Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Arizona Medicaid Managed Care Medical Loss Ratio (MLR) Audit

Audit Period: Contract Year Ending 2021 Reporting Period

Final Report

July 2026

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) conducted an audit of the Medical Loss Ratio (MLR) reported by the nine managed care plans (MCPs)[1] contracted with the Arizona Health Care Cost Containment System (Arizona) during the October 1, 2020 through September 30, 2021 contract year ending (CYE) 2021 (audit period). Arizona has partnered with nine different MCPs across the following five Medicaid programs: Arizona Complete Care (ACC), Arizona Long Term Care System (ALTCS), Regional Behavioral Health Authorities (RBHA), Division of Economic Security Division of Developmental Disabilities (DES/DDD), and Department of Child Safety Comprehensive Health Plan (CHP). The MCPs partnering with Arizona to serve each of the five Medicaid programs are shown in Appendix B.

The primary objectives of the MLR audit were to determine whether (1) MCPs submitted annual MLR reports to Arizona in accordance with federal requirements, and (2) annual MLR reporting and MLR calculations for the MCPs were supported by the underlying data and documentation and were consistent with applicable federal requirements.

To meet these objectives, CMS reviewed Arizona's CYE 2021 MLR Reporting Template and Instructions, supporting documentation provided by the state, and additional detail and documentation obtained directly from MCPs to substantiate reported MLR calculations and understand Arizona's oversight procedures. All Medicaid data collected for this audit were aggregated on a program-wide basis.

This report includes CMS' findings, recommendations, and observations that were identified during the MLR audit that primarily reflect inconsistencies in how certain payments and costs were defined, reported, and validated rather than systemic issues with MCP financial performance. All MCPs remained above the federal minimum threshold of 85 percent, and no remittances would have been owed for the audit period. These results indicate that Arizona's reported MLR outcomes are sound; however, improvements are needed to strengthen the consistency, transparency, and auditability of MLR reporting.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified 11 instances of findings across all MCPs requiring correction to the MLR calculations reported by MCPs. Because none of these corrections resulted in a recalculated MLR that fell below the federally required minimum threshold (85 percent for all programs), CMS did not identify any remittances that would have been paid to the state and CMS had a required remittance arrangement been in place. In response to these findings, CMS identified recommendations that will enable the state to come into compliance with federal and/or state Medicaid MLR requirements. These recommendations include the following:

[1] Further references to "MCPs" will be inclusive of all MCPs across ACC, ALTCS, RBHA, DDD, and CHP.

Provider Incentive Payments, Alternative Payment Models (PI/APM), and Contracts

1. In accordance with 42 CFR § 438.8(e)(2)(iii)(A), Arizona should update the MLR Reporting Template Instructions to augment oversight activities to verify the proper classification and inclusion of PI/APMs.

State Directed Payments (SDP), Special Payments, and Risk Sharing Arrangements

2. In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should augment the MLR Reporting Instructions to incorporate additional specificity and guidance to clarify the appropriate treatment of special payments, pass-through payments, and SDPs within the MLR calculation.

3. Effective July 9, 2024, §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii) requires SDPs, inclusive of separate payment terms, to be included in both the numerator and denominator of the MLR calculation. SDPs from MCPs to providers should be included in the numerator and SDP revenue from Arizona should be reflected in the denominator and included as separate line item(s) in the MLR Reporting Template.

4. In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should closely monitor MCPs' reporting of SDPs by reviewing the reported incurred claims payments in the MLR calculation and reconcile all amounts with MCPs' MLR reporting.

5. In accordance with § 438.6(a), Arizona should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' proper treatment of special payments as pass-through payments as defined in § 438.6(a).

6. In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify that risk corridor amounts for subcontracted health plans are appropriately reflected within the MLR Reporting Templates.

7. In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify the accounting of accruals to validate the proper classification and inclusion of risk sharing arrangements.

Third-Party Vendor Data and Contracts

8. In accordance with §§ 438.8(e)(2)(v)(A)(1) and 438.8(e)(2)(v)(A)(2), Arizona should augment the MLR Reporting Instructions to clarify that any portion of capitation payments to third party vendors attributable to non-claims costs should be excluded from the MLR calculation. Arizona should augment their oversight activities to validate that these payments have been excluded from the MLR calculation.

Quality Improvement Activity Expenditures and Contracts

9. In accordance with § 438.8(e)(3), Arizona should update MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of QIA.

Non-Claims Costs

10. In accordance with § 438.8(e)(2)(v)(A), Arizona should revise the MLR Reporting Template Instructions to include explicit guidance on the treatment of non-claims costs and require non-claims cost amounts to be reported on the MLR Reporting Templates to verify the proper exclusion of the costs from the numerator.

11. In accordance with § 438.8(e)(2)(v)(A) and 45 CFR § 158.150(c)(8), Arizona should update the MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and reporting of non-claims costs.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified 10 observations related to Arizona's oversight of MCPs' MLR reporting. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this audit include the following:

State Oversight of MCP MLR Reporting

1. CMS encourages Arizona to update the MLR Reporting Template Instructions to clarify that PI/APM expenses should be reported on an accrual basis for the specified reporting period only. Additionally, oversight activities should be augmented to verify that reported PI/APM amounts are on an accrual basis for the specified reporting period only.

2. CMS encourages Arizona to enhance oversight and monitoring processes to ensure all instructions, guidance, and formulas are accurate within the MLR Reporting Templates.

3. CMS encourages Arizona to submit amended pre-prints when total state payments for SDP arrangements exceed their originally submitted pre-print amount.

Provider Incentive Payments, Alternative Payment Models (PI/APM) and Contracts

4. CMS encourages Arizona to require MCPs to maintain contracts that are available for review with providers related to incentive payments by the first rating period on or after July 9, 2025, consistent with regulations at § 438.3(i)(3)(i-iv) and § 438.8(e)(2)(iii)(A).

5. CMS encourages Arizona to require defined contract termination dates within the MCPs' PI/APM contracts to allow the state to determine whether PI/APM contracts are applicable for the CYE reported by the first rating period on or after July 9, 2024, consistent with regulations at § 438.3(i)(3)(i).

6. CMS encourages Arizona to implement a process to collect proof of payment from the MCPs for PI/APM programs to verify that PI/APM payments made to providers are appropriately accounted for in the MLR calculation.

State Directed Payments, Special Payments, and Risk Sharing Arrangements

7. CMS encourages Arizona to create separate line items in the MLR Reporting Template for each SDP to improve the monitoring of payment amounts and incorporate various payment types into the MLR calculation as applicable.

8. CMS encourages Arizona to require the Risk Corridor calculation be finalized prior to the submission of MLR Reporting Templates to allow the final reconciliation amounts to be used in the MLR calculation.

Allocation of Expenses Methodology

9. CMS encourages Arizona to enhance future Medicaid MLR reporting instructions to indicate that any non-Medicaid LOB expenses should be omitted from the Medicaid MLR reporting in accordance with § 438.8(g).

Quality Improvement Activity Expenditures and Contracts

10. CMS encourages Arizona to implement additional oversight procedures and provide clear guidance and instruction for MCPs to validate overhead and indirect expenses reported as QIA expenditures.

Conclusion

While the audit identified areas for improvement in reporting consistency and oversight, Arizona's MCPs demonstrated MLR performance above the federal minimum threshold for the audit period. Implementing the recommended enhancements will help ensure continued compliance, improve data integrity, and support more consistent and transparent MLR reporting in future years.

Arizona's Medicaid Managed Care MLR Audit

Background

A key component of CMS' Medicaid oversight strategy includes conducting targeted audits of states' Medicaid MCP MLR financial reporting. Under federal regulations, all Medicaid managed care contracts, including those with managed care organizations, prepaid inpatient health plans, and prepaid ambulatory health plans, are required to calculate and report an MLR to their respective states. The requirement provides for a sufficient percentage of the premium payments to be spent on medical services and quality improvements rather than health plan administrative expenses, reserves, and profit.

The primary objectives of the MLR audits are to determine if (1) MCPs submitted annual MLR reports to the state pursuant to federal requirements, and (2) the annual MLR reporting and minimum MLR calculations are supported by the underlying data and related documentation received by the state. Through these audits, CMS also provides states with feedback and leading practices that may be used to enhance program integrity in Medicaid.

Overview of CMS' Medicaid Managed Care MLR Requirements

Federal regulations require that capitation payments made by states to MCPs be actuarially sound.[2] The MLR is a retrospective tool to assess health plan financial performance that demonstrates that a sufficient percentage of the total capitation is spent on Medicaid services and quality improvements rather than health plan administration expenses, reserves, and profit. Federal regulations do not require states to implement a minimum MLR or a remittance arrangement with MCPs. Under § 438.8(c), if a state elects to mandate a minimum MLR for its MCPs, that minimum MLR must be equal to or higher than 85 percent, and the MLR must be calculated and reported for each MLR reporting year by the MCPs. States that implement a minimum MLR can also determine whether to require their MCPs to pay remittances if they fail to meet their state's minimum MLR requirement. If a state requires a remittance arrangement, it can decide the methodology for calculating or collecting remittances, but it must specify any differences from the MLR methodology under § 438.8 in its contracts with its MCPs and develop separate MLR reports for rate setting and compliance reporting to CMS.

Pursuant to § 438.8(k), MCPs are required to submit a report to the state that includes at least thirteen data elements for the MLR reporting year. This report, which must be submitted for each reporting year and within twelve months after the end of the reporting year, must follow the MLR methodology outlined in § 438.8. While the MLR formula methodology for rate setting and annual reporting purposes must follow the formula outlined in § 438.8, states have flexibility in setting the calculation methods for remittance arrangements. In other words, minimum MLR remittance calculations can differ methodologically from the federal regulations in § 438.8.

[2] §1903(m)(2)(A) of the Social Security Act

Overview of Arizona's Medicaid Managed Care Program and the MLR Audit

The Arizona Health Care Cost Containment System contracted with nine MCPs to provide health care coverage for the Medicaid managed care population. MCPs are contracted with the state to provide Medicaid physical health, behavioral health, and long-term care services benefits to Medicaid enrollees or recipients across five managed care programs, leveraging a managed care model to incentivize high-quality and cost-effective care. While Arizona holds the MCPs as the responsible party for all service provisions within their contracts with the state, two MCPs, DCS and DES/DDD, contract with Subcontracted Health Plans (SHPs) to provide and administer benefits and services to members.

CMS conducted an audit of the MLR calculation for the Medicaid managed care population in Arizona, covering the CYE 2021 contract period.[3] To assess compliance with federal and state MLR requirements, CMS reviewed the CYE 2021 Arizona State MLR Reporting Template submitted by each MCP[4] and additional supporting documentation provided by Arizona. CMS also requested additional information from MCPs to substantiate the reported MLRs and to review Arizona's oversight procedures.

Risk-sharing mechanisms are leveraged by states to help protect the stability and continuity of the Medicaid delivery system. Arizona has a long-standing risk corridor within the managed care programs to mitigate risks for both the MCPs and the state. For each program, Arizona utilizes risk corridors, rather than a minimum MLR remittance requirement, to limit the maximum profit on total medical expenses that an MCP can retain each year. CMS did not perform a detailed review of Arizona's risk corridor to determine if settlement amounts were calculated appropriately.

On April 22, 2024, CMS published the Final Rule entitled "Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" (2024 Final Rule) which advances CMS' efforts to improve access to care, quality and health outcomes for Medicaid and CHIP managed care enrollees. The 2024 Final Rule addresses standards for timely access to care and states' monitoring and enforcement efforts, reduces state burdens for implementing some SDPs and certain quality reporting requirements, adds new standards that will apply when states use in lieu of services and settings (ILOSs) to promote effective utilization and that specify the scope and nature of ILOSs, adjusts and revises MLR requirements, and establishes a quality rating system for Medicaid and CHIP managed care plans. The MLR audit period for Arizona is prior to the effective date of the 2024 Final Rule; therefore, any area identified wherein the state or its MCPs would need to take action to be considered in compliance with the 2024 Final Rule have been documented as an observation. For MLR audit periods that begin after the various applicable dates of new requirements beginning July 9, 2024, any area identified in noncompliance would be considered a finding and require corrective action.

During this audit, CMS identified a total of 11 recommendations and 10 observations. Appendix

[3] All Medicaid data collected for this audit were aggregated on a program-wide basis.
[4] Arizona's MLR methodology is calculated on an annual basis.

A contains additional detail on this audit's scope and methodology. CMS also included MCP-specific information in Appendix B. Arizona's response to CMS' draft report can be found in Appendix C, with the final report reflecting all changes CMS made based on Arizona's response.

This audit encompasses eight following areas:

1. **State Oversight of MCP MLR Reporting** – CMS regulations at § 438.74 outline the requirements for state oversight of MLR reporting. The requirements at § 438.74(a) require states to submit an annual summary description of the MLR reports received from each MCP to CMS. The summary description is required to include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each MCP for the MLR reporting year.

2. **Provider Incentive/Alternative Payment Models and Contracts** – Alternative Payment Models (APMs) reward health care providers for delivering high-quality and coordinated care. § 438.8(e)(2)(iii)(A) more specifically addresses provider incentive and bonus payments by allowing such amounts to be treated as incurred claims only when they are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards applicable to providers, while § 438.3(i) incorporates the physician incentive plan safeguards in 42 CFR § 422.208 and § 422.210, including prohibiting inducements to reduce or limit medically necessary services and requiring protection against substantial financial risk where applicable. Consistent with CMS guidance and best practices, provider incentive arrangements should therefore be transparent, linked to quality and patient outcomes, and supported by measurable performance standards and appropriate oversight.

3. **State Directed Payments and Risk Sharing Arrangements** – Under § 438.6(c), SDPs are managed care payments directed by a state that must be based on the utilization of services, advance at least one of the state's goals in quality strategy in a way that is regularly measured and evaluated, be directed equally and under the same performance terms among providers covered under contract, do not require provider participation in intergovernmental transfer agreements, and are not automatically renewed. Regulations at § 438.6(b) name risk sharing arrangements, such as risk corridors, which must be documented in the contract and rate certification documents prior to the rating period.

4. **Third-Party Vendor Data and Contracts** – Medicaid managed care regulations at § 438.230(c)(1) require specific contractual obligations when the MCPs delegate certain activities to a subcontractor. In addition, under § 438.8(k)(3), MCPs must require those third-party vendors providing claims adjudication activities for MCPs to report all underlying data associated with MLR reporting to the MCPs in sufficient detail to allow the MCP to incorporate the subcontractors' expenditures into the MCPs' overall MLR calculation. Consequently, all subcontractors that administer claims for the managed care

plan must report the incurred claims, expenditures for activities that improve health care quality, and information about mandatory deductions or exclusions from incurred claims (e.g., overpayment recoveries, rebates, and other non-claims costs, etc.) to the managed care plan.

5. **Allocation of Expenses Methodology** – To accurately report the annual MLR to the state, MCPs must allocate expenses using an appropriate method as instructed by CMS regulations at § 438.8(g). If MCPs fail to provide sufficient documentation on the methodology used for expense apportionment, certain reported expense amounts in the MLR report cannot be verified. In addition, improper allocation of expenditures may require adjustments to the original MLR report.

6. **Quality Improvement Activity Expenditures and Contracts** – Under § 438.8(e)(3)(i), which incorporates a reference to § 158.150(a), quality improvement activity (QIA) expenditures must be directly related to QIAs. As defined in § 158.150(b), QIAs are designed to improve health quality; increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results; be directed toward enrollees, specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities; and be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized organizations.

7. **Non-Claims Costs** – CMS regulations at § 438.8(b) define non-claims costs as expenses for administrative services. § 438.8(e)(2)(v) provide specific examples of non-claims costs that must be excluded from incurred claims within the MLR calculation. MCPs are required to exclude all non-claims costs from incurred claims. Failure to properly identify and exclude relevant non-claims costs, as required, results in erroneous inflation of the MLR numerator.

8. **Other High-Risk Expenditures** – Unlike Medicare and private insurance, states may allow plans to report the results of state-mandated reinsurance arrangements as an adjustment to premium in accordance with § 438.8(f)(2)(vi). Fraud prevention expenditures cannot be included in the Medicaid MLR calculation until the expenditures are defined in the private market regulations; § 438.8(e)(4) serves as a placeholder for fraud prevention expenditures until that time. MCPs report an estimate of unpaid claims reserve on the Arizona MLR Reporting Template. CMS regulations at § 438.8(e)(2) outline the components to be reported as incurred claims and unpaid claims liabilities.

CMS also recalculated the CYE 2021 MLR to determine if the recalculated data results in an MLR lower than 85 percent. None of the identified findings resulted in a recalculated MLR that fell below the 85 percent threshold.

Arizona's MLR Methodology and Policies

Under § 438.8(d), the MLR formula is defined as the ratio of the "Numerator" to the "Denominator", which is increased by a credibility adjustment when applicable. This formula is depicted below:

$$MLR = \frac{Numerator}{Denominator} + Credibility\ Adjustment$$

§ 438.8(e) and § 438.8(f) further provide a detailed list of expenditures included in the numerator and the denominator.

The Arizona CYE 2021 MLR Reporting Template Instructions specified a number of components supported in regulation for both the numerator and denominator of the MLR. Each component is defined below.

The template's MLR numerator included the following line items: paid claims, changes in other claims-related reserves, provider incentive/bonus payments, payments recovered through fraud recovery efforts less related expenses, contingent benefits/ medical claim portion of lawsuits, value added services, provider/subcontractor overpayment recoveries, drug rebates, pharmacy performance guarantee, third-party liability, coordination of benefits, subrogation recoveries, and QIA.

The template's MLR denominator included the following line items: prospective capitation, alternative payment model settlements, performance-based payments, delivery supplement, unpaid cost sharing amounts, changes to unearned premium reserves, risk adjustment, reconciliation settlements, other reconciliation settlements, share of cost settlement, home and community-based services (HCBS) settlement, health insurance providers fee revenue, other income, patient contributions, reinsurance, other accruals, and pass-through payments revenue[5].

The credibility adjustment is added to the MCP's calculated MLR if the MCP is partially credible[6] to account for the likelihood that the actual and target MLRs differ from a lack of fully sufficient claims experience (measured in member months).[7]

In Arizona, an MCP is not required to remit the difference to the state if the MCP reports an MLR under the 85 percent threshold for the Medicaid population; however, Arizona uses risk

[5] According to §438.8(e)(2)(v)(C) and §438.8(f)(2)(i), payments made under §438.8(d), pass-through payments, should be excluded from the numerator and denominator of the MLR reporting template. The inclusion of pass-through payments within the Arizona MLR reporting template is inaccurate and addressed within the findings of this report.
[6] See § 438.8(b) for the definition of credibility adjustment and § 438.8(h) for information on how the credibility adjustment is implemented in the Medicaid MLR.
[7] See the CMCS Information Bulletin from July 31, 2017, which defines non-credibility, partial credibility, full credibility, and the credibility adjustment calculation methodology required by MCPs. Arizona utilizes the credibility adjustment calculation methodology delineated in this bulletin for its calculation.

corridors in all Medicaid programs which limit the profits for total medical expenses that MCPs are able to retain.

Initial MLR Calculation Results

Results of the CYE 2021 MLR calculations are included below. The MLR results were calculated by Arizona based on data reported by each MCP in the MLR Reporting Template. Arizona reviewed the MLR reports to determine that the data was consistent and met the guidelines and that all expenditures reported were allowable.

Figures 1 through 3 depict the credibility-adjusted annual MLR for CYE 2021 based on the reports submitted by MCPs to Arizona for minimum MLR calculations.

Figure 1

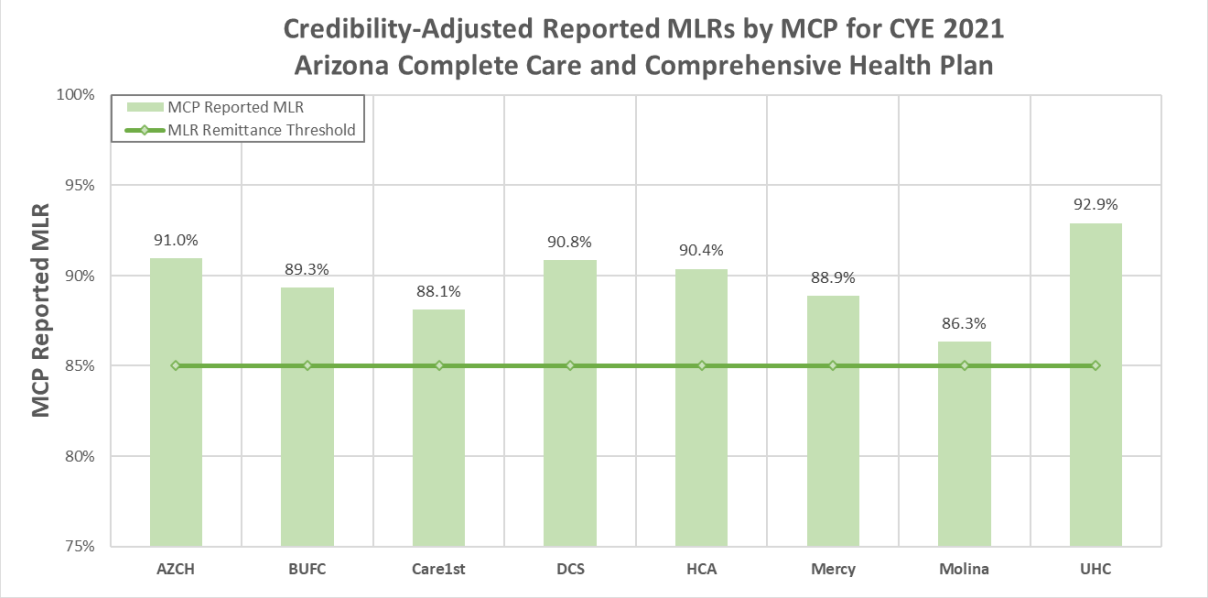


Figure 2

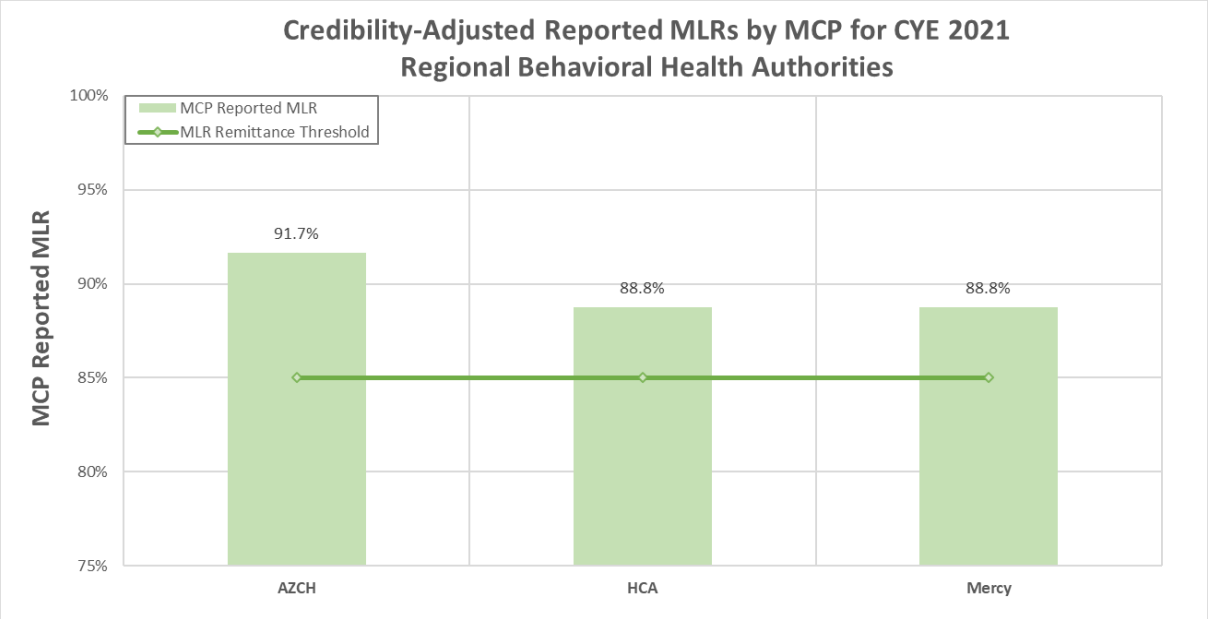
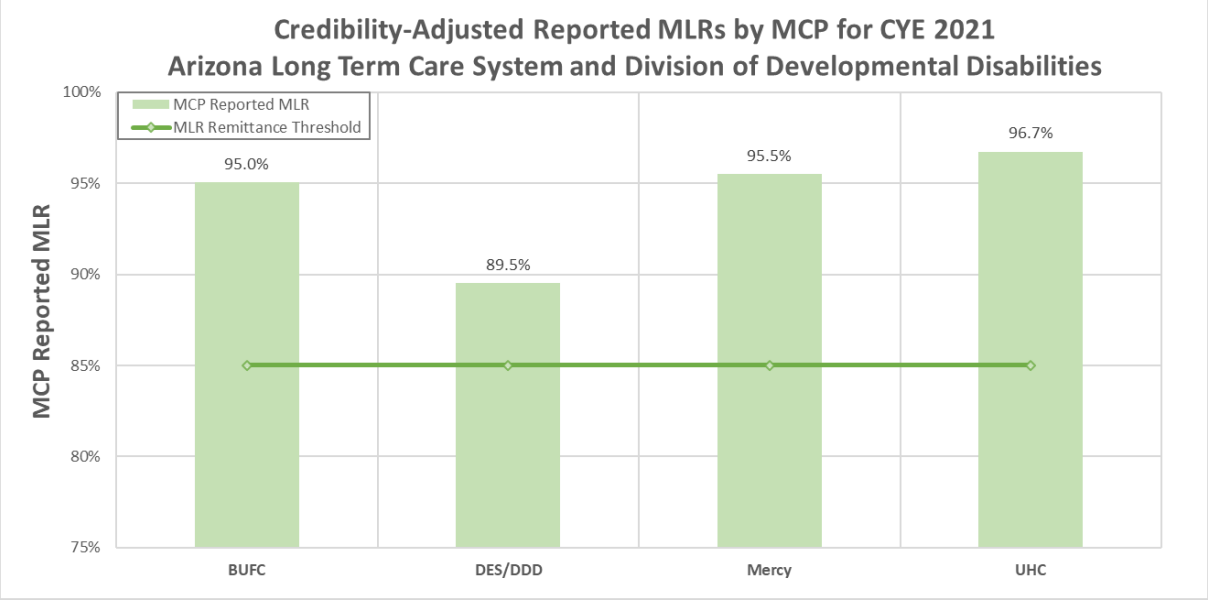


Figure 3



MLR Components

Figures 4 and 5 show the average incurred medical related costs (numerator) and average medical related revenues (denominator) as a percentage of gross premiums reported in the CYE 2021 minimum MLR calculations by all nine MCPs and five programs.

Figure 4

	Numerator	
	Arizona MLR Components	***% of Gross Premium***
	Paid Claims*	84.3%
	Changes in other claims-related reserves**	2.2%
	Provider Withholds from Payments	0.0%
	Provider Incentive/Bonus Payments	0.3%
	Payments recovered through Fraud Recovery efforts less related expenses	0.0%
	Contingent Benefits/ Medical claim portion of lawsuits	0.0%
	Value Added Services	0.0%
	Provider/Subcontractor Overpayment Recoveries	-0.2%
	Rx Rebates (received/accrued)	-0.1%
	Pharmacy Performance Guarantee	0.0%
	TPL, COB, Subrogation Recoveries and recoverable COB claims	-0.1%
Quality Improvement Activities	Improvement of health outcomes	0.3%
	Activities to prevent hospital readmission	0.1%
	Improvement of patient safety and reduce medical errors	0.1%
	Wellness and health promotion activities	0.6%
	Health information technology expenses related to improving health care quality	0.1%
	Activities related to external quality review	0.1%
	Total Incurred Medical Related Costs	**87.7%**

* Exception for Subcontractors who provide Medicaid-covered services directly to Medicaid enrollees. The costs of the delegated managed care activities cannot be included in the managed care plan's medical loss ratio calculation. Contractors who have subcontractors with delegated managed care activities must include these costs in admin unless they are quality improvement activities.

** Change in unpaid claims between the prior year's and the current year's unpaid claims (i.e., RBUC) and change in claims incurred but not reported (IBNR) from the prior year to the current year

Figure 5

	Denominator	
	Arizona MLR Components	***% of Gross Premium***
Gross Premium	Prospective Capitation	98.1%
	APM 1% Withhold Settlement 42 CFR 438.6(b)(3) and Performance Based Payments (PBP)	0.1%
	Delivery Supplement	1.5%
	Health Insurance Providers Fee (HIPF) Revenue	0.4%
	Unpaid Cost Sharing Amounts	0.0%
	Changes to Unearned Premium Reserves	0.0%
	Risk Adjustment	0.0%
	Prospective Tiered or Title XIX/XXI Reconciliation Settlement	-3.1%
	Reserved	0.0%
	Other Reconciliation Settlements	0.0%
	Share of Cost (SOC) Settlement	0.0%
	HCBS Settlement	0.0%
	Other Income	0.2%
	Patient Contributions	0.0%
	Reinsurance	2.5%
	Other Accruals	0.0%
	Pass - Through Payments Revenue	0.1%
Taxes and Fees	Federal Income & Federal Tax (include Tax Benefit)	-0.4%
	Premium Tax	-2.1%
	Health Insurance Providers Fee (HIPF)	-0.2%
	Other Federal, State, Local Taxes and Licensing and Regulatory Fees	0.0%
	Community Benefit Expenses (otherwise exempt from Federal income tax) and Community Reinvestment Expenses meeting requirements of 45 CFR 158.162c	-0.1%
	Total Medical Related Revenues	**96.8%**

The average MLR, excluding credibility adjustments, for the reporting period CYE 2021 was 90.6 percent, which was calculated by dividing the total incurred medical related costs (87.7 percent) by the total medical related revenues (96.8 percent). In the numerator, incurred claims, including unpaid claim liabilities, IBNR for claims, withholds, incentives and bonuses accounted for 99 percent of the numerator, with all the other components only accounting for a combined 1 percent of the numerator. In the denominator, the risk corridor settlement adjustment accounted for a reduction of 0.6 percent to the average denominator. These along with federal and state taxes and other expenses were subtracted from gross premium to calculate net premium.[8]

Results of the Audit

Based on the results of this audit, Arizona's MCPs did not always follow federal requirements when reporting MLRs. While the errors identified in this audit did not result in any MLRs that would have fallen below the minimum MLR threshold, CMS identified several findings and observations for improvement in future MLR reporting.

1. State Oversight of MCP MLR Reporting

In the 2016 Medicaid Managed Care Final Rule,[9] CMS established requirements for state oversight of MLR reporting at § 438.74. The requirements at § 438.74(a) require states to submit an annual summary description of the MLR reports received from MCPs to CMS. The summary description is to be submitted with the related rate certifications under § 438.7. The summary description is required to include, at a minimum, the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed by each MCP for the MLR reporting year. Effective state oversight of MLR reporting is key to validating MLR reporting and remittance calculations are accurate for rate setting.

This audit reviewed Arizona's oversight efforts of MCPs' MLR reporting. While CMS did not identify any recommendations related to Arizona's oversight efforts, CMS identified three overarching observations where Arizona could improve its oversight efforts. **Specifically, CMS identified four MCPs' (AzCH, DES/DDD, HCA, and Mercy) MLR Templates which had formula errors that could impact the MLR calculation.** CMS confirmed that for all but one MCP (Mercy), the identified formula errors did not impact the MLR calculation for each MCP. **CMS also identified that Arizona referenced the incorrect footnote in their MLR Reporting Template.** Arizona referenced Footnote 16 Accrued Sanctions instead of Footnote 17 Provider Incentive/ Bonus Payment in lines # 26 and # 27 of the MLR Reporting Template. Arizona should consider enhancing oversight and monitoring processes to ensure that all instructions, guidance, and formulas within the state's MLR Reporting Templates.

Further, CMS identified that Arizona financial and MLR Reporting Template Instructions do not explicitly state that for PI/APM contracts that are effective for calendar year (CY) 2020 or CY 2021, only CYE 2021 expense amounts should be included in CYE 2021 MLR

[8] All component amounts are as reported in the original MLR filings before any corrections by CMS.
[9] Medicaid and CHIP Managed Care Final Rule, 81 Fed. Reg. 27587-27592 (May 6, 2016) (to be codified at § 438.6)

Template. Arizona also indicated that they do not have a finalized process in place for addressing any instances of PI/APM reporting inconsistencies between MCPs reporting expenses occurred and MCPs reporting expenses earned. Arizona should consider augmenting their oversight activities to verify that reported PI/APM amounts are on an accrual basis for the specified reporting period only.

CMS verified whether appropriate documentation of SDP amounts in required CMS reporting and approval documents and payment amounts for each directed payment arrangement provided by the state were consistent with the total amounts provided in the most recent submitted CMS approval documents, such as pre-prints. For all but three of the eight SDP arrangements, the total payment amounts reported by the state did not exceed the amount in the preprint or waiver approved. For SDP arrangements paid within the monthly capitation payments, the estimated amount paid out to the MCPs exceeded the pre-print amounts. **CMS recommends that Arizona submit updated pre-print amendments to CMS to reflect an accurate total payment amount for any SDP arrangements that exceed the total amount that was approved in the original pre-print.** For the Targeted Investments (TI) arrangement, pre-print documentation was not required or submitted because TI was approved by CMS as part of a multi-year 1115 waiver amendment effective January 2017. CMS determined that in this specific circumstance of a multi-year directed payment arrangement, an updated waiver amendment is not required beyond the reporting and evaluation requirements required in the 1115 waiver amendment approval.

Further detailed observations applicable to specific focus areas of this audit are discussed in the relevant sections, below.

- ✓ **Observation #1:** CMS encourages Arizona to update the MLR Reporting Template Instructions to clarify that PI/APM expenses should be reported on an accrual basis for the specified reporting period only. Additionally, oversight activities should be augmented to verify that reported PI/APM amounts are on an accrual basis for the specified reporting period only.

- ✓ **Observation #2:** CMS encourages Arizona to enhance oversight and monitoring processes to ensure all instructions, guidance, and formulas are accurate within the MLR Reporting Templates.

- ✓ **Observation #3:** CMS encourages Arizona to submit amended pre-prints when total state payments for all SDP arrangements exceed their originally submitted pre-print amount.

2. Provider Incentives/Alternative Payment Models and Contracts

CMS regulations at § 438.3(i) require Medicaid contracts to comply with the MA program requirements at §§ 422.208 and 422.210, which allow MCPs to enter into a physician incentive plan with a healthcare provider as long as the incentive plan does not act as an inducement to reduce or limit medically necessary services, and that if the incentive plan places the provider at substantial financial risk, the MCP must assure that all provider groups have appropriate

reinsurance arrangements in place. Medicaid MCPs often use these incentive plans as a way to increase and maintain their provider network.

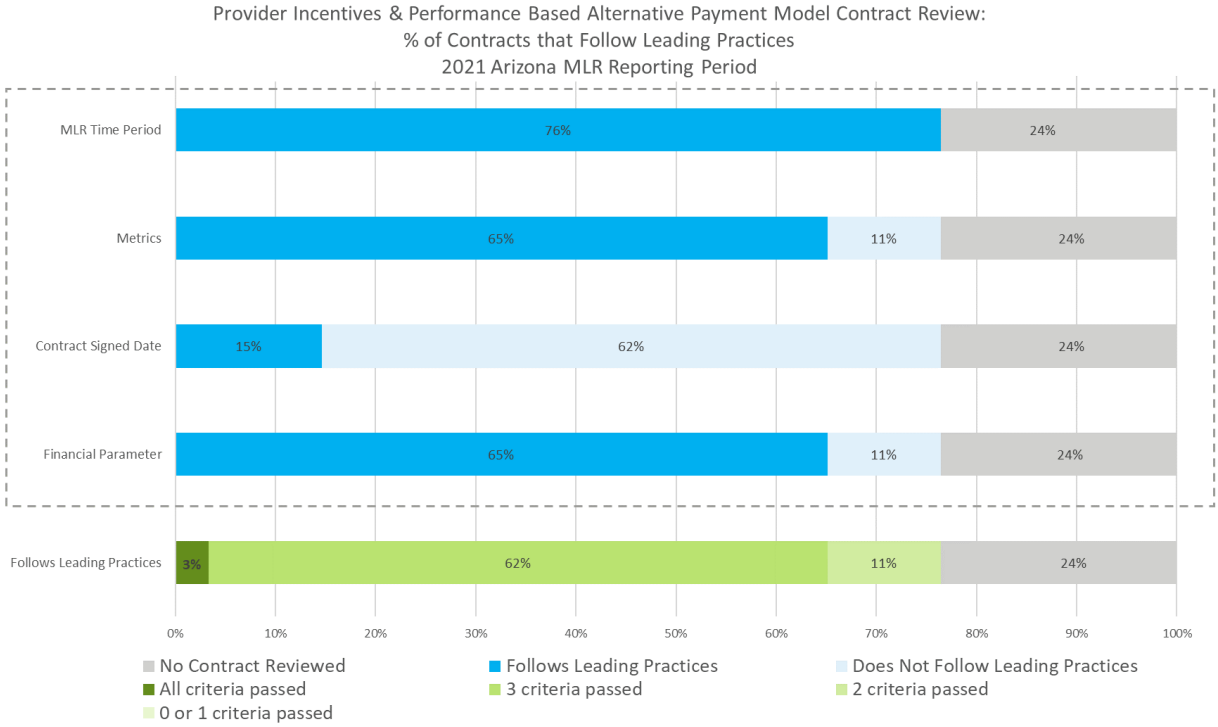
Under this audit, all MCPs were reviewed and assessed as to whether each PI/APM contract followed specified leading practices. At the time of the audit period, the leading practices were not federal or state requirements; however, per the 2024 Final Rule, these leading practices are required with the first rating period beginning on or after July 9, 2025, and are intended to help verify Medicaid dollars are appropriately paid to providers and included in the MLR calculation[10]. The leading practices related to incentive payment contracting are as follows:

- Having a defined performance period that can be tied to the applicable MLR reporting period.
- Include clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that the provider must meet to receive the incentive payment.
- The contract was signed and dated by all appropriate parties before the commencement of the applicable performance period.
- Specify a dollar amount or a percentage of a verifiable dollar amount that can be clearly linked to successful completion of the metrics defined in the incentive payment contract, including a date of payment.

As noted above, because these leading practices were not federal or state requirements in effect for the audit period, no findings were identified in this audit related to adherence to these leading practices. However, CMS identified one observation where the MCP incentive payment documentation did not always follow the leading practices. The results of the incentive payment analysis shown as percentages related to each decision are shown in Figure 6, below.

[10] Per the 2024 Final Rule, these leading practices has since become required under § 438.3(i)(3)(i-iv) and § 438.8(e)(2)(iii)(A) with the first rating period beginning on or after July 9, 2025.

Figure 6[11]



Within the audit period, three percent of contracts followed all leading practices, while 62 percent followed three of the leading practices and 11 percent followed two or less. **Contracts were either not submitted to CMS or MCPs responded indicating that contracts were not established for 24 percent of PI/APM contracts.** MCPs noted some contracts were archived or drafted in paper form and not readily available for the MLR Audit. In these instances, CMS requested and reviewed a sample of contracts to validate whether a contract was in place for every PI/APM arrangement. One MCP (DES/DDD) paid out PI/APMs without a contract in place. **CMS also identified that several of the PI/APM contracts had effective dates during CYE 2021 with unclear contract termination dates or contract renewal dates.**

Due to the small portion of PI/APMs in the MLR calculation, approximately 0.9 percent of total medical incurred costs, no MCP would fall below the 85 percent MLR minimum threshold if there was a federal or state requirement for states and MCPs to follow the leading practices.

CMS noted more state oversight is needed on verification of the timing and amount of incentive payments made to providers. **Six MCPs had PI/APM contracts with effective dates before the start of CYE 2021 and unclear end dates/renewability details.** CMS also identified several instances where amounts from prior contract years were erroneously included in the CYE 2021

[11] Figure 6 illustrates the results of the incentive payment analysis, with each category shown as a percent of the total incentive payment dollars reported by MCPs. CMS evaluated a contract's compliance with each leading practice independently. All incentive payment dollars for which CMS did not receive a contract, or which did not fall within the audit period, were labelled as "No Contract Reviewed".

MLR calculation. **One MCP (HCA) included $4.1K in flu vaccine gift cards as a PI/APM rather than non-claims costs, incorrectly including this amount in the MLR calculation.**

The Arizona MLR calculations included estimates for PI/APM payments that had not yet been paid at the time of MLR reporting submissions and which varied from the final payment amounts. Arizona's contracts with the MCPs do not describe a process in place to collect and verify PI/APM proof(s) of payment from the MCPs against the reported payment amounts. In order to validate final PI/APM payment amounts provided by the MCPs, CMS requested the MCPs provide proof of payment to providers in the form of copies of checks, bank statements, or some other audited financial report to verify that the MCPs made incentive payments to providers in a timely manner. All MCPs provided supporting documentation on verification of payments, payment cycles, and timeliness of payment to providers. CMS confirmed that MCPs made incentive payments to providers in a timely manner. CMS also verified whether the MLR calculation accounted for the appropriate amount of PI/APM payments. CMS was not able to verify variances for one MCP (DES/DDD) which had PI/APM contracts with unexplained variance between amounts documented in the corresponding proofs of payment and the final payment amounts included in the MLR calculation.

- ✓ **Recommendation #1:** In accordance with 42 CFR § 438.8(e)(2)(iii)(A), Arizona should update MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of PI/APMs.

- ✓ **Observation #4:** CMS encourages Arizona to require MCPs to maintain contracts that are available for review with providers related to incentive payments by the first rating period on or after July 9, 2025, consistent with regulations at § 438.3(i)(3)(i-iv) and § 438.8(e)(2)(iii)(A).

- ✓ **Observation #5:** CMS encourages Arizona to require defined contract termination dates within the MCPs' PI/APM contracts to allow the state to determine whether PI/APM contracts are applicable for the CYE reported by the first rating period on or after July 9, 2024, consistent with regulations at § 438.3(i)(3)(i).

- ✓ **Observation #6:** CMS encourages Arizona to implement a process to collect proof of payment from the MCPs for PI/APM programs to verify that PI/APM payments made to providers are appropriately accounted for in the MLR calculation.

3. State Directed Payments, Special Payments, and Risk Sharing Arrangements

State-Directed Payments

Under § 438.6(c), SDPs are managed care payments directed by a state that are permissible under federal regulation provided that the payments are based on the utilization of services (e.g., by number of inpatient hospital discharges, outpatient visits, physician visits); advance at least one of the state's goals in the quality strategy in a way that is regularly measured and evaluated;

be directed equally and under the same performance terms among providers covered under contract; do not require provider participation in intergovernmental transfer agreements; and are not automatically renewed. The Medicaid MLR regulation at §438.8(e)(2)(iii)(C) notes that direct claims for services or supplies covered under the contract and services meeting the requirements at § 438.3(e) provided to enrollees must be included in the numerator of the MLR. CMS identified that Arizona does not have clear instructions describing how to include or exclude special payment arrangements in the MLR calculation even though different types of payment arrangements are treated differently in the MLR calculation. The special payment arrangements Arizona had in place during the audit period include pass-through payments and SDPs. Arizona should consider providing clear instructions to specify the type of payment arrangements and report all payment arrangements as separate line items.

Arizona had eight SDPs in place during CYE 2021:

1. Paid within the monthly capitation payments:
    a. Differential Adjusted Payments Non-FQHC (DAP Non-FQHC)
    b. Differential Adjusted Payments FQHC (DAP FQHC)
2. Paid as a separate payment term outside of the monthly capitation payments:
    a. Access to Professional Services Initiative (APSI)
    b. Pediatric Services Initiative (PSI)
    c. Hospital Enhanced Access Leading to Health Improvements Initiative (HEALTHII)
    d. Nursing Facility Supplemental Payments (NF-SP)
    e. American Rescue Plan Act Home and Community Based Services Enhanced Funding (ARPA HCBS)
    f. Targeted Investments (TI)

CMS noted that all MCPs excluded the payment amounts associated with one or more of these SDPs in the MLR calculation because a) they considered the payment as a pass-through payment or b) because the guidance from Arizona was unclear as to whether the payment should be included in the MLR calculation; however, Arizona confirmed that these payments are not pass-through payments and should be reported as SDPs. **Accordingly, CMS identified that the MCP expenditures and revenues associated with these SDP payments should have been reported in the MLR numerator and denominator.**

CMS noted that Arizona's CYE 2021 MLR Reporting Instructions did not provide guidance to the MCPs to correctly classify SDPs applicable for CYE 2021. To enhance clarity and accuracy in MLR calculations, CMS recommends that Arizona refine the MLR Reporting Instructions to clearly specify that SDP arrangements should be included in the MLR calculation. Arizona should consider creating separate line items in their MLR Reporting Template for each SDP to better monitor payment amounts and incorporate the payments into the MLR calculation as applicable. This allows for consistency and accuracy in the calculation process.

To substantiate all SDP amounts including payments included in the capitation rates, CMS requested documentation on payment amounts disbursed to the providers. All MCPs provided

supporting documentation consistent with what was provided to Arizona as part of the data request process for the annual capitation rate development. **The documentation represented monthly payments for each state-directed program; however, the supporting documentation did not reconcile to the reported special payment amounts from Arizona for four of the MCPs (BUFC, HCA, Mercy, and UHC). Two MCPs (BUFC and UHC) were unable to explain the variance between the supporting documentation and the amounts reported by Arizona.** Arizona should closely monitor reporting of SDPs in accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii) and reconcile all amounts with MCPs' MLR reporting.

Special Payments (Pass-through and non-pass-through payments)

Under § 438.8(e)(2)(v)(C) and §438.8(f)(2)(i), amounts paid to network providers under § 438.6(d), pass-through payments, should be excluded from incurred claims and premium revenue. Arizona's CYE 2021 MLR Reporting Instructions do not provide guidance to the MCPs to correctly classify and exclude pass-through payments applicable for CYE 2021. **Pass-through payments are incorrectly categorized as a component of the denominator within the Arizona MLR Reporting Template.** The instruction for the pass-through payment revenue line of the MLR Reporting Template directed MCPs to include several payment arrangements which Arizona later confirmed do not meet CMS' definition of a pass-through payment and should not be included in the pass-through payment revenue line of the MLR Reporting Template. Arizona should augment the instructions for the MLR Reporting Template to provide clear guidance for the MCPs' proper treatment of special payments as pass-through payments as defined in § 438.6(a). For example, the instructions should state that all pass-through payments should be excluded from the MLR calculation, and that Nursing Facility and TI payments do not meet the definition of a pass-through payment under in § 438.6 and should be treated as SDPs in the MLR Reporting Template. Additionally, Arizona should augment the MLR Reporting Instructions by incorporating additional specificity and guidance to clarify the appropriate treatment of special payments, pass-through payments, and SDPs within the MLR calculation.

CMS confirmed that the Rural Hospital Inpatient Fund meets the definition of a pass-through payment and should be excluded from the MLR calculation. All MCPs noted that they excluded the amounts associated with the Rural Hospital Inpatient Fund as a pass-through payment in the MLR Reporting Template.

Risk Corridor Settlement

Under § 438.6(a), risk corridors are defined as risk sharing mechanisms by which states and MCPs may share in profits and losses within a specified threshold. Effective for CYE 2021, Arizona had several risk corridor arrangements in place with MCPs:

- ACC Tiered
- CHP Risk Corridor
- DDD Risk Corridor
- RBHA Profit Limit
- ALTCS-Elderly and Physical Disability (EPD) Tiered

- ALTCS EPD Share of Cost (SOC)
- Fixed Administration Cost Component Reconciliation for ACC (Fixed Admin)
- Reconciliation of Title XIX Behavioral Health Prior Period Coverage (BH PPC)

These risk corridor arrangements are summarized in Figure 7, below.

Figure 7

Risk Corridor Arrangement	Programs Impacted	Type of Expenses	Gain Limit	Loss Limit
ACC Tiered	ACC	Total medical cost	4%	2%
ALTCS-EPD Tiered	ALTCS	Total medical cost	4%	2%
CHP Risk Corridor	CHP	Total medical cost	6%	2%
DDD Risk Corridor	DDD	Total medical cost	6%	1%
RBHA Profit Limit	RBHA	Total medical cost	4%	2%
Fixed Admin	ACC	Projected Fixed Administrative Provision	N/A	N/A
BH PPC	RBHA	Total medical costs for prior period coverage	N/A	N/A
SOC	ALTCS	Member SOC payments	N/A	N/A

Additionally, within the CHP and DDD programs, MCPs and the SHPs are entered into risk corridor arrangements to reconcile excess profit or losses for total medical expenses to medical capitation paid in accordance with the MCPs' respective contracts with their SHPs. Arizona reconciles with DCS and DES/DDD by making a payment for excess losses to be reimbursed to the SHP or recouping from the MCP the amount reflecting any excess profits recouped from the SHP and returning the federal share to CMS. Arizona confirmed that guidance was provided to MCPs that contract with SHPs to report SHP reconciliations on an accrual basis within the financial reporting guides.

Under this audit, CMS reviewed templates and materials provided by Arizona and the MCPs related to the risk corridors to validate the CYE 2021 risk corridor settlement amounts, determine if these amounts were properly included in the MLR calculation, and evaluate Arizona's oversight and monitoring of the risk corridor.

At the time of submission of the CYE 2021 MLR Reporting Templates by each MCP to Arizona, the CYE 2021 risk corridor reconciliations were not final. In the MLR calculations submitted by the MCPs, all but one MCP included risk corridor settlement accrual amounts in the MLR calculation. **One MCP (Care1st) classified risk corridor reconciliation accruals as pass-through payments in the MLR calculation, incorrectly excluding these amounts from the denominator. One MCP (DES/DDD) did not include accrued risk corridor amounts from their subcontracted health plans in the MLR calculation.** DES/DDD's SHPs owed a total net recoupment of $50.0M, which should have been included in both the numerator (as a reduction to paid claims) and the denominator (as a reduction to premium revenue).

The aggregate impact of corrections made for inconsistencies found during the review of SDPs, Special Payments, and Risk Sharing Arrangements was not significant and would not result in any MCP's recalculated MLR falling below the threshold of 85 percent.

- ✓ **Recommendation #2:** In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should augment the MLR Reporting Instructions to incorporate additional specificity and guidance to clarify the appropriate treatment of special payments, pass-through payments, and SDPs within the MLR calculation.

- ✓ **Recommendation #3:** Effective July 9, 2024, §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii) requires SDPs, inclusive of separate payment terms, to be included in both the numerator and denominator of the MLR calculation. SDPs from MCPs to providers should be included in the numerator and SDP revenue from Arizona should be reflected in the denominator and included as separate line item(s) in the MLR Reporting Template.

- ✓ **Recommendation #4:** In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should closely monitor MCPs' reporting of SDPs by reviewing the reported incurred claims payments in the MLR calculation and reconcile all amounts with MCPs' MLR reporting.

- ✓ **Recommendation #5:** In accordance with § 438.6(a), Arizona should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' proper treatment of special payments as pass-through payments as defined in § 438.6(a).

- ✓ **Recommendation #6:** In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify that risk corridor amounts for subcontracted health plans are appropriately reflected within the MLR Reporting Templates.

- ✓ **Recommendation #7:** In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify the accounting of accruals to validate the proper classification and inclusion of risk sharing arrangements.

- ✓ **Observation #7:** CMS encourages Arizona to create separate line items in the MLR Reporting Template for each SDP to improve the monitoring of payment amounts and incorporate various payment types into the MLR calculation as applicable.

- ✓ **Observation #8:** CMS encourages Arizona to require the Risk Corridor calculation be finalized prior to the submission of MLR Reporting Templates to allow the final reconciliation amounts to be used in the MLR calculation.

4. Third-Party Vendor Data and Contracts

In May 2019, CMS issued a Center for Medicaid and CHIP Services (CMCS) informational bulletin (CIB) providing additional guidance on current federal regulations surrounding MLR

requirements related to third-party vendors.[12] This guidance clarified the provisions in §§ 438.8(e)(2)(v)(A)(1), 438.8(e)(2)(v)(A)(2), 438.8(k)(3), and 438.230(c)(1) for when an MCP uses a third-party vendor in a subcontracted agreement. The guidance provided several examples to assist states in ensuring MCPs appropriately classified revenues, expenditures, and amounts for MLR reporting.

CMS requested documentation on underlying third-party vendor data related to MLR reporting and calculations. All MCPs were able to provide underlying third-party vendor data that aligned with the requirements of § 438.8(k)(3). Arizona requires MCPs to submit their subcontracts with third-party vendors for review prior to the contracts becoming active. Arizona requires that all contractual agreements comply with the requirements listed in §438.230 as well as the Arizona Minimum Subcontract Provisions. MCPs are required to formally review subcontractor's performance annually. Should a subcontractor be found to be in non-compliance at any time, MCPs must notify Arizona with details including a Corrective Action Plan.

Treatment of Pharmacy Benefit Manager Non-Claims Costs

Under § 438.8(e)(2)(v)(A)(2), non-medical costs of any subcontractor, whether sub-capitated or not, should be excluded from incurred costs in the MLR calculation. Arizona's CYE 2021 MLR Reporting Template Instructions properly instructed MCPs on the exclusion of administrative costs from paid claims to providers, specifically paid claims to pharmacies. Six MCPs reported contracts with third-party vendors that provided claims adjudication activities and provided examples of the corresponding underlying data collected to verify the exclusion of non-claims costs.

Treatment of Prescription Drug Rebates

Under § 438.8(e)(2)(ii)(B), prescription drug rebates received and accrued must be deducted from incurred claims. In Arizona's CYE 2021 MLR Reporting Templates and Instructions, MCPs were instructed to omit pharmacy drug rebates paid to providers from the incurred claims line items. If MCPs are required to provide drug rebate information separately, this reporting facilitates the state's assessment of whether third-party vendors accurately reported pharmacy incurred claims after accounting for prescriptions drug rebates.

Reporting of Additional Third-Party Non-Medical Costs

Under § 438.8(e)(2)(v)(A), incurred claims must exclude expenses for administrative services as well as the following non-claims costs:

(i) Amounts paid to third-party vendors for secondary network savings;
(ii) Amounts paid to third-party vendors for network development, administrative fees, claims processing, and utilization management;
(iii) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for State Plan services or

[12] CIB: Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors

services meeting the definition for in-lieu-of services in § 438.3(e) and provided to an enrollee; and

(iv) Fines and penalties assessed by regulatory authorities.

Arizona's CYE 2021 MLR Reporting Template Instructions advised plans to list excluded non-claims costs associated with third-party vendor contracts in separate line items. In doing so, Arizona complied with § 438.8(2)(v)(A)(1)-(4) by guiding plans on the exclusion of non-medical costs from incurred claims. **Three MCPs (BUFC, Mercy, and UHC) included full capitation payments as paid claims in the MLR calculation and did not exclude non-medical costs from the MLR calculation.** Of these MCPs, one MCP (UHC) asserted that the full capitation payment amount belonged within the paid claims in their MLR calculation because the providers contracted met the four-part test included in CMS technical guidance[13] to be considered a clinical risk-bearing entity. CMS guidance indicates a state may use discretion to apply the four-part test. Arizona noted they had not provided MCPs guidance to apply the four-part test on third party vendor payments for CYE 2021 MLR reporting.

Of the three MCPs that did not exclude non-medical costs from the MLR calculation, one (BUFC) was able to provide an estimated administrative load to validate that excluding these amounts from the MLR calculation would not result in the recalculated MLR falling below the threshold of 85 percent. Two MCPs (Mercy and UHC) stated that the capitation rate to third-party vendors was not broken out between medical and non-medical costs. According to the Kaiser Family Foundation, the average non-medical load for Medicaid MCPs in CY 2021 and 2022 was 14 percent[14]. Assuming a 14 percent administrative load for Mercy and UHC's third party provider capitation payments, a recalculation to exclude non-medical costs from capitation payments made to third-party vendors would not result in the MLR calculation falling below the 85 percent MLR minimum threshold for either MCP.

Establishment and Maintenance of Third-Party Vendor Data and Contracts

Under § 438.230(c)(1), if an MCP delegates any of its activities or obligations under its contract with the state to a subcontractor, then:

(i) The delegated activities or obligations, and related reporting responsibilities, must be specified in a contract or written agreement;
(ii) The subcontractor must agree to perform the delegated activities and reporting responsibilities specified in compliance with the MCP's contract obligations; and
(iii) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the state or the MCP determine that the subcontractor has not performed satisfactorily.

[13] I Center for Consumer Information and Insurance Oversight . (2012, February 10). *CCIIO Technical Guidance (CCIIO 2012—001): Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule*. Insurance Standards Bulletin Series—INFORMATION (cms.gov). https://www.cms.gov/CCIIO/Resources/Files/Downloads/2012-02-10-guidance-mlr-ipas.pdf

[14] Kaiser Family Foundation. (2023, September 29). *Health insurer financial performance*. KFF. https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/

Within the audit period, all contracts received by CMS for review met all three requirements under § 438.230(c)(1). CMS was able to confirm that all third-party vendor relationships were compliant with the regulations.

- ✓ **Recommendation #8:** In accordance with §§ 438.8(e)(2)(v)(A)(1) and 438.8(e)(2)(v)(A)(2), Arizona should augment the MLR Reporting Instructions to clarify that any portion of capitation payments to third party vendors attributable to non-claims costs should be excluded from the MLR calculation. Arizona should augment their oversight activities to validate that these payments have been excluded from the MLR calculation.
- ✓

5. Allocation of Expenses Methodology

CMS regulations at § 438.8(g) contain general requirements and methodological requirements for the allocation of expenses. To accurately report the annual MLR to the state, MCPs must allocate expenses using an appropriate method. If MCPs fail to provide sufficient documentation on the methodology used for expense apportionment, certain reported expense amounts in the MLR report cannot be verified. In addition, improper allocation of expense may require adjustment.

CMS regulations at § 438.8(g)(1) define the general requirements for allocation of expenses:

(i) 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.
(ii) Expenditures that benefit multiple contracts or populations, or contracts other than those being reported, must be reported on a pro rata basis.

In addition, § 438.8(k)(1)(vii) further requires that MCPs include a detailed description of their allocation of expenses methodologies in their MLR report submitted to the state annually.

CMS obtained documentation from MCPs to understand how each plan determined Medicaid non-claims costs for CYE 2021 relative to the total non-claims costs incurred across all lines of business (LOBs). All MCPs provided a clear description of how allocation percentages were determined across LOBs in accordance with § 438.8(k)(1)(vii). Allocation between LOBs for other expense types (e.g., taxes, licensing fees, QIAs, fraud reduction expenditures) were not reviewed under this audit.

CMS required Arizona to explain the guidance provided to MCPs to obtain their allocation of expenses methodologies annually and what steps are taken to approve the details of the methodologies provided. Arizona explained the MCPs are required to include the allocation of expenses methodology description in their annual MLR submissions. As a part of the audit, CMS reviewed the descriptions of these methodologies for the allocation of expenses in the CYE 2021

MLR Reporting Templates from the MCPs. All MCPs provided a brief explanation detailing the methodology employed to determine the classification of expenses in adherence to regulations at § 438.8(g)(1)(i). All MCPs provided a sufficient description of the methodology used to allocate expenses between Medicaid and non-Medicaid LOBs as required by § 438.8(g)(1)(ii). Arizona informed CMS that when Arizona receives the MLR Reporting Templates from the MCPs, the MLR submission is reviewed to verify that it includes the required allocation of expenses methodology description. Arizona then approves or denies the allocation of expenses methodology.

Arizona reviews the allocation of expenses methodology description to verify that acceptable methods of allocation between LOBs were used by the MCPs. Examples of commonly used and acceptable methods of allocation by MCPs between LOBs included share of claim volume, premium revenue, or population distribution by member months. All MCPs provided a clear description of how allocation percentages were determined across LOBs in accordance with § 438.8(k)(1)(vii). MCPs may use different methods of allocation for different types of non-claims costs; therefore, Arizona should request detailed information regarding the allocation of various non-claims costs. For example, an individual MCP may use member months as the allocation basis for salaries expenses while premium revenue may be used for taxes and licensing fees.

Arizona's CYE 2021 MLR Reporting Template Instructions include a section on expense allocation, highlighting that certain expenses may not be directly attributable to one LOB. MCPs are required to report the methodologies employed for allocating these expenses and how they factor into the MLR calculated for this report. Arizona's CYE 2021 MLR Reporting Template Instructions lack explicit direction regarding the allocation of expenses solely to the Medicaid LOB. **The CYE 2021 MLR Reporting Template Instructions do not offer guidance on the treatment of expense related to non-Medicaid LOBs in MLR reporting and calculations.** This lack of instructions may lead to the inadvertent inclusion of non-Medicaid LOB expenses in the MLR reporting and calculations. Therefore, CMS recommends that Arizona consider enhancing future Medicaid MLR reporting instructions to indicate that any non-Medicaid LOB expenses should be omitted from the Medicaid MLR reporting in accordance with § 438.8(g).

- ✓ **Observation #9** CMS encourages Arizona to enhance future Medicaid MLR reporting instructions to indicate that any non-Medicaid LOB expenses should be omitted from the Medicaid MLR reporting in accordance with § 438.8(g).[15]

6. Quality Improvement Activity Expenditures and Contracts

To qualify as a QIA expenditure, expenditures must be directly related to activities that improve health care quality as described in § 158.150.[16] QIAs are designed to improve health quality; increase the likelihood of desired health outcomes in ways that are capable of being objectively

[15] Per the 2024 Final Rule, these leading practices has since become required under §§ 438.8(k)(1)(vii) and 457.1203(f),with the first rating period beginning on or after July 9, 2024.
[16] 42 CFR § 438.8(e)(3)

measured and of producing verifiable results; be directed toward enrollees, specific groups of enrollees, or other populations as long as enrollees do not incur additional costs for population-based activities; and 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.[17] Incorrectly including unqualified QIA expenses can inappropriately inflate the reported MLR. According to § 438.8(e)(3), activities that improve health care quality must fall within specified categories, including but not limited to, activities related to any external quality review (EQR)-related activity as described in § 438.358(b) and § 438.358(c). In addition, § 158.150(b)(2) describes what the activity must primarily be designed to do, including but not limited to, improve health outcomes and reduce health disparities among specified populations, and implement, promote, and increase wellness and health activities. Finally, § 158.150(c) specifies the expenditures and activities that must be excluded from QIAs, including but not limited to, those that are designed primarily to control or contain costs, fraud prevention activities, and those activities that can be billed or allocated by a provider for care delivery, and which are, therefore, reimbursed as clinical services.

Oversight of QIAs can be a challenge for states due to several categories of expenditures included in the above regulations. CMS encourages states to implement strong documentation, clinical expertise, and appropriate cost accounting methodologies. Such leading oversight practices should include standard reporting templates and prior approval processes.

Upon request, eight MCPs were able to provide a detailed breakdown of expenses that collectively amount to the figures reported as QIA on the MLR Reporting Template. **One MCP (Mercy) was unable to provide substantiation consistent with the total QIA expense amount which was described as an indirect calculation based on 5.5 percent of a total management fee in their MLR calculations.** When asked for supporting analysis for their reported amounts, Mercy responded that they were provided an estimate of total expenses for the Quality Management department for CYE 2021; this estimate was not consistent with the total QIA expenses reported in their CYE 2021 MLR calculations. CMS recommends that Arizona consider implementing additional oversight procedures and provide clear guidance and instruction for MCPs to validate overhead and indirect expenses reported as QIA expenditures. This approach will enable Arizona to gain insight into whether costs are calculated indirectly and better verify that only expenditures directly related to activities that improve health care quality are included in QIA expenses[18].

All MCPs but one (Mercy) were able to provide a breakdown of expenses with proper qualifying details in accordance with § 158.150(b)(2). Upon reviewing the data received from the MCPs, Mercy was unable to provide substantiation consistent with the total QIA expenses reported in their MLR calculations.

[17] 45 CFR § 158.150

[18] [18] Per the 2024 Final Rule, § 438.8(e)(3)(i) will require that only those expenses that are directly related to health care quality improvement activities may be included in the MLR numerator, with the first rating period beginning on or after July 9, 2024.

Additionally, one MCP (UHC) incorrectly included $18.6M in Case Management Expenses as Paid Claims instead of QIA. CMS recommends that Arizona consider updating MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of QIA.

- ✓ **Recommendation #9:** In accordance with § 438.8(e)(3), Arizona should update MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of QIA.

- ✓ **Observation # 10:** CMS encourages Arizona to implement additional oversight procedures and provide clear guidance and instruction for MCPs to validate overhead and indirect expenses reported as QIA expenditures.

7. Non-Claims Costs

CMS regulations at § 438.8(b) generally define non-claims costs as expenses for administrative services and those at § 438.8(e)(2)(v)(A) specify certain types of non-claims costs that must be excluded from incurred claims within the MLR calculation. Under § 438.8(e)(2)(v)(A), MCPs are required to exclude all non-claims costs from incurred claims. According to § 438.8(e)(2)(v)(A), non-claims costs include:

(1) Amounts paid to third party vendors for secondary network savings.
(2) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management.
(3) Amounts paid, including amounts 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 § 438.3(e) and provided to an enrollee.
(4) Fines and penalties assessed by regulatory authorities.

Arizona's CYE 2021 MLR Reporting Template Instructions provide instructions for reporting non-claims costs, requiring the MCPs to list different types of expenses for non-claims costs as separate line items. CMS requested further detail from MCPs to substantiate the reported non-claims costs. **Upon review, CMS identified that one MCP (DES/DDD) classified $0.4M in case management services as non-claims costs instead of QIA. Therefore, this amount was incorrectly excluded from the numerator of their MLR Calculation.**

One MCP (HCA) included $3.7M in QIA and Fraud, Waste, and Abuse (FWA) prevention as non-claims costs. Therefore, QIA amounts were incorrectly excluded from the numerator of their MLR Calculation. HCA submitted a corrected CYE 2021 MLR reporting template on March 29, 2024. In this submission, HCA reclassified $3.7M of non-claims costs as $3.5M of QIA and the remainder as fraud reduction expense. To prevent future inclusion of QIA and FWA expenses as non-claims costs, CMS recommends that Arizona consider updating MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and reporting of non-claims costs.

- ✓ **Recommendation #10:** In accordance with § 438.8(e)(2)(v)(A), Arizona should revise the MLR Reporting Template Instructions to include explicit guidance on the treatment of non-claims costs and require non-claims costs amounts to be reported on the MLR Reporting Templates to verify the proper exclusion of the costs from the numerator.

- ✓ **Recommendation #11:** In accordance with § 438.8(e)(2)(v)(A) and § 158.150(c)(8), Arizona should update the MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and reporting of non-claims costs.

8. Other High-Risk Expenditures

Reinsurance Expenditures

Under § 438.8(f)(2)(vi), risk sharing mechanisms should be reported as adjustments to premium revenue. Under § 438.8(e)(2)(vi), incurred claims paid by one entity that are later assumed by another entity must be reported by the assuming entity. The CMS CY2021 MLR Reporting Instructions[19] clarify that the reinsurance premiums earned must be subtracted from the total premium revenue, and reinsurance receipts are subtracted from total incurred claims. Unlike Medicare and private insurance, Medicaid regulations do not explicitly prohibit the reporting of private reinsurance arrangements in the MLR. States may allow plans to report the results of state-mandated reinsurance arrangements as an adjustment to premium revenue. Arizona does mandate MCPs to have reinsurance arrangements; therefore, a review was necessary for the reporting of reinsurance expenditures.

For Arizona MCPs, reinsurance is provided by Arizona to the MCPs for the partial reimbursement of covered medical services. Reinsurance is paid for services incurred for a member beyond an annual deductible level, subject to applicable contractual cost sharing and limitations. Arizona is self-insured for the reinsurance program.

For CYE 2021, the MLR Reporting Template developed by Arizona incorrectly categorized reinsurance recoveries as an increase in premium. After receiving MCP MLR submissions, Arizona discovered that reinsurance recoveries should be a reduction to claims. Instead of requiring each MCP to update the final MLR Reporting Template already submitted, Arizona performed the calculation on behalf of each MCP, based on Arizona's determination that the change in MLR was nominal and all plans remained above the minimum MLR threshold. Arizona informed CMS that they have corrected the MCP MLR Reporting Templates and MCP guidance for reinsurance so that reinsurance receipts are subtracted from total incurred claims rather than added to total premium revenue going forward. Arizona provided supporting documentation illustrating the reinsurance recalculations between the MCP-submitted MLR reports and the final MLR summaries provided by Arizona.

[19] Centers for Medicare & Medicaid Services (CMS). (2022, May 31). *Instructions for the 2021 MLR Reporting Year.* MLR Annual Reporting Form Instructions. https://www.cms.gov/files/document/2021-mlr-form-instructions.pdf

Fraud Prevention Activity Expenditures

The 2016 Medicaid Managed Care Final Rule finalized § 438.8(e)(4), which referenced the private market MLR regulations at §158. At that time, fraud prevention expenditures were (and continue to be) undefined for the private market. MCP reporting of fraud prevention requirements in § 438.8(k)(1)(iii) served as a placeholder for the fraud prevention reporting requirement. Expenditures for fraud prevention cannot be included in the Medicaid MLR calculation until the expenditures are defined in regulation.

Arizona's CYE 2021 MLR Reporting Instructions properly guide plans on the exclusions of fraud prevention activities in the MLR calculation. CMS reviewed each MCP's MLR Reporting Template and determined all MCPs successfully complied with the exclusion of all fraud prevention activities from the numerator of the MLR calculation. However, one MCP (HCA) incorrectly reported fraud prevention activity as non-claims costs. The amount of this error had no material impact on their MLR.

Paid Claims and Incurred but Not Reported (IBNR) Analysis

According to Arizona's CYE 2021 MLR Reporting Instructions, paid claims includes both claim liabilities that have not yet been paid as of the reporting date and the change in IBNR from the prior year to the current year. These two lines compose the paid claims and IBNR within Arizona's MLR Reporting Template. Federal regulations at § 438.8(e)(2) outline the components to be reported as incurred claims and unpaid claims liabilities. Separate financial reports are used as benchmarks to assess reasonableness.

CMS reviewed claims triangles provided by Arizona for dates of service from October 2020 to September 2021 paid through September 2021 to benchmark against the IBNR reported in the MLR Reporting Template. Within Arizona's quarterly financial reporting template, MCPs are required to submit a lag report for medical claims payable. This lag report and run-out period is uniform for each MCP and includes a line for MCPs to report adjustments to expenses by month outside of the claims lag triangles. If any adjustment is greater than 10 percent of total medical claims payable, Arizona requires the MCP to provide a general explanation for their adjustments as well as additional detail. For eight out of nine MCPs, CYE 2021 claims were 85 percent to 93 percent complete. For DCS, which subcontracts with its SHP to provide the covered services to members through a full-risk prospective capitation arrangement, less than 0.5 percent of CYE 2021 claims were incomplete. CMS noted that MCP IBNR reserves generally aligned with past claims development experience as indicated in the provided claims triangles, with variation primarily driven by MCP manual adjustments for which MCPs provided explanations within the financial templates.

Additional Arizona financial instructions within the lag report were identified as measures to promote reporting consistency and oversight. Arizona requires expenses reported in the current period on the lag report to equal the expenses reported in the statement of revenues. Arizona also requires the remaining balance on all lag reports to align with the medical claims payable total as reported on the balance sheet. CMS reviewed each lag report and confirmed all MCPs met these two criteria.

MLR Recalculation

Based on the results of this audit, CMS identified 80 errors and updated amounts across all MCPs that CMS applied to recalculate CYE 2021 MLR calculations to determine if any MCPs' MLR fell below the 85 percent federal minimum threshold. In Arizona, there is no remittance requirement for any MCPs falling below the 85 percent threshold; however, the recommendations in this report are intended to enhance accuracy of MLR reporting and program integrity. CMS included changes to the MCP-submitted MLR calculations based on the following corrections:

- Correction for formula errors in the MCP MLR Reporting Templates.
- Inclusion of SDPs in the numerator and denominator of the MLR calculation.
- Inclusion of reinsurance as a reduction to paid claims rather than a positive revenue.
- Exclusion of non-medical third-party vendor costs from the numerator of the MLR calculation.
- Exclusion of erroneous amounts incorrectly reported as pass-through payments in the denominator of the MLR calculation.
- Inclusion of SHP risk corridor reconciliation amounts in the numerator and denominator of the MLR calculation.
- MCP-identified corrected and final paid amounts to originally reported QIA, non-claims costs, risk corridor, and PI/APM amounts.

Figure 8 summarizes the original MLR calculations reported by MCPs on the CYE 2021 MLR reporting template, and the revised MLR calculations based on CMS' recalculations, and the variance between the two. Figure 8 illustrates that twelve of the fifteen MCPs exhibited an increase in their MLRs ranging from 0.1 percent to 3.0 percent. Three MCPs exhibited a decrease in their MLRs of 0.9 percent or less. None of these corrections resulted in a recalculated MLR that fell below the 85 percent minimum threshold.

Figure 8[20]

Program and MCP[21]	Original CYE 2021 MLR Calculation	Revised CYE 2021 MLR Calculation[22]	Variance (Revised MLR minus Original MLR)
AZCH ACC	91.0%	92.8%	1.8%
AZCH RBHA	91.7%	94.7%	3.0%
BUFC ACC	89.3%	90.0%	0.7%
BUFC ALTCS	95.0%	95.1%	0.1%
Care1st ACC	88.1%	91.1%	2.9%
DCS	90.8%	90.0%	-0.9%
DES/DDD	89.5%	90.3%	0.8%
HCA ACC	90.4%	92.8%	2.4%
HCA RBHA	88.8%	90.8%	2.0%
Mercy ACC	88.9%	90.7%	1.8%
Mercy ALTCS	95.5%	96.7%	1.1%
Mercy RBHA	88.8%	90.6%	1.8%
Molina ACC	86.3%	86.3%	-0.0%
UHC ACC	92.9%	93.1%	0.1%
UHC ALTCS	96.7%	96.2%	-0.5%

[20] Values reflected in Figure 8 are rounded to the nearest tenth of a percent.
[21] Please see Appendix B for MCP abbreviations.
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Appendix A: Audit Scope and Methodology

Scope

CMS' audit covered the MLR reported for Arizona's nine MCPs for the reporting period CYE 2021. CMS performed audit work from January 2024 to November 2024.

Methodology

To accomplish the objectives, CMS:

1. Reviewed applicable federal regulations for the annually reported MLR and Arizona-specific methodology requirements regarding the minimum MLR requirements.
2. Notified and met with Arizona to discuss and understand State policies and procedures for overseeing its Medicaid MLR reporting and calculations.
3. Requested from Arizona available data, financial statements, and contractual documentation necessary for a proper analysis.
4. Requested from MCPs available data and contractual documentation necessary for a proper analysis and not already provided by Arizona.
5. Verified completeness of available data and contractual documentation; requested additional documentation from MCPs as necessary.
6. Reconciled MLR data received against available financial statements.
7. Performed data benchmarking using all MCP data to identify MCPs with relatively high or low MLR components.
8. Sent questions to both Arizona and MCPs on data and contract observations.
9. Identified and recalculated, by year and MCP, reporting components that were not properly incorporated in the annually reported minimum MLR calculation.
10. Updated recalculated MLR components in the MLR final calculation to determine potential changes in payments to Arizona and CMS.
11. Discussed the audit with Arizona via a written report and an exit meeting.

Review of State Oversight of MLR Reporting

1. Reconciled financial statements, provided by Arizona, to MLR reporting.
2. Determined whether Arizona's MLR Reporting Template was structured correctly to calculate the MLR results consistent with the applicable regulations and guidelines.
3. Verified that Arizona's oversight of MLR reporting process and calculations was consistent with the applicable regulations and guidelines. Specifically, determined due diligence in oversight of the following items:
    a. MLR data and documentation collected by Arizona.
    b. Guidance provided to MCPs for calculations including methodologies and implemented timeframes.

c. State procedures related to annual MLR reporting and minimum MLR calculation reconciliation, including any exceptions made in reviewing data and the impact on the final calculation.
d. Frequency and topics of ongoing meetings between Arizona and MCPs relating to financial reporting indicators.

Focus Areas for Audit

CMS identified focus areas to help guide this audit. These focus areas are considered by CMS areas of oversight risk. The following steps were taken to conduct the audit of these focus areas:

1. Treatment of Third-Party Vendor Data:
    a. Reviewed applicable federal regulations and CMS guidance on third-party vendors and their treatment in MLR reporting.
    b. Requested MCP available data and documentation on third-party vendor costs.
    c. Requested information from Arizona on their oversight of third-party vendor contracts and date.
    d. Evaluated Arizona instructions to MCPs. Assessed compliance with reporting requirements against federal regulations outlined in the May 2019 CIB.
    e. Verified completeness of available documentation. As necessary, requested additional documentation.
2. Treatment of QIA Expenditures:
    a. Reviewed applicable federal regulations related to treatment and categorization of QIA activities in MLR reporting.
    b. Requested MCPs' available data and documentation on QIA expenditure categorization. Requested and analyzed Arizona's oversight of QIA expenditure reporting.
    c. Verified compliance of reporting requirements outlined in § 438.8(e)(3) and § 438.8(k)(1)(ii).
    d. Verified completeness of available documentation. As necessary, requested additional documentation on an ongoing basis.
    e. Requested additional substantiation on accurate categorization of QIA activities based on §§ 158.150 and 158.151.
    f. Recalculated reported QIA amounts as necessary.
3. Treatment of Special Contract Provisions Related to Payment (with an emphasis on SDPs):
    a. Reviewed applicable federal regulations and CMS guidance about special contract provisions related to payment and their treatment in MLR reporting.
    b. Confirmed with Arizona applicable special payment programs (SDPs, pass-through payments)

   c. Requested from Arizona and MCPs available data and documentation on special payment data and contracts, including documentation separated out by provider where applicable.
   d. Verified completeness of available data and documentation.
   e. Cross-checked reported pass-through and SDP amounts against available financial statement and CMS approval documentation.
   f. Recalculated reported special payment amounts as necessary.
4. Treatment of PI/APM Data and Contracts:
   a. Reviewed applicable federal regulations related to the treatment of incentive pools and bonus payments in MLR reporting.
   b. Requested from Arizona and MCPs available data and documentation on PI/APM data and contracts, including provider contract and proof of payment documentation.
   c. Verified compliance of incentive and bonus payment reporting requirements outlined in § 438.8(e)(2)(i)(C) and § 438.8(e)(2)(iii)(A).
   d. Verified completeness of available documentation. As necessary, requested additional documentation.
   e. Analyzed PI/APM amounts and contracts against four leading practices and developed hypothetical impacts to the minimum MLR calculation.
5. Methodology for Allocation of Expenses:
   a. Reviewed applicable federal regulations related to the methodologies for the AOE in MLR reporting.
   b. Requested from Arizona and MCPs available data and documentation on methodologies for the allocation of QIA expenditures and non-claims costs across LOBs.
   c. Verified compliance of data reporting requirements outlined in § 438.8(k)(1)(vii).
   d. Verified completeness of available data and documentation. As necessary, requested additional data to understand allocation methodologies for non-claims costs across LOBs.
6. Non-Claims Costs:
   a. Reviewed applicable federal regulations related to the categorization of non-claims costs in MLR reporting.
   b. Requested from Arizona and MCPs available data and documentation on non-claims costs across LOBs.
   c. Reviewed compliance of data reporting requirements outlined in § 438.8(e)(2)(v)(A).
   d. Verified completeness of available data and documentation. As necessary, requested additional data to verify accuracy of reported non-claims costs.

Appendix B: Managed Care Plans

Arizona Complete Care (ACC)

MCP Full Name	MCP Abbreviation	MCP Number of CYE 2021 Member Months
Arizona Complete Health	AzCH	2,947,724
Banner University Family Care	BUFC	3,208,395
Care1st Health Plan	Care1st	2,271,244
Health Choice Arizona	HCA	2,636,327
Mercy Care	Mercy	4,528,426
Molina Healthcare	Molina	529,367
UnitedHealthcare Community Plan	UHC	5,032,933

Arizona Long Term Care System (ALTCS)

MCP Full Name	MCP Abbreviation	MCP Number of CYE 2021 Member Months
Banner University Family Care	BUFC	77,178
Mercy Care	Mercy	137,829
UnitedHealthcare Community Plan	UHC	104,356

Regional Behavioral Health Authority (RBHA)

MCP Full Name	MCP Abbreviation	MCP Number of CYE 2021 Member Months
Arizona Complete Health	AzCH	7,013,912
Health Choice Arizona	HCA	3,341,900
Mercy Care	Mercy	14,206,470

Division of Developmental Disabilities (DDD)

MCP Full Name	MCP Abbreviation	MCP Number of CYE 2021 Member Months
Department of Economic Security/Division of Developmental Disabilities	DES/DDD	439,119

Comprehensive Health Plan (CHP)

MCP Full Name	MCP Abbreviation	MCP Number of CYE 2021 Member Months
Department of Child Safety	DCS	163,239

Appendix C: Medicaid MLR Audit Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	In accordance with 42 CFR § 438.8(e)(2)(iii)(A), Arizona should update MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of PI/APMs.	**Please see Arizona's letter below.**	
Recommendation #2	In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should augment the MLR Reporting Instructions to incorporate additional specificity and guidance to clarify the appropriate treatment of special payments, pass-through payments, and SDPs within the MLR calculation.	**Please see Arizona's letter below.**	
Recommendation #3	Effective July 9, 2024, §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii) requires SDPs, inclusive of separate payment terms, to be included in both the numerator and denominator of the MLR calculation. SDPs from MCPs to providers should be included in the numerator and SDP revenue from the Arizona should be reflected in the denominator and included as separate line item(s) in the MLR Reporting Template.	**Please see Arizona's letter below.**	
Recommendation #4	In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should closely monitor MCPs' reporting of SDPs by reviewing the reported incurred claims payments in the MLR calculation and	**Please see Arizona's letter below.**	

Classification	Issue Description	Agree	Disagree
	reconcile all amounts with MCPs' MLR reporting.		
Recommendation #5	In accordance with § 438.6(a), Arizona should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' proper treatment of special payments as pass-through payments as defined in § 438.6(a).	**Please see Arizona's letter below.**	
Recommendation #6	In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify that risk corridor amounts for subcontracted health plans are appropriately reflected within the MLR Reporting Templates.	**Please see Arizona's letter below.**	
Recommendation #7	In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify the accounting of accruals to validate the proper classification and inclusion of risk sharing arrangements.	**Please see Arizona's letter below.**	
Recommendation #8	In accordance with §§ 438.8(e)(2)(v)(A)(1) and 438.8(e)(2)(v)(A)(2), Arizona should augment the MLR Reporting Instructions to clarify that any portion of capitation payments to third party vendors attributable to non-claims costs should be excluded from the MLR calculation. Arizona should augment their oversight activities to validate that these payments have been excluded from the MLR calculation.	**Please see Arizona's letter below.**	
Recommendation #9	In accordance with § 438.8(e)(3), Arizona should update MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of QIA.	**Please see Arizona's letter below.**	
Recommendation #10	In accordance with § 438.8(e)(2)(v)(A), Arizona should revise the MLR Reporting		**Please see Arizona's**

Classification	Issue Description	Agree	Disagree
	Template Instructions to include explicit guidance on the treatment of non-claims costs and require non-claims costs amounts to be reporting on the MLR Reporting Templates to verify the proper exclusion of the costs from the numerator.		**letter below.**
Recommendation #11	In accordance with § 438.8(e)(2)(v)(A) and § 158.150(c)(8), Arizona should update the MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and reporting of non-claims costs.	**Please see Arizona's letter below.**	

Acknowledged by:

_____

[Name], [Title]

_____

Date (MM/DD/YYYY)

June 2, 2026

Ms. Jamie Rollin, CPA, MS
Audits & Vulnerabilities Group
Center for Program Integrity
Center for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop DO-01-40
Baltimore, Maryland 21244-1850

RE: Draft Report Response

Dear Ms. Rollin:

The Arizona Health Cost Containment System (AHCCCS) is pleased to provide a response to the Centers for Medicare & Medicaid Services' (CMS) draft report titled, "Arizona Medicaid Managed Care Medical Loss Ratio (MLR) Audit." The examination report resulted in zero findings; however, CMS identified eleven recommendations to strengthen the consistency, transparency, and auditability of MLR reporting. For each draft recommendation below, AHCCCS has indicated agreement or disagreement and provided a detailed explanation including supporting documentation.

Recommendation #1: *In accordance with 42 CFR § 438.8(e)(2)(iii)(A), Arizona should update MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of Provider Incentives / Alternate Payment Models (PI/APMs).*

AHCCCS Response: Agree.

AHCCCS will augment oversight activities to verify the proper classification and inclusion of PI/APMs.

While the CYE 21 MLR H-1 form specifies that reporting should be conducted on a GAAP basis for each quarter (as noted above columns H-L in the upper right-hand corner), AHCCCS will further enhance the MLR Reporting Template Instructions to explicitly state that PI/APM expenses are to be reported on an accrual basis solely for the specified reporting period.

Recommendation #2: *In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should augment the MLR Reporting Instructions to incorporate additional specificity and guidance to clarify the appropriate*

treatment of special payments, pass-through payments, and SDPs within the MLR calculation.

AHCCCS Response: Agree.

AHCCCS will incorporate additional specificity and guidance in the MLR Reporting Template instructions to clarify the appropriate treatment of special payments, pass-through payments, and SDPs within the MLR calculation.

Recommendation #3: *Effective July 9, 2024, §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii) requires SDPs, inclusive of separate payment terms, to be included in both the numerator and denominator of the MLR calculation. SDPs from MCPs to providers should be included in the numerator, and SDP revenue from Arizona should be reflected in the denominator and included as separate line item(s) in the MLR Reporting Template.*

AHCCCS Response: Agree.

Beginning with CYE 24 reporting (October 1, 2023, through September 30, 2024), AHCCCS updated the MLR Reporting Template to include SDP reporting as distinct line item(s). The SDP revenue from AHCCCS (Line #16) is reflected in the denominator, and SDP payments from the MCPs to providers (Line #32) are reflected in the numerator.

Recommendation #4: *In accordance with §§ 438.8(e)(2)(iii)(c) and 438.8(f)(2)(vii), Arizona should closely monitor MCPs' reporting of SDPs by reviewing the reported incurred claims payments in the MLR calculation and reconcile all amounts with MCPs' MLR reporting.*

AHCCCS Response: Agree.

AHCCCS will implement processes to monitor SDPs by reviewing the reported incurred claims payments in the MLR calculation and reconciling all amounts with the MCPs' MLR reporting.

Recommendation #5: *In accordance with § 438.6(a), Arizona should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' proper treatment of special payments as pass-through payments as defined in § 438.6(a).*

AHCCCS Response: Agree.

AHCCCS will augment the instructions for the MCP's in the MLR Reporting Template to provide clear guidance regarding proper treatment of special payments as pass-through payments as defined in *§ 438.6(a).*

Recommendation #6: *In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify that risk corridor amounts for subcontracted health plans are appropriately reflected within the MLR Reporting Templates.*

AHCCCS Response: Agree.

Oversight and monitoring processes will be enhanced by AHCCCS to verify that the risk corridor amounts for subcontracted health plans are appropriately reflected within the MLR Reporting Templates.

Recommendation #7: *In accordance with § 438.8(f)(2)(vi), Arizona should enhance oversight and monitoring processes to verify the accounting of accruals to validate the proper classification and inclusion of risk sharing arrangements.*

AHCCCS Response: Agree.

AHCCCS currently performs a thorough data validation process to ensure that the MLR data reported aligns with the corresponding quarterly and annual financial statements. Upon receipt of the financial reporting packages submitted by the MCPs, the assigned Health Care Financial Consultant (HC FC) performs an initial review, followed by a subsequent evaluation by a manager or lead HC FC. During this financial review, accruals related to risk sharing arrangements are carefully assessed. AHCCCS will review and further strengthen its oversight and monitoring processes to verify the accounting of accruals to validate the accurate classification and inclusion of risk sharing arrangements.

Recommendation #8: In accordance with §§ 438.8(e)(2)(v)(A)(1) and 438.8(e)(2)(v)(A)(2), Arizona should augment the MLR Reporting Instructions to clarify that any portion of capitation payments to third party vendors attributable to non-claims costs should be excluded from the MLR calculation. Arizona should augment their oversight activities to validate that these payments have been excluded from the MLR calculation.

AHCCCS Response: Agree.

AHCCCS will augment the MLR Reporting Instructions to clarify that any portion of capitation payments to third party vendors attributable to non-

claims costs should be excluded from the MLR calculation. AHCCCS will augment oversight activities to validate that the payments have been excluded from the MLR calculation.

Recommendation #9: *In accordance with § 438.8(e)(3), Arizona should update MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and inclusion of QIA.*

AHCCCS Response: Partially agree.

AHCCCS concurs with the recommendation to enhance oversight activities to ensure the proper classification and inclusion of QIA.

AHCCCS updates MLR Reporting instructions on an annual basis. For CYE 21 MLR reporting, AHCCCS issued detailed guidance related to QIA for MCPs in the Medical Loss Ratio Report Guidance (MLR Guidance), available on the AHCCCS website under the Financial Reporting Guidelines section. This document provides comprehensive information on several areas of MLR reporting, including health care quality improvements (QIA), subcontractors (third-party vendors), and expense allocation methodologies.

Recommendation #10: In accordance with § 438.8(e)(2)(v)(A), Arizona should revise the MLR Reporting Template Instructions to include explicit guidance on the treatment of non-claims costs and require non-claims costs amounts to be reported on the MLR Reporting Templates to verify the proper exclusion of the costs from the numerator.

AHCCCS Response: Partially disagree.

CMS' recommendation to revise the MLR Reporting Template to require non-claims costs amounts to be reported on the MLR Reporting Templates is not applicable, as AHCCCS has mandated MCPs to report non-claims costs in the MLR Reporting Template for CYE 18 and all subsequent contract years, including CYE 21. This requirement is documented on page 26 of CMS' publication, Medical Loss Ratio (MLR) Monitoring, Reporting, and Oversight: A Toolkit for States to Ensure Complete and Accurate MLR Reporting, "...*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...*"

MLR Reporting instructions are updated annually. Where appropriate, AHCCCS will further revise the MLR Reporting Templates to provide even more explicit guidance on the treatment of non-claims costs than the CYE 21 MLR Reporting Template guidance.

Recommendation #11: In accordance with § 438.8(e)(2)(v)(A) and § 158.150(c)(8), Arizona should update the MLR Reporting Template Instructions and augment oversight activities to verify the proper classification and reporting of non-claims costs.

AHCCCS Response: Agree.

AHCCCS updates MLR Reporting Template instructions annually and will revise the MLR Reporting Template Instructions. In addition, AHCCCS will augment oversight activities to verify the proper classification and reporting of non-claims costs.

AHCCCS appreciates the work performed by CMS and the opportunity to respond to the audit report. If you have any questions, please contact Jeffery Tegen at (602) 417-4705.

Sincerely,

Jeffery Tegen, Chief Financial Officer
Assistant Director, AHCCCS
Division of Business and Finance

cc: Jamie Rollin, CPA, CMS/CPI
Donald Carr, CMS/CPI
Michelle Cox, CMS/CPI
Emanuel Ryan, CMS/CPI
Shirin Hormozi, CMS/CPI
Cynthia Layne, CPA, Deputy Assistant Director, AHCCCS
Katie Morris, Chief Compliance Officer, AHCCCS
Pamela McMillen, Finance and Reinsurance Administrator, AHCCCS
Cathy Young, Finance Manager, AHCCCS
Mary Mason, HC Financial Consultant, AHCCCS