Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Washington Medicaid Managed Care Medical Loss Ratio (MLR) Audit

Audit Period: Calendar Year 2021 Reporting Period

Final Report

August 2025

TABLE OF CONTENTS

Executive Summary

The Centers for Medicare & Medicaid Services (CMS) conducted an audit of the Medical Loss Ratio (MLR) reported by the five managed care plans (MCPs)[1] contracted with the Washington State Health Care Authority (Washington) during calendar year (CY) 2021 (audit period). Washington has partnered with the following five different MCPs across both of the Integrated Managed Care (IMC) and Integrated Foster Care (IFC) programs,[2] with one of the five MCPs serving both IMC and IFC and four MCPs serving only IMC. The primary objectives of the MLR audit were to determine if (1) MCPs submitted annual MLR reports to Washington 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 Washington.

To meet the objectives of this MLR audit, CMS reviewed the CY 2021 MLR Reporting Template and Instructions, including remittance documentation and additional supporting documentation provided by Washington. CMS also requested additional detail from MCPs to substantiate reported MLR calculations and understand Washington'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 non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified eight instances of findings requiring correction to one or more of the MLR calculations reported by MCPs. Because none of these corrections resulted in a recalculated MLR that fell below the remittance threshold (85 percent for both IMC and IFC), CMS did not identify any remittances that should have been paid to the state and CMS. In response to these findings, CMS identified six 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), Special Payments, and Risk Sharing Arrangements

[1] Further references to "MCPs" will be inclusive of both IMC and IFC plans.
[2] In Washington, approximately 99 percent of individuals enrolled in Medicaid are covered through Integrated Managed Care program. Integrated Foster Care is a managed care program developed specifically to meet the physical and behavioral needs of children and youth in foster care and adoption supports programs, and former foster children between the ages 18 and 26 who are eligible for medical coverage as a result of the Affordable Care Act.

1. In accordance with 42 CFR §§ 438.6(c)(2)(ii)(A) and 438.8(e)(2)(i)(A), Washington 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.

2. In accordance with § 438.6(a), wrap-around payments for Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Rural Health Clinic T1015 Service Based Enhancement (RHC SBE) are not pass-through payments. Washington should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' accurate classification and treatment of special payments as pass-through payments.

3. In accordance with § 438.6(b)(2), incentive payments made by Washington to the MCPs are not considered premium revenue and should not be included in the denominator of the MLR calculation. These payments are in addition to the capitation payments received under the managed care contract. Washington should closely monitor the proper exclusion of incentive payments from the MLR calculation, and reconcile all incentive payment amounts with MCPs' MLR reporting.

4. In accordance with § 438.8, only services covered under a Medicaid managed care contract should be included in the MLR calculation. Washington should implement additional oversight and monitoring procedures to validate that the expenditures and revenues associated with payments made outside of the Managed Care contract (e.g., Medicaid Personal Care/Behavioral Health Personal Care (MPC/BHPC) services) are excluded from the MLR numerator and denominator.

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

Quality Improvement Activity Expenditures and Contracts

6. Washington should implement additional oversight procedures by requesting additional documentation to validate numbers reported in the MLR Reporting Template to address MCPs' reporting of QIA expenses. By taking this approach, Washington can more easily validate MCPs' adherence to federal standards regarding the proper reporting of QIA expenditures in the MLR calculation.

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 14 observations related to Washington'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 Washington to expand the scope of the verification and validating process of the MLR submissions and supporting documentation submitted by each MCP to identify reporting errors and verify MCPs' adherence to federal compliance standards.

2. CMS encourages Washington to sufficiently review MCP submissions using the state's MLR Reporting Template and instruct MCPs to resubmit MLR reports for errors that are discovered in the MLR Reporting Templates.

Provider Incentives Payments and Contracts

3. CMS encourages Washington to require MCPs to 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).

4. CMS encourages Washington to require clear contract termination dates within the MCPs' provider incentive contracts to determine whether provider incentive contracts are applicable for the MLR reporting period reported by the first rating period on or after July 9, 2025, consistent with regulations at § 438.3(i)(3)(i).

5. CMS encourages Washington to implement a process to collect proof of payment from the MCPs for provider incentive programs to verify incentive payments are made to providers in a timely manner and that the appropriate amount of incentive payments is accounted for in the MLR calculation.

State Directed Payments, Special Payments, and Risk Sharing Arrangements

6. Effective July 9, 2024 § 438.6(c)(2)(ii)(A) 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 Washington should be reflected in the denominator and included as separate line item(s) in the MLR Reporting Template. CMS encourages Washington to create separate line items in the MLR Reporting Template for each separate payment term SDP to improve the monitoring of payment amounts and incorporate various payment types into the MLR calculation as applicable.

7. CMS encourages Washington to revise the MLR Reporting Template Instructions to require MCPs to exclude incentive payments received from Washington under § 438.6(b)(2) that are paid outside of the capitation rate from the MLR calculation.

8. CMS encourages Washington to augment risk corridor oversight activities to verify all appropriate MCP contract expenses, including sub-capitated provider payments, are identified and classified within the risk corridor calculations accurately.

Allocation of Expenses Methodology

9. CMS encourages Washington to enhance their oversight activities to validate the Allocation of Expenses (AOE) methodology provided by MCPs. Future MLR Reporting Template Instructions could be revised to provide a clear and detailed description of the information required, incorporating specific methodology requirements for the MCPs' MLR submission.

10. CMS encourages Washington to enhance future Medicaid MLR reporting instructions to indicate that any non-Medicaid line of business (LOB) expenses should be omitted from the Medicaid MLR reporting and remittance calculations in accordance with § 438.8(g).

11. Effective July 9, 2024, § 438.8(k)(1)(vii), requires MCPs to provide a methodology for the AOE across LOBs. For example, Washington 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.

Quality Improvement Activity Expenditures and Contracts

12. CMS encourages Washington to implement more detailed line-item reporting and reviews of the activities reported as QIA. In doing so, Washington can more easily validate that the expenditures included in the numerator by each MCP meet the definition of QIA expenditures as defined in federal compliance standards.

Non-Claims Costs

13. CMS encourages Washington to require reporting of specific categories of non-claims costs under 438.8(e)(2)(v)(A) and specify additional types of non-claims costs to be reported in separate line items on the MLR Reporting Templates to verify the proper exclusion of these costs from the numerator.

Other High-Risk Expenditures

14. CMS encourages Washington to require all MCPs to submit the MLR Reporting Templates using a consistent, standard runout period such as three months when reporting incurred but not reported (IBNR) liabilities.

Washington'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 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 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 the set of required data elements in the regulation 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.

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

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

The Washington Health Care Authority contracted with five MCPs to provide health coverage for the Medicaid managed care population: Amerigroup, Community Health Plan of Washington (CHPW), Molina Healthcare of Washington (Molina), UnitedHealthcare of Washington (UHC), and Coordinated Care of Washington (CCW) for the IMC program, and CCW as the sole MCP for the IFC program. MCPs are contracted with the state to provide Medicaid health benefits and additional services to Medicaid enrollees or recipients, using a risk-based managed care delivery system.

CMS conducted an audit of the MLR calculation for the Medicaid managed care population in Washington, covering the CY 2021 contract period.[4] To assess compliance with federal and state MLR requirements, CMS reviewed the CY 2021 Washington State MLR Reporting Template submitted by each MCP[5] and additional supporting documentation provided by Washington. CMS also requested additional information from MCPs to substantiate the reported MLRs and remittance amounts and to review Washington's oversight procedures.

In light of the COVID-19 public health emergency (PHE), Washington transitioned from a risk sharing arrangement to a two-sided risk corridor as a means of addressing financial uncertainty for the IMC program. The two-sided risk corridor for IMC was implemented for CY 2021 while the gain sharing program for the IFC program continued in CY 2021. CMS did not perform a detailed review of Washington's risk corridor; however, CMS did perform a high-level review of Washington's IMC risk corridor and IFC gain sharing program implementation to determine if settlement amounts were calculated appropriately and incorporated into the MLR calculation pursuant to federal regulations.

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 Washington 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 as being in noncompliance would result in a recommendation and require corrective action.

During this audit, CMS identified a total of six recommendations and fourteen observations. Appendix

[4] All Medicaid data collected for this audit were aggregated on a program-wide basis.
[5] Washington's minimum MLR remittance 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. Washington's response to CMS' draft report can be found in Appendix C, with the final report reflecting all changes CMS made based on Washington's 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 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 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, Special 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, 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. 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 MCP 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, other non-claims costs) to the MCP.

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 45 CFR § 158.150(a), quality improvement activity (QIA) expenditures must be directly related to QIAs. As defined in 45 CFR § 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 MCPs 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 provided by the state. 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 2021 MLR remittance calculations to determine if the recalculated data results in an MLR lower than 85 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 85 percent remittance threshold.

Washington'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 Washington CY 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: incurred claims, including unpaid claim liabilities, incurred but not reported (IBNR) lines for claims, withholds, incentives and bonuses, changes in other claims-related reserves, reserves for contingent benefits and medical claim portion of lawsuits, net payments or receipts related to state-mandated solvency funds, fraud recoveries exceeding expenses related to fraud recovery activities, and QIA.

The template's MLR denominator included the following line items: premium revenue minus federal, state, and local taxes. The template included definitions for premium revenues as state capitation payments, including adjustments, excluding pass-through payments, state developed one-time payments for specific life events of enrollees, earned premium withholds, unpaid cost-sharing amount, changes to unearned premium reserves, and net payments/receipts related to risk sharing mechanisms. Allowable taxes are defined as statutory assessments to defray the operating expense of any state or federal department, examination fees in lieu of premium taxes as specified by state law, federal taxes and assessments allocated to MCPs, and state and local taxes and assessments. Health plans that are exempt from federal income taxes can adjust the MLR denominator using community benefit expenditures, up to specific limits.

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 Washington, for both the IMC and IFC programs, an MCP is required to remit the difference to the state if the MCP reports an MLR under the 85 percent threshold for the Medicaid population.

Initial MLR Remittance Results

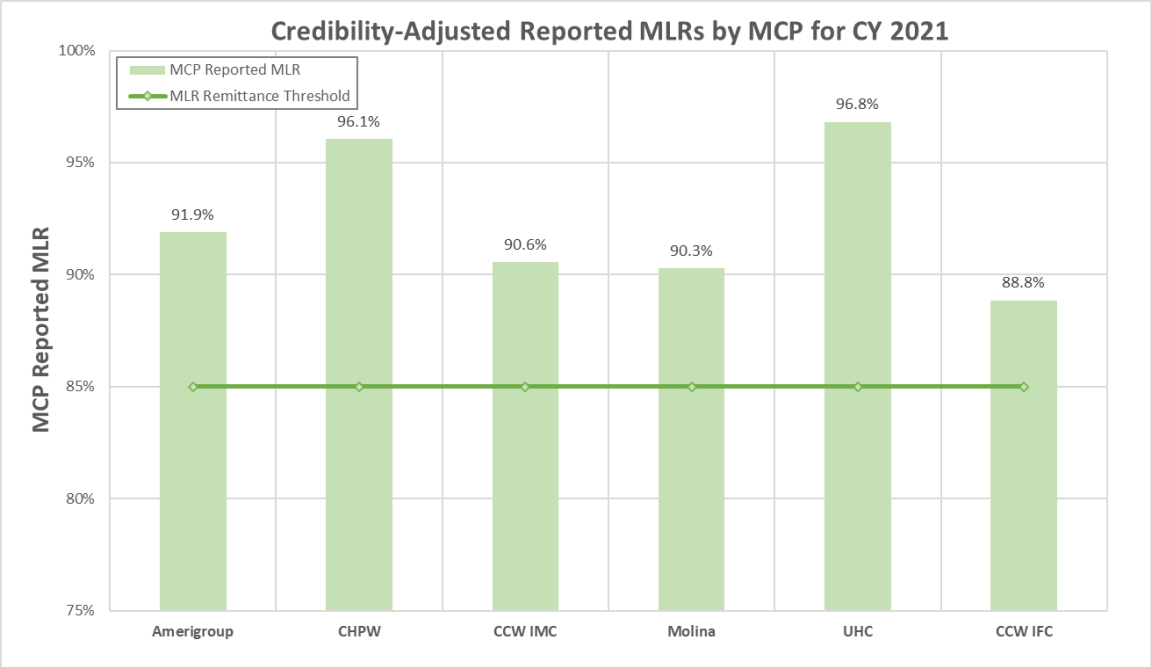
Combined results of the CY 2021 MLR remittance calculations are included below. The MLR remittance results were calculated by Washington based on data reported by each MCP in the MLR

[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. Washington utilizes the credibility adjustment calculation methodology delineated in this bulletin for its remittance calculation.

Reporting Template. Washington reviewed the MLR reports to determine that the data was consistent and met the guidelines and that all expenditures reported were allowable. The remittance calculations were not revised for MLR reporting errors.

Figure 1 depicts the credibility-adjusted annual MLR for CY 2021 based on the reports submitted by MCPs to Washington for minimum MLR remittance calculations. Note that these calculations include the risk corridor reconciliations, as the final amounts for these arrangements were not available at the time of the original MLR reporting submission.

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 2021 minimum MLR remittance calculations by all five MCPs.

Figure 2

	Numerator	
	Washington MLR Components	***% of Gross Premium***
	Incurred claims, including unpaid claim liabilities for the MLR reporting year	83.0%
	IBNR for claims incurred in the period expected to be paid in months after the known runout	2.9%
	Withholds from payments made to network providers	0.0%
	Amount of incentive and bonus payments made, or expected to be made to network providers	1.4%
	Changes in other claims-related reserves	0.0%
	Reserves for contingent benefits and the medical claim portion of lawsuits	0.0%
	Net payment or receipts related to state-mandated solvency funds	0.0%
	Amount recovered through fraud reduction efforts	0.0%
	Claims that are recoverable for anticipated coordination of benefits	-0.1%
	Claims payments recoveries received as a result of subrogation	0.0%
	Overpayment recoveries received from network providers	-0.3%
	Prescription drug rebates received and accrued	-0.2%
Quality Improvement Activities	MCO activity that meets 45 CFR § 158.150(b) and is NOT EXCLUDED under 45 CFR § 158.150(c)	1.3%
	MCO activity related to any EQR-related activity as described in § 438.358(b) and (c)	0.0%
	45 CFR § 158.151	0.1%
	Total Incurred Medical Related Costs	**88.3%**

Figure 3

	Denominator	
	Washington MLR Components	***% of Gross Premium***
Gross Premium	State capitation payments, including adjustments, excluding pass-through payments	96.0%
	State developed one time payments for specific life events of enrollees	3.2%
	Earned premium withholds approved under § 438.6(b)(3)	0.9%
	Net payments/receipts related to risk sharing mechanisms	-1.3%
	Unpaid cost-sharing amount that the health plan could have collected from enrollees under the	0.0%
	All changes to unearned premium reserves	0.0%
Taxes and Fees	Statutory assessments to defray the operating expense of any state or federal department	0.0%
	Examination fees in lieu of premium taxes as specified by state law	0.0%
	Federal taxes and assessments allocated to MCOs	-0.9%
	State and local taxes and assessments	-1.9%
	Amounts otherwise exempt from Federal income taxes for community benefit expenditures	0.0%
	Total Medical Related Revenues	**95.8%**

The average MLR, excluding credibility adjustments, for the reporting period CY 2021 was 92.2 percent, which was calculated by dividing the total incurred medical related costs (88.3 percent) by the total medical related revenues (95.8 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 only accounted for a reduction of 1.3 percent to the average denominator, and reflects only the amounts reported by Molina; all other MCPs did not

include any risk corridor amounts in the initial MLR remittance calculations. 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, Washington's MCPs did not consistently comply with federal MLR reporting requirements. 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,[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 ensuring MLR reporting and remittance calculations are accurate for rate setting.

This audit reviewed Washington's oversight efforts of MCPs' MLR reporting. Washington advised CMS that annual MLR submissions for the state's MLR Reporting Template and any additional documentation submitted by the MCPs are only reviewed for completeness and reasonableness. While this is an important aspect for ensuring compliance with federal MLR reporting regulations, **Washington lacks supplementary processes to verify and validate the accuracy of the submissions for the state's MLR Reporting Template.** Washington should consider refining existing oversight review processes by developing supplemental measures to request supporting documentation from the MCPs to validate the appropriateness of values for each line item and verify accuracy of annual MLR submissions. **Washington's oversight practices did not include a mandate for MCPs to resubmit templates with corrected values for the MLR calculation if an error was made.** Correction of inaccurate values would directly impact the MLR.

- ✓ **Observation #1:** CMS encourages Washington to expand the scope of the verification and validating process of the MLR submissions and supporting documentation submitted by each MCP to identify reporting errors and verify MCPs' adherence to federal compliance standards.

- ✓ **Observation #2:** CMS encourages Washington to sufficiently review MCP submissions using the state's MLR Reporting Template and instruct MCPs to resubmit MLR reports for errors that are discovered in the MLR Reporting Templates.

[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)

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 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 to increase and maintain their provider network.

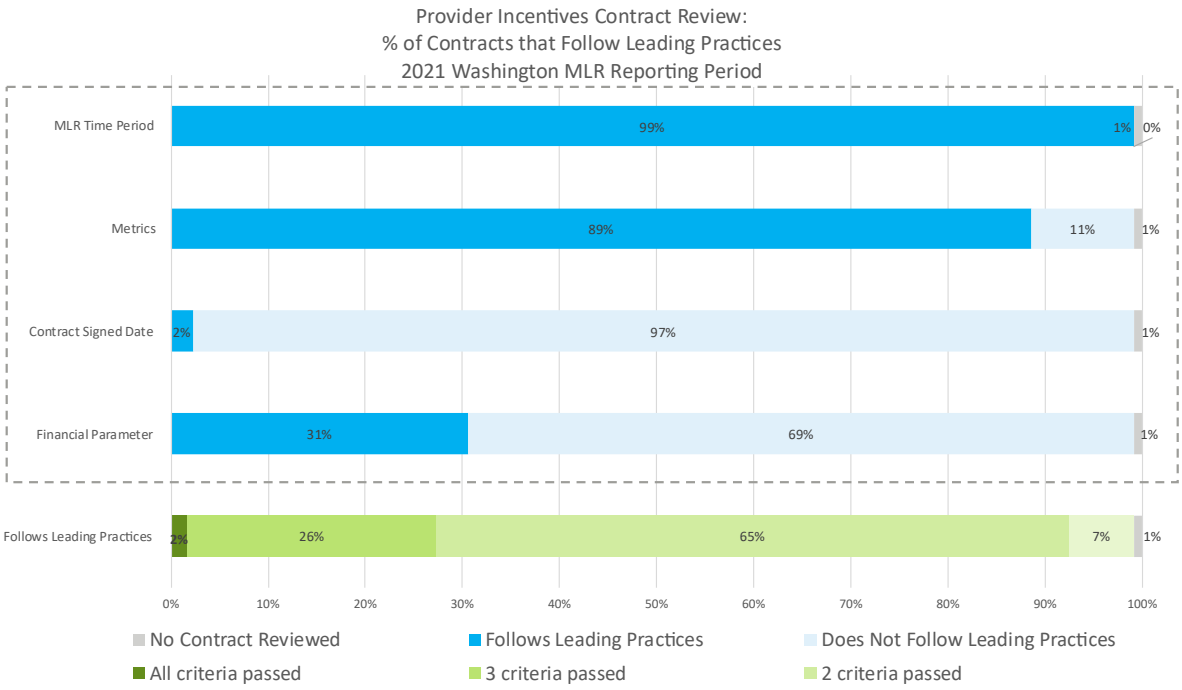
Under this audit, all MCPs were reviewed and assessed as to whether each provider incentive contract followed specified leading practices. At the time of this audit period, the leading practices were not federal or state requirements; however, codified in the 2024 Final Rule, these leading practices 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 requirements during the audit period, no findings were identified in this audit. However, CMS identified three observations where the MCP incentive payment documentation did not always follow the leading practices. The results of the incentive payment analysis shown as percentages of final payment amounts provided by the MCPs during the audit related to each decision are shown in Figure 4, below.

[10] 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 2[11]



Within the audit period, two percent of provider incentive payments followed all leading practices, 26 percent followed three of the leading practices, and 72 percent followed two or less. **Contracts were either not submitted to CMS or MCPs responded that contracts were not in place for a portion of provider incentives that were paid out.** For three MCPs (CCW, CHPW, and UHC), these non-contract incentives made up nearly one percent of all provider incentives paid. **CMS also identified that several of the provider incentive contracts had effective dates during CY 2021 but the contract termination or renewal dates were unclear.**

Due to the small portion of provider incentives in the MLR calculation, approximately 1.6 percent of final total medical incurred costs, no MCP would fall below the 85 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 the timing and amount of incentive payments made to providers. Washington did not perform adequate oversight of the MCPs' interactions with contracted providers, aside from verifying that the MCPs implement the legislatively

[11] 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".

mandated rate increases to contracted providers using SDPs. CMS requested that the MCPs provide proof of payment to providers in the form of copies of checks, bank statements, or some other audited financial report and verified 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 confirmed that the MLR calculation duly accounted for the appropriate amount of provider incentive payments.

- ✓ **Observation #3:** CMS encourages Washington to require MCPs to 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 Washington to require clear contract termination dates within the MCPs' provider incentive contracts to determine whether provider incentive contracts are applicable for the MLR reporting period reported by the first rating period on or after July 9, 2025, consistent with regulations at § 438.3(i)(3)(i).

- ✓ **Observation #5:** CMS encourages Washington to implement a process to collect proof of payment from the MCPs for provider incentive programs to verify incentive payments are made to providers in a timely manner and that the appropriate amount of incentive payments is accounted for in the MLR calculation.

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

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)(i)(A) 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 Washington 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 Washington had in place during the audit period include pass-through payments, non-pass-through payments, and SDPs. Washington should consider providing clear instructions to specify the type of payment arrangements and report all payment arrangements as separate line items.

Washington had one SDP in place during CY 2021 that was paid as a separate payment term outside of the monthly capitation payments: Provider Access Payment (PAP).[12]. CMS noted that all MCPs excluded the payment amounts associated with PAP in the MLR calculation because they considered the payment as a pass-through payment; however, Washington confirmed that PAP is not a pass-through payment during CY 2021 and should be reported as an SDP. **Accordingly, CMS identified that the MCP expenditures and revenues associated with this SDP payment should have been reported in the MLR numerator and denominator.**

CMS noted that Washington's CY 2021 MLR Reporting Instructions did not provide guidance to the MCPs to correctly classify SDPs applicable for CY 2021. To enhance clarity and accuracy in MLR calculations, CMS recommends for Washington to refine the MLR Reporting Instructions by clearly specifying that SDP arrangements should be included in the MLR calculation. Washington 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 providers. All MCPs provided supporting documentation that was consistent with what was provided to Washington as part of the data request process for the annual capitation rate development. **The documentation represented monthly payments for each SDP; however, the supporting documentation did not reconcile to the reported SDP amounts from the MCPs because the documentation was based on the paid date basis and not the service date basis.** Washington should closely monitor reporting of SDPs in accordance with § 438.6(c)(2)(ii)(A) and § 438.8(e)(2)(i)(A) and reconcile all amounts with MCPs' MLR reporting.

Special Payments (Pass-through and other special payments)

CMS confirmed four special payments arrangements applicable to this audit: Safety Net Assessment Fund (SNAF).[13], FQHC.[14] Wrap-Around Payment, RHC Wrap-Around Payment, and RHC SBE Wrap-Around Payment.

Under § 438.8(e)(2)(v)(C), amounts paid to network providers under § 438.6(d), pass-through payments, should be excluded from incurred claims. § 438.6(a) also states that if the FQHC and RHC payments are wrap-around payments, they are not considered pass-through payments, thus should be included in the MLR calculation.

[12] PAP program is a uniform rate increase SDP that provides additional payments to eligible providers for both IMC and IFC programs.
[13] SNAF is a program that increases payment for hospital claims for Medicaid Enrollees, authorized under chapter 74.60RCW, for the IMC program.
[14] FQHC is a community-based organization that provides comprehensive primary care and preventive care, including health, dental, and behavioral health services to people of all ages, regardless of their ability to pay or health insurance status.

CMS confirmed that SNAF meets the definition of a pass-through payment and should be excluded from the MLR calculation. CMS also confirmed that FQHC, RHC, and RHC SBE meet the definition of wrap-around payments; however, as the plans were not at risk for the wrap-around payments these payments should be excluded from the MLR calculation and the MLR calculation was not impacted.

All MCPs noted that they excluded the amounts associated with SNAF, FQHC, RHC, and RHC SBE as pass-through payments in the MLR Reporting Template. **These payments were correctly excluded from the MLR calculation; however, the FQHC, RHC, and RHC SBE payments are incorrectly categorized as pass-through payments.** Given that FQHC, RHC, and RHC SBE do not qualify as pass-through payments, Washington should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' accurate classification and treatment of special payments as pass-through payments. Additionally, Washington should consider creating separate line items in the state's MLR Reporting Template specifically for the different types of special payment arrangements.

Delivery System Reform Incentive Payment (DSRIP)

CMS reviewed the DSRIP[15] payment arrangement, which is an incentive payment to the MCPs under the IMC Contract.

Washington described the DSRIP payment as an incentive payment that the MCPs are eligible to receive over and above the capitation rates implemented under the Healthier Washington Medicaid Transformation Demonstration, Section 1115 Waiver. These incentive payments are retained by the MCPs and not disbursed to the providers. CMS observed discrepancies in the reporting of payment amounts for DSRIP by the MCPs within the CY 2021 MLR Reporting Template. Two MCPs (CCW IMC and UHC) reported the DSRIP amount in the denominator in the MLR calculation. Three MCPs (Molina, Amerigroup, and CHPW) did not include the DSRIP payment in the MLR calculation. In accordance with § 438.8(f)(2), incentive payments made to the MCPs under § 438.6(b)(2) should not be included in the denominator as such payments are in addition to the capitation payments received under the contract. To reflect the incentive payments accurately in the MLR submissions, Washington should closely monitor the proper exclusion of incentive payments from the MLR calculation, ensuring thorough reconciliation of all amounts with MCPs' MLR submissions.

Additionally, Washington's MLR Reporting Template Instructions do not provide guidance for MCPs to accurately exclude incentive payment amounts received from the state that are paid outside of the capitation rate from the denominator of the MLR calculation.

Medicaid Personal Care/Behavioral Health Personal Care (MPC/BHPC)

[15] MCPs are eligible to receive incentive payments tied to meeting certain P4P performance targets funded through a challenge pool implemented by Washington as part of the DSRIP System under the 1115 Waiver, applicable for the IMC program.

MPC/BHPC services are covered through the Washington Aging and Long-Term Support Administration (ALTSA), and these payment arrangements are outside of the IMC contract. Washington informed CMS that the MPC/BHPC services are reimbursements to providers for services not covered in the IMC contract and the MCPs receive payments using state general funds. CMS confirmed the CY 2021 contract excluded payment for these services. Since the payments associated with these services are outside of the IMC contract, Washington should inform the MCPs to exclude the MCP expenditures and revenues associated with these payments from the MLR numerator and denominator. **CMS observed that all MCPs except Amerigroup excluded the payments associated with the MPC/BHPC services from the numerator and denominator of the MLR calculation.**

The impact of corrections made to the MLR based on the above identified inconsistencies did not result in any MCPs' recalculated MLRs falling below the remittance threshold of 85 percent.

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 CY 2021, Washington implemented a two-sided risk corridor for the contract period from January 1, 2021 to December 31, 2021 for the IMC program.

In the CY 2021 MLR Reporting Templates submitted by each MCP, four of the five MCPs did not include a risk corridor settlement amount in the MLR calculation, while one MCP (Molina) included an estimated risk corridor settlement adjustment in the denominator of the MLR calculation.

Under this audit, CMS reviewed risk corridor reports and final settlement amounts provided by Washington and the MCPs related to the risk corridor to validate the CY 2021 risk corridor settlement amounts used in the MLR calculation and determine if these amounts were properly included in the MLR calculation.

Washington implemented a risk corridor for each IMC MCP consistent with the examples provided in the May 14, 2020, Center for Medicaid and CHIP Services (CMCS) information bulletin (CIB). This provision applied only to the contract period from January 1, 2021 to December 31, 2021. Under this approach, the risk corridor is a two-sided risk mitigation strategy calculated by Washington based on the formula to determine gain or loss as described in the CY 2021 IMC Contract. Under the risk corridor, Washington will share risk with each of the MCPs based on the following provisions:

1. For MCP gains between one percent and two percent, 50 percent of gains are shared.
2. For MCP gains beyond two percent, all 100 percent of gains are shared.
3. For MCP losses beyond three percent, 50 percent of losses are shared.
4. For MCP gains within one percent and MCP losses within three percent, no gain or loss is shared with Washington.

Two MCPs (Wellpoint and Molina) disputed the CY 2021 risk corridor settlement calculations, for reasons related to specific payments made to certain providers, sub-capitated payments, and provider payments for which Washington had data quality concerns. A portion of the total disputed amount was settled in favor of Molina. Final CY 2021 risk corridor settlement amounts resulted in increases to the recalculated MLRs.

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 remittance threshold of 85 percent.

- ✓ **Recommendation #1:** In accordance with §§ 438.6(c)(2)(ii)(A) and 438.8(e)(2)(i)(A), Washington 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 #2:** In accordance with § 438.6(a), wrap-around payments for FQHCs, RHCs, and RHC SBE are not pass-through payments. Washington should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' accurate classification and treatment of special payments as pass-through payments.

- ✓ **Recommendation #3:** In accordance with § 438.6(b)(2), incentive payments made by Washington to the MCPs are not considered premium revenue and should not be included in the denominator of the MLR calculation. These payments are in addition to the capitation payments received under the managed care contract. Washington should closely monitor the proper exclusion of incentive payments from the MLR calculation, and reconcile all incentive payment amounts with MCPs' MLR reporting.

- ✓ **Recommendation #4:** In accordance with § 438.8, only services covered under a Medicaid managed care contract should be included in the MLR calculation. Washington should implement additional oversight and monitoring procedures to validate that the expenditures and revenues associated with payments made outside of the Managed Care contract (e.g., MPC/BHPC services) are excluded from the MLR numerator and denominator.

- ✓ **Recommendation #5**: In accordance with § 438.8(f)(2)(vi), Washington should enhance oversight and monitoring processes to verify the accounting of accruals to validate the proper classification and inclusion of risk sharing arrangements.

- ✓ **Observation #6:** Effective July 9, 2024 § 438.6(c)(2)(ii)(A) 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 Washington should be reflected in the denominator and included as separate line item(s) in the MLR Reporting Template. CMS encourages Washington to create separate line items in the MLR Reporting

Template for each separate payment term SDP to improve the monitoring of payment amounts and incorporate various payment types into the MLR calculation as applicable.

- ✓ **Observation #7:** CMS encourages Washington to revise the MLR Reporting Template Instructions to require MCPs to exclude incentive payments received from Washington under § 438.6(b)(2) that are paid outside of the capitation rate from the MLR calculation.

- ✓ **Observation #8**: CMS encourages Washington to augment risk corridor oversight activities to verify all appropriate MCP contract expenses, including sub-capitated provider payments, are identified and classified within the risk corridor calculations accurately.

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.[16] 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. All MCPs were able to provide underlying third-party vendor data that aligned with the requirements of § 438.8(k)(3). Washington requires MCPs to submit their subcontracts with third-party vendors for review prior to the contracts becoming active. Washington confirms there is language maintaining responsibility for all contracted requirements from the vendor and legal responsibility for work performed is maintained by the MCP. Washington also receives annual deliverables to monitor current delegated entities and claims denials, as well as direct feedback of any issues with MCPs vendors via Washington's Managed Care Programs mailbox. Additionally, Washington requires MCPs to have Corrective Action Plan language in all agreements to address deficiencies identified by Washington.

Treatment of Pharmacy Benefit Manager Non-Claims Costs

Under § 438.8(e)(2)(v)(A), non-medical costs of any subcontractor, whether sub-capitated or not, should be excluded from incurred costs in the MLR calculation. Washington's CY 2021 MLR Reporting Template Instructions properly instructed MCPs on the exclusion of administrative costs from paid claims to providers, specifically paid claims to pharmacies. All 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.

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

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 Washington's CY 2021 MLR Reporting Templates and Instructions, MCPs were instructed to report pharmacy drug rebates paid to providers as a deduction 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.

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, all third-party vendor contracts received by CMS for review met the requirements under § 438.230(c)(1).

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 expenditures 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 expenses for CY 2021 relative to the total non-claim expenses incurred across all 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 Washington 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. Washington informed CMS that Washington requires the MCPs to include the AOE methodology description in their annual MLR submissions. As a part of the audit, CMS reviewed the descriptions of their AOE methodologies in the CY 2021 MLR Reporting Templates from the MCPs. **Three MCPs (CCW, CHPW, and Molina) provided a brief explanation of the methodology employed to determine the classification of expenses in adherence to regulations at § 438.8(k)(1)(vii). Two MCPs (Amerigroup and UHC) provided a sufficient description of the methodology used to allocate expenses between Medicaid and non-Medicaid LOBs as required by § 438.8(k)(1)(vii).** Washington informed CMS that when Washington receives the MLR Reporting Templates from the MCPs, the MLR submission is reviewed to verify that it includes the required AOE methodology description. However, Washington does not approve or deny the AOE methodology.

Washington does not review the AOE methodology description to ensure 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 premium revenue, share of population (measured in member months), or a blend of the two. All MCPs except Molina provided a description of the AOE methodology. Molina stated the MCP utilizes financial statement record keeping to properly allocate expenses to the Medicaid LOB. The methodology description provided by Molina lacks sufficient detail to verify whether an acceptable method was utilized. MCPs may use different methods of allocation for different types of non-claims expenses; therefore, Washington should request detailed information regarding the allocation of various non-claims expenditures. 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.

Washington's CY 2021 MLR Reporting Template Instructions include a section on expense allocation. MCPs are required to report the methodologies employed for allocating expenses and how they factor into the MLR calculated for this report. While Washington's MLR Reporting Template Instructions state that certain expenses may not be directly attributable to one LOB, it did not clearly state that the MLR should only include expenses allocated to the Medicaid LOB. **The CY 2021 MLR Reporting Template Instructions do not offer guidance on the treatment of expense related to non-Medicaid LOBs in**

MLR reporting and remittance calculations. This lack of instructions may lead to the inadvertent inclusion of non-Medicaid LOB expenses in the MLR reporting and remittance calculations.

- ✓ **Observation #9:** CMS encourages Washington to enhance their oversight activities to validate the AOE methodology provided by MCPs. Future MLR Reporting Template Instructions could be revised to provide a clear and detailed description of the information required, incorporating specific methodology requirements for the MCPs' MLR submission.

- ✓ **Observation #10:** CMS encourages Washington to enhance future Medicaid MLR reporting instructions to indicate that any non-Medicaid LOB expenses should be omitted from the Medicaid MLR reporting and remittance calculations in accordance with § 438.8(g).

- ✓ **Observation #11:** Effective July 9, 2024, § 438.8(k)(1)(vii) requires MCPs to provide a methodology for the AOE across LOBs. For example, Washington 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.

6. Quality Improvement Activity Expenditures and Contracts

To qualify as a QIA[17] expenditure, expenditures must be directly related to activities that improve health care quality 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 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.[18] 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, 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, § 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

[17] 42 CFR § 438.8(e)(3)
[18] 45 CFR § 158.150

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, all MCPs were able to provide a detailed breakdown of expenses that summed to the amounts reported as QIA on the MLR Reporting Template. All MCPs, except Amerigroup and CHPW, were able to provide a breakdown of expenses with proper qualifying details in accordance with § 158.150(b)(2). **Amerigroup incorrectly included fraud prevention activities into the calculation of indirect QIA expenses.** According to the CY 2021 CMS MLR Reporting Instructions[19], fraud prevention activities do not qualify to be included in the MLR. **CHPW did not provide an explanation sufficient to support the inclusion of salary and health information technology (HIT) expenses that were reported as QIA.** CMS requested CHPW provide an explanation for the salary and HIT expenses qualified as QIAs, but CMS did not receive a sufficient response from the MCP. CMS would expect QIA expenses to include salaries and HIT; however, sufficient detail about these expenses should be available to support their inclusion as QIA. For the MCPs (CCW IFC, CCW IMC, Molina, and UHC) that provided proper qualifying details, CMS noted that there was a large variation in the level of information provided across the MCPs. **CMS recommends that Washington implement a detailed review of the activities reported as QIA by requesting the MCPs to provide additional documentation or description for the QIA expenditures.** In doing so, the state can confirm the MCPs maintain federal compliance with the reporting of QIAs in the MLR calculation.

- ✓ **Recommendation #6:** Washington should implement additional oversight procedures by requesting additional documentation to validate numbers reported in the MLR Reporting Template to address MCPs' reporting of QIA expenses. By taking this approach, Washington can more easily validate MCPs' adherence to federal standards regarding the proper reporting of QIA expenditures in the MLR calculation.

- ✓ **Observation #12:** CMS encourages Washington to implement more detailed line-item reporting and reviews of the activities reported as QIA. In doing so, Washington can validate that the expenditures included in the numerator by each MCP meet the definition of QIA expenditures as defined in federal compliance standards.

7. Non-Claims Costs

[19] MLR Annual Reporting Form Instructions: https://www.cms.gov/files/document/2021-mlr-form-instructions.pdf

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.

Washington's CY 2021 MLR Reporting Template Instructions provide instructions for reporting non-claims costs, requiring the MCPs to list different types of non-claims expenses as separate line items. **CMS identified that two MCPs (Molina and UHC) did not report non-claims costs for payments to third party vendors for network development, administrative fees, claims processing, and utilization management.** However, CMS determined that $16,917,647 for Molina and $32,759,122 for UHC should have been reported as non-claims costs for these MCPs. Molina and UHC confirmed that the non-claims costs identified by CMS have been excluded in the numerator; therefore, the MLR calculation was not impacted.

Washington's CY 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, Washington complied with § 438.8(2)(v)(A)(1)-(4) by guiding plans on the exclusion of non-medical costs from incurred claims.

- ✓ **Observation #13:** CMS encourages Washington to require reporting of specific categories of non-claims costs under 438.8(e)(2)(v)(A) and specify additional types of non-claims costs to be reported in separate line items on the MLR Reporting Templates to verify the proper exclusion of these 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 MCPs to report the results of state-mandated reinsurance arrangements as an adjustment to premium revenue. In CY 2021, Washington did not mandate MCPs to have reinsurance arrangements; therefore, no review was necessary for the reporting of reinsurance expenditures.

Fraud Prevention Activity Expenditures

The 2016 Medicaid Managed Care Final Rule finalized § 438.8(e)(4), which referenced the private market MLR regulations at 45 CFR Part 158. At that time, and at the time of this audit, fraud prevention expenditures were 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.

Washington's CY 2021 MLR Reporting Instructions properly guide plans on the exclusion of fraud prevention activities in the MLR calculation. CMS reviewed each MCP's MLR Reporting Template and determined all MCPs except Amerigroup successfully complied with the exclusion of all fraud prevention activities. Amerigroup incorrectly included fraud prevention expenditures as QIA. The amount of this error had no material impact on their MLR.

Paid Claims and Incurred but Not Reported (IBNR) Analysis

According to Washington's CY 2021 MLR Reporting Instructions, incurred claims include direct claims that the MCP paid to providers and unpaid claim liabilities. MCPs also report an estimate of IBNR for claims incurred in the period expected to be paid in months after the known runout in the MLR Reporting Template, which represents an approximation of the claims that were incurred in the reporting period but had not yet been paid. CMS regulations at § 438.8(e)(2) outline the components to be reported as incurred claims and unpaid claims liabilities. CMS used separate MCP financial reports as benchmarks to assess reasonableness of the IBNR estimates.

CMS requested claims triangles for dates of service from January 2021 to December 2021 or summaries of IBNR data to benchmark against the IBNR reported in the MLR Reporting Template. Each MCP provided supporting documentation that supported the IBNR reported in the MLR Reporting Template. For four of the five MCPs, 97 to 99 percent of the reported claims were complete. For CHPW, 85.7 percent of the reported claims were complete.

CMS reviewed IBNR estimates by comparing the paid claims triangles, MCP IBNR data, and the IBNR reported in the MLR Reporting Template. One MCP (CCW) exhibited no discernible difference between the values. All other MCPs noted differences, but the MCPs were able to provide supporting details to reconcile the differences between the IBNR values. CMS observed that all MCPs, except for CHPW, utilized a three-month runout period to calculate the IBNR estimate. CHPW did not use any runout data. **CMS noted that Washington's instructions for the MLR Reporting Template did not specify a required runout period for determining the IBNR.** Requiring the use of consistent, standard runout periods such as three months for all MCPs would allow the MCPs to report comparable completions of claims payments and incorporate more actuals in the MLR calculations reported to CMS. 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 85 percent remittance threshold.

✓ **Observation #14:** CMS encourages Washington to require all MCPs to submit the MLR Reporting Templates using a consistent, standard runout period such as three months when reporting IBNR liabilities.

MLR Remittance Recalculation

Based on the results of this audit, CMS identified 16 errors and updated amounts across all MCPs that CMS applied to recalculate CY 2021 MLR remittance calculations to determine if any MCPs' MLR fell below the 85 percent threshold, thus resulting in a remittance due to errors. CMS included changes to the remittance calculations based on the following corrections:

- Inclusions of PAP payments in the numerator and denominator of the MLR calculation
- Exclusions of DSRIP payments in the denominator of the MLR calculation
- Exclusion of MPC/BHPC payments from the numerator and denominator of the MLR calculation
- MCP-identified corrected and final paid amounts to original reported QIA, risk corridor, and Provider Incentives amounts

Figure 5 summarizes the original MLR remittance calculations reported by MCPs on the CY 2021 MLR reporting template and the revised MLR remittance calculations based on CMS' recalculations. Figure 5 illustrates that all five MCPs exhibited an increase in their MLRs. None of these corrections resulted in a recalculated MLR that fell below the 85 percent remittance threshold.

Figure 5.[20]

MCP[21]	Original CY 2021 MLR Remittance Calculation	Revised CY 2021 MLR Remittance Calculation[22]	Variance (Revised MLR minus Original MLR)
Amerigroup	91.9%	94.3%	2.5%
CHPW	96.1%	96.1%	0.0%
CCW IMC	90.6%	90.8%	0.2%
Molina	90.3%	90.4%	0.1%
UHC	96.8%	97.0%	0.2%
CCW IFC	88.8%	88.9%	0.1%

[20] Values reflected in Figure 5 are rounded to the nearest tenth of a percent.
[21] Please see Appendix B for MCP abbreviations.
[22] Revised CY 2021 MLR Remittance Calculations in Figure 5 reflect the final risk corridor settlements provided in February 2025.

Appendix A: Audit Scope and Methodology

Scope

CMS' audit covered the MLR reported for Washington's five MCPs for the reporting period CY 2021. CMS performed audit work from June 2023 to March 2025.

Methodology

To accomplish the objectives, CMS:

1. Reviewed applicable federal regulations for the annually reported MLR and Washington-specific methodology requirements regarding the minimum MLR remittance requirements.
2. Notified and met with Washington to discuss and understand state policies and procedures for overseeing its Medicaid MLR reporting and remittance calculations.
3. Requested from Washington 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 Washington.
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 Washington 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 Washington and CMS.
11. Discussed the audit with Washington via a written report and an exit meeting.

Review of State Oversight of MLR Reporting

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

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 Washington 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 as 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 Washington on their oversight of third-party vendor contracts and data.
    d. Evaluated Washington's 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 Washington 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 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 about special contract provisions related to payment and their treatment in MLR reporting.
    b. Confirmed with Washington applicable special payment programs (Quality Pool incentive arrangement between Washington and MCP; SDP; pass-through payment)

   c. Assessed current treatment of special payments in MLR reporting and 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 Washington on treatment of SDPs in minimum MLR remittance calculation for future MLR reporting periods.
   e. Requested from Washington 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 Washington and MCPs available data and documentation on provider incentives data and contracts, including provider contracts aligned with Washington'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. Requested additional documentation 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 developed 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 Washington and MCPs available data and documentation on methodologies for the allocation of QIA expenditures and non-claims expense 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 expense 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 Washington 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)(A).
d. Verified completeness of available data and documentation. Requested additional data to verify accuracy of reported non-claims costs as necessary.

Appendix B: Managed Care Plans

Integrated Managed Care Plans

MCP Full Name	MCP Abbreviation	MCP Number of CY 2021 Member Months
Amerigroup[23]	Amerigroup	2,743,243
Community Health Plan of Washington	CHPW	3,020,576
Coordinated Care of Washington, Inc. IMC	CCW IMC	2,270,128
Molina Healthcare of Washington, Inc.	Molina	11,598,734
UnitedHealthcare of Washington	UHC	3,035,740

Integrated Foster Care Plan

MCP Full Name	MCP Abbreviation	MCP Number of CY 2021 Member Months
Coordinated Care of Washington, Inc. IFC	CCW IFC	295,409

[23] Amerigroup's name changed to Wellpoint Washington Inc, effective CY 2024.

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 §§ 438.6(c)(2)(ii)(A) and 438.8(e)(2)(i)(A), Washington should closely monitor reporting of SDPs by reviewing the reported incurred claims payments in the MLR calculation and reconcile all amounts with MCPs' MLR reporting.	X	
Recommendation #2	In accordance with § 438.6(a), wrap around payments for FQHCs, RHCs, and RHC SBE are not pass-through payments. Washington should augment the instructions in the MLR Reporting Template to provide clear guidance for the MCPs' accurate classification and treatment of special payments as pass-through payments.	X	
Recommendation #3	In accordance with § 438.6(b)(2), incentive payments made by Washington to the MCPs are not considered premium revenue and should not be included in the denominator of the MLR calculation. These payments are in addition to the capitation payments received under the managed care contract. Washington should closely monitor the proper exclusion of incentive payments from the MLR calculation, and reconcile all incentive	X	

Classification	Issue Description	Agree	Disagree
	payment amounts with MCPs' MLR reporting.		
Recommendation #4	In accordance with § 438.8, only services covered under a Medicaid managed care contract should be included in the MLR calculation. Washington should implement additional oversight and monitoring procedures to validate that the expenditures and revenues associated with payments made outside of the Managed Care contract (e.g., MPC/BHPC services) are excluded from the MLR numerator and denominator.	X	
Recommendation #5	In accordance with § 438.8(f)(2)(vi), Washington should enhance oversight and monitoring processes to verify the accounting of accruals to validate the proper classification and inclusion of risk sharing arrangements.	X	
Recommendation #6	Washington should implement additional oversight procedures by requesting additional documentation to validate numbers reported in the MLR Reporting Template to address MCPs' reporting of QIA expenses. By taking this approach, Washington can more easily validate MCPs' adherence to federal standards regarding the proper reporting of QIA expenditures in the MLR calculation.	X	

Acknowledged by:

Madina Cavendish, Section Manager, Healthcare Rates & Finance

[Name], [Title]

08/08/2025

Date (MM/DD/YYYY)