Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Ohio Medicaid Managed Care Medical Loss Ratio Audit

Audit Period: Calendar Year 2020 Reporting Period

Final Report

July 2025

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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 six managed care plans (MCPs) contracted with the Ohio Department of Medicaid (Ohio) during calendar year (CY) 2020.[1] Ohio has partnered with six different MCPs across both of the Medicaid Managed Care (MMC) and Medicaid MyCare (MyCare) programs,[2] with four of the six MCPs serving both MMC and MyCare and two MCPs serving only MMC or MyCare. The primary objectives of the MLR audit were to determine if (1) MCPs submitted annual MLR reports to Ohio pursuant to federal requirements, and (2) annual MLR reporting and minimum MLR remittance calculations for the MCPs were supported by the underlying data and supporting documentation received by Ohio.

To meet the objectives of this MLR audit, CMS reviewed the CY 2020 MLR Reporting Template and Instructions, including remittance documentation and additional supporting documentation provided by Ohio. CMS also requested additional detail from MCPs to substantiate reported MLR calculations and understand Ohio'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.

Findings and Recommendations

Findings represent areas of noncompliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified 23 instances across all MCPs requiring correction to the MLR remittance calculations reported by MCPs. Because none of these corrections resulted in a recalculated MLR that fell below the remittance threshold (86 percent for MMC plans and 85 percent for MyCare plans), CMS did not identify any remittances that should have been paid. In response to these findings, CMS identified eight recommendations that will enable the state to come into compliance with federal and/or state Medicaid MLR requirements. These recommendations include the following:

State Directed Payments (SDP) and Risk Sharing Arrangements

1. In accordance with 42 CFR § 438.6(c)(2)(ii)(A) and § 438.8(e)(2)(i)(A), Ohio should closely monitor receipt of SDP and pass-through payments and reconcile all amounts with MCPs' MLR reporting.

2. In accordance with § 438.6(c)(2)(ii)(A), SDPs to MCPs should be included in the numerator and SDP revenue from the state should be reflected in the denominator – both as line items.

[1] Further references to "MCPs" will be inclusive of both MMCs and MyCare plans.
[2] In Ohio approximately 90 percent of individuals enrolled in Medicaid are covered through managed care plans. MyCare Ohio is a managed care program designed for Ohio residents who receive both Medicaid and Medicare benefits.

3. Ohio should update the MLR Reporting Template Instructions and Templates to direct MCPs to report only service-related costs for special payments in the numerator and to report total reimbursement received from the state, which should include both service-related costs and non-claims costs for the program, in the denominator as required by § 438.8(e)(2)(i)(A) and § 438.8(f)(2)(i).

4. Ohio should revise the MLR Reporting Template Instructions to guide plans on the proper inclusion of health care quality activity related expenses as required by 158.150(b)(2)(A)(1) for the Enhanced Maternal Program in the numerator and capitation revenue from the state in the denominator of the MLR Reporting Template and update the MLR Reporting Template to incorporate the correct calculation.

Third-Party Vendor Data and Contracts

5. In accordance with § 438.8(k)(3), Ohio should require MCPs to collect all required underlying data associated with MLR reporting from third-party vendors providing claims adjudicating activities so that the MCP can calculate and validate the accuracy of the reported MLR.

6. In accordance with § 438.230(c)(1), Ohio should require MCPs to establish and maintain contracts with their subcontractors to reinforce compliance with third-party reporting responsibilities.

Allocation of Expenses (AOE) Methodology

7. In accordance with § 438.8(k)(1)(vii), Ohio should request information from MCPs on the methodology for the AOE across lines of business (LOBs). For example, Ohio should request specific information on how certain types of non-claims expenditures (e.g., salaries and human resource expenses) are allocated across LOBs, as well as request information on how quality improvement activity (QIA) program expenditures that affect multiple LOBs were allocated across LOBs.

8. In accordance with § 438.8(g)(ii), Ohio should update future Medicaid MLR Reporting Template Instructions to clearly state that non-Medicaid LOB expenses should not be included with the Medicaid MLR Reporting Template and remittance calculations.

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 12 observations related to Ohio'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 Ohio to sufficiently review MCP submissions for the Risk Corridor and MLR Reporting Templates and instruct MCPs to resubmit for all errors that are discovered in the reporting templates.

2. CMS encourages Ohio to require the MCPs to submit the Risk Corridor and MLR Reporting Templates using the same runout period to allow for consistency of values used in the Risk Corridor and MLR calculations reported to CMS.

Provider Incentive Payments and Contracts

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

4. CMS encourages Ohio to collect additional data from MCPs to substantiate evidence of timely payments to providers demonstrating that incentive payments are made to providers in a timely manner.

State Directed Payments and Risk Sharing Arrangements

5. CMS encourages Ohio to create separate line items in its MLR Reporting Template for each special payment to better monitor payment amounts and incorporate different types of payments into the MLR calculation as applicable.

6. CMS encourages Ohio to correct errors in the Risk Corridor Template submissions as inconsistencies are discovered with the MLR Reporting Template submissions.

7. CMS encourages Ohio to remove the following language from the MLR Risk Corridor Template Instructions to the MCPs: "The calculation of the Actual MLR and Target MLR are consistent with the description included under § 438.8," where the Actual MLR refers to the MLR calculated for the purpose of the risk corridor settlement or change the calculation of the MLRs calculated for risk corridor to be consistent with regulations.

8. CMS encourages Ohio to revise the MLR Reporting Template Instructions to clarify that the exact risk corridor settlement amount calculated should be paid/received by the MCP and reported on the MLR Reporting Template.

9. CMS encourages Ohio to implement a regular reporting mechanism which requires the MCPs to report on the status and expenditures of the special payment programs.

Allocation of Expenses Methodology

10. CMS encourages Ohio to increase oversight activities and update future MLR Reporting Instructions to provide a clear and detailed description of the information required, including targeted methodology as part of the MCPs' MLR submission.

Quality Improvement Activity Expenditures and Contracts

11. CMS encourages Ohio to implement more detailed line item reviews of the activities reported as QIA. In doing so, the state can confirm the MCPs maintain federal compliance of the inclusion or exclusion of QIA expenditures in the MLR calculation.

Non-Claims Costs

12. CMS encourages Ohio to 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.

Ohio'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 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 remittance 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.[3] The MLR is a component of rate setting that demonstrates that a sufficient percentage of the total capitation is spent on 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 MCP. States that implement a minimum MLR for its MCPs 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 MLR regulations in § 438.8.

[3] §1903(m)(2)(A) of the Social Security Act

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

The Ohio Department of Medicaid contracted with six MCPs to provide health care coverage for the Medicaid managed care population: Buckeye Health Plan (BHP), CareSource (CS), Molina Healthcare of Ohio (MO), Paramount (PMT), UnitedHealthcare (UHC), and Aetna Better Health. MCPs are contracted with the state to provide Medicaid health benefits and additional services to Medicaid enrollees or recipients, focusing on managed care as a model to limit costs and keep quality of care high.

CMS conducted an audit of the MLR calculation for the Medicaid managed care population in Ohio covering the CY 2020 contract period.[4] To assess compliance with federal and state MLR requirements, CMS reviewed the submitted CY 2020 MLR Reporting Template, MLR Remittance submissions,[5] and additional supporting documentation provided by Ohio. CMS requested additional detail from MCPs to substantiate the reported MLRs and remittance amounts and to review Ohio's oversight procedures.

In light of the COVID-19 public health emergency (PHE), Ohio elected to implement a two-sided risk corridor as a means of sharing risk between the state and the MCPs. This risk corridor was retroactively instated for CY 2020 following guidance from CMS that allowed states to request to amend or implement risk mitigation strategies due to the uncertainty around the COVID-19 PHE.[6] CMS performed a high-level review of Ohio's risk corridor implementation to determine if settlement amounts were calculated appropriately and incorporated into the MLR calculation pursuant to federal regulations.

On April 22, 2024, CMS released the Final Rule entitled "Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality" (2024 Final Rule) which advances CMS's efforts to improve access to care, quality and health outcomes, and better address health equity issues 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 Ohio 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 eight recommendations and twelve observations. Appendix A contains additional detail on this audit's scope and methodology. CMS also included MCP-specific information in Appendix B. Ohio's response to CMS' draft report can be found in Appendix C, with the final report reflecting all changes CMS made based on Ohio's

[4] All Medicaid data collected for this audit were aggregated on a program-wide basis.
[5] Ohio's minimum MLR remittance methodology is calculated on an annual basis.
[6] CIB - Medicaid Managed Care Options in Responding to COVID-19

response.

This audit encompasses the 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 MCPs 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 Payments and Contracts** – CMS regulations at § 438.3(i), require Medicaid contracts to comply with the Medicare Advantage (MA) program requirements set forth in §§ 422.208 and 422.210, which allows 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.

3. **State Directed Payments and Risk Sharing Arrangements** – Under § 438.6(c), SDPs are 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, that 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. Those third-party vendors providing claims adjudication activities for MCPs must comply with federal regulations at § 438.8(k)(3), meaning incurred claims, expenditures for activities that improve health care quality, and information on mandatory deductions or exclusions from incurred claims must be reported to the MCPs in sufficient detail to allow the MCP to incorporate the subcontractors' expenditures into the MCPs' overall MLR calculation.

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 adjustment.

6. **Quality Improvement Activity Expenditures and Contracts** – Under § 438.8(e)(3), to qualify as a QIA expenditure, expenditures must be directly related to QIAs. As described in 45 CFR § 158.150, 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(e)(2)(v) provide general guidance on the treatment of amounts 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 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 CY 2020 MLR remittance calculations to determine if the recalculated data results in an MLR lower than 86 percent, which would require remittances be made to the state and CMS. None of the identified findings resulted in a recalculated MLR that fell below the 86 percent remittance threshold.

Ohio'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 Ohio CY 2020 MLR Reporting Template Instructions specified the exact components that were allowable within the numerator and denominator. Each component is defined below.

The numerator is defined as the following components: claims paid or owed to providers for Medicaid covered services, sub-capitated claims attributed to state plan services provided, incentives, bonuses, withholds, and other settlements paid to providers, recoveries from third party liability, subrogation, overpayments, and supplemental prescription drug rebates, net payments or receipts related to state mandated solvency funds, reserves for contingent benefits and the medical claims portion of lawsuits, recoveries related to state mandated reinsurance arrangements, fraud recoveries exceeding expenses related to fraud recovery activities, QIA, and non-state plan service expenses (NSPS).

The denominator is defined as premium revenue minus taxes and fees. Premium revenues are defined as Medicaid risk-adjusted capitation payments, quality withhold earned back, copays waived by MCP from provider's collection responsibility, unearned premium reserve changes, premiums related to state mandated reinsurance arrangements, risk adjustment settlements, and risk corridor settlements. Allowable taxes and fees are defined as federal taxes and federal assessments, state insurance, premium, Health Insuring Corporation (HIC) tax, HIC Franchise Fee, and other taxes, regulatory license and fees, and community benefit expenditures if exempt from federal income taxes.

The credibility adjustment is added to the MCP's calculated MLR if the MCP is partially credible[7] to account for the likelihood that the actual and target MLRs differ from a lack of fully sufficient claims experience (measured in member months).[8]

In Ohio, an MCP is required to remit the difference to the state if the MCP reports an MLR under the 86 percent threshold for the Medicaid population.

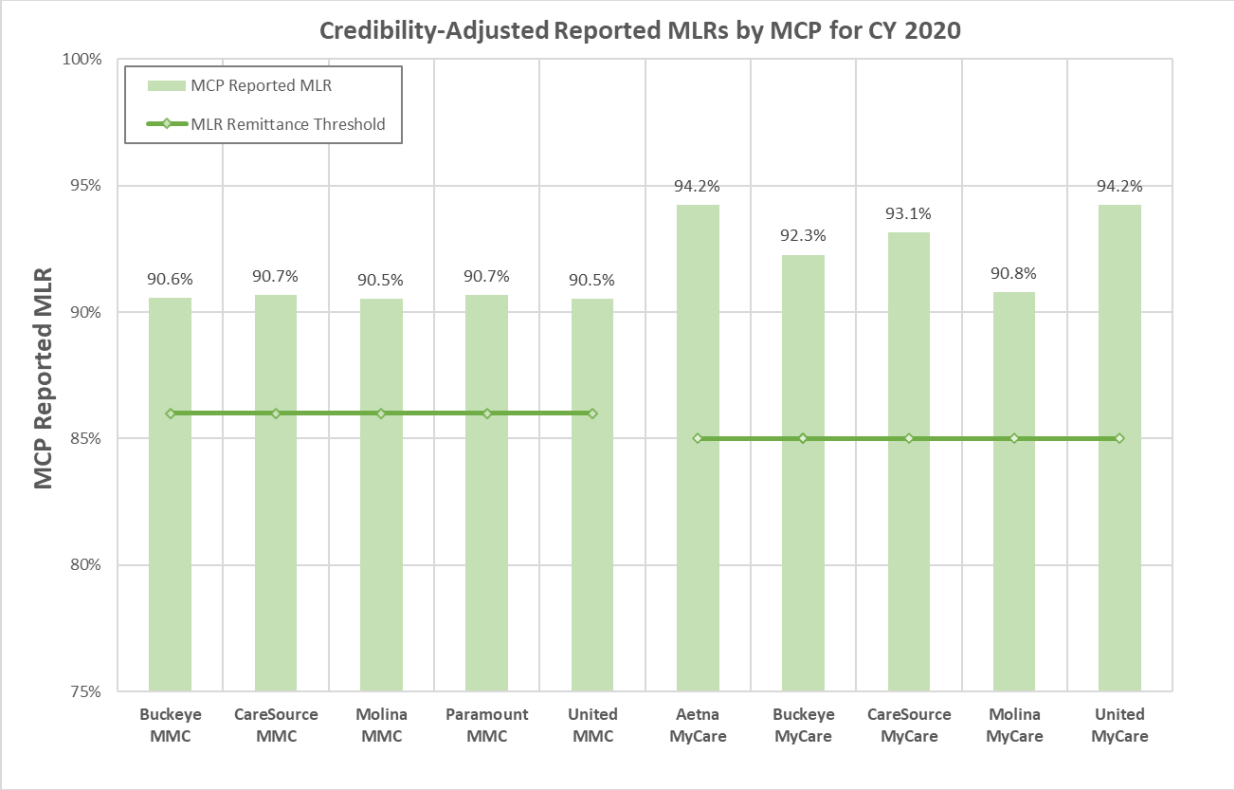
Initial MLR Remittance Results

Results of the CY 2020 MLR remittance calculations are included below. The MLR remittance results were calculated by Ohio based on data reported by each MCP in the MLR Reporting Template. Ohio reviewed the data to determine that the data was consistent and met the guidelines and that all expenditures reported were allowable.

Figure 1 depicts the credibility-adjusted annual MLR for CY 2020 based on the reports submitted by MCPs to Ohio for minimum MLR remittance calculations.

[7] 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.
[8] 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. Ohio utilizes the credibility adjustment calculation methodology delineated in this bulletin for its remittance calculation.

Figure 1



MLR Components

Figures 2 and 3 show the average incurred medical related costs (numerator) and average medical related revenues (denominator) as a percentage of gross premiums reported in the CY 2020 minimum MLR remittance calculations by all six MCPs.

Figure 2.[9]

	Numerator	
	Ohio Components	***% of Gross Premium***
	Claims Paid (Sub-Capitated Payment included)	**79.3%**
	Incentives, Bonuses, Withholds, and Other Settlements Paid to Providers	0.2%
	Unpaid Claim Reserve and Liability at December 31, 2021	0.1%
	Total Fraud Recoveries Added Back to Incurred Claims	0.0%
QIA	Improve Health Outcomes	1.2%
QIA	Activities to Prevent Hospital Readmissions	0.2%
QIA	Improve Patient Safety and Reduce Medical Errors	0.1%
QIA	Wellness and Health Promotion Activities	0.1%
QIA	HIT Expenses Related to Improving Health Care Quality	0.2%
QIA	Activities Related to EQR	0.0%
	Third Party Liability/Recoveries	-0.4%
	Reserve for Incentive Pool, Withhold Adjustments, and Bonus Amounts Payable to Providers	0.2%
	Prescription Drug Rebates Collected	-0.2%
Non-State Plan Services	Non-State Plan Services - NEMT	0.2%
Non-State Plan Services	Non-State Plan Services - All Other	0.1%
	Contingent Benefit and Lawsuit Reserves at December 31, 2021	0.0%
	Subrogation Recoveries	0.0%
	Overpayments Recoveries Received from Network Providers	0.0%
	Net Payments (or Receipts) Related to State Mandated Solvency Funds	0.0%
	Enhanced Maternal Program, MCP/Hospital Incentive, CICIP Program Paid	0.0%
	Supplemental Dispensing Fee	0.0%
	Prescription Drug Rebates Accrued	0.0%
	Total Incurred Medical Related Costs	**81.3%**

Figure 3.[10]

	Denominator	
	Ohio Components	***% of Gross Premium***
Gross Premium	State Capitation Payments	96.7%
Gross Premium	MCP Withhold Earned Back – Related to January - December 2020	3.1%
Gross Premium	Total Amount of Copays Waived by MCP from Provider's Collection Responsibility	0.2%
	Gross Premium	**100.0%**
Taxes and Fees	Federal Taxes and Federal Assessments	-0.4%
Taxes and Fees	State Insurance, Premium and Other Taxes	-5.6%
Taxes and Fees	Regulatory Authority Licenses and Fees	0.0%
Taxes and Fees	Community Benefit Expenditures Used	-0.1%
	Risk Corridor Settlements (Payment)/Recoupment	-3.1%
	Risk Adjustment Settlements (Payment)/Recoupment	0.1%
	Risk Pool Settlements (Payment)/Recoupment	0.0%
	Enhanced Maternal Program, MCP/Hospital Incentive, CICIP Program	-1.1%
	Unearned Premium Reserve Changes	0.0%
	Supplemental Dispensing Fee	0.0%
	Total Medical Related Revenues	**89.7%**

The average MLR, excluding credibility adjustments, for the reporting period CY 2020 was 90.6 percent, which was calculated by dividing the total incurred medical related costs (81.3 percent)

[9] Enhanced Maternal Program was excluded from the numerator of the MLR Reporting Template but was included in the numerator of the Risk Corridor Template.
[10] Enhanced Maternal Program was excluded from the denominator of the MLR Reporting Template but was included in the denominator of the Risk Corridor Template.

by the total medical related revenues (89.7 percent). In the numerator, paid claims, sub-capitated payments, and incentive payments accounted for 97.7 percent, with all the other components only accounting for a combined 2.3 percent. In the denominator, risk corridor settlements accounted for a reduction of 3.1 percent, while the Enhanced Maternal Program, MCP/Hospital Incentive, and Care Innovation and Community Improvement Program (CICIP) accounted for a reduction of 1.1 percent. These along with federal and state taxes and other expenses were subtracted from gross premium to calculate net premium.[11]

Results of the Audit

Based on the results of this audit, Ohio's MCPs did not always follow federal requirements when reporting MLRs. While the errors identified in this audit did not result in any remittances that should have been paid, 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,[12] 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 ensuring that MLR reporting and remittance calculations are accurate for rate setting.

This audit reviewed Ohio's oversight efforts of MCPs' MLR reporting. While CMS did not identify any recommendations related to Ohio's oversight efforts, CMS identified two overarching observations where Ohio could improve its oversight efforts. **Specifically, CMS identified several instances in which MCPs inaccurately documented items in either the Risk Corridor Template or the MLR Reporting Template. In these instances, Ohio did not mandate the re-submission of templates to correct these errors and require the use of the corrected values for the MLR calculation.** Correction of the inaccurate values would have a direct impact on the MLR, with either an increase or decrease. Inaccurate values in the Risk Corridor Template could also result in Ohio not returning the appropriate federal share of the reconciliation results. Ohio should consider sufficiently reviewing the MCP submissions of the Risk Corridor and MLR Reporting Templates and instruct the MCPs to resubmit for any errors discovered in those reporting templates. **In addition, CMS identified that Ohio's instructions for the MLR Risk Corridor Template and MLR Reporting Template required different runout periods.** The differing runout periods can impact the consistency of MLR determination when evaluating the Risk Corridor submissions to the MLR submissions provided to CMS. Ohio should consider requiring the MCPs to submit the Risk Corridor and MLR Reporting Templates

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

using the same runout period to allow for consistency of values used in the Risk Corridor and MLR calculations reported to CMS.

- ✓ **Observation #1:** CMS encourages Ohio to sufficiently review MCP submissions for the Risk Corridor and MLR Reporting Templates and instruct MCPs to resubmit for all errors that are discovered in the reporting templates.

- ✓ **Observation #2:** CMS encourages Ohio to require the MCPs to submit the Risk Corridor and MLR Reporting Templates using the same runout period to allow for consistency of values used in the Risk Corridor and MLR calculations reported to CMS.

2. Provider Incentives Payments and Contracts

CMS regulations at § 438.3(i) require Medicaid contracts to comply with the MA program requirements set forth in § 422.208 and § 422.210, which allows 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.

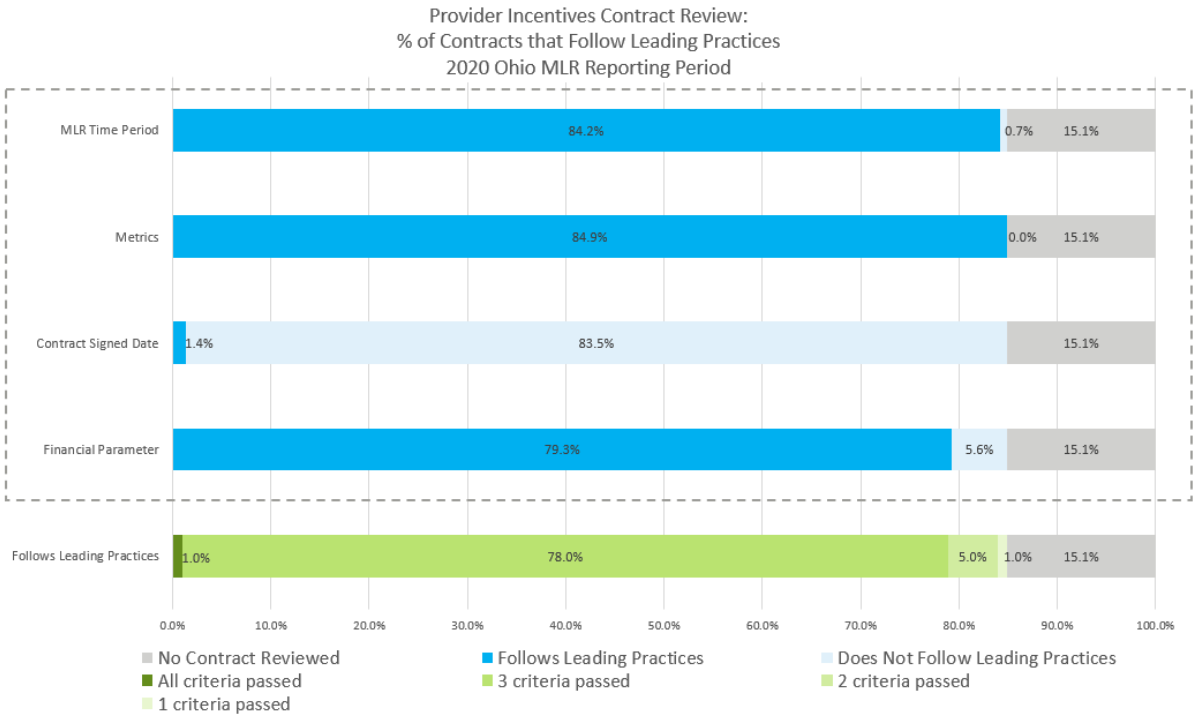
Under this audit, all MCPs were reviewed and assessed as to whether each provider incentive contract followed specified leading practices. At the time of the audit period, the leading practices were not federal or state requirements; however, per the 2024 Final Rule, these leading practices are required 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.[13] The leading practices related to incentive payment contracting are as follows:

1. The contract effective period was within the MLR period.
2. Some form of metrics was included within the contract.
3. The contract was signed by both parties, with the signed date evaluated in comparison to the listed effective date.
4. The contract specified financial parameters for payment.

Inconsistent documentation practices by the MCPs led to difficulties in confirming and verifying the appropriateness of some incentive payments. As noted above, because these leading practices were not federal or state requirements during the audit period, no findings were identified in this audit. However, CMS identified two observations 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 4, below.

[13] Per the 2024 Final Rule, these leading practices are 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 4.[14]



Within the audit period, 1 percent of contracts followed all leading practices, 78 percent followed at least three of the leading practices, and 6 percent followed two or less. **Contracts were either not submitted to CMS or MCPs responded that contracts were not in place for 15.1 percent of provider incentives that were paid out.** Five MCPs (BHP MMC and MyCare, CS MyCare, MO MMC and MyCare, PMT MMC, UHC MMC) paid out provider incentives without a contract in place. Due to the COVID-19 PHE, two MCPs (CS MMC, UHC MMC) instated retroactive provider incentives, representing 72.4 percent of the contracts signed after the effective period.

Due to the small portion of provider incentives in the MLR calculation, about 0.2 percent of total incurred costs, no MCP would fall below the 86 percent MLR remittance threshold if there was a federal or state requirement for states and MCPs to follow the leading practices during the audit period.

CMS noted more state oversight is needed on verification of timely incentive payments made to providers. Ohio did not have comprehensive details on incentive payments at the provider-level. Ohio stated that they began monitoring value-based payment arrangements, including provider incentives, in CY 2023; however, as of August 2023 the state is not

[13] Per the 2024 Final Rule, these leading practices are 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.
[14] Figure 4 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 that CMS did not receive a contract for were labelled as "No Contract Reviewed".

monitoring the timeliness of these payments. CMS requested proof of payment to providers from MCPs in the form of copies of checks, bank statements, or some other audited financial report and verified that most MCPs made incentive payments to providers in a timely manner. All MCPs, excluding CS, provided supporting documentation on verification of payments, payment cycles, and timeliness of payment to providers.

- ✓ **Observation #3:** CMS encourages Ohio to require that MCPs maintain contracts 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 #4:** CMS encourages Ohio to collect additional data from MCPs to substantiate evidence of timely payments to providers demonstrating incentive payments are made to providers in a timely manner.

3. State Directed Payments and Risk Sharing Arrangements

Under § 438.6(c), SDPs are 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 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 in § 438.8(e)(2)(i)(A) notes that direct claims for services or supplies covered under the contract and services meeting the requirements of § 438.3(e) provided to enrollees must be included in the numerator of the MLR.

CMS confirmed four special payment programs[15] applicable to this audit: MCP/Hospital Incentive,[16] Supplemental Dispensing Fee,[17] CICIP,[18] and Enhanced Maternal Program.[19] CMS confirmed that the Supplemental Dispensing Fee and CICIP are both SDPs, and MCP/Hospital Incentive is a pass-through payment. **Ohio was uncertain how to classify the Enhanced Maternal Program and excluded it from the federal summary MLR calculation even though funding for the program was provided in the non-benefit portion of the capitation rates.**

CMS noted that Ohio's CY 2020 MLR Reporting Template excluded the Supplemental Dispensing Fee and CICIP SDPs from the numerator and the denominator. **Accordingly, CMS identified that the MCP expenditures and revenues associated with these payments should have been reported in the MLR numerator and denominator.**

[15] Special payment programs reviewed in this audit were applicable to MMC MCPs only.
[16] An incentive arrangement to participating providers based on the contractual agreement.
[17] Payments made to non-exempt retail pharmacies in accordance with the supplemental dispensing fee.
[18] Developed to increase alignment of quality improvement strategies and goals among Ohio, MCPs, and four public and nonprofit hospital participating agencies.
[19] Enhanced Maternal Program is created to improve birth outcomes and reduce infant mortality.

To substantiate special payment amounts, CMS requested documentation on special payment amounts disbursed to each qualifying provider. Of the five MMC MCPs, three provided supporting documentation that successfully tied back to the reported special payment amounts in the CY 2020 MLR Reporting Template. Ohio's MLR Reporting Template Instructions directed MCPs that the numerator and denominator totals for special payments are expected to be the same. **However, special payment reimbursement to MCPs may include reimbursement for administrative costs, premium tax, or other non-medical related costs that should be excluded from the numerator of the MLR calculation, and the numerator and denominator for special payment amounts should be reported separately.**

Additionally, Ohio directed MCPs to report Enhanced Maternal Program, MCP/Hospital Incentive, and CICIP in one line item on the MLR Reporting Template. These three programs are categorized as different types of special payments and should be accounted for in the MLR calculation based on the type of special payment. **CMS observed that these three programs should be reported in separate line items 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. CMS released guidance allowing states to retroactively amend or implement risk mitigation strategies due to uncertainties surrounding the COVID-19 PHE.[20, 21] Ohio updated their provider agreements in June 2020 for the CY 2020 rating year to implement a two-sided risk corridor.

Under this audit, CMS reviewed templates and materials provided by Ohio and the MCPs related to the risk corridor to:

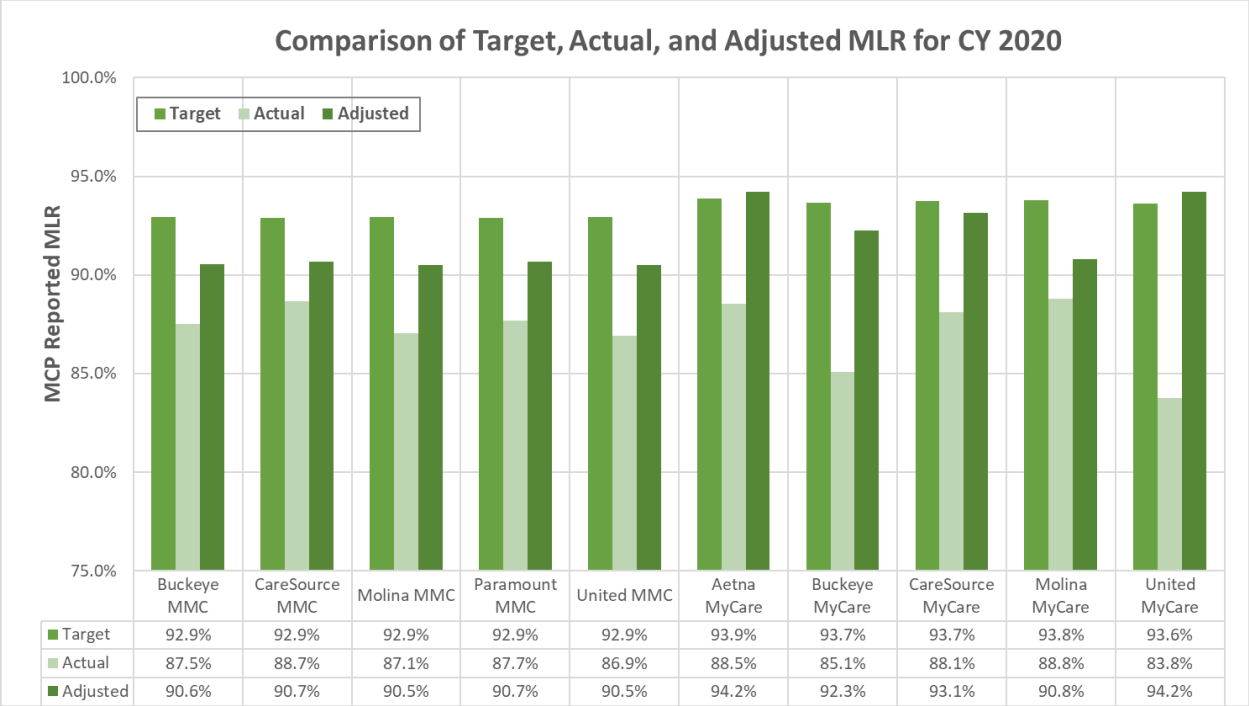
1. Validate the CY 2020 risk corridor settlement amounts,
2. Determine if the risk corridor settlement amounts were properly included in the MLR calculation, and
3. Evaluate Ohio's oversight and monitoring of the risk corridor.

Ohio implemented a risk corridor for each MCP consistent with the examples provided in the May 14, 2020 Center for Medicaid and CHIP Services (CMCS) information bulletin (CIB). Under this approach, the risk corridor is a two-sided risk mitigation strategy calculated based on the difference between the MLR assumed in the certified capitation rates, or the Target MLR, and the Actual MLR results based on actual CY 2020 experience. The difference between the Target MLR and the Actual MLR for each MCP was used to calculate the risk corridor settlement amount. If the Actual MLR was higher than the Target MLR, the MCPs would receive a payment from Ohio, and if the Actual MLR was lower than the Target MLR, Ohio would receive a recoupment from the MCPs. To calculate the final MLR adjusted for the risk corridor settlement, or the Adjusted MLR, the premium revenue in the denominator was adjusted

[20] Per CMS's Final Rule effective for contract periods beginning after December 14, 2020, risk-sharing mechanisms may not be added or modified after the start of the rating period.
[21] CIB - Medicaid Managed Care Options in Responding to COVID-19

by risk corridor settlement payment or recoupment. Figure 5 below shows the Actual and Target MLR for each MCP, and the Adjusted MLR after incorporating the risk corridor settlement.

Figure 5



	Buckeye MMC	CareSource MMC	Molina MMC	Paramount MMC	United MMC	Aetna MyCare	Buckeye MyCare	CareSource MyCare	Molina MyCare	United MyCare
Target	92.9%	92.9%	92.9%	92.9%	92.9%	93.9%	93.7%	93.7%	93.8%	93.6%
Actual	87.5%	88.7%	87.1%	87.7%	86.9%	88.5%	85.1%	88.1%	88.8%	83.8%
Adjusted	90.6%	90.7%	90.5%	90.7%	90.5%	94.2%	92.3%	93.1%	90.8%	94.2%

The increase from the Actual MLR to the Adjusted MLR was driven by two main factors:

1. Risk Corridor Settlement: A portion of the difference between the Actual MLR and Adjusted MLR for each MCP was due to risk corridor settlement payments from each MCP to Ohio. The risk corridor settlement payment was calculated from the difference between the actual MLR and the target MLR. These payments decreased each MCPs' revenue and denominator, thus increasing the Adjusted MLR.
2. Credibility Adjustments: All MCPs operating MyCare programs received credibility adjustments based on member month thresholds which are not reflected in the actual MLR. The increase to the Adjusted MLR by MCP ranged from 1.7%-2.0%.

CMS noted several instances where MCPs had errors in submission for the Risk Corridor Template, including misreporting taxes and misreporting of QIA expenses. Through Ohio's oversight and monitoring process, Ohio notified MCPs of errors identified in the Risk Corridor Template and requested that the MCPs correct the errors in the MCPs' final MLR Reporting Template. However. Ohio did not request MCPs to resubmit the MLR Risk Corridor Template to correct the errors and revise the MLR calculation. **CMS noted that because Ohio did not require the MCPs to resubmit the MLR Risk Corridor Template with the corrected errors, the denominator of the Adjusted MLR calculation incorporated incorrect risk corridor settlement amounts.**

CMS observed inconsistent language in Ohio's Risk Corridor Template Instructions to the MCPs. Ohio's Risk Corridor Template Instructions stated that the Target and Actual MLR used to calculate the risk corridor settlement was calculated consistent with § 438.8. **CMS determined that it was not consistent with federal regulations, as the instructions directed MCPs to include pass-through payments in the Actual MLR calculation.**

In calculating the risk corridor settlements for each MCP in CY 2020, all MCPs were required to pay a settlement back to Ohio, and CMS identified inconsistencies with the amount reported for the MLR remittance calculation. Ohio directed MCPs to pay their settlement amounts rounded to the nearest $100,000. Ohio should direct the MCPs to pay and report unrounded settlement amounts, not round to the nearest $100,000, per leading practices.

Other Special Payments

Ohio described the Enhanced Maternal Program as an agreement between MCPs and providers to provide enhanced maternal care services to Medicaid recipients. This program provides enhanced maternal case management to help reduce infant mortality rates. Ohio did not provide MCPs with contract language or written guidance about the types of expenditures that were allowable under this program. Ohio indicated that funding for this program may result in expenditures attributable to identifiable members or services, but it may also result in expenditures that are administrative in nature.

CMS observed that Ohio paid capitation payments to the MCPs for the Enhanced Maternal Program, but the CY 2020 MLR Reporting Template excluded all payments related to this program from the MLR calculation from both the numerator and denominator. MCPs can use the revenue from this program to implement QIAs, administrative activities, or a combination of both. **Accordingly, CMS observed that MCP revenues associate with Enhanced Maternal Program should be included in the capitation revenue, and payments to providers for providing enhanced maternal services or other benefits that can be considered incurred claims or QIAs should be included in the numerator.**

Additionally, CMS identified Ohio does not currently have a regular reporting mechanism for any of the non-benefit special payment programs, such as the Enhanced Maternal Program and the MCP/Hospital Incentive.

The impact of corrections made to the MLR based on the above identified inconsistencies were not significant and did not result in any MCP's recalculated MLR falling below the remittance threshold of 86 percent.

- ✓ **Recommendation #1:** In accordance with § 438.6(c)(2)(ii)(A) and § 438.8(e)(2)(i)(A), Ohio should closely monitor receipt of SDP and pass-through payments and reconcile all amounts with MCPs' MLR reporting.

- ✓ **Recommendation #2:** In accordance with § 438.6(c)(2)(ii)(A), SDPs to MCPs should be included in the numerator and SDP revenue from the state should be reflected in the denominator – both as line items.

- ✓ **Recommendation #3**: Ohio should update the MLR Reporting Template Instructions and Templates to direct MCPs to report only service-related costs for special payments in the numerator and to report total reimbursement received from the state, which should include both service-related costs and non-claims costs for the program, in the denominator as required by § 438.8(e)(2)(i)(A) and § 438.8(f)(2)(i).

- ✓ **Recommendation #4**: Ohio should revise the MLR Reporting Template Instructions to guide plans on the proper inclusion of health care quality activity related expenses as required by 158.150(b)(2)(A)(1) for the Enhanced Maternal Program in the numerator and capitation revenue from the state in the denominator of the MLR Reporting Template and update the MLR Reporting Template to incorporate the correct calculation.

- ✓ **Observation #5:** CMS encourages Ohio to create separate line items in their MLR Reporting Template for each special payment to better monitor payment amounts and incorporate different types of payments into the MLR calculation as applicable.

- ✓ **Observation #6:** CMS encourages Ohio to correct errors in the Risk Corridor Template submissions as inconsistencies are discovered with the MLR Reporting Template submissions.

- ✓ **Observation #7:** CMS encourages Ohio to remove the following language from the MLR Risk Corridor Template Instructions to the MCPs: "The calculation of the Actual MLR and Target MLR are consistent with the description included under § 438.8," where the Actual MLR refers to the MLR calculated for the purpose of the risk corridor settlement or change the calculation of the MLRs calculated for risk corridor to be consistent with regulations.

- ✓ **Observation #8:** CMS encourages Ohio to consider revising the MLR Reporting Template Instructions to clarify that the exact risk corridor settlement amount calculated should be paid/received by the MCP and reported on the MLR Reporting Template.

- ✓ **Observation #9**: CMS encourages Ohio to consider implementing a regular reporting mechanism that requires the MCPs to report on the status and expenditures of the special payment programs.

4. Third-Party Vendor Data and Contracts

In May 2019, CMS issued a CIB providing additional guidance on current federal regulations surrounding MLR requirements related to third-party vendors.[22] This guidance clarified the provisions in §§ 438.8(e)(2)(ii)(B), 438.8(e)(2)(v)(A), 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 remittance calculations. **Two MCPs (Aetna and PMT) did not provide underlying third-**

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

party vendor data that aligned with the requirements of § 438.8(k)(3). Based on this audit, Ohio MCPs' reporting and documentation of data for third-party vendors did not align with regulations. However, Ohio does require MCPs to provide detailed data on a regular basis. The reporting of the data is achieved through three separate workstreams: cost reports, an annual MCP survey, and the annual risk corridor/MLR reporting. MCPs are instructed to provide specific data from each workstream that includes but is not limited to the following: benefit expenses, administrative expenses, ceded revenue, profitability, scope of services, health quality improvement data, and cost data by eligibility group / rate cell / region / category of service.

Treatment of Pharmacy Benefit Manager (PBM) Non-Claims Costs

Under the federal guidance, non-medical costs of any subcontractor, whether sub-capitated or not, should be excluded from incurred costs in the MLR calculation. Ohio appropriately requires the MCPs to provide detailed data on subcontractors on a regular basis. Ohio's CY 2020 MLR Reporting Template Instructions properly oriented MCPs on the inclusion of paid claims to providers, specifically paid claims to pharmacies.

Two MCPs (BHP and UHC) reported contracts with PBMs that provided claims adjudication activities and provided examples of the corresponding underlying data collected to verify non-medical costs. **However, the MCPs did not provide documentation with sufficient detail for CMS to validate the exclusion of any non-medical amounts from MLR reporting or estimate the potential impact on the MLR.**

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 Ohio's CY 2020 MLR Reporting Templates and Instructions, MCPs were instructed to omit pharmacy drug rebates paid to providers from the incurred claims line items. This facilitates the 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 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 services meeting the definition for in-lieu-of services in § 438.3(e) and provided to an enrollee.
(iv) Fines and penalties assessed by regulatory authorities.

Ohio's CY 2020 MLR Reporting Template Instructions advised plans to include sub-capitated claims attributed to State Plan services provided in the total medical incurred claims, and exclude sub-capitation paid amounts related to administrative expenses from the total medical

incurred claims. In doing so, Ohio complied with § 438.8(e)(2)(v)(A) by guiding plans on the exclusion of non-medical costs as part of the MLR calculation.

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.
(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.

Within the audit period, 50.8 percent of contracts received met all three requirements, 9.5 percent followed two of the requirements, and 27 percent followed only one. Contracts were either not submitted to CMS or MCPs responded that contracts were not in place for 12.7 percent of the reported third-party vendor relationships. **Upon review, 36.5 percent of the contracts received from the MCPs did not comply with all three requirements cited in § 438.230(c)(1).** Ohio informed CMS about the formal review process that MCPs are required to complete prior to entering into a First-Tier, Downstream, and Related Entity (FDR) or a sole source sub contractual relationship. **Although Ohio has a review process in place, 12.7 percent of the contacts for the reported third-party vendor relationships were missing, therefore, CMS is unable to confirm that Ohio verifies that the MCPs are establishing and maintaining contracts with all subcontractors to reinforce compliance with third-party reporting responsibilities.**

CMS observed varying degrees of completeness of supporting documentation for amounts paid for non-medical administrative function costs, expenditures for activities that improve health care quality, and other non-claims costs. **Because this data must be reported by third-party vendors to their MCP for accurately reporting of MLR expenditures, CMS was not able to confirm that all MCPs are complying with § 438.8(k)(3).**

- ✓ **Recommendation #5:** In accordance with § 438.8(k)(3), Ohio should require MCPs collect all required underlying data associated with MLR reporting from third-party vendors providing claims adjudicating activities so that the MCP can calculate and validate the accuracy of the reported MLR.

- ✓ **Recommendation #6:** In accordance with § 438.230(c)(1), Ohio should require that MCPs are establishing and maintaining contracts with their subcontractors to reinforce compliance with third-party reporting responsibilities.

5. Allocation of Expenses Methodology

Federal 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 expenditures may require adjustment.

Federal requirements 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 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 expenses for CY 2020 relative to the total non-claim expenses incurred across all LOBs. **Two MCPs (Aetna and CS) did not provide details specifying 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, QIA, fraud reduction expenditures) were not reviewed under this audit.

CMS required Ohio to explain the guidance provided to MCPs to obtain their AOE methodologies annually and what steps are taken to approve the details of the methodologies provided. Ohio informed CMS that **MCPs were not provided guidance on AOE methodologies and were not instructed to provide the information annually rendering the state out of compliance with § 438.8(k)(1)(vii)**. However, Ohio advised that MCPs are expected to complete the MLR Reporting Templates consistent with the National Association of Insurance Commissioners (NAIC) filings. As a part of the audit, CMS required the MCPs to provide descriptions of their methodologies for the AOEs in CY 2020. **Five MCPs provided a brief explanation of how the type of expenses were determined in line with regulations at § 438.8(g)(1)(i), but only one MCP (Aetna) 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)**.

Ohio's MLR Reporting Template Instructions do not provide guidance on the treatment of non-Medicaid LOBs within the MLR reporting and remittance calculations in accordance with § 438.8(g). Examples of commonly used and acceptable methods of allocation between LOBs included share of premium revenue, share of population (measured in member months), or a blend of the two. Many MCPs used one allocation method across all non-claims expenses,

which may not be appropriate for all types of expenditures reported in the MLR. For example, member months may be used as the allocation basis for salaries expenses while premium revenue may be used for taxes and licensing fees.

- ✓ **Recommendation #7:** In accordance with § 438.8(k)(1)(vii), Ohio should request information from MCPs on the methodology for the AOE across LOBs. For example, Ohio should request specific information on how certain types of non-claims expenditures (e.g., salaries and human resource expenses) are allocated across LOBs, as well as request information on how QIA program expenditures that affect multiple LOBs were allocated across LOBs.

- ✓ **Recommendation #8:** In accordance with § 438.8(g), Ohio should update future Medicaid MLR Reporting Template Instructions to clearly state that any non-Medicaid LOB expenses should not be included within the Medicaid MLR reporting and remittance calculations.

- ✓ **Observation #10:** CMS encourages Ohio to increase oversight activities and update future MLR Reporting Instructions to provide a clear and detailed description of the information required, including targeted methodology as part of the MCPs' MLR submission.

6. Quality Improvement Activity Expenditures and Contracts

To qualify as a QIA expenditure, expenditures must be directly related to QIAs.[23] 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 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.[24] Incorrectly including unqualified QIA expenses can inappropriately inflate the reported MLR. According to § 438.8(e)(3), activities that improve health care quality must be within specified categories, including but not limited to, activities related to any external quality review (EQR) as described in § 438.358(b) and § 438.358(c). In addition, 45 CFR § 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, 45 CFR § 158.150(c) specifies the expenditures and activities that must not be included in QIAs, including but not limited to, those that are designed primarily to control or contain costs 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,

[23] 42 CFR § 438.8(e)(3)
[24] 45 CFR § 158.150

clinical expertise, and appropriate cost accounting methodologies. Such leading oversight practices should include standard reporting templates and prior approval processes.

Upon request by CMS, three of the six MCPs were able to provide a breakdown of expenses that summed to the amounts reported as QIA on the Risk Corridor and MLR Reporting Templates for both MMC and MyCare. CMS obtained detailed expense explanations from two of the three remaining MCPs. Three out of the six MCPs were able to provide a breakdown of expenses with proper qualifying details in accordance with 45 CFR § 158.150(b)(2). All six MCPs generally described the purpose of the QIA, so they qualify as QIAs in accordance with federal regulations. Although, there was a variation in the level of detail of the responses across the MCPs. CMS was able to verify the proper inclusion of QIA expenses among the MCPs' MLR calculations.

UHC MyCare provided an expense breakdown that corresponded with the MLR Reporting Template and was the only plan to have differing QIA amounts from the Risk Corridor Template to the MLR Reporting Template. Ohio provided additional information advising that the difference is attributable to differences in paid-through dates included in both the Risk Corridor and MLR Reporting Templates. The Risk Corridor Template instructed MCPs to report expenditures paid through December 31, 2021, while the MLR Reporting Template instructed MCPs to report expenditures paid through the most recent month available. Upon further review of UHC MyCare QIA expenses, CMS noted a reallocation of dollars among differing QIA expense categories. UHC advised that the reallocation was due to the incorrect categorization and manual summing of the Health Care Quality Improvement (HCQI) expenditures as they were incurred. **CMS recommends that Ohio implements additional oversight to address any reallocation of QIA expenses to maintain federal compliance of the inclusion or exclusion of QIA expenditures from the MLR calculation.**

Non-State Plan Services (NSPS)

Ohio's CY 2020 MLR Reporting Templates and Instructions include NSPS in the numerator of the MLR calculation. Ohio advised that while the NSPS are excluded from being funded via capitation rates, the services meet the definition of those that may be covered by an MCP under § 438.3(e)(1). Under 438.8(e)(2)(i)(A), these "value-added" services may be included in the MLR numerator. Ohio's MLR Reporting Template Instructions account for NSPS in line 5.1 of the MLR Reporting Template and report the services in two categories: NEMT (non-emergency medical transportation) and All Other. The NEMT expenses accounted for in line 5.1a are specific to NEMT services that are not included in the Medicaid State Plan and are offered as additional value-added services. Under the contract with the state, MCPs may offer beneficiaries "value-added" transportation services which may be used to access activities, such as eligibility redetermination appointments. These value-added NEMT service options include non-emergency ambulance, rideshare, ambulette, public transit, and taxi rides. Examples of the services that have historically been reported as "NSPS- All Other" include medication management therapy, beneficiary incentives for attending prenatal care and baby well care appointments, sleep studies, as well as medical appliances and other durable medical equipment that are not included in the State Plan.

While Ohio did provide a general list of the NSPS that were provided by plans for the CY 2020 time period, CMS was unable to obtain a detailed list and description of the NSPS provided by MCPs to verify qualification as QIAs.

- ✓ **Observation #11:** CMS encourages Ohio to implement more detailed line item reviews of the activities reported as QIAs. In doing so, the state can confirm the MCPs maintain federal compliance with the reporting of "value-added" services in the MLR calculation.

7. Non-Claims Costs

CMS regulations at § 438.8(e)(2)(v) provide general guidance on the treatment of amounts 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.

Upon further review, CMS determined that Ohio's CY 2020 MLR Reporting Template Instructions did not provide explicit guidance instructing the MCPs on the treatment of non-claims costs. Ohio's MLR Reporting Templates instruct MCPs to report expenses for incurred claims separately from non-claims costs, but the templates did not include separate line items for the reporting of non-claims costs. In response to a CMS follow-up requesting additional information, Ohio stated that plans were asked to confirm that their reported incurred claim amounts exclude certain non-claims costs. Ohio reviewed the MCPs' MLR Reporting Template submissions compared to the MCPs' cost report submissions to verify the amounts reported for incurred claims were reasonably consistent. While there is not a line item which specifically accounts for non-claims costs, Ohio validated and identified any variances between the amounts reported for the final risk corridor and MLR Reporting Templates. Observations were drafted by the state based on the variances noted and MCPs were subsequently required to provide a response explaining the differences.

- ✓ **Observation #12:** CMS encourages Ohio to revise the MLR Reporting Template Instructions to include explicit guidance on the treatment of non-claims costs and to require non-claims costs amounts to be reported on the MLR Reporting Templates to verify the proper exclusion of the costs from the numerator.

8. Other High-Risk Expenditures

Reinsurance Expenditures

Under § 438.8(f)(2)(vi), risk sharing mechanisms should be reported as adjustments to premium revenue. Unlike Medicare and private insurance, Medicaid regulations do not explicitly prohibit the reporting of private reinsurance arrangements in the MLR. The state may allow plans to

report the results of state-mandated reinsurance arrangements as an adjustment to premium revenue.

Ohio's CY 2020 MLR Reporting Template Instructions provide guidance on the inclusion or exclusion of reinsurance premiums and expenditures. The instructions advise MCPs to include reinsurance recoveries related to state mandated reinsurance arrangements in the incurred claims of the MLR calculation, and include premiums related to state mandated reinsurance arrangements in the denominator as a part of the premium revenue. Furthermore, Ohio instructs MCPs to exclude premiums related to MCP-elected reinsurance contracts. CMS reviewed each MCP's MLR Reporting Template and determined that the plans successfully complied with Ohio's instructions for both state-mandated and MCP-elected reinsurance.

Fraud Prevention Activity Expenditures

The 2016 Medicaid Managed Care Final Rule finalized § 438.8(e)(4), which served as a placeholder for fraud prevention expenditures. This regulation mirrored private market regulations at 45 CFR Part 158, and, at that time, fraud prevention expenditures were (and continue to be) undefined for the private market. Expenditures for fraud prevention cannot be included in the Medicaid MLR calculation until the expenditures are defined in regulation.

Ohio's CY 2020 MLR Reporting Template 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 that the plans successfully complied with the exclusion of all fraud prevention activities.

Paid Claims and Incurred but Not Reported (IBNR) Analysis

According to Ohio's CY 2020 MLR Reporting Template Instructions, paid claims include non-sub-capitated claims paid to providers and the benefit expense portion of sub-capitated amounts paid to providers that represent direct compensation for medical services. MCPs also report an estimate of IBNR, under "unpaid claims reserve" on the MLR Reporting Template, which represents the number of claims that were incurred in the reporting period but had not yet been paid. 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. In general, 85 to 95 percent of unpaid claims are paid after three months. Ohio's CY 2020 MLR Reporting Template Instructions require at least twelve months of runout when determining the IBNR. MCPs that use twelve months or more of runout in the IBNR determination represent over 95 percent of actual paid claims which allows CMS to conclude consistency of reported IBNR estimates.

All five MMC MCPs and all five MyCare MCPs provided documentation on paid claims triangles for claims incurred in 2020 and paid through March 2021. Each MCP also provided summaries of IBNR data to benchmark against the IBNR reported in the MLR Reporting Template.

CMS reviewed IBNR estimates by comparing the paid claims triangles, MCP IBNR data, and the IBNR reported in the MLR Reporting Template. For 7 out of 10 MCPs, there is no difference noted between the values. For the three MCPs with the noted differences, the MCPs were able to

provide supporting details to reconcile the differences between the IBNR values. Explanations for differences included allocation methodology between programs and adjustments due to extension of benefit reserves.

While a change to the IBNR amounts reported impacts the MLR calculation, none of these updates would have resulted in a recalculated MLR that fell below the 86 percent remittance threshold. As such, CMS did not identify any recommendations or observations for this focus area.

MLR Remittance Recalculation

Based on the results of this audit, CMS identified 23 errors and inconsistencies across all MCPs that CMS applied to recalculate CY 2020 MLR remittance calculations to determine if any MCPs' MLR fell below the 86 percent threshold for MMC and 85 percent for MyCare, thus resulting in a remittance due to errors. CMS included changes to the remittance calculations based on the following corrections:

- Inclusions of SDPs in the numerator and denominator of the MLR calculation
- Inclusion of the Enhanced Maternal Program in the MLR calculation
- Corrections to the risk corridor settlement amounts
- Corrections to federal and state taxes and federal assessments
- MCP-identified errors to original reported QIA and provider incentives amounts

Additionally, while going through the audit, BHP self-identified errors from the final MLR calculation that are being reflected in the recalculations. The errors identified are as follows:

- Sub-capitation Paid Attributed to Services Provided: Correction of service-related cost amount, decrease from previously reported amount, for Partners for Kids (PFK) capitation includable in the numerator.
- Sub-capitation Paid Related to Administrative Expenses: Correction of administrative expense amount, increase from previously reported amount, in PFK capitation excludable in the numerator (does not impact calculation).
- Incentives, Bonuses, Withholds, and Other Settlements Paid to Providers: Correction of Restatement Error.
- Incurred HCQI Expenses, Improve Health Outcomes: Addition for includable HCQI expense in PFK, Dental, Vision, RX capitated arrangements.
- Federal Taxes and Federal Assessments.
- State Insurance, Premium, and Other Taxes.

Figure 6 summarizes the original MLR remittance calculations reported by MCPs on the CY 2020 MLR Reporting Template and the revised MLR remittance calculations based on CMS' recalculations. Figure 6 illustrates that oneMCP (CS MyCare) had no change to its MLR, two MCPs (BHP MMC and MyCare, UHC MyCare) exhibited a decrease in their MLRs of 0.75 percent or less, and five MCPs (Aetna MyCare, CS MMC, MO MMC and MyCare, PMT MMC, UHC MMC) exhibited an increase in their MLRs. None of these corrections resulted in a

recalculated MLR that fell below the 86 percent remittance threshold for MMC MCPs and 85 percent for MyCare MCPs.

Figure 6[25]

MCP[26]	Original CY 2020 MLR Remittance Calculation	Revised CY 2020 MLR Remittance Calculation	Variance (Revised MLR minus Original MLR)
Aetna MyCare	94.2%	96.8%	2.6%
BHP MMC	90.6%	90.4%	-0.1%
BHP MyCare	92.3%	92.2%	0.0%
CS MMC	90.7%	90.8%	0.2%
CS MyCare	93.1%	93.1%	0.0%
MO MMC	90.5%	90.7%	0.2%
MO MyCare	90.8%	93.8%	3.0%
PMT MMC	90.7%	90.7%	0.1%
UHC MMC	90.5%	90.7%	0.2%
UHC MyCare	94.2%	93.6%	-0.7%

[25] All programs for each MCP had a variance between the Original and Revised CY 2020 MLR Remittance calculation. Values reflected in Figure 6 are rounded to the nearest tenth of a percent.
[26] Please see Appendix B for MCP abbreviations.

Appendix A: Audit Scope and Methodology

Scope

CMS' audit covered the MLR reported for Ohio's six MCPs for the reporting period CY 2020. CMS performed audit work from January 2023 to September 2023.

Methodology

To accomplish the objectives, CMS:

Annually Reported MLR

1. Reviewed applicable federal regulations for the annually reported MLR and Ohio-specific methodology requirements regarding the minimum MLR remittance requirements.
2. Notified and met with Ohio to discuss and understand state policies and procedures for overseeing its Medicaid MLR reporting and remittance calculations.
3. Requested from Ohio 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 Ohio.
5. Verified completeness of available data and contractual documentation, requesting 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 Ohio 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 remittance calculation.
10. Updated recalculated MLR components in the MLR final calculation to determine potential changes in remittance payments to Ohio and CMS.
11. Discussed the audit with Ohio via a written report and an exit meeting.

Review of State Oversight of MLR Reporting

1. Reconciled financial statements, provided by Ohio, to MLR reporting.
2. Determined whether Ohio's MLR Reporting Template was structured correctly to calculate the MLR results consistent with the applicable regulations and guidelines.
3. Verified that Ohio's oversight of MLR reporting process and remittance 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 Ohio.

B. Guidance provided to MCPs for remittance 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 Ohio 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 an area of oversight risk and were selected based on several factors. (See Audit Objectives section.) 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. Requested information from Ohio on their oversight of third-party vendor data.
    c. Evaluated Ohio's instructions to MCPs. Assessed compliance of reporting requirements against federal regulations outlined in the May 2019 CIB.
    d. Verified completeness of available documentation and requested additional documentation on an ongoing basis, as necessary.
2. Treatment of QIA Expenditures:
    a. Reviewed applicable federal regulations related to treatment and categorization of QIAs in MLR reporting.
    b. Requested MCPs' available data and documentation on QIA expenditure categorization. Requested and analyzed Ohio oversight of QIA categorization.
    c. Verified compliance of reporting requirements outlined in §§ 438.8(e)(3) and 438.8(k)(1)(ii).
    d. Verified completeness of available documentation and requested additional documentation on an ongoing basis, as necessary.
    e. Requested additional substantiation on accurate categorization of QIAs based on 45 CFR §§ 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 special contract provisions related to payment and their treatment in MLR reporting.
    b. Discussed with Ohio to confirm applicable special payment programs (Quality Pool incentive arrangement between Ohio and MCP; SDP; pass-through payment)

   c. Assessed current treatment of special payments in minimum MLR remittance calculation:
      i. Exclusion of incentive arrangement revenue from denominator.
      ii. Exclusion of pass-through payments from numerator and denominator.
      iii. Inclusion of SDPs in numerator and denominator.
   d. Provided guidance to Ohio on treatment of SDPs in minimum MLR remittance calculation for future MLR reporting periods.
   e. Requested from Ohio and MCPs available data and documentation on special payment data and contracts, including documentation separated out by provider where applicable.
   f. Verified completeness of available data and documentation.
   g. Cross-checked reported pass-through and SDP amounts against available financial statement documentation.
   h. Recalculated reported special payment amounts as necessary.
4. Treatment of Provider Incentives Data and Contracts:
   a. Reviewed applicable federal regulations related to the treatment of incentive pools and bonus payments in MLR reporting.
   b. Requested from Ohio and MCPs available data and documentation on provider incentives data and contracts, including provider contracts aligned with Ohio's Quality Pool incentive arrangement and additional contracts outside of the Quality Pool.
   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 and requested additional documentation on an ongoing basis, as necessary.
   e. Developed four leading practices for an analysis of available provider incentives contracts.
   f. Analyzed provider incentives amounts and contracts against four leading practices and hypothetical impacts to the minimum MLR remittance calculation.
5. Methodology for Allocation of Expenses:
   a. Reviewed applicable federal regulations related to the methodologies for the allocation of expenses in MLR reporting.
   b. Requested from Ohio and MCPs available data and documentation on methodologies for the allocation of QIA expenditures and non-claims expenses across LOBs.
   c. Verified compliance of data reporting requirements outlined in § 438.8(k)(1)(vii).
   d. Verified completeness of available data and documentation and requested additional data to understand allocation methodologies for non-claims expenses across LOBs, as necessary.
6. Non-Claims Costs:

a. Reviewed applicable federal regulations related to the categorization of non-claims costs in MLR reporting.
b. Requested from Ohio and MCPs available data and documentation on non-claims expenses across LOBs.
c. Reviewed compliance of data reporting requirements outlined in § 438.8(e)(2)(v).
d. Verified completeness of available data and documentation and requested additional data to verify accuracy of reported non-claims costs, as necessary.

Appendix B: Managed Care Plans

MMC Plans

MCP Abbreviation	MCP Full Name	MCP Number of CY 2020 Member Months	Ranked Size of MCP
BHP MMC	Buckeye Health Plan MMC	4,330,274	2
CS MMC	CareSource MMC	15,106,441	1
MO MMC	Molina Healthcare MMC	3,530,511	4
PMT MMC	Paramount Health Care MMC	2,657,456	5
UHC MMC	United Healthcare MMC	3,748,895	3

MyCare Plans

MCP Abbreviation	MCP Full Name	MCP Number of CY 2020 Member Months	Ranked Size of MCP
Aetna MyCare	Aetna MyCare	119,974	3
BHP MyCare	Buckeye Health Plan MyCare	113,143	4
CS MyCare	CareSource MyCare	122,756	2
MO MyCare	Molina Healthcare MyCare	103,313	5
UHC MyCare	United Healthcare MyCare	154,140	1

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 § 438.6(c)(2)(ii)(A) and § 438.8(e)(2)(i)(A), Ohio should closely monitor receipt of SDP and pass-through payments and reconcile all amounts with MCPs' MLR reporting.	X	
ODM Response: Since the 2020 template, we have expanded recent MLR templates to include a separate line item for each SDP and pass-through payment. When administering the templates, we review the reported values compared to the cost report submissions.			
Recommendation #2	In accordance with § 438.6(c)(2)(ii)(A), SDPs to MCPs should be included in the numerator and SDP revenue from the state should be reflected in the denominator – both as line items	**X**	
ODM Response: The MLR templates (including the 2020 version) do include separate line items for SDPs in both the numerator and denominator of the worksheet with the more detailed MLR calculation but are bundled into the Total Incurred Claims and Total Premium Revenue line items for the summary MLR calculation. We will expand the final CY 2022 and CY 2022 MLR templates to include separate line items in the summary MLR calculation worksheet.			
Recommendation #3	Ohio should update the MLR Reporting Template Instructions and Templates to direct MCPs to report only service-related costs for special payments in the numerator and to report total reimbursement received from the state, which should include both service-related costs and non-claims costs for the program, in the denominator as required by § 438.8(e)(2)(i)(A) and § 438.8(f)(2)(i).	**X**	
ODM Response: We will clarify the instructions accordingly for the final CY 2022 and CY 2023 MLR templates.			
Recommendation #4	Ohio should revise the MLR Reporting Template Instructions to guide plans on the proper inclusion of health care quality	**X**	

Classification	Issue Description	Agree	Disagree
	activity related expenses as required by 158.150(b)(2)(A)(1) for the Enhanced Maternal Program in the numerator and capitation revenue from the state in the denominator of the MLR Reporting Template and update the MLR Reporting Template to incorporate the correct calculation.		
ODM Response: We will clarify the instructions accordingly for the final CY 2022 and CY 2023 MLR templates.			
Recommendation #5	In accordance with § 438.8(k)(3), Ohio should require MCPs to collect all required underlying data associated with MLR reporting from third-party vendors providing claims adjudicating activities so that the MCP can calculate and validate the accuracy of the reported MLR.	**X**	
ODM Response: ODM will review this recommendation and work with MCPs to extend this requirement to third-party vendors providing claims adjudicating activities. This will require a change to ODM's provider agreements and plan contracts.			
Recommendation #6	In accordance with § 438.230(c)(1), Ohio should require MCPs to establish and maintain contracts with their subcontractors to reinforce compliance with third-party reporting responsibilities.	**X**	
ODM Response: ODM agrees with this recommendation. Language has been included in MCP contracts to require third-party vendors provide data to MCPs to ensure compliance with ODM reporting requirements.			
Recommendation #7	In accordance with § 438.8(k)(1)(vii), Ohio should request information from MCPs on the methodology for the AOE across LOBs. For example, Ohio should request specific information on how certain types of non-claims expenditures (e.g., salaries and human resource expenses) are allocated across LOBs, as well as request information on how QIA program expenditures that affect multiple LOBs were allocated across LOBs.		
ODM Response: We added the Allocation Methodology worksheet to the draft CY 2022 and CY 2023 templates in accordance with recent revisions in the Medicaid Managed Care Final Rule; however, we are considering expanding this worksheet in the final CY 2022 and CY 2023 MLR templates to request a higher level of detail from the MCEs.			

Classification	Issue Description	Agree	Disagree
Recommendation #8	In accordance with § 438.8(g)(ii), Ohio should update future Medicaid MLR Reporting Template Instructions to clearly state that any non-Medicaid LOB expenses should not be included with the Medicaid MLR Reporting Template and remittance calculations.		
ODM Response: We will clarify the instructions accordingly for the final CY 2022 and CY 2023 MLR templates.			

Acknowledged by:

Shane T Ford, Compliance Coordination Manager

Name, Title

2/19/2025

Date