U.S. Department of Health and Human Services

Office of Inspector General

Data Brief

August 2021, OEI-03-20-00230

Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets

Key Results

- In the 34 States that required minimums for medical loss ratios (MLRs), 91 percent of Medicaid managed care plans met the State-set minimum MLR. An MLR is the percentage of revenue that a plan spends on health care services and quality improvements.
- Nineteen plans reported owing a total of $198 million to States that chose to require plans to return money if minimum MLRs were not met. For all but one plan, the owed amount covered a 12-month reporting period.
- Regardless of whether States set minimum MLRs, 92 percent of all plans achieved MLRs that met or exceeded the Federal MLR standard of 85 percent.

Why OIG Did This Review

Managed care has replaced fee-for-service as the predominant payment model in Medicaid. State and Federal spending on Medicaid managed care is growing and totaled $360 billion in 2020, accounting for more than half of total Medicaid spending that year. Federal requirements for medical loss ratios (MLRs) were established to ensure that plans spend most of their revenue on health care services and quality improvements, thereby limiting the amount that plans can spend on administration and keep as profit. These requirements also enhance fiscal stewardship of Medicaid expenditures by helping to ensure that States have sufficient information to oversee spending by their Medicaid managed care plans.

Federal regulations give States the option to establish a minimum MLR of at least 85 percent for their Medicaid managed care plans. Regardless of whether a State establishes a minimum MLR, it must use plan-reported MLR data to set future payment rates for managed care so that its plans will "reasonably achieve" an MLR of at least 85 percent.

This data brief provides stakeholders with national data on (1) the MLRs of Medicaid managed care plans and (2) the extent to which plans met State-set minimum MLRs and the Federal MLR standard of 85 percent.

How OIG Did This Review

We requested that Medicaid agencies from the 50 States and the District of Columbia (which we refer to collectively as States) complete an online survey and submit information about their managed care plans that are subject to Federal MLR requirements. We also requested that States provide the annual MLR reports that they received from their Medicaid managed care plans. All 51 States responded to our information request, and 43 States had plans that were subject to Federal MLR requirements as of September 1, 2020. States submitted annual MLR reports for reporting periods ending in 2017, 2018, or 2019. We analyzed States' survey responses and annual MLR reports for 513 plans to identify States' MLR requirements and the extent to which plans had met State-set minimum MLRs and the Federal 85-percent standard.

What OIG Found

Although Federal MLR regulations do not require States to set minimum MLRs, 34 States had established minimum MLRs for 434 Medicaid managed care plans for annual reporting periods ending in 2017, 2018, or 2019. Ninety-one percent of plans met these State-set minimum MLRs. However, 39 plans failed to meet their State-set minimum MLRs for the period reviewed. Nineteen of these plans reported owing a total of $198 million to States that had opted to require their plans to return money to the State when minimum MLRs were not met. For all but one plan, the owed amount covered a 12-month MLR reporting period. Finally, 92 percent of Medicaid managed care plans (471 of 513) achieved MLRs that met or exceeded the Federal 85-percent MLR standard regardless of whether their States had established minimum MLR requirements. This data brief shows that nationwide, almost all managed care plans met or exceeded MLR requirements to direct funds toward patient care and quality improvements. Further, it demonstrates that States that chose to establish minimum MLRs with requirements to return monies may recoup millions of Medicaid dollars from plans that failed to meet the State-set minimum MLR thresholds.

BACKGROUND

Managed care has replaced fee-for-service as the predominant payment model in Medicaid. State and Federal expenditures on Medicaid managed care are growing and totaled $360 billion in 2020, which was 55 percent of total Medicaid expenditures in that year.[1] Federal requirements for MLRs in Medicaid managed care were established to help ensure the appropriate use of Federal and State dollars for health care services and for quality improvements for Medicaid enrollees.[2] This data brief provides stakeholders with national data on (1) the MLRs of Medicaid managed care plans and (2) the extent to which plans have met State-set minimum MLRs and the Federal MLR standard of 85 percent.

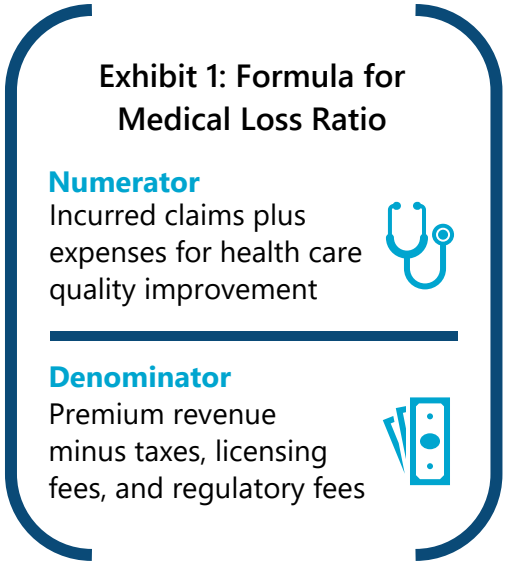
Medicaid Managed Care

Medicaid is a complex landscape of State-specific programs that offer health coverage to eligible groups, such as low-income families, pregnant women, children, and individuals with disabilities. States administer and finance Medicaid using State and Federal funds. States have the flexibility to structure their programs on the basis of their unique needs and Federal regulations. For Medicaid managed care, States contract with and oversee the health plans that operate in the State. States pay these contracted managed care plans a monthly premium, known as a capitation payment, for each enrollee regardless of whether the enrollee uses any covered services each month. Federal MLR requirements were established to ensure that Medicaid managed care plans spend most of these payments on enrollees' covered services and quality improvements, thereby limiting the amount that plans can spend on administration and keep as profit.

Medicaid Managed Care MLRs

Medicaid managed care plans, including managed care organizations (MCOs), prepaid ambulatory health plans (PAHPs), and prepaid inpatient health plans (PIHPs) are subject to Federal MLR requirements.[3] The Federal MLR is the percentage of revenue that a managed care plan spent on health care services and quality improvements, as specified in regulation, and calculated using a standard formula, as shown in Exhibit 1.[4]

Exhibit 1: Formula for Medical Loss Ratio



Medicaid MLR requirements

To comply with Federal MLR regulations, States had to include requirements for MLR reporting in their Medicaid managed care plan contracts beginning on or after July 1, 2017.[5] Specifically, States must require managed care plans to use their revenue and expenditure figures for the MLR reporting year to calculate MLRs, and require plans to submit an annual MLR report to the State within 12 months after the end of the MLR reporting year.[6, 7] A plan's annual MLR report must include specific data elements such as the calculated MLR, premium revenue, and (if applicable) any remittance amounts owed to the State.[8] A plan must attest to the accuracy of the MLR calculation when the plan submits its annual MLR report to the State.[9] States are required, for contracts starting on or after July 1, 2019, to set their managed care plans' capitation rates so that plans will "reasonably achieve" MLRs of at least 85 percent.[10] As part of the process for setting capitation rates, States must take into account the MLR data that their managed care plans have reported.[11]

Optional minimum MLR and remittance policies

Federal regulations give States the option to choose whether to require minimum MLRs for their Medicaid managed care plans, as shown in Exhibit 2. If a State opts to set a minimum MLR, it must be at least 85 percent.[12] States that set minimum MLRs also have the option to require that their managed care plans pay remittances to the State if a plan fails to meet the minimum MLR.[13] States determine their own methodology for calculating the remittance amounts that plans owe. For example, a plan could owe the State a portion of its revenue equal to the percentage by which the plan missed a State-set minimum MLR. In this example, if a plan achieved an MLR that was 5 percent below the State-set minimum, the plan may owe the State a remittance amount equal to 5 percent of its revenue.

Exhibit 2: Federal MLR Requirements and Optional MLR Policies

States *must require* Medicaid managed care plans to:

Calculate MLRs using revenue and expenditure figures. Plans must attest to the accuracy of these MLR calculations.

Submit an annual MLR report to the State within 12 months of the end of the reporting year. The report must include the MLR, premium revenue, any remittance owed, and other data.

States *may choose* to require Medicaid managed care plans to:

Meet a minimum MLR of at least 85 percent. States can set a minimum MLR above 85 percent.

Pay remittances if they fail to meet the State-set minimum MLR.

Related OIG Work

From 2015 to 2017, OIG issued a series of seven State-specific audits that estimated potential Medicaid savings if the State had implemented a minimum MLR requirement.[14] These audits occurred before the Centers for Medicare & Medicaid Services' (CMS's) MLR requirements were incorporated into the Medicaid regulations. The audits used a hypothetical Medicaid MLR calculation based on a formula similar to the Federal MLR standard for certain private insurers and Medicare Advantage plans. These audits found that five States could have realized savings if they had required an 85-percent minimum MLR and collected remittances from managed care plans if the minimum MLR was not met.

Methodology

We requested that States provide to OIG one annual MLR report for each Medicaid managed care plan subject to Federal MLR requirements. All 51 States (including the District of Columbia) responded to our request for information.[15] We received annual MLR reports from the 43 States that had contracts with Medicaid managed care plans that were subject to Federal MLR requirements as of September 1, 2020. [16, 17]

To provide a national landscape of Medicaid managed care MLRs, we included in our review all annual MLR reports submitted by States, except those that were only for the Children's Health Insurance Program (CHIP). States submitted annual MLR reports for reporting periods ending in 2017, 2018, or 2019. For each annual MLR report included in our review, we analyzed the MLR, remittance, and revenue data contained in the report.[18]

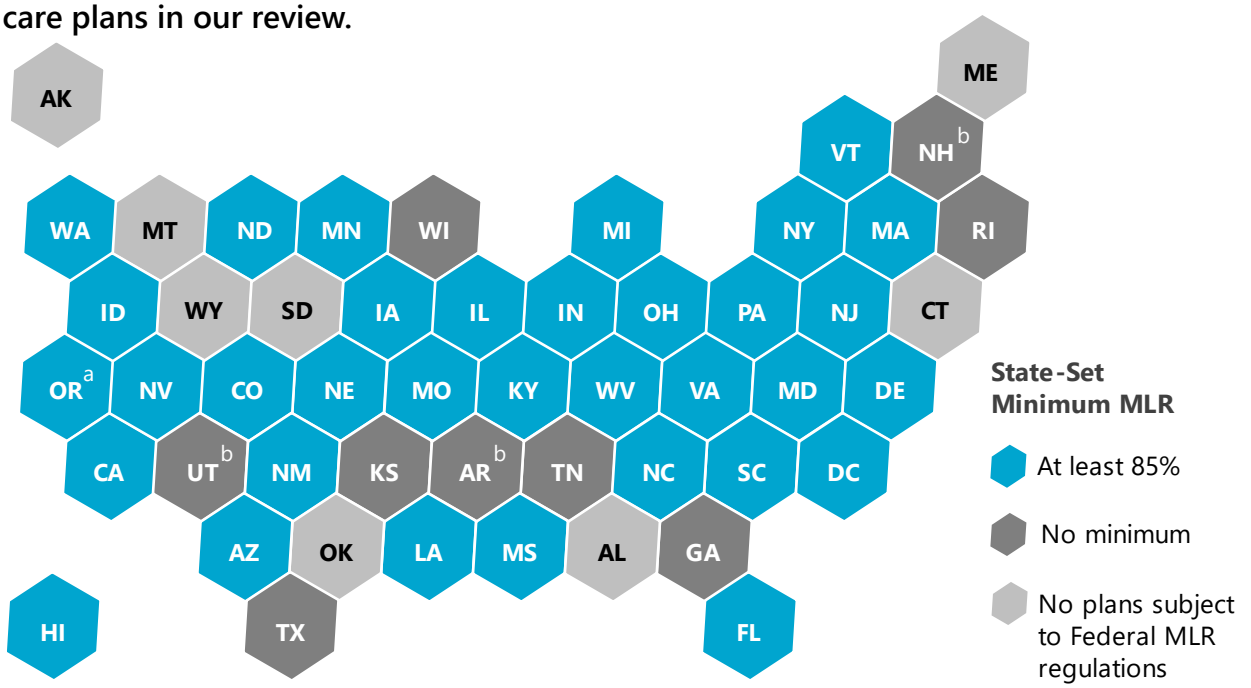
States submitted annual MLR reports that incuded plans' aggregated plan-level MLR and/or separate MLRs for specific Medicaid populations (e.g., children in foster care) or geographic areas (e.g., county, region).[19] When an annual MLR report contained population-level MLRs or geographic-level MLRs and also contained an aggregated plan-level MLR, we analyzed the plan-level MLR. When an annual MLR report contained population-level MLRs or geographic-level MLRs and did *not* contain an aggregated plan-level MLR, we analyzed each of these MLRs separately. In our results, we use the terms "managed care plans" and "plans" to mean a single MLR for an entire plan, a specific Medicaid population, or a geographic area. See the Detailed Methodology section for more information.

RESULTS

Most States established minimum MLR requirements for Medicaid managed care plans, even though Federal regulations do not require States to do so

Federal MLR regulations give States the option to set minimum MLRs of at least 85 percent for their managed care plans. Of the 43 States that had Medicaid managed care plans subject to Federal MLR regulations, 34 chose to adopt minimum MLR requirements, as shown in Exhibit 3. These State-set minimum MLRs covered 434 of the 513 plans in our review. Only nine States did not establish minimum MLRs for any plans.

Exhibit 3: Most States had established minimum MLR requirements for the managed care plans in our review.



Source: OIG analysis of plan-level information collected from State Medicaid agencies.
Note: This exhibit reflects the State-set minimum MLR for plans subject to Federal MLR regulations for annual MLR reporting periods ending in 2017, 2018, or 2019.
[a] Oregon set minimum MLRs for all but one plan in our review.
[b] Arkansas, New Hampshire, and Utah reported that they did set minimum MLRs as of September 2020.

Of the 33 States that chose to adopt minimum MLR requirements for all of their plans, 25 set the minimum MLR at 85 percent, 1 set it at 86 percent, 1 set it at 88 percent, and 1 set it at 90 percent. In addition, 5 of the 33 States set minimum MLRs for all of their plans, but the minimum MLRs varied by plan. These minimum MLRs varied between 85 percent and 90 percent depending on the plan's performance on quality

metrics, population served, type of service delivered, or plan type.[20] An additional State set a minimum MLR of 85 percent for all but one plan. This plan was not required to meet a minimum MLR.

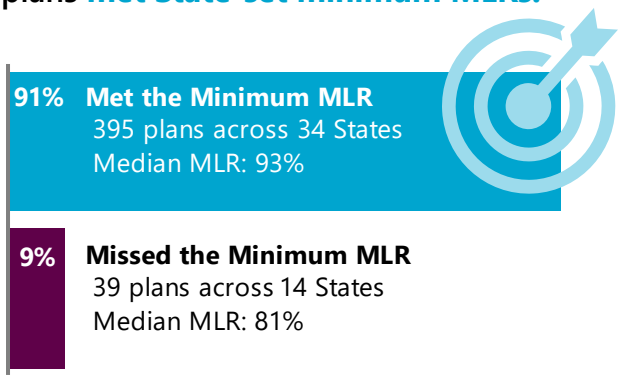
Three of the nine States that had not set any minimum MLRs during the period we reviewed did require minimum MLRs as of September 2020. This raises the number of States that require minimum MLRs to 37 of 43 States. An additional State is planning to set a minimum MLR in future plan contracts.

The remaining five States reported that they had not established minimum MLR requirements for their plans. Two of these States said that the reason they do not set minimum MLRs is that they set plans' capitation rates so that plans achieve target MLRs. Another State said that it has a profit-sharing mechanism built into plans' contracts. The fourth State said that it did not need a minimum MLR because plans have "historically exhibited stable MLRs." The last of these States said that "it is not in the State's best interest to pursue a minimum MLR."

Almost all Medicaid managed care plans met their State-set minimum MLRs

Ninety-one percent of plans that were required to meet minimum MLRs (395 of 434) met the minimum MLRs established by their States, as shown in Exhibit 4. Among the 434 plans required to meet minimum MLRs, 326 had to meet a State-set minimum MLR of 85 percent and the remaining 108 had to meet State-set minimum MLRs between 86 percent and 90 percent.

Exhibit 4: Most Medicaid managed care plans met State-set minimum MLRs.



Source: OIG analysis of Medicaid managed care plans' annual MLR reports and plan-level information collected from State Medicaid agencies.

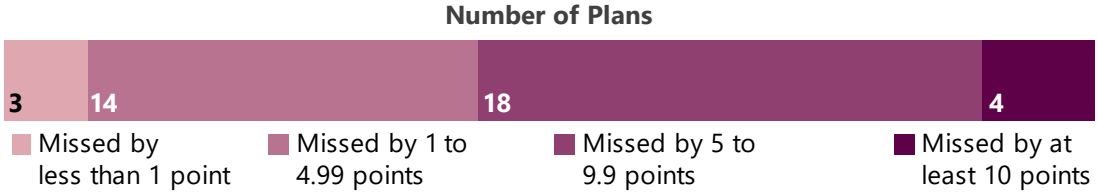
The 39 plans that failed to meet State-set minimum MLR requirements were spread across 14 States. For these 39 plans, 22 did not meet an 85-percent minimum MLR and 17 did not meet minimum MLRs set above 85 percent.

Overall, a greater percentage of plans did not meet the higher minimum MLRs set by States. Of all plans subject to an 85-percent State-set minimum MLR, 7 percent (22 of 326 plans) did not meet it. Of all plans subject to higher State-set minimum MLRs, 16 percent (17 of 108 plans) did not meet them.

For the 39 plans that failed to meet their State-set minimum MLR requirements, the difference between the plans' MLRs and the State-set minimum MLRs ranged from 0.06 percentage points to 32 percentage points. The majority of these plans missed

their State-set minimum MLRs by at least 5 percentage points, as shown in Exhibit 5. Four of these plans missed their State-set minimum MLRs by at least 10 percentage points.

Exhibit 5: Of plans that missed their State-set minimum MLRs, the majority missed by at least 5 percentage points.



Source: OIG analysis of Medicaid managed care plans' annual MLR reports and plan-level information collected from State Medicaid agencies.

Nineteen Medicaid managed care plans that failed to meet their State-set minimum MLRs reported owing a total of $198 million to States

Federal regulations allow States to require payments from plans that fail to meet State-established minimum MLRs. For the annual MLR reports that we reviewed, 19 of the 39 plans that missed their minimum MLRs reported owing millions of dollars in remittances back to States and the Federal government. These 19 plans reported owing a total of $198 million to 6 States, with the amounts owed ranging from $1.8 million to $40.2 million per plan.[21] For all but 1 of the 19 plans, the owed amounts covered a 12-month MLR reporting period. The remaining plan provided an MLR for a 17-month reporting period.

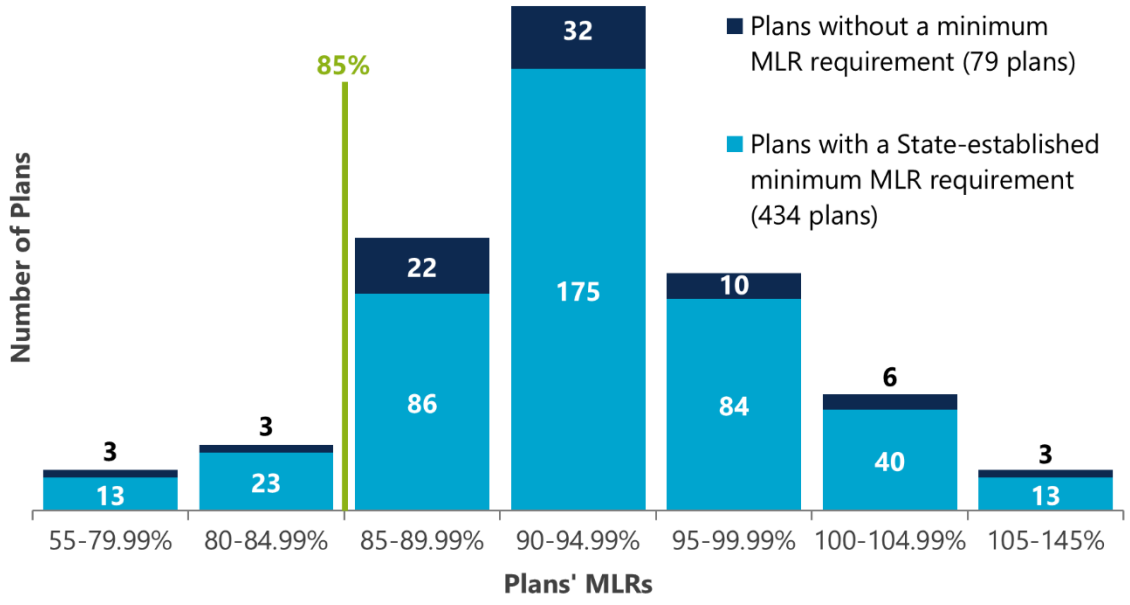
Not all States require their managed care plans to pay remittances when plans fail to meet State-set minimum MLRs. Of the 37 States that had established minimum MLR requirements as of September 2020, 28 had also established remittance requirements for all of their plans. Another four States required remittances for some of their plans. For example, one State exempted behavioral health plans but required remittances for all other plans. In contrast, 5 of the 37 States had not adopted remittance requirements for any plans as of September 2020, despite requiring minimum MLRs. These States reported that they take actions other than requiring remittance payments, including changing plans' future capitation rates on the basis of the MLRs the plans achieved, or using other types of fiscal management strategies, such as risk corridors and profit-sharing.[22] One State said that it had established MLR remittance requirements in plans' contracts starting October 2020.

Nationwide, 92 percent of plans achieved the Federal 85-percent MLR standard, regardless of whether States set minimum MLR requirements

Nearly all plans met or exceeded the Federal 85-percent MLR standard regardless of whether their States had established minimum MLRs, as shown in Exhibit 6. For managed care contracts starting on or after July 1, 2019, Federal regulations require States to set capitation rates so that Medicaid managed care plans will "reasonably achieve" an MLR of at least 85 percent. Ninety-two percent of plans (471 of 513) achieved MLRs equal to or greater than 85 percent, with a median MLR of 93 percent across all plans.

MLRs ranged from 55.8 percent to 144.7 percent, including 42 plans with MLRs below 85 percent. Most plans (409) achieved MLRs between 85 percent and 99.9 percent, and 62 plans had MLRs of 100 percent and above. When a plan's MLR is below 85 percent, the plan failed to meet the spending targets for health care services and quality improvements. When a plan's MLR is above the State-set minimum MLR or the Federal standard, the plan exceeded spending targets for health care services and quality improvements and may keep less of its revenue as profit.

Exhibit 6: Regardless of whether States set minimum MLR requirements, most Medicaid managed care plans achieved MLRs that met or exceeded the Federal standard of 85 percent.



Source: OIG analysis of Medicaid managed care plans' annual MLR reports and plan-level information collected from State Medicaid agencies.

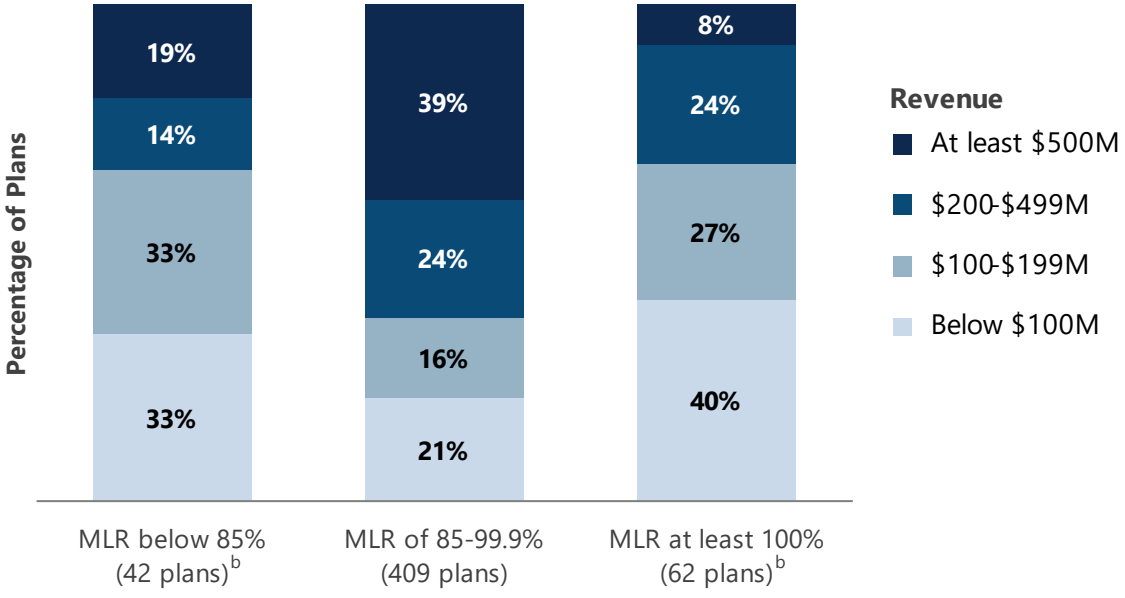
Of the 42 plans that did not meet the 85-percent MLR standard, only 6 were from States that did not establish minimum MLR requirements for any of their plans. Although these six plans were not required to meet any State-set minimum MLRs or

pay remittances to their States, four of these plans' annual MLR reports included the amounts they would have owed if the States had required an 85-percent minimum MLR. These four plans would have collectively owed $139 million to three States if requirements for minimum MLRs and remittances had been in effect.

Compared to larger plans, smaller plans more frequently reported MLRs that were either lower or much higher than 85 percent

Just over 100 plans reported MLRs of less than 85 percent or equal to or greater than 100 percent. These plans tended to be smaller plans, as determined by the plans' revenue amounts (Exhibit 7). These 104 plans reported an average revenue of $250 million. In contrast, the 409 plans with MLRs between 85 and 99.9 percent reported an average revenue of $670 million. Smaller plans are expected to experience more variation in their MLRs when compared to larger plans because the expected cost for medical issues is more difficult to predict for smaller plans. In a July 2017 Informational Bulletin, CMS specifically noted that "a smaller managed care plan's reported MLR is more likely to vary, and vary more widely, around a targeted standard, due to the disproportionate effect random variations can have on smaller managed care plans."[23]

Exhibit 7: Plans that reported MLRs on the lower and higher ends of the range tended to be smaller.[a]



Source: OIG analysis of Medicaid managed care plans' annual MLR reports.

[a] In this analysis, we used plan revenue as a proxy for plan size. For plans that had MLR reporting periods that were shorter or longer than 12 months, we calculated a 12-month revenue based on each plan's average monthly revenue.

[b] Because of rounding, the total percentage does not equal 100.

CONCLUSION

Federal MLR requirements help ensure the use of Federal and State Medicaid dollars for health care services and quality improvements for Medicaid enrollees. States must set their capitation rates so that their Medicaid managed care plans will reasonably achieve an MLR of at least 85 percent.[24] Nationwide, nearly all Medicaid managed care plans achieved MLRs that met this Federal standard. These plans spent at least 85 percent of their revenue on the direct provision of health care and on activities that improve the quality of care, while devoting 15 percent or less of their revenue to administration and profit.

States are leveraging minimum MLRs to help ensure the appropriateness of their Medicaid managed care spending. Most States chose to require all or some of their managed care plans to meet a minimum MLR of 85 percent, with some States setting the minimum MLR at a higher bar than 85 percent. In turn, most plans nationwide achieved MLRs that met or exceeded their State-set minimums or the Federal 85-percent standard. However, 36 plans missed both the State and Federal targets, 6 plans missed only the Federal standard, and 3 plans missed only their State-set minimum MLRs. States that opt to establish minimum MLRs with remittance requirements have the potential to recoup millions of Medicaid dollars when plans fail to meet State-set minimum MLRs. In fact, in 6 States that required remittances, 19 plans reported owing $198 million to their States and the Federal government.

This data brief shows that nationwide, almost all managed care plans met or exceeded MLR requirements to direct funds toward patient care and quality improvements. Further, it demonstrates that States that choose to require minimum MLRs with remittance requirements may recoup millions of dollars from plans that fail to meet State-set minimum MLRs. In a separate forthcoming report, OIG will (1) evaluate States' oversight of their Medicaid managed care plans' compliance with MLR reporting requirements and (2) assess the completeness of MLR data that plans have reported to the States.

DETAILED METHODOLOGY

Data Sources

Self-administered survey. We requested that all State Medicaid agencies respond to an online survey regarding implementation of the Federal MLR requirements as of September 1, 2020. The survey included questions about whether the State established minimum MLR and remittance requirements for its Medicaid managed care plans. For States that had not established requirements for minimum MLRs and remittances, we asked why they had not done so.

Information request. We requested that States provide information, including the State-set minimum MLR (if applicable), for each managed care plan they contracted with as of September 1, 2020.

Plans' annual MLR reports. We requested that States provide to OIG the annual MLR report(s) for each Medicaid managed care plan subject to Federal MLR requirements. All 51 States (including the District of Columbia) responded to our request for information.[25] We received annual MLR reports from the 43 States that had contracts with Medicaid managed care plans that were subject to Federal MLR requirements as of September 1, 2020.[26, 27] States submitted annual MLR reports for the following types of plans: managed care organization (MCO) plans; prepaid inpatient health plans; prepaid ambulatory health plans; MCOs plus managed long-term services and supports plans (MLTSS); MLTSS-only plans; Medicare-Medicaid plans; behavioral health plans; and dental plans.

States submitted annual MLR reports for reporting periods ending in 2017, 2018, or 2019, as shown in Exhibit 8. Almost all plans' annual MLR reports (94 percent or 484 plans) reflected MLR reporting periods of 12 months. However, States also provided annual MLR reports that reflected MLR reporting periods that were shorter than 12 months (23 plans) or longer than 12 months (6 plans). We did not exclude any annual MLR reports from the analysis on the basis of the length of the MLR reporting period.

Exhibit 8: MLR reporting periods included in this review

Year MLR reporting period ended	Number of plans
2017	19
2018	301
2019	193
Total	513

Source: OIG analysis of Medicaid managed care plans' annual MLR reports.

We did not request from States information about CHIP. However, when States provided annual MLR reports that contained combined MLR data for Medicaid and CHIP, we included these data in our analysis. Some annual MLR reports were for plans that served recipients eligible for both Medicare and Medicaid and did not contain separate, Medicaid-only figures for the MLR calculations. We included these data in our analysis. However, remittance amounts for the combined Medicare-Medicaid plans were based only on the Medicaid portion.

States submitted annual MLR reports where plans reported an aggregated plan-level MLR and/or separate MLRs for specific Medicaid populations (e.g., children in foster care) or geographic areas (e.g., county, region).[28] When an annual MLR report contained population-level MLRs or geographic-level MLRs and also contained an aggregated plan-level MLR, we analyzed the plan-level MLR. When an annual MLR report contained population-level MLRs or geographic-level MLRs and did *not* contain an aggregated plan-level MLR, we analyzed each of these MLRs separately. In our results, we use the terms "managed care plans" and "plans" to mean a single MLR for an entire plan, a specific Medicaid population, or a geographic area.

Federal MLR regulations consider plans to be "non-credible" if they have less than 5,400 member months for standard plans and less than 630 member months for MLTSS-only plans. A non-credible plan is assumed to meet or exceed the 85-percent MLR standard or State-set minimum MLR, regardless of the plan's calculated MLR.[29] We excluded from our analysis 26 plans that indicated in their annual MLR reports that they were non-credible. Eighty plans had annual MLR reports that did not include credibility information, and some of these annual MLR reports were also missing information on member months. We included these 80 plans in our analysis.

Analysis of Plans' Annual MLR Reports

For the 513 annual MLR reports in our review, we analyzed the calculated MLR contained in each report. For the annual MLR reports that contained a credibility adjustment, the calculated MLR includes the credibility adjustment.[30] However, we did not validate credibility adjustments based on each plan's member months.

We examined the distribution of plans' calculated MLRs and determined the proportion of plans that reported MLRs of at least 85 percent. We examined calculated MLRs by plan size, using revenue amounts listed in plans' annual MLR reports as a proxy for size. For plans that had MLR reporting periods that were shorter or longer than 12-months, we calculated a 12-month revenue amount based on their average monthly revenue. For plans that were required to meet State-set minimums, we compared the calculated MLR to the State-set minimum MLR. For plans that failed to meet State-set minimums, we identified the amounts by which plans had missed the State-set minimums and summarized the reported remittance amounts.

Limitations

We did not independently verify the self-reported information from State Medicaid agencies or the information contained in the annual MLR reports that States received from their Medicaid managed care plans. However, we did, where possible, review the information for inconsistencies or missing data. We followed up with State Medicaid agencies to resolve issues when identified.

Standards

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

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

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

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To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

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ENDNOTES

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

[2] 81 Fed. Reg. 27498, 27521 (May 6, 2016).

[3] 42 CFR § 438.8(a) and CMS, *Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio,* June 2020. Accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/cib060520_new.pdf on April 22, 2021. The Federal MLR requirements for managed care plans apply only to risk-based MCOs, PAHPs, and PIHPs, as defined in 42 CFR § 438.2. However, PAHPs that deliver only nonemergency medical transportation (NEMT) are exempted from the MLR requirements. For Vermont, the Federal MLR requirements apply to its single managed care plan, even though it is a non-risk-based PIHP. Therefore, we included Vermont's plan in our analysis.

[4] 42 CFR § 438.8(d-f). Although these Medicaid regulations include expenditures on fraud prevention activities in the numerator of the MLR formula, 42 CFR § 438.8(e)(4) specifies that adoption of fraud prevention activities in the MLR calculation would follow Federal private insurance regulations at 45 CFR pt. 158. According to CMS, the Medicaid MLR formula does not include expenditures on fraud prevention activities because these have not been outlined in 45 CFR pt. 158.

[5] 42 CFR § 438.8(a).

[6] 42 CFR § 438.8(b) and CMS, *Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio,* June 2020. Accessed at https://www.medicaid.gov/federal-policy-guidance/downloads/cib060520_new.pdf on April 22, 2021. States may select any 12-month period (e.g., the calendar year, the State fiscal year, the contract year, etc.) as the contract rating period for each of their managed care plans. Plans within one State may have different contract rating periods and therefore different MLR reporting years.

[7] 42 CFR § 438.8(k)(2). States determine the manner and timeframe for the submission of MLR reports. Reports must be submitted within 12 months of the end of the MLR reporting year.

[8] 42 CFR § 438.8(k).

[9] 42 CFR § 438.8(n).

[10] 42 CFR § 438.4(b)(9) and 81 Fed. Reg. 27499.

[11] 42 CFR § 438.5(b)(5).

[12] 42 CFR § 438.8(c).

[13] 42 CFR § 438.8(j).

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

[15] Eight States reported that they did not contract with any Medicaid managed care plans subject to Federal MLR requirements as of September 2020. The Federal MLR requirements for managed care plans apply only to MCOs, PIHPs, and PAHPs, as defined in 42 CFR § 438.2.

[16] As part of OIG's information request, we asked States to provide, for each plan, the most recent annual MLR report that had also been reviewed by the State. If the State had not yet reviewed a plan's most recent annual MLR report, we requested the prior report. Alternatively, if the State had not yet reviewed any of a plan's annual MLR reports, we requested the most recent of the "pre-review" reports. We analyzed 376 reviewed and 137 "pre-review" annual MLR reports from the States.

[17] There were 12 cases in which States sent annual MLR reports for plans that were no longer under contract with the State as of September 1, 2020. We included these reports in our analysis.

[18] For 11 plans in 1 State, we used remittance data contained in a separate document that the State provided to us.

[19] States may require plans to calculate and report MLRs separately for specific populations covered under the plan contract. If States do not require such population-based MLR reporting, plans must aggregate MLR data to include all covered populations and submit plan-based annual MLR reports to the State. See 42 CFR § 438.8(i).

[20] One State lowers minimum MLRs if an MCO meets certain quality metrics. The State sets the minimum MLR at 89 percent, and if an MCO achieves any of four quality metrics, the State lowers the minimum MLR. If an MCO achieves one quality metric, the MCO's minimum MLR would be 88 percent. If an MCO achieves all four quality metrics, the MCO's minimum MLR would be 85 percent. Another State sets the minimum MLR according to the type of service provided by its plans. This State sets different minimum MLRs for the "acute" and "managed long-term services and supports" services within those plans.

[21] If States collect remittance money from plans, the States must reimburse CMS for an amount equal to the Federal share of the remittance. See 42 CFR § 438.74(b).

[22] Under risk corridor arrangements, States and plans agree to share profit or losses (at percentages specified in plan contracts) if aggregate spending falls above or below specified thresholds (two-sided risk corridor). Kaiser Family Foundation, *Medicaid Managed Care Rates and Flexibilities: State Options to Respond to COVID-19 Pandemic*, September 2020. Accessed at https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-rates-and-flexibilities-state-options-to-respond-to-covid-19-pandemic/ on July 19, 2021.

[23] CMS, *Medical Loss Ratio (MLR) Credibility Adjustments*, July 2017. Accessed at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib073117.pdf on January 5, 2021.

[24] 42 CFR § 438.4(b)(9).

[25] Eight States reported that they did not contract with any Medicaid managed care plans subject to Federal MLR requirements as of September 2020. The Federal MLR requirements for managed care plans apply only to MCOs, PIHPs, and PAHPs, as defined in 42 CFR § 438.2.

[26] As part of OIG's information request, we asked States to provide, for each plan, the most recent annual MLR report(s) that had also been reviewed by the State. If the State had not yet reviewed a plan's most recent annual MLR report(s), we requested the prior report. Alternatively, if the State had not yet reviewed any of a plan's annual MLR reports, we requested the most recent of the "pre-review" reports. We analyzed 376 reviewed and 137 "pre-review" annual MLR reports from the States.

[27] There were 12 cases in which States sent annual MLR reports for plans that were no longer under contract with the State as of September 1, 2020. We included these reports in our analysis.

[28] States may require plans to calculate and report MLRs separately for specific populations covered under the plan contract. If States do not require such population-based MLR reporting, plans must aggregate MLR data to include all covered populations and submit plan-based annual MLR reports to the State. See 42 CFR § 438.8(i).

[29] CMS, *Medical Loss Ratio (MLR) Credibility Adjustments*, July 2017. Accessed at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib073117.pdf on January 5, 2021.

[30] For standard plans with 5,400 to 380,000 member months and MLTSS only plans with 630 to 45,000 member months, Federal MLR regulations allow them to add a credibility adjustment to their calculated MLRs to account for random statistical variation related to the number of enrollees in a plan. See 42 CFR § 438.8(h) and CMS, *Medical Loss Ratio (MLR) Credibility Adjustments*, July 2017. Accessed at https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/cib073117.pdf on January 5, 2021.