interpreting federal and state laws and regulations regarding health care.
Required skills	• Above average analyst skills. • Above average Excel skills. • Attention to detail. • Project management skills. • Researching and collecting data from multiple sources. • Documenting and presenting data in a format appropriate to the audience. • Effective interpersonal skills. • Effective written and verbal communication skills. • Problem solving. • Effective project coordination skills.	• Considerable skill using spreadsheets for problem solving and project management. Must be proficient user of statistical software packages; SAS preferred. • Ability to write effective SAS programs designed to extract and analyze large volumes of data.

Appendix VII. CMS Technical Resource for Plan-to-State MLR Reporting

Prior to CMS' release of the technical resource for plan-to-state MLR reporting in Microsoft Excel format, states may use the CMS technical resource to modify their existing MLR data collection tools that they provide to MCPs.

Review Section VII: Using the CMS Technical Resource before using the CMS technical resource for MLR reporting.

These states should review Appendix Table VII.1 through Appendix Table VII.8 below. Appendix Table VII.1 provides the set of data fields that states can use for MLR reporting. Appendix Table VII.2 provides the instructions for completing each data field in Appendix Table VII.1. States should customize the gray highlighted lines from each table to reflect the characteristics of their Medicaid and CHIP managed care programs.

States can use Appendix Table VII.3 to collect information on MCPs' expense allocation methodologies per 42 CFR §438.8(k)(1)(vii). Appendix Table VII.4 provides instructions for use of Appendix Table VII.3.

States can use Appendix Table VII.5 to collect information on MCPs' audited financial statements. Appendix Table VII.6 provides instructions for use of Appendix Table VII.5. States can use Appendix Table VII.7 to compare MCPs' reported MLR information to information in audited financial statements per 42 CFR §438.8(k)(1)(xi). Appendix Table VII.8 provides instructions for use of Appendix Table VII.7.

Appendix Table VII.1. CMS technical resource for Plan-to-State MLR reporting: Summary of Data

Appendix Table VII.1 provides the set of data fields that states can use for plans' MLR reporting. Customized line items (for example, risk sharing mechanisms) can be added to meet state program and reporting requirements. Use of this technical resource is optional for states. Required fields per regulation in 42 CFR §438.8(k) are marked with an asterisk.

Information reported in Appendix Table VII.1 should be reported for services covered by the managed care contract with the state during the state-defined MLR reporting year. Per 42 CFR §438.8(b), MLR reporting year means a period of 12 months consistent with the rating period selected and set by the state. This includes incurred claims for member dates of service during the MLR reporting year regardless of paid date, and capitation payments paid for members covered during the MLR reporting year, regardless of paid date. Source documentation, such as general ledgers, allocation schedules, etc. should be available upon request to support amounts reported. Expenditures and revenues reported for MLR should be comparable to audited financial statements per 42 CFR §438.8(k)(1)(xi).

Appendix Table VII.1. CMS technical resource for MLR reporting: Summary of Data

1	2	3
Line #	**Line Description**	**Regulatory Definitions**
1.0	**Member Months**	
1.1	Member months*	42 CFR §438.8(b)
2.0	**Premium**	
2.1	Total premium revenue*	42 CFR §438.8(f)(2)
2.2	State capitation payments	42 CFR §438.8(f)(2)(i)
2.3	**Net payments or receipts related to risk sharing mechanisms**	42 CFR §438.8(f)(2)(vi)
2.3a	[State to customize line description for applicable risk sharing mechanism]	
2.3b	[State to customize line description for applicable risk sharing mechanism]	
2.4	State-developed one time payments, for specific life events of enrollees	42 CFR §438.8(f)(2)(ii)
2.5	Other withhold payments to the plan approved under 438.6(b)(3) (withhold payments)	42 CFR §438.8(f)(2)(iii)
2.6	**State directed payments paid under separate payment terms**	42 CFR §438.8(f)(2)(vii)
2.6a	[State to customize line description for applicable state directed payment paid under separate payment terms]	
2.6b	[State to customize line description for applicable state directed payment paid under separate payment terms]	
2.7	**Changes to unearned premium**	42 CFR §438.8(f)(2)(v)
2.7a	Unearned premium MLR reporting year	
2.7b	Unearned premium prior year	
2.8	Net payments or receipts from state-mandated reinsurance	42 CFR §438.8(f)(2)(vi)

1	2	3
Line #	**Line Description**	**Regulatory Definitions**
2.0	**Premium**	
2.9	Unpaid cost sharing amounts	42 CFR §438.8(f)(2)(iv)
2.10	Pass-through revenues (informational only; already excluded from total premium above)	42 CFR §438.8(f)(2)(i)
3.0	**Claims**	
3.1	Total incurred claims*	42 CFR §438.8(e)(2)
3.2	Direct claims incurred paid through claims adjudication system only during the MLR reporting year, paid through the runout date of the following year, including state directed payments	42 CFR §438.8(e)(2)(i)(A) and (iii)(C)
3.3	Direct claims incurred paid outside claims adjudication system only during the MLR reporting year, paid through the runout date of the following year, including state directed payments	42 CFR §438.8(e)(2)(i)(A) and (iii)(C)
3.4	Delegated vendor/subcontractor claims incurred paid through the runout date of the following year	42 CFR §438.8(e)(2)(i)(A) CIB: MLR Requirements Related to Third Party Vendors dated May 15, 2019
3.5	Value-added services	42 CFR §438.8(e)(2)(i)(A)
3.6	Unpaid claims liabilities for the MLR reporting year, calculated as of the runout date	42 CFR §438.8(e)(2)(i)(B)
3.7	Incurred but not reported claims modified to reflect current conditions, such as changes in exposure or claim frequency or severity	42 CFR §438.8(e)(2)(i)(F)
3.8	**Changes to claims-related reserves**	42 CFR §438.8(e)(2)(i)(G)
3.8a	Reserves for claims incurred only during the MLR reporting year, calculated as of the runout date of the following year	
3.8b	Direct claim reserves prior year	
3.9	Prescription drugs (informational only; already included in total incurred claims above)	42 CFR §438.8(e)(2)(i)(A) CIB: MLR Requirements Related to Third Party Vendors dated May 15, 2019
3.10	Pharmaceutical rebates received and accrued (informational only; already included in total incurred claims above)	42 CFR §438.8(e)(2)(ii)(B) CIB: MLR Requirements Related to Third Party Vendors dated May 15, 2019
3.11	Pharmacy performance guarantee settlements between the pharmacy benefit manager or pharmacy benefit administrator and the pharmacies (informational only; already included in total incurred claims above)	42 CFR §438.8(e)(2)(ii)(B) CIB: MLR Requirements Related to Third Party Vendors dated May 15, 2019
3.12	**Incurred medical incentive pool and bonuses**	42 CFR §438.8(e)(2)(iii)(A)
3.12a	Paid medical incentive pools and bonuses for the MLR reporting year	
3.12b	Accrued medical incentive pools and bonuses for the MLR reporting year	
3.13	Medical portion of contingent benefit and lawsuit reserves	42 CFR §438.8(e)(2)(i)(H)
3.14	Provider overpayment recoveries (enter as positive)	42 CFR §438.8(e)(2)(ii)(A)
3.15	Third party liability, coordination of benefits (COB), subrogation recoveries and recoverable COB claims (enter as positive)	42 CFR §438.8(e)(2)(i)(D) and (E)
3.16	Withholds from payments made to network providers (enter as positive)	42 CFR §438.8(e)(2)(i)(C)
3.17	Net payments or receipts related to state mandated solvency funds	42 CFR §438.8(e)(2)(iv)

1	2	3
Line #	**Line Description**	**Regulatory Definitions**
3.0	**Claims**	
3.18	**Allowable claims recovered through fraud reduction efforts**	42 CFR §438.8(e)(2)(iii)(B)
3.18a	Total fraud reduction expense	
3.18b	Total fraud recoveries that reduced paid claims in Line 3.1	
3.19	Other adjustments due to MLR calculations – claims incurred	
4.0	**Federal and State Taxes and Licensing or Regulatory Fees**	
4.1	Total federal and state taxes and licensing or regulatory fees*	42 CFR §438.8(f)(3)
4.2	**Federal taxes and assessments incurred by the reporting MCP during the MLR reporting year**	42 CFR §438.8(f)(3)(i)-(iii)
4.2a	Federal income taxes deductible from premium in MLR calculations	
4.2b	Other federal taxes and assessments deductible from premium	
4.3	**State insurance, premium and other taxes incurred by the reporting MCP during the MLR reporting year (deductible from premium in MLR calculation)**	42 CFR §438.8(f)(3)(iv)
4.3a	State income, excise, business, and other taxes	
4.3b	State premium taxes	
4.4	Community benefit expenditures deductible from premium in MLR calculations (only applicable to entities exempt from federal taxes)	42 CFR §438.8(f)(3)(v)
4.5	Other federal and state regulatory authority licenses and fees	42 CFR §438.8(f)(3)
5.0	**Health Care Quality Improvement Activities (QIA) Expenses Incurred**	
5.1	Total allowable quality improvement expenses*	42 CFR §438.8(e)(3)
5.2	**Expenditures for activities that improve health care quality**	42 CFR §438.8(e)(3)(i) 45 CFR §158.150(a),(b) and (c)
5.2a	Improve health outcomes	45 CFR §158.150(b)(2)(i)
5.2b	Activities to prevent hospital readmission	45 CFR §158.150(b)(2)(ii)
5.2c	Improve patient safety and reduce medical errors	45 CFR §158.150(b)(2)(iii)
5.2d	Wellness and health promotion activities	45 CFR §158.150(b)(2)(iv)
5.3	Health information technology expenses related to improving health care quality	42 CFR §438.8(e)(3)(iii) 45 CFR §158.150(b)(2)(v) 45 CFR §158.151
5.4	External quality review (EQR) expenses related to improving health care quality	42 CFR §438.8(e)(3)(ii)
6.0	**Non-Claims Costs**	
6.1	**Total non-claims costs***	42 CFR §438.8(e)(2)(v)(A)
6.1a	Amounts paid to vendors for secondary network savings	42 CFR §438.8(e)(2)(v)(A)(1)
6.1b	Amounts paid to vendors or providers for network development, administrative fees, claims processing, and utilization management	42 CFR §438.8(e)(2)(v)(A)(2)
6.1c	Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee	42 CFR §438.8(e)(2)(v)(A)(3)

1	2	3
Line #	**Line Description**	**Regulatory Definitions**
6.0	**Non-Claims Costs**	
6.1d	Cost containment expenses not included in lines 6.1a through 6.1c	
6.1e	All other claims adjustment expenses	
6.1f	Pharmacy benefit manager/pharmacy benefit administrator expenses not allowable as incurred claims	42 CFR §438.8(e)(2)(i)(A); CIB: MLR Requirements Related to Third Party Vendors dated May 15, 2019
6.1g	Salaries and benefits (excluding amounts reported in QIA expenses)	
6.1h	Depreciation	
6.1i	Fees, such as bank service charges	
6.1j	Insurance	
6.1k	Interest expense	
6.1l	Office supplies and equipment	
6.1m	Professional and outside services	
6.1n	Repairs and maintenance	
6.1o	Travel	
6.1p	Indirect expense for health care quality improvement	45 CFR §158.150
6.1q	Lobbying expenses [Exclude from administrative load for capitation rate setting]	
6.1r	Marketing, advertising, and public relations expenses [Exclude from administrative load for capitation rate setting]	
6.1s	Entertainment and alcoholic beverages [Exclude from administrative load for capitation rate setting]	
6.1t	Contributions and donations [Exclude from administrative load for capitation rate setting]	
6.1u	[State to customize line description for applicable state-specified non-claims cost]	
6.1v	[State to customize line description for applicable state-specified non-claims cost]	
6.1w	All other administrative expense	
6.2	**Other taxes**	
6.2a	Taxes and assessments (exclude amounts reported in section 4)	
6.2b	Fines and penalties of regulatory authorities	42 CFR §438.8(e)(2)(v)(A)(4)
6.2c	Federal and state employment taxes and assessments (excluding amounts reported in QIA expenses)	42 CFR §438.8(e)(2)(v)(A)
7.0	**Medical Loss Ratio (MLR) Summary Mapping for Medicaid Data Collection Tool – Managed Care Reporting (MDCT-MCR)**	
7.1	Incurred Claims* [MDCT-MCR line 1.1]	42 CFR §438.8(e)(2)
7.2	Health care quality improvement* [MDCT-MCR line 1.2]	42 CFR §438.8(e)(3)
7.3	MLR numerator [MDCT-MCR line 1.3]	42 CFR §438.8(e)

1	2	3
Line #	**Line Description**	**Regulatory Definitions**
7.0	**Medical Loss Ratio (MLR) Summary Mapping for Medicaid Data Collection Tool – Managed Care Reporting (MDCT-MCR)**	
7.4	Non-claims costs* [MDCT-MCR line 1.4]	42 CFR §438.8(e)(2)(v)(A)
7.5	Premium revenue* [MDCT-MCR line 2.1]	42 CFR §438.8(f)(2)
7.6	Federal and state taxes and licensing or regulatory fees* [MDCT-MCR line 2.2]	42 CFR §438.8(f)(3)
7.7	MLR denominator [MDCT-MCR line 2.3]	42 CFR §438.8(f)
7.8	Member months* [MDCT-MCR line 3.1]	42 CFR §438.8(b)
7.9	Unadjusted MLR [MDCT-MCR line 3.2]	42 CFR §438.8(d)
7.10	Credibility adjustment* [MDCT-MCR line 3.3]	42 CFR §438.8(h)
7.11	Adjusted MLR* [MDCT-MCR line 3.4]	42 CFR §438.8(d)
7.12	Remittance dollar amount owed for MLR reporting period* [MDCT-MCR line 4.6.1]	42 CFR §438.8(j)

Appendix Table VII.2. Instructions for using CMS' technical resource for MLR reporting: Summary of Data

The instructions in Appendix Table VII.2 indicate how states and MCPs should complete Appendix Table VII.1 to ensure an accurate calculation of the MCP's Medicaid MLR. States should customize the lines shown in gray to reflect the characteristics of the state's Medicaid program.

Appendix Table VII.2. Instructions for using CMS' technical resource for MLR reporting: Summary of Data

Line #	Line Description	Data Format	Instructions
1.0	**Member Months**		
1.1	Member months	Whole number	Report member months for members eligible for coverage under the Medicaid managed care contract for the MLR reporting period.
2.0	**Premium**		
2.1	Total premium revenue	Calculated field	Total direct premium earned: Sum of lines 2.2 through 2.3, lines 2.4 through 2.6, line 2.7 (if applicable), and lines 2.8 through 2.10. Note that incentive payments made to the MCP in accordance with 42 CFR §438.6(b)(2) should not be included in premium revenues.
2.2	State capitation payments	Dollar	Payments the state makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the state plan. The state makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment. Report state capitation payments, developed in accordance with 42 CFR §438.4 for all enrollees under a risk contract approved under 42 CFR §438.3(a), excluding payments made under 42 CFR §438.6(d). Exclude premium revenues which are not at risk per the applicable Medicaid managed care contract with the state. State directed payments paid through capitation should be included here. Report state directed payments paid through separate payment terms on line 2.6.
2.3	Net payments or receipts related to risk sharing mechanisms	Calculated field	Total net payments or receipts related to risk sharing mechanisms: Sum of lines 2.3a and 2.3b. Includes premium revenue related to risk sharing mechanisms developed in accordance with 42 CFR §438.5 or 42 CFR §438.6 for each type of risk sharing mechanism specified by the state. Examples include risk corridors, stop-loss, and risk adjustment settlements. Input payments to the state as negative numbers and receipts from the state as positive numbers.

Line #	Line Description	Data Format	Instructions
2.0	**Premium**		
2.3a	[State to customize line description for applicable risk sharing mechanism]	Dollar	[State to customize instructions related to risk sharing mechanism]
2.3b	[State to customize line description for applicable risk sharing mechanism]	Dollar	[State to customize instructions related to risk sharing mechanism]
2.4	State-developed one time payments, for specific life events of enrollees	Dollar	One time payments for specific life events of enrollees. For example, Maternity Kick Payments. Exclude amounts reported elsewhere.
2.5	Other withhold payments to the plan approved under 438.6(b)(3) (withhold payments)	Dollar	Capitation withhold amount related to pay-for-performance measures outlined in the contract.
2.6	State directed payments paid under separate payment terms	Calculated field	Total state directed payments paid under separate payment terms: Sum of lines 2.6a and 2.6b. Includes state directed payments paid under separate payment terms specified by the state not included in the state capitation payments on line 2.2.
2.6a	[State to customize line description for applicable state directed payment paid under separate payment terms]	Dollar	[State to customize instructions related to state directed payment]
2.6b	[State to customize line description for applicable state directed payment paid under separate payment terms]	Dollar	[State to customize instructions related to state directed payment]
2.7	Changes to unearned premium	Calculated field	Changes to unearned premium: Line 2.7a - line 2.7b.

Line #	Line Description	Data Format	Instructions
2.0	**Premium**		
2.7a	Unearned premium MLR reporting year	Dollar	Whether an amount should be reported on this line depends on how the capitation revenues on line 2.2 are reported. Are the premium revenues reported limited to premium revenues for members eligible for covered benefits for the MLR reporting year above? In other words, do the premium revenues reported exclude the impact of unearned premium revenues for members eligible for covered benefits for dates outside of the MLR reporting year above? If not, report reserves established to account for the portion of premium paid in the MLR reporting year that was intended to provide coverage during the following MLR reporting year. If yes, leave this line blank.
2.7b	Unearned premium prior year	Dollar	Whether an amount should be reported on this line depends on how the capitation revenues on line 2.2 are reported. Are the premium revenues reported limited to premium revenues for members eligible for covered benefits for the MLR reporting year above? In other words, do the premium revenues reported exclude the impact of unearned premium revenues for members eligible for covered benefits for dates outside of the MLR reporting year above? If not, report reserves established to account for the portion of premium paid prior to the MLR reporting period that was intended to provide coverage during the MLR reporting year. If yes, leave this line blank.
2.8	Net payments or receipts from state-mandated reinsurance	Dollar	If reinsurance is mandated by the state, report net payments or receipts from state-mandated reinsurance.
2.9	Unpaid cost sharing amounts	Dollar	Unpaid cost sharing amounts represent the amount of unpaid member cost sharing dollars where the MCP intentionally waived the provider's responsibility to collect the member pay. Report unpaid cost sharing amounts that could have been collected from enrollees under the contract, except for those for which the MCP can show it made a reasonable, but unsuccessful, effort to collect.
2.10	Pass-through revenues (informational only; already excluded from total premium above)	Dollar	Report other payments approved under 42 CFR §438.6(b)(3).

Line #	Line Description	Data Format	Instructions
3.0	**Claims**		
3.1	Total incurred claims	Calculated field	Total incurred claims: Sum of lines 3.2 through 3.7, plus line 3.8 (if applicable), plus lines 3.12 and 3.13, less lines 3.14 through 3.17, plus line 3.18, less line 3.19.
3.2	Direct claims incurred paid through claims adjudication system only during the MLR reporting year, paid through the runout date of the following year, including state directed payments	Dollar	Direct claims are amounts paid to providers whose services and supplies are covered by the state's contract and services meeting the requirements of 42 CFR §438.3(e) based on dates of service. Report amounts paid for covered services through the MCP's claims adjudication system for the MLR period, excluding amounts for delegated vendors/subcontractors and value-added services, which are separately reported on lines 3.4 and 3.5, respectively. Amounts reported here should be supported by paid lag triangles. Include state directed payment expense paid through the claims adjudication system for the MLR period.
3.3	Direct claims incurred paid outside claims adjudication system only during the MLR reporting year, paid through the runout date of the following year, including state directed payments	Dollar	Direct claims are amounts paid to providers whose services and supplies are covered by the state's contract with the MCP based on dates of service. Report amounts paid for covered services through mechanisms outside of the MCP's claims adjudication system such as monthly, quarterly, or annual remittances for claims paid, excluding amounts for delegated vendors/subcontractors, and value-added services, which are separately reported on lines 3.4 and 3.5, respectively. Amounts reported here are amounts not included in paid lag triangles. Include state directed payment expense paid outside the claims adjudication system for the MLR period.
3.4	Delegated vendor/subcontractor claims incurred paid through the runout date of the following year	Dollar	Report amounts paid by vendors/subcontractors to providers for claims incurred, including amounts paid for prescription drugs, and amounts for pharmaceutical rebates received and accrued. The MCP may only include reimbursement for incurred claims (i.e., the amount the vendor actually pays the medical provider or supplier for providing covered medical services or supplies to enrollees). This should reconcile to the vendor lag tables. Amounts for vendor/subcontractor administrative services or vendor/subcontractor profit should be excluded.
3.5	Value-added services	Dollar	Report amounts paid for services not covered under the Medicaid state plan but are voluntarily provided by the MCP and meet the requirements under 42 CFR §438.3(e). Value-added services are allowable as incurred claims in the MLR but are excluded from rate setting.
3.6	Unpaid claims liabilities for the MLR reporting year, calculated as of the runout date	Dollar	Calculate an estimate of costs and underlying utilization for claims that have been incurred but not reported (IBNR) or incurred but not paid (IBNP), which would be expected to generate a claim/encounter. Amounts should reflect unpaid claims liabilities for the MLR reporting year, calculated as of the runout date. Unpaid claims liabilities should be based on past claims experience. Exclude amounts for administrative costs, such as margin.
3.7	Incurred but not reported claims modified to reflect current conditions, such as changes in exposure or claim frequency or severity	Dollar	Calculate an estimate of any additional IBNR or IBNP costs, modified to reflect current conditions, such as changes in exposure or claim frequency or severity. Exclude amounts for administrative costs, such as margin.

Line #	Line Description	Data Format	Instructions
3.0	**Claims**		
3.8	Changes to claims-related reserves	Calculated field	Changes to claims-related reserves: Line 3.8a - line 3.8b.
3.8a	Reserves for claims incurred only during the MLR reporting year, calculated as of the runout date of the following year	Dollar	Whether an amount should be reported on this line depends on how incurred claims on lines 3.2 through 3.5 are reported. Are the incurred claims reported on lines 3.2 through 3.5 limited to claims incurred for members eligible for covered benefits for the MLR reporting year above? In other words, do the incurred claims reported on Appendix Table VII.1 exclude the impact of prior year accruals for claims incurred for members eligible for covered benefits for dates outside of the MLR reporting year above? If not, report reserves established to account for the portion of claims incurred in the current MLR reporting year, but not yet paid. If yes, leave this line blank.
3.8b	Direct claim reserves prior year	Dollar	Whether an amount should be reported on this line depends on how incurred claims on lines 3.2 through 3.5 are reported. Are the incurred claims reported on lines 3.2 through 3.5 limited to claims incurred for members eligible for covered benefits for the MLR reporting year above? In other words, do the incurred claims reported on Appendix Table VII.1 exclude the impact of prior year accruals for claims incurred for members eligible for covered benefits for dates outside of the MLR reporting year above? If not, report reserves established to account for the portion of claims incurred in the previous MLR reporting year, but not yet paid at the end of the previous MLR reporting year. If yes, leave this line blank.
3.9	Prescription drugs (informational only; already included in total incurred claims above)	Dollar - informational only; amount should already be included in appropriate incurred claims lines above	Report amounts paid for prescription drugs. Prescription drugs reported on this line should only include those billed and reimbursed separately through the submission of a National Council for Prescription Drug Programs (NCPDP) Universal Claim Form (UCF). Exclude amounts paid to pharmacy benefit managers (PBMs) and pharmacy benefit administrators (PBAs) for administrative services, any amounts not passed through to the pharmacies by the PBM/PBA for transaction fees or other like fees or spread pricing, and any amounts recouped or clawed back from the pharmacies by the PBM/PBA. Prescription drugs reported on this line should exclude prescription drugs that are paid through a bundled payment methodology, such as a diagnosis-related group (DRG) or similar inpatient hospital payment methodology, as part of the hospital/medical benefits. Amount reported here should be included in line 3.4 for inclusion in incurred claims. Amount reported on this line is informational only.

Line #	Line Description	Data Format	Instructions
3.0	**Claims**		
3.10	Pharmaceutical rebates received and accrued (informational only; already included in total incurred claims above)	Dollar - informational only; amount should already be included in appropriate incurred claims lines above	Report pharmaceutical rebates received and accrued. The amount reported here should reduce the amount in line 3.4 for inclusion in incurred claims. Amount reported on this line is informational only.
3.11	Pharmacy performance guarantee settlements between the pharmacy benefit manager or pharmacy benefit administrator and the pharmacies (informational only; already included in total incurred claims above)	Dollar - informational only; amount should already be included in appropriate incurred claims lines above	Report pharmacy performance guarantee settlements associated with agreements between the PBM/PBA and the pharmacies. These settlements are typically based on the contracts between the PBM/PBA and the pharmacy and result in either additional prescription drug payouts to pharmacies or recoupments of pharmacy overpayments by the PBM/PBA. Amount reported here should be included in line 3.4 for inclusion in incurred claims. Amount reported on this line is informational only.
3.12	Incurred medical incentive pool and bonuses	Calculated field	Incurred medical incentive pool and bonuses: Line 3.12a + line 3.12b.
3.12a	Paid medical incentive pools and bonuses for the MLR reporting year	Dollar	Report paid medical incentive pools and bonuses for the MLR reporting year for incentive payments tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers receiving payments. Exclude payments to vendors or providers for services qualifying as health care quality improvement activities (QIA) under 45 CFR §158.150(b). Amounts qualifying as QIA should be reported in section 5 of Appendix Table VII.1.
3.12b	Accrued medical incentive pools and bonuses for the MLR reporting year	Dollar	Report accrued but not paid medical incentive pools and bonuses for the MLR reporting year for incentive payments tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers receiving payments. Exclude payments to vendors or providers for services qualifying as QIA under 45 CFR §158.150(b). Amounts qualifying as QIA should be reported in section 5 of Appendix Table VII.1.
3.13	Medical portion of contingent benefit and lawsuit reserves	Dollar	Report reserves for contingent benefits and the medical claim portion of lawsuits. Exclude non-medical claim portion and portion for other lines of business.
3.14	Provider overpayment recoveries (enter as positive)	Dollar	Report overpayment recoveries received from network providers incurred for the MLR reporting period. Enter amount as positive. Amounts are a reduction to incurred claims and should reflect recovered overpayments to providers not captured in a paid lag triangle. MCPs should report any recoveries regardless of type – offsets, settlements, or cash recoveries from providers. Overpayments are defined at 42 CFR §438.2.
3.15	Third party liability, coordination of benefits (COB), subrogation recoveries and recoverable COB claims (enter as positive)	Dollar	Report third party liability, coordination of benefits, subrogation recoveries, and recoverable coordination of benefits (COB) claims incurred for the MLR reporting period. Enter amount as positive. Amounts are a reduction to incurred claims and should include any claim-related recoveries not captured in a paid lag triangle.

Line #	Line Description	Data Format	Instructions
3.0	**Claims**		
3.16	Withholds from payments made to network providers (enter as positive)	Dollar	Report withholds from payments made to network providers. Enter amount as positive. Amounts are a reduction to incurred claims.
3.17	Net payments or receipts related to state mandated solvency funds	Dollar	Report net payments or receipts related to state mandated solvency funds.
3.18	Allowable claims recovered through fraud reduction efforts	Calculated field	Allowable claims recovered through fraud reduction efforts: If line 3.18b is greater than zero, the lesser of lines 3.18a and 3.18b.
3.18a	Total fraud reduction expense	Dollar	Report the amount of fraud reduction expenses excluding expenditures on activities related to fraud reduction. Fraud reduction activities are incurred subsequent to the payment of a claim to specifically identify and detect fraudulent claims for recoupment. All other post-payment claim review activities ensuring proper claim payment performed by the plan as part of the program integrity duties are considered administrative expenses. Amounts reported here must not include expenditures for activities related to fraud prevention as adopted for the private market at 45 CFR part 158.
3.18b	Total fraud recoveries that reduced paid claims in Line 3.1	Dollar	Report the amount of claims payments recovered through fraud reduction efforts, not to exceed the amount of fraud reduction expenses.
3.19	Other adjustments due to MLR calculations – claims incurred	Dollar	Any amounts excluded from claims for MLR calculation purposes that are normally included in claims for financial statement purposes. Provide a description of the types of expenses included on this line with template submission.
4.0	**Federal and State Taxes and Licensing or Regulatory Fees**		
4.1	Total federal and state taxes and licensing or regulatory fees	Calculated field	Total federal and state taxes and licensing or regulatory fees incurred: If not federal tax exempt, Line 4.2 + line 4.3 + line 4.5. If federal tax exempt, Line 4.3 + line 4.4 + line 4.5.
4.2	Federal taxes and assessments incurred by the reporting MCP during the MLR reporting year	Calculated field	Federal taxes and assessments incurred: Line 4.2a + line 4.2b. Federal taxes reported in this section should exclude federal income taxes on investment income and capital gains and federal employment taxes. Amounts should be reported consistently year over year, using the same methodology (GAAP or Statutory Accounting Principles [SAP]). If the MCP/parent company changes the methodology across all lines of business, an explanation should be provided for the basis for the change at Pt 2 Allocation Methodologies. Note that the change in deferred taxes is treated differently between GAAP and SAP reporting. If using SAP financial statements to report taxes, ensure the tax calculation used to allocate taxes to the MCP's Medicaid line of business incorporates the impact of the change in deferred taxes. The only federal employment taxes allowed for MLR reporting are the portion included in the salaries and benefits of employees performing qualifying QIA activities (see section 5). All other federal employment taxes are non-claims costs.

Line #	Line Description	Data Format	Instructions
4.0	**Federal and State Taxes and Licensing or Regulatory Fees**		
4.2a	Federal income taxes deductible from premium in MLR calculations	Dollar	Report federal income taxes allocated to the MCP, excluding federal employment taxes.
4.2b	Other federal taxes and assessments deductible from premium	Dollar	Report other federal taxes and assessments allocated to the MCP that are deductible from premium. This excludes federal employment taxes and taxes qualifying as non-claims (see section 6).
4.3	State insurance, premium and other taxes incurred by the reporting MCP during the MLR reporting year (deductible from premium in MLR calculation)	Calculated field	State taxes and assessments incurred: Line 4.3a + line 4.3b. State taxes reported in this section should exclude state income taxes on investment income and capital gains and state employment taxes. Amounts should be reported consistently year over year, using the same methodology (GAAP or SAP). If the MCP/parent company changes the methodology across all lines of business, an explanation should be provided for the basis for the change at Pt 2 Allocation Methodologies. The only state employment taxes allowed for MLR reporting are the portion included in the salaries and benefits of employees performing qualifying QIA activities (see section 5). All other state employment taxes are non-claims costs.
4.3a	State income, excise, business, and other taxes	Dollar	Report state and local taxes and assessments including: (A) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the state or locality directly. (B) Guaranty fund assessments. (C) Assessments of state or locality industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by states. (D) State or locality income, excise, and business taxes other than premium taxes and state employment and similar taxes and assessments.
4.3b	State premium taxes	Dollar	If applicable, report state or locality premium taxes plus state or locality taxes based on reserves, if in lieu of premium taxes.
4.4	Community benefit expenditures deductible from premium in MLR calculations (only applicable to entities exempt from federal taxes)	Dollar	Community benefit expenditures can only be included in the MLR for entities that are exempt from federal taxes. Report payments made by the company for community benefit expenditures as defined in 45 CFR §158.162(c), limited to the higher of either: (A) Three percent of earned premium; or (B) The highest premium tax rate in the state for which the MLR report is being submitted, multiplied by the MCP's earned premium in the state.

Line #	Line Description	Data Format	Instructions
4.0	**Federal and State Taxes and Licensing or Regulatory Fees**		
4.5	Other federal and state regulatory authority licenses and fees	Dollar	Report other applicable federal and state regulatory authority licenses and fees, not reported in lines 4.2 through 4.3. (A) Statutory assessments to defray the operating expenses of any state or federal department; (B) Examination fees in lieu of premium taxes as specified by state law.
5.0	**Health Care Quality Improvement Activities (QIA) Expenses Incurred**		
5.1	Total allowable quality improvement expenses	Calculated field	Total allowable quality improvement expenses: Line 5.2 + line 5.3 + line 5.4.
5.2	Expenditures for activities that improve health care quality	Calculated field	Total expenditures for activities that improve health care quality (QIA): Sum of Lines 5.2a through 5.2d. Under 42 CFR §438.8(e)(3) QIA expenditures must only include activities that improve health care quality. Examples of administrative expenses unallowable as QIA include office space (including rent or depreciation, facility maintenance, janitorial, utilities, property taxes, insurance, wall art), human resources, salaries of counsel and executives, equipment, computer and telephone usage, travel and entertainment, company parties and retreats, IT infrastructure and systems, and software licenses. See 45 CFR §158.150(c) for other exclusions from QIA cost. Per 45 CFR §158.150, salaries and benefits of employees performing qualifying QIA activities must be apportioned based on the amount of the employees' time spent performing qualifying QIA on behalf of state Medicaid beneficiaries to total time worked. See 45 CFR §158.150(c) for exclusions from QIA cost. Reported salaries and benefits expenses should be allocated using a reasonable allocation methodology, such as a time study, employee time reports, or other auditable records that provide sufficient data to determine the amount of time employees spend performing qualifying QIA activities. Additionally, if the activities benefit multiple lines of business, a reasonable allocation methodology should be utilized to allocate the qualifying QIA salaries and benefits expense to the Medicaid line of business. The allocation methodology utilized should be the one that is expected to yield the most accurate allocation. Vendor costs for QIA must be reported at the cost of the vendor providing services. They are limited to the same costs that could be claimed by the MCP should the MCP have performed the activities. The commentary from 45 CFR §158.150 states "Where an issuer performs its own QIA without engaging a vendor, any ''profit'' that it makes on such QIA cannot be included in the MLR calculation. Accordingly, where an issuer chooses to outsource its QIA to a third party, rather than developing the necessary skills in-house, as it does for other issuer functions such as claims processing, network development, clinical policies, and case and utilization management, for example, for MLR reporting and rebate purposes that vendor stands in the shoes of the issuer. Consequently, the vendor's indirect costs, as well as any profit, cannot be reported as a QIA expense that is included in the MLR calculation."

Line #	Line Description	Data Format	Instructions
5.0	**Health Care Quality Improvement Activities (QIA) Expenses Incurred**		
5.2 *(cont'd.)*	Expenditures for activities that improve health care quality *(cont'd.)*	Calculated field *(cont'd.)*	Other direct expenses for items or services that primarily or exclusively support QIA as opposed to regular business or other functions are likely to constitute direct expenses that are appropriately included in QIA expense. Expenses which otherwise meet the definition of QIA but which were paid for with grant money or funding separate from premium revenue shall NOT be included in QIA expenses.
5.2a	Improve health outcomes	Dollar	Report the Medicaid managed care portion of qualifying QIA expenses for activities designed to improve health outcomes. Include the apportioned salaries and benefits costs incurred by vendors and/or providers to which the QIA activities have been outsourced.
5.2b	Activities to prevent hospital readmission	Dollar	Report the Medicaid managed care portion of qualifying QIA expenses for activities designed to prevent hospital readmission. Include the apportioned salaries and benefits costs incurred by vendors and/or providers to which the QIA activities have been outsourced.
5.2c	Improve patient safety and reduce medical errors	Dollar	Report the Medicaid managed care portion of qualifying QIA expenses for activities designed to improve patient safety and reduce medical errors. Include the apportioned salaries and benefits costs incurred by vendors and/or providers to which the QIA activities have been outsourced.
5.2d	Wellness and health promotion activities	Dollar	Report the Medicaid managed care portion of qualifying QIA expenses for activities designed to promote health and wellness. Include the apportioned salaries and benefits costs incurred by vendors and/or providers to which the QIA activities have been outsourced.
5.3	Health information technology expenses related to improving health care quality	Dollar	45 CFR §158.151 allows health information technology (HIT) expenses to be included to the extent expenses are required to accomplish the activities allowed as QIA expense. In order to qualify as an allowed HIT expense, the expense must, in whole or in part, contribute to improving the quality of care, provide the technological infrastructure to enhance current quality improvement, or make new quality improvement initiatives possible. Report the portion of expenses incurred for the Medicaid managed care line of business for qualifying HIT per 45 §CFR 158.151. General use software does not qualify as HIT. Specifically, allocations of dual functioning systems that serve primarily for functions outside of QIA. Unless the software is primarily related to QIA activities, it cannot be included. The commentary from the rule states "We affirm and clarify that HIT expenses that meet the applicable requirements in 45 CFR §158.150 and §158.151 are permissible costs that can be included as QIA expenses. For example, the cost of software designed and used primarily for QIA purposes, such as HEDIS reporting, constitutes a direct expense related to activities that improve health care quality and can be included in QIA expenses

Line #	Line Description	Data Format	Instructions
5.0	**Health Care Quality Improvement Activities (QIA) Expenses Incurred**		
5.3 *(cont'd.)*	Health information technology expenses related to improving health care quality *(cont'd.)*	Dollar *(cont'd.)*	for MLR reporting and rebate purposes. In contrast, as explained above and in the proposed rule, the costs of IT infrastructure that primarily supports regular business functions such as billing, enrollment, claims processing, financial analysis, and cost containment, even when the same IT infrastructure also happens to support QIA activities in addition to regular business functions, do not constitute a direct expense related to activities that improve health care quality and cannot be included in QIA expenses for MLR reporting and rebate purposes."
5.4	External quality review (EQR) expenses related to improving health care quality	Dollar	Report the portion of expenses incurred for the Medicaid managed care line of business for qualifying EQR-related activities as described in 42 CFR §438.358(b) and (c).
6.0	**Non-Claims Costs**		
6.1	Total non-claims costs	Calculated field	Total non-claims costs: Sum of lines 6.1a through 6.2. Non-claims costs are defined as those expenses for administrative services, such as cost containment, that are not incurred claims as defined in 42 CFR §438.8(e)(2), expenditures on QIA, as defined in 42 CFR §438.8(e)(3), or licensing and regulatory fees, or federal and state taxes, as defined in 42 CFR §438.8(f)(3). Non-claims costs include all costs for the Medicaid line of business that do not qualify as incurred claims, expenditures on QIA, licensing and regulatory fees, or federal and state taxes as described above. The sum of incurred claims, expenditures on activities to improve health care quality, licensing and regulatory fees, federal and state taxes, and non-claims costs should be comparable to the company financial statements for the Medicaid and/or CHIP line of business. Examples of non-claims costs include, but are not limited to, cost-containment expenses not included as an expenditure related to an activity at 45 CFR §158.150; loss adjustment expenses not classified as cost containment expense; direct sales salaries, workforce salaries and benefits; agents and brokers fees and commissions; general and administrative expenses; community benefit expenditures for MCPs subject to income taxes; prescription drug rebates and other price concessions that are received and retained by an entity providing pharmacy benefit management services to the issuer and are associated with administering the issuer's prescription drug benefits; and 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 to an enrollee, such as medical records copying costs, attorneys' fees, subrogation vendor fees, bona fide service fees, compensation for paraprofessionals, janitors, quality assurance analysists, administrative supervisors, secretaries to medical personnel, and medical record clerks.

Line #	Line Description	Data Format	Instructions
6.0	**Non-Claims Costs**		
6.1a	Amounts paid to vendors for secondary network savings	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1b	Amounts paid to vendors or providers for network development, administrative fees, claims processing, and utilization management	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1c	Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1d	Cost containment expenses not included in lines 6.1a through 6.1c	Dollar	Report expenses that serve to actually reduce the number of health services provided or the cost of such services. This category can include costs only if they result in reduced costs or services such as: • Post- and concurrent- claim case management activities associated with past or ongoing care. • Pre-service utilization review. • Detection and prevention of payment for fraudulent requests for reimbursement (including amounts reported in line 3.18a). • Expenses for internal and external appeals. Exclude: Cost-containment expenses that improve the quality of health care reported as QIA expense in line 5.2 through 5.4.
6.1e	All other claims adjustment expenses	Dollar	Report other claims adjustment expenses not included in lines 6.1a through 6.1d.
6.1f	Pharmacy benefit manager/pharmacy benefit administrator expenses not allowable as incurred claims	Dollar	Costs paid to the PBM/PBA for administrative functions cannot be included as incurred claims. Administrative costs include any difference between the amount the MCP pays the PBM/PBA and the amount the PBM/PBA pays to its pharmacies, which includes spread pricing, transaction fees, network fees, claw-backs, and settlements for performance guarantee arrangements between the health plan and the PBM/PBA. Prescription drug rebates received and accrued must be deducted from incurred claims regardless of the source of the rebate, and who retains the rebate (the MCP or the third-party vendor). Amounts for prescription drug rebates retained by the PBM/PBA can be included in non-claims costs. Report non-claims PBM/PBA expenses for the MLR period based on financial statements.

Line #	Line Description	Data Format	Instructions
6.0	**Non-Claims Costs**		
6.1g	Salaries and benefits (excluding amounts reported in QIA expenses)	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1h	Depreciation	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1i	Fees, such as bank service charges	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1j	Insurance	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1k	Interest expense	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1l	Office supplies and equipment	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1m	Professional and outside services	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1n	Repairs and maintenance	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1o	Travel	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1p	Indirect expense for health care quality improvement	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements.
6.1q	Lobbying expenses [Exclude from administrative load for capitation rate setting]	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements. This item should be excluded from the administrative load for capitation rate setting.
6.1r	Marketing, advertising, and public relations expenses [Exclude from administrative load for capitation rate setting]	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements. This item should be excluded from the administrative load for capitation rate setting.
6.1s	Entertainment and alcoholic beverages [Exclude from administrative load for capitation rate setting]	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements. This item should be excluded from the administrative load for capitation rate setting.
6.1t	Contributions and donations [Exclude from administrative load for capitation rate setting]	Dollar	Report expenses per the line description applicable to the expense incurred for the MLR reporting period based on financial statements. This item should be excluded from the administrative load for capitation rate setting.

Line #	Line Description	Data Format	Instructions
6.0	**Non-Claims Costs**		
6.1u	[State to customize line description for applicable state-specified non-claims cost]	Dollar	[State to customize instructions related to non-claims cost]
6.1v	[State to customize line description for applicable state-specified non-claims cost]	Dollar	[State to customize instructions related to non-claims cost]
6.1w	All other administrative expense	Dollar	Report all other administrative expense for the Medicaid line of business that is not incurred claims, health care QIA expense, licensing and regulatory fees, or federal and state taxes and not included in another non-claims cost category.
6.2	Other taxes	Calculated field	Other taxes: Sum of lines 6.2a through 6.2c.
6.2a	Taxes and assessments (exclude amounts reported in section 4)	Dollar	Include taxes and assessments not allowable for MLR reporting purposes. Examples include income tax on investment income and capital gains.
6.2b	Fines and penalties of regulatory authorities	Dollar	Include fines and penalties expense incurred for the MLR reporting period.
6.2c	Federal and state employment taxes and assessments (excluding amounts reported in QIA expenses)	Dollar	Include any federal and state employment taxes and assessments not included in the QIA expenses in section 5.
7.0	**Medical Loss Ratio (MLR) Summary Mapping for Medicaid Data Collection Tool – Managed Care Reporting (MDCT-MCR)**		
7.1	Incurred Claims [MDCT-MCR line 1.1]	Calculated field	Formulaic field linked to line 3.1.
7.2	Health care quality improvement [MDCT-MCR line 1.2]	Calculated field	Formulaic field linked to line 5.1.
7.3	MLR numerator [MDCT-MCR line 1.3]	Calculated field	MLR Numerator: Line 7.1 + line 7.2.
7.4	Non-claims costs [MDCT-MCR line 1.4]	Calculated field	Formulaic field linked to line 6.1.
7.5	Premium revenue [MDCT-MCR line 2.1]	Calculated field	Formulaic field linked to line 2.1.
7.6	Federal and state taxes and licensing or regulatory fees [MDCT-MCR line 2.2]	Calculated field	Formulaic field linked to line 4.1.

Line #	Line Description	Data Format	Instructions
7.0	**Medical Loss Ratio (MLR) Summary Mapping for Medicaid Data Collection Tool – Managed Care Reporting (MDCT-MCR)**		
7.7	MLR denominator [MDCT-MCR line 2.3]	Calculated field	MLR Denominator: Line 7.5 - line 7.6.
7.8	Member months [MDCT-MCR line 3.1]	Calculated field	Formulaic field linked to line 1.1.
7.9	Unadjusted MLR [MDCT-MCR line 3.2]	Calculated field	Unadjusted MLR: Line 7.3 / line 7.7.
7.10	Credibility adjustment [MDCT-MCR line 3.3]	Calculated field	Calculated field based on tables in CMS guidance: "Medical Loss Ratio (MLR) Credibility Adjustments" Center for Medicaid & CHIP Services (CMCS) Informational Bulletin, July 31, 2017: https://www.medicaid.gov/federal-policy-guidance/downloads/cib073117.pdf. The calculation must consider whether the managed care program is a standard or MLTSS-only program.
7.11	Adjusted MLR [MDCT-MCR line 3.4]	Calculated field	Adjusted MLR: Line 7.9 + line 7.10.
7.12	Remittance dollar amount owed for MLR reporting period [MDCT-MCR line 4.6.1]	Calculated field using state-determined remittance formula	Remittance dollar amount owed for MLR reporting period as defined by the state Medicaid managed care contract for the MLR reporting period.

Appendix Table VII.3. CMS technical resource for MLR reporting: Expense Allocation Methodologies

States can use Appendix Table VII.3 to collect information on MCPs' expense allocation methodologies per 42 CFR §438.8(k)(1)(vii). States can customize expense types to meet state program(s) and reporting requirements.

Appendix Table VII.3. CMS technical resource for MLR reporting: Expense Allocation Methodologies

1	2	3	4	5	6
Line #	**Type of Expense**	**Expense Methodology, Including Statistical Basis, Current Year**	**Consistent with Prior Year?**	**Consistent with Other Markets?**	**Comments, including: Justification for Change in Methodology from Prior Year and/or Inconsistency in Methodology with Other Markets, if applicable**
1.0	**Incurred Claims**				
1.1	Pharmacy rebates				
1.2	Fraud reduction expense				
1.3	Provider incentives				
1.4	[Describe expense]				
1.5	[Describe expense]				
2.0	**Health Care Quality Improvement Activities (QIA)**				
2.1	Corporate or parent company QIA expense	*[No user entry required]*			
2.1a	Expenditures for activities that improve health care quality				
2.2	Managed care plan QIA expense	*[No user entry required]*			
2.2a	Expenditures for activities that improve health care quality				
2.3	Vendor/provider QIA expense	*[No user entry required]*			
2.3a	Expenditures for activities that improve health care quality				
2.4	Health information technology (HIT) expense				
2.5	External quality review (EQR) expense				

1	2	3	4	5	6
Line #	**Type of Expense**	**Expense Methodology, Including Statistical Basis, Current Year**	**Consistent with Prior Year?**	**Consistent with Other Markets?**	**Comments, including: Justification for Change in Methodology from Prior Year and/or Inconsistency in Methodology with Other Markets, if applicable**
3.0	**Federal and State Taxes and Licensing or Regulatory Fees**				
3.1	Federal taxes and assessments incurred by the reporting issuer during the MLR reporting year	*[No user entry required]*			
3.1a	Federal income taxes deductible from premium in MLR calculations				
3.1b	Other federal taxes and assessments deductible from premium				
3.2	State insurance, premium and other taxes incurred by the reporting issuer during the MLR reporting year (deductible from premium in MLR calculation)	*[No user entry required]*			
3.2a	State income, excise, business, and other taxes				
3.2b	State premium taxes				
3.2c	Community benefit expenditures deductible from premium in MLR calculations (only applicable to MCPs exempt from federal income taxes)				
3.3	Regulatory authority licenses and fees	*[No user entry required]*			
3.3a	[Describe expense]				
3.3b	[Describe expense]				
4.0	**Non-Claims Costs**				
4.1	Corporate or parent company non-claims costs	*[No user entry required]*			
4.1a	Salaries and benefits of employees				
4.1b	Indirect expense				
4.2	Managed care plan non-claims costs	*[No user entry required]*			
4.2a	Salaries and benefits of employees				
4.2b	Indirect expense				

1	2	3	4	5	6
Line #	**Type of Expense**	**Expense Methodology, Including Statistical Basis, Current Year**	**Consistent with Prior Year?**	**Consistent with Other Markets?**	**Comments, including: Justification for Change in Methodology from Prior Year and/or Inconsistency in Methodology with Other Markets, if applicable**
4.0	**Non-Claims Costs**				
4.3	Vendor/provider non-claims costs				
4.4	Other non-claims costs	*[No user entry required]*			
4.4a	[Describe expense]				
4.4b	[Describe expense]				
5.0	**Other Expense**				
5.1	[Describe expense]				
5.2	[Describe expense]				

Appendix Table VII.4. Instructions for using CMS' technical resource for MLR reporting: Expense Allocation Methodologies

42 CFR §438.8(k)(1)(vii) requires the state to collect the MCP's methodologies for allocations of expenses, which must include incurred claims, quality improvement expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs, as described in 45 CFR §158.170(b). The allocation methodologies should describe the types of expenses allocated, how the expenses met the criteria for inclusion in the MLR, and the method(s) used to allocate the expenses across states and markets. Appendix Table VII.3 is designed to collect data on allocation methodologies for expenditures that are often allocated among states and/or lines of business, including incurred claims, quality improvement expenses, taxes, licensing or regulatory fees, and non-claims costs. Per 42 CFR §438.8(g)(2)(i), allocation methodologies must be based on a generally accepted accounting method that is expected to yield the most accurate results. With that in mind, it is expected that allocation methodologies remain consistent year over year and across markets unless an operational or accounting methodology change by the company requires a change to the allocation statistic utilized.

Refer to Section V: MLR Reporting Guidance for Key Areas for additional information for accurate reporting of expense allocation methodologies.

Appendix Table VII.4. Instructions for using CMS' technical resource for MLR reporting: Expense Allocation Methodologies

Column #	Column Name	Data Format	Instructions
1	Line #	No input by the MCP	This column provides a line number for reference.
2	Type of Expense	No input by the MCP except for cells with "[Describe expense]"	The types of expense for which the MCP should provide a description of allocation methodologies are listed in this column. The MCP has flexibility to define additional expense types using lines with the description "[Describe expense]."
3	Expense Methodology, Including Statistical Basis, Current Year	Free text	Describe the expense allocation methodology, including the statistical basis, used in the current year. If multiple methods of allocation are used for a single expense type, describe all methods used.
4	Consistent with Prior Year?	Binary (Yes/No)	Enter "Yes" if the expense methodology(ies) used in the current year is(are) consistent with the methodology(ies) used by the MCP in the prior year. Otherwise, enter "No."
5	Consistent with Other Markets?	Binary (Yes/No)	Enter "Yes" the expense methodology(ies) used in the current year is(are) consistent with the methodology(ies) used by the MCP's parent company in other markets. Otherwise, enter "No."

Column #	Column Name	Data Format	Instructions
6	Comments, including: Justification for Change in Methodology from Prior Year and/or Inconsistency in Methodology with Other Markets, if applicable	Free text	Include applicable comments to further explain or clarify reported methodologies. For all "No" or "N/A" responses in the "Consistent with Prior Year" and/or "Consistent with Other Markets" columns, explain why the current year allocation methodology provides a more reasonable expense allocation than the prior year methodology/methodology in other markets, including any changes in operations that prompted the expense allocation methodology change.

Appendix Table VII.5. CMS technical resource for MLR reporting: Financial Statements

States can use Appendix Table VII.5 to collect information on MCPs' audited financial statements. This information can be used to compare information between audited financial statements and reported MLR information in Appendix Table VII.7. States can customize financial statement line items to meet state program(s) and reporting requirements.

Appendix Table VII.5. CMS technical resource for MLR reporting: Financial Statements

1	2	3	4	5	6	7
Line #	**Financial Statement Line Description**	**Financial Statements Period 1**	**Financial Statements Period 2**	**Pro-Rated Financial Statements – Flows to Appendix Table VII.7, column 4**	**Financial Statement Item Reported on MLR**	**Comments**
1.0	**Pro-ration of Financial Statements**			100%	*[Not applicable]*	*[Not applicable]*
2.0	**Member Months**					
2.1	Total Member Months					
3.0	**Revenues**					
3.1	[Enter financial statement line description]					
3.2	[Enter financial statement line description]					
3.3	Total Revenues	Line 3.1 + Line 3.2	Line 3.1 + Line 3.2		*[Not applicable]*	
4.0	**Incurred Claims**					
4.1	[Enter financial statement line description]					
4.2	[Enter financial statement line description]					
4.3	Total Incurred Claims	Line 4.1 + Line 4.2	Line 4.1 + Line 4.2		*[Not applicable]*	

1	2	3	4	5	6	7
Line #	**Financial Statement Line Description**	**Financial Statements Period 1**	**Financial Statements Period 2**	**Pro-Rated Financial Statements – Flows to Appendix Table VII.7, column 4**	**Financial Statement Item Reported on MLR**	**Comments**
5.0	**Taxes**					
5.1	[Enter financial statement line description]					
5.2	[Enter financial statement line description]					
5.3	Total Taxes	Line 5.1 + Line 5.2	Line 5.1 + Line 5.2		*[Not applicable]*	
6.0	**Non-Claims**					
6.1	[Enter financial statement line description]					
6.2	[Enter financial statement line description]					
6.3	Total Non-Claims	Line 6.1 + Line 6.2	Line 6.1 + Line 6.2		*[Not applicable]*	
7.0	**Other**					
7.1	[Enter financial statement line description]					
7.2	[Enter financial statement line description]					
7.3	Total Other	Line 7.1 + Line 7.2	Line 7.1 + Line 7.2		*[Not applicable]*	
8.0	**Net Income**					
8.1	Net underwriting gain	Line 3.3 – Line 4.3 – Line 6.3	Line 3.3 – Line 4.3 – Line 6.3		*[Not applicable]*	
8.2	Net underwriting gain per financial statements				*[Not applicable]*	
8.3	Variance in underwriting gain	Line 8.1 – Line 8.2	Line 8.1 – Line 8.2		*[Not applicable]*	
8.4	Net income before federal income taxes	Line 7.3 + Line 8.1	Line 7.3 + Line 8.1		*[Not applicable]*	
8.5	Net income before federal income taxes per financial statements				*[Not applicable]*	
8.6	Variance in net income before federal taxes	Line 8.5 – Line 8.4	Line 8.5 – Line 8.4		*[Not applicable]*	

1	2	3	4	5	6	7
Line #	**Financial Statement Line Description**	**Financial Statements Period 1**	**Financial Statements Period 2**	**Pro-Rated Financial Statements – Flows to Appendix Table VII.7, column 4**	**Financial Statement Item Reported on MLR**	**Comments**
8.0	**Net Income**					
8.7	Net income after federal income taxes	Line 8.4 – Line 5.3	Line 8.4 – Line 5.3		*[Not applicable]*	
8.8	Net income after federal income taxes per financial statements				*[Not applicable]*	
8.9	Variance in net income after federal taxes	Line 8.8 – Line 8.7	Line 8.8 – Line 8.7		*[Not applicable]*	

Appendix Table VII.6. Instructions for using CMS' technical resource for MLR reporting: Financial Statements

42 CFR §438.8(k)(1)(xi) requires the state to collect a comparison of the information reported on the MLR with the MCP's audited financial statements. The purpose of Appendix Table VII.5 is to collect financial statement information that will be used on Appendix Table VII.7 to reconcile the MLR amounts from Appendix Table VII.1 to the financial statements. In many cases, annual MCP financial statement reporting periods do not align with the state's MLR reporting period. Appendix Table VII.5 therefore allows two financial statement periods to be reported so they can be pro-rated to the state MLR reporting period.

Appendix Table VII.6. Instructions for using CMS' technical resource for MLR reporting: Financial Statements

Column #	Column Name	Data Format	Instructions
1	Line #	No input by the MCP	This column provides a line number for reference.
2	Financial Statement Line Description	Free text	This column provides a line description for pre-defined lines. This column also allows user input in cells with bracketed text "[Enter financial statement line description]." Input applicable financial statement line descriptions by financial statement category, ensuring that all lines necessary to trace reported financial statement amounts to the supporting financial statement records are provided.
3	Financial Statements Period 1	Numeric	If the MCP's financial statement period aligns with the MLR reporting period, input the financial statement amounts for the financial statements covering the MLR reporting period. Input 100% in this column on line 1. Pro-Ration of Financial Statements. If the MCP's financial period does not align with the MLR reporting period, the MCP will need to provide values from each of the overlapping financial statement periods so the financial statements can be pro-rated to the MLR reporting period. Input amounts from the earlier of the two overlapping financial statement periods. Report the full amount per the financial statements, as column 5 will pro-rate the total financial statement amounts to the MLR period using the pro-ration percentages in line 1. On line 1, enter a proportion that represents the portion of months of the financial statements that overlaps the MLR period. For example, if the MLR period is from July through June and the financial statements are from January through December, enter 0.5, for 6 overlapping months out of 12 total months in the MLR period.

Column #	Column Name	Data Format	Instructions
3 *(cont'd.)*	Financial Statements Period 1 *(cont'd.)*	Numeric *(cont'd.)*	At the bottom of Appendix Table V, lines 8 through 8.9 include net income check figures. This section is intended to help the state and/or the MCP ensure the correct revenue and expense amounts have been entered into lines 1 through 7.11 by providing various net income calculations that can be compared to the financial statement net income values. After entering the relevant data, review the variances on lines 8.3, 8.6, and 8.9. Resolve any errors in the amounts entered in the schedule above and/or explain in the Comments column why the variances are expected.
4	Financial Statements Period 2	Numeric	If the MCP's financial statement period aligns with the MLR reporting period, this column is not applicable, and should be left blank. If the MCP's financial period does not align with the MLR reporting period, input amounts from the later of the two overlapping financial statement periods. Report the full amount per the financial statements, as column 5 will pro-rate the total financial statement amounts to the MLR period using the pro-ration percentages in line 1. On line 1, the proportion should calculate by subtracting the proportion entered on line 1, column 3 from 100% At the bottom of the Appendix Table V, lines 8 through 8.9 include net income check figures. This section is intended to help the state and/or the MCP ensure the correct revenue and expense amounts have been entered into lines 1 through 7.11 by providing various net income calculations that can be compared to the financial statement net income values. After entering the relevant data, review the variances on lines 8.3, 8.6, and 8.9. Resolve any errors in the amounts entered in the schedule above and/or explain in the Comments column why the variances are expected.
5	Pro-Rated Financial Statements - Flows to Appendix Table VII.7, column 4	Calculated field	This column should pro-rate the amounts input in each financial statement column using the proportions entered on line 1. Pro-Ration of Financial Statements.
6	Financial Statement Item Reported on MLR	Binary (Yes/No)	Enter "Yes" if the financial statement line item reported on this schedule is included in the MLR either in part or in whole. This is requested to help readers understand differences between financial statement reporting and MLR reporting. Otherwise, enter "No."
7	Comments	Free text	Include applicable comments to explain information deemed relevant by the MCP to assist readers of the template with understanding reported amounts, and comparing financial statement records to amounts reported on the template.

Appendix Table VII.7. CMS technical resource for MLR reporting: Comparison to Financial Statements

States can use Appendix Table VII.7 to compare MCPs' reported MLR information to information in audited financial statements per 42 CFR §438.8(k)(1)(xi). States can customize financial statement and MLR line items to meet state program(s) and reporting requirements.

Appendix Table VII.7. CMS technical resource for MLR reporting: Comparison to Financial Statements

1	2	3	4	5	6	7
Line #	**MLR Reporting Category**	**Amount per MLR**	**Financial Statements**	**MLR Above/(Below) Financial Statements**	**% Difference Above/(Below) Financial Statements**	**Explanation for Variances Exceeding [State-Specified Variance Threshold]**
1.0	**Member Months**	Linked to Appendix Table VII.1, Line 7.8	Linked to Appendix Table VII.5, Column 5, Line 2.1	*[Not applicable]*		
1.1	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
1.2	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
1.3	Total Financial Statements	*[Not applicable]*	Line 1.0 + Line 1.1 + Line 1.2			
2.0	**Premium Revenues**	Linked to Appendix Table VII.1, Line 7.5	Linked to Appendix Table VII.5, Column 5, Line 3.3	*[Not applicable]*		
2.1	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
2.2	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
2.3	Total Financial Statements	*[Not applicable]*	Line 2.0 + Line 2.1 + Line 2.2			
3.0	**Incurred Claims**	Linked to Appendix Table VII.1, Line 7.1	Linked to Appendix Table VII.5, Column 5, Line 4.3	*[Not applicable]*		
3.1	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
3.2	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
3.3	Total Financial Statements	*[Not applicable]*	Line 3.0 + Line 3.1 + Line 3.2			
4.0	**Health Care Quality Improvement Activities Expenses Incurred**	Linked to Appendix Table VII.1, Line 7.2	See instructions in Appendix Table VII.8	*[Not applicable]*		
4.1	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		

1	2	3	4	5	6	7
Line #	**MLR Reporting Category**	**Amount per MLR**	**Financial Statements**	**MLR Above/(Below) Financial Statements**	**% Difference Above/(Below) Financial Statements**	**Explanation for Variances Exceeding [State-Specified Variance Threshold]**
4.2	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
4.3	Total Financial Statements	*[Not applicable]*	Line 4.0 + Line 4.1 + Line 4.2			
5.0	**Non-Claims Costs**	Linked to Appendix Table VII.1, Line 7.4	Linked to Appendix Table VII.5, Column 5, Line 6.3	*[Not applicable]*		
5.1	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
5.2	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
5.3	Total Financial Statements	*[Not applicable]*	Line 5.0 + Line 5.1 + Line 5.2			
6.0	**Federal and State Taxes and Licensing or Regulatory Fees**	Linked to Appendix Table VII.1, Line 7.6	Linked to Appendix Table VII.5, Column 5, Line 5.3	*[Not applicable]*		
6.1	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
6.2	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
6.3	Total Financial Statements	*[Not applicable]*	Line 6.0 + Line 6.1 + Line 6.2			
7.0	**Total Expenses**	Linked to Appendix Table VII.1, Line 7.1 + Line 7.2 + Line 7.4 + Line 7.6	Linked to Appendix Table VII.5, Column 5, Line 4.3 + Line 5.3 + Line 6.3	*[Not applicable]*		
7.1	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
7.2	[Describe reconciling item]	*[Not applicable]*		*[Not applicable]*		
7.3	Total Financial Statements	*[Not applicable]*	Line 7.0 + Line 7.1 + Line 7.2			

Appendix Table VII.8. Instructions for using CMS' technical resource for MLR reporting: Comparison to Financial Statements

42 CFR §438.8(k)(1)(xi) requires the state to collect a comparison of the information reported on the MLR with the audited financial statements. The purpose of Appendix Table VII.7 is to ensure that MLR reporting on Appendix Table VII.1 reconciles to the MCP's Medicaid and/or CHIP line of business financial statements. The state has defined a threshold of acceptable variances between financial statement and MLR reporting. The MCP should provide a detailed reconciliation of the pro-rated (if applicable) financial statements as reported on Appendix Table VII.5 to the MLR amounts calculated based on the company's inputs on Appendix Table VII.1. The reconciliations should provide sufficient information to reduce variances between MLR and financial statement amounts to the tolerable threshold set by the state agency. If financial statements cannot be reconciled within the tolerable variance, a detailed explanation should be provided. The MCP's financial statements must be specific to the Medicaid and/or CHIP line of business.

Appendix Table VII.8. Instructions for using CMS' technical resource for MLR reporting: Comparison to Financial Statements

Column #	Column Name	Data Format	Instructions
1	Line #	No input by the MCP	This column provides a line number for reference.
2	MLR Reporting Category	No input by the MCP except for cells with "[Describe reconciling item]."	This column includes MLR reporting lines from section 7 of Appendix Table VII.1. This column allows user input in cells with bracketed text "[Describe reconciling item]." Input applicable reconciling line descriptions by MLR reporting category.
3	Amount per MLR	Calculated field	Values in this column should be calculated using the formulas in Appendix Table VII.7.
4	Financial Statements	Calculated field with additional numeric input	Financial statement amounts, with the exception of QIA, should be calculated using the formulas in Appendix Table VII.7. If QIA can be isolated from the financial statement reporting, amounts can be entered or linked to Appendix Table VII.5 for reconciliation purposes. Enter applicable reconciling items in this column to identify differences between amounts included in the financial statements and amounts included in the MLR. Use section 7 of Appendix Table VII.7 to reconcile total expenses from the financial statements in Appendix Table VII.5, including incurred claims, non-claims, and taxes, to total expenses from the MLR, including total incurred claims, QIA, non-claims, and taxes.
5	MLR Above/(Below) Financial Statements	Calculated field	This column should subtract the total financial statement amount, considering all entered reconciling items, from the total MLR amount derived from Appendix Table VII.1.

Column #	Column Name	Data Format	Instructions
6	% Difference Above/(Below) Financial Statements	Calculated field	This column should divide the total difference calculated in the "MLR Above/(Below) Financial Statements" column by the total financial statement amount by MLR category to determine a percentage variance.
7	Explanation for Variances Exceeding [State-Specified Variance Threshold]	Free text	States should input a threshold value over which the MCP should explain variances. For variances exceeding the state-defined variance threshold, MCPs should provide a detailed explanation for the variance.

Acronyms

ALR = Administrative Loss Ratio

APL = All Plan Letters

CAP = Corrective action plan

CBE = Community benefit expenditures

CEO = Chief executive officer

CFO = Chief financial officer

CHIP = Children's Health Insurance Program

CIB = CMCS Informational Bulletin

CMCS = Center for Medicaid and CHIP Services

CMS = Centers for Medicare & Medicaid Services

CPA = Certified public accountant

EQR = External quality review

FFS = Fee-for-Service

FY = Fiscal year

HRSN = Health-related social needs

ILOS = In lieu of services and settings

IBNR = Incurred but not reported

LOB = Line of business

LTSS = Long term services and supports

MCO = Managed care organization

MCP = Managed care plan

MLR = Medical loss ratio

PAHP = Prepaid ambulatory health plan

PBA = Pharmacy benefit administrator

PBM = Pharmacy benefit manager

PIHP = Prepaid inpatient health plan

PMPM = Per member per month

QIA = Health care quality improvement activity

SDOH = Social determinants of health

SDP = State directed payment

Glossary of Terms

Capitation or capitated payment. Consistent with 42 CFR §438.2, a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract and based on the actuarially sound capitation rate for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Comprehensive managed care. Medicaid managed care programs that provide acute, primary, and specialist care, and sometimes other services and supports, to people in return for a prepaid fee.[21]

Corrective action plan (CAP). A corrective action plan is a step-by-step plan of action that is developed to achieve targeted outcomes for resolution of identified errors in an effort to: (1) identify the most cost-effective actions that can be implemented to correct error causes; (2) develop and implement a plan of action to improve processes or methods so that outcomes are more effective and efficient; (3) achieve measurable improvement in the highest priority areas; and (4) eliminate repeated deficient practices.[22]

Managed care organization (MCO). An entity that has a comprehensive risk contract, is responsible for providing a comprehensive benefit package of services to enrollees and meets the requirements set out in the definition at 42 CFR §438.2.

Managed care plan (MCP). This toolkit uses the term "managed care plan" to refer to all managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs), as defined in 42 CFR §438.2, that hold risk-based contracts with state Medicaid agencies.

Managed care program. Consistent with 42 CFR §438.2, managed care program means a managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act. For purposes of the MLR toolkit, a program is defined by a specified set of benefits and eligibility criteria that is articulated in a contract between the state and managed care plans, and that has associated rate cells.

Medical loss ratio (MLR). As specified under 42 CFR §438.8(d)-(h), MLR is the sum of an MCP's incurred claims and quality expenditures divided by its adjusted premium revenue. The MCP's adjusted premium revenue is its aggregated premium revenue minus taxes, licensing, and regulatory fees. For states that mandate minimum MLR values for MCPs, minimum values must be at least 85% under 42 CFR §438.8(c).

[21] https://www.macpac.gov/subtopic/types-of-managed-care-arrangements/

[22] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/PERM/Downloads/2013correctiveActionPowerpoint.pdf

Prepaid ambulatory health plan (PAHP). Consistent with 42 CFR §438.2, an entity that provides services to enrollees under contract with the state and on the basis of capitation payments or other payment arrangements that do not use state plan payment rates; does not provide or arrange for and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

Prepaid inpatient health plan (PIHP). Consistent with 42 CFR §438.2, an entity that provides services to enrollees under contract with the state and on the basis of capitation payments or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and does not have a comprehensive risk contract.

Reporting year. As defined at 42 CFR §438.8(b), a period of 12 months consistent with the rating period selected by the State. Consistent with the definition of rating period at 42 CFR §438.2, MLR reporting periods cannot be longer than 12 months. The CMCS Information Bulletin published June 5, 2020, provides examples of MLR reporting options for reporting periods that exceed 12 months.

Runout period. The specified extended reporting period for claims incurred during the policy year but not submitted or paid until the after the end of the policy year, also referred to as "Claims Runout."[23]

Sanction. An enforcement action taken against a managed care plan. Such actions include monetary and other forms of remedies, such as suspending all or part of new member enrollments and suspending or terminating all or part of the contract. Federal regulations related to MCP sanctions are found at 42 CFR §§438.700 – 730.

Subcontractor. For purposes of this toolkit, an individual or entity that has a contract with a MCO, PIHP, or PAHP that relates directly or indirectly to the performance of the MCO's, PIHP's, or PAHP's, obligations under its contract with the state. A network provider is not a subcontractor by virtue of the network provider agreement with the MCO, PIHP, or PAHP.

Validation. The act of confirming something as true or correct; the act of officially or legally certifying or approving something.

[23] Naic.org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