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September 2026 | OEI-03-23-00040

Medicaid Managed Care: CMS's Accuracy Check Process For State-Submitted Medical Loss Ratio Data Has Limitations

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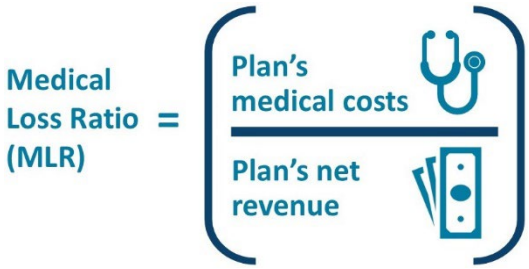
Why OIG Did This Review

- Medical loss ratios (MLRs) are an important part of Medicaid managed care fiscal oversight.
- An MLR shows whether a managed care plan spent most of its Medicaid funds on medical costs. Specifically, an 85-percent MLR—the Federal standard—means that a plan spent 85 percent on patient care and quality improvements and 15 percent on administration and profit.



- States must develop their managed care plans' fixed monthly payment rates (hereafter "capitation rates") so that they will reasonably achieve at least 85-percent MLRs.
- This review looks at how CMS verifies the accuracy of State-submitted MLR data. Accurate MLR data helps States set appropriate capitation rates for managed care plans.

What OIG Found

We found limitations in CMS's process to check the accuracy of the MLR data that States are required to submit to CMS. Specifically, we found that:

CMS performed only limited accuracy checks on the four required MLR data elements, and those checks showed that some State-submitted MLR data may be inaccurate.

CMS did not follow up with the States that submitted potentially inaccurate MLR data.

Results of MLR accuracy checks were not shared across CMS staff, and therefore, CMS missed the opportunity for these results to inform its review of managed care plans' capitation rates.

What OIG Recommends

1. CMS should establish procedures that outline the steps to be taken to address potentially inaccurate Medicaid MLR data submitted by States and follow up with States, as needed.
2. CMS should ensure that insights from its reviews of State-submitted Medicaid MLR data are communicated to CMS staff responsible for reviewing plans' capitation rates.
3. CMS should improve the efficiency and effectiveness of its oversight of the accuracy of State-submitted Medicaid MLR data.

CMS concurred with OIG's recommendations.

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BACKGROUND

OBJECTIVE

To determine the oversight activities, if any, CMS conducted to verify that States submitted accurate medical loss ratio (MLR) data to CMS.

MLRs and Medicaid managed care spending

MLRs inform the government's stewardship of Medicaid funds. A Medicaid managed care MLR is the percentage of premium revenue that managed care organizations, prepaid ambulatory health plans, and prepaid inpatient health plans (hereafter "plans") spent on covered health care services and quality-improvement activities in a 12-month period.[1] An MLR of 85 percent—the Federal MLR standard—indicates that a plan spent 85 percent of its revenue on enrollees' health care services and quality improvements and 15 percent of it on administrative costs and profit. States must require each plan to calculate its MLR and submit an annual MLR report to the State.[2]

States develop capitation rates to pay plans to cover contracted Medicaid services. In advance of each contract year, States must use plans' past encounter data and other detailed financial data to develop plans' capitation rates.[3] Capitation rates determine the set amount that plans are paid for each covered enrollee each month during the contract year. States must develop capitation rates that provide plans enough funds to cover reasonable, appropriate, and attainable costs of contracted services for enrollees and to operate the plan.[4]

MLRs are a tool to help States develop their plans' capitation rates. To develop capitation rates, States must take into account the past MLR reported by a plan, as well as consider the future MLR the plan could achieve with the capitation rates being developed.[5] Specifically, States are required to develop a plan's future capitation rates so that the plan will "reasonably achieve" an MLR of at least 85 percent.[6] According to CMS, if a plan's past MLR is lower or much higher than expected, the State should determine whether this is due to certain circumstances (such as the COVID-19 pandemic) or due to errors in the development of the plan's past capitation rates. If it is the latter, the State should correct the errors in the rate development process when developing future capitation rates for this plan.

Accurate MLRs are needed to develop appropriate capitation rates for plans. States need accurate MLR information from their plans to effectively use MLRs to evaluate past capitation rates, as well as to inform the development of future capitation rates.

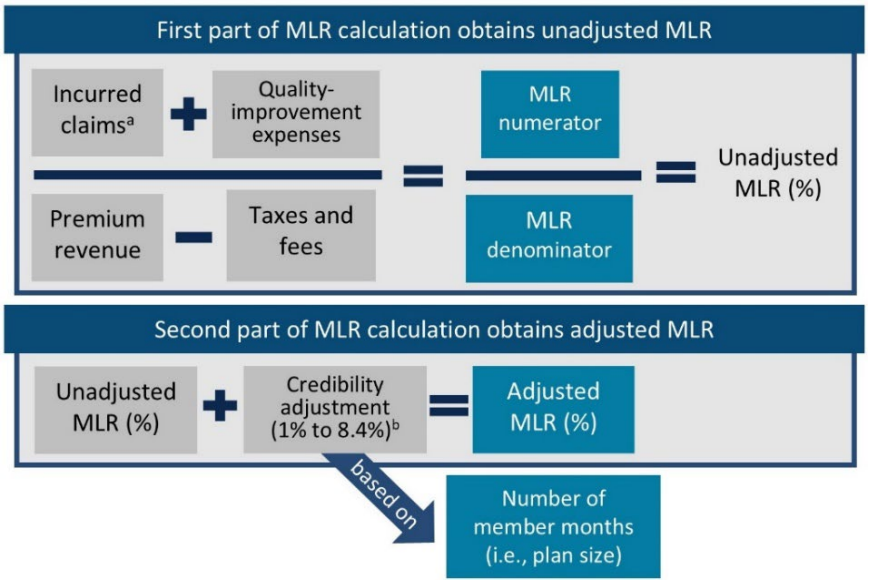
In September 2024, CMS published an MLR Toolkit for States that provides States information about how to validate plans' past MLR data and also how to use validated MLR data to inform the development of future capitation rates.[7] In addition, for each of their plans, States must submit rate certifications to CMS that document their process for developing capitation rates.[8] The rate certification must contain enough information to show that the State has complied with rate development regulations and followed CMS guidelines. As of July 2024, States had to include in the rate certification how they used MLRs to inform the development of plans' future capitation rates.[9]

CMS's MLR oversight

CMS's oversight of MLR requirements is critical to improve fiscal transparency, monitor costs, and promote high-quality care in Medicaid managed care. Toward this end, CMS requires States to submit summaries of their plans' MLR data[10] and makes this data available to the public.[11] According to CMS, staff from one team reviews the State-submitted MLR data for each plan. A different CMS team reviews State-submitted rate certifications and determines compliance with all applicable regulations. CMS is also responsible for approving plans' contracts that must include final capitation rates that are consistent with the rate certifications.[12]

States submit MLR data to CMS. States submit certain MLR data to CMS in MLR summary reports created from their plans' annual MLR reports.[13] As of October 2022, CMS required States to use a State-to-CMS MLR summary reporting template to submit these data.[14] Specifically, this template includes 10 data elements that make up the MLR calculation.[15] Of these, four are required data elements that States must submit to CMS and six are optional data elements that States can decide whether to submit to CMS, as shown in Exhibit 1. According to CMS, it lacks

Exhibit 1: The six optional and the four required MLR data elements that make up the MLR calculation in States' submissions to CMS



Sources: OIG's depiction of 42 CFR § 438.8, CMS's, MLR Credibility Adjustments, and CMS's State-to-CMS MLR summary reporting template.

[a] As part of determining "incurred claims," plans must exclude "non-claims costs." These costs are not a distinct data element in the "MLR numerator."

[b] For credible plans, credibility adjustments are percentages that plans with fewer "member months" may add to their "unadjusted MLRs" to account for smaller plan size. The credibility adjustment percentage increases as the "number of member months" decreases.

regulatory authority to require the six optional data elements.

CMS takes steps to ensure that States submit all required MLR data elements. As of July 2024, CMS has required States to use a web-based portal to submit their MLR summary reports.[16] According to CMS, this web-based portal ensures that States submit MLR summary reports that contain all required MLR data elements. Prior to implementing the web-based portal, CMS staff reviewed State-submitted MLR data and determined whether States failed to submit or submitted incomplete MLR summary reports. If CMS identified MLR summary reports or required MLR data elements that were missing, CMS staff followed up with States to request the information.[17]

CMS also reviews the accuracy of MLR data that States submit. CMS conducts five systematic, analytic checks that result in identifying whether the four required MLR data elements included in the MLR calculation are potentially inaccurate (hereafter "accuracy checks"). To verify the amounts for the required "MLR numerator," "MLR denominator," and "adjusted MLR," CMS determines whether each calculation was performed correctly using the optional MLR data that makes up each required MLR data element. Additionally, for the "MLR denominator," CMS determines whether the "premium revenue" was less than the "MLR denominator" because this result could also indicate an incorrect calculation. For the required "number of member months," CMS compares the number to that in an alternate State-submitted data source—the Medicaid Managed Care Enrollment Report (hereafter "Enrollment Report")—when possible.[18]

According to CMS, it needs to evaluate whether the size of potential inaccuracies result in "material" differences to plans' MLRs. Then, CMS may use other available information to determine whether any of the "material" potential inaccuracies likely represent actual errors. After this further evaluation, CMS would decide whether to follow up with States.

Related OIG work

In 2022, OIG issued a report examining the MLR data that plans submitted to 43 States.[19] We determined that nearly half of the 495 plan-to-State MLR reports did not contain all required MLR data elements under review. Specifically, we found that these plan-to-State MLR reports were missing at least one of the following required data elements: "quality-improvement expenses," "taxes and fees," the "number of member months" or "non-claims costs." In addition, we found that some States did not review selected MLR data elements in plans' MLR reports for accuracy. In response to OIG's recommendations, CMS (1) published the MLR Toolkit mentioned above that explains States' responsibility to verify the completeness and accuracy of their plans' annual MLR reports[20] and (2) published an optional plan-to-State MLR reporting template in July 2025.[21] These actions may improve the completeness and accuracy of the annual MLR reports that plans submit to States which may, in turn,

improve the completeness and accuracy of the MLR summary reports that States submit to CMS. See Appendix A for additional related OIG work.

Methodology

For this report, we reviewed information about the oversight activities that CMS conducted to verify the accuracy of State-submitted MLR data. CMS provided responses to information requests and documentation requests and participated in interviews. In addition, CMS provided an MLR data file in December 2023 that contained (1) MLR data from 595 final MLR summary reports submitted by 44 States for the 12-month rating period that ended in 2019 (hereafter "the 2019 MLR reporting year"), (2) the results of CMS's five accuracy checks of the four required MLR data elements included in the MLR calculation, and (3) the results of CMS's follow-up with States when CMS identified other issues with States' submissions, such as missing MLR data.[22] CMS identified the 595 final MLR summary reports as complete reports—meaning that they contained the four required MLR data elements. For this report, we reviewed CMS's accuracy checks, not CMS's checks related to completeness.

We reviewed CMS's five accuracy checks, as shown in Exhibit 2.

Exhibit 2: CMS's accuracy checks of the four required MLR data elements included in the MLR calculation

OIG name for CMS accuracy check	Definition of CMS accuracy check
MLR Numerator Check	The "MLR numerator" did not equal the sum of its "incurred claims" and "quality-improvement expenses"
MLR Denominator Check 1	The "MLR denominator" did not equal the subtraction of its "taxes and fees" from its "premium revenue"
MLR Denominator Check 2	The "premium revenue" was less than the "MLR denominator"
Adjusted MLR Check	The "adjusted MLR" did not equal the sum of its "unadjusted MLR" and "credibility adjustment"
Member Months Check[a]	The "number of member months" differed by more or less than 50 percent from CMS's "approximate number of member months based on enrollment information"

Source: Mathematica, "MLR Analytic File Data Dictionary, Version 1.3," November 2023.

[a] For the Member Months Check, when CMS could match a plan in the MLR summary report to the same plan in the Enrollment Report, it compared the State-submitted "number of member months" to CMS's "approximate number of member months"—estimated using the number of plan enrollees in the Enrollment Report multiplied by 12.

We determined the extent to which CMS could conduct these five accuracy checks for the four required MLR data elements in the MLR summary reports for the 2019 MLR reporting year. We also determined the total number of MLR summary reports that contained at least one potential inaccuracy in a required MLR data element.

For the first four accuracy checks listed in Exhibit 2, we determined the percentage of MLR summary reports that CMS could not check because States did not submit the optional MLR data. For the MLR summary reports that contained the data necessary for CMS to conduct each of the four accuracy checks, we summarized CMS's results for the number of potential inaccuracies CMS identified.

For the fifth and final accuracy check, the Member Months Check, we determined the percentage of MLR summary reports that CMS could not match to an Enrollment Report—the other State-submitted source that CMS uses to cross-check the "number of member months." For the MLR Summary reports that could be matched to an Enrollment Report, we summarized CMS's results for the number of potential inaccuracies identified.

Limitations

Given that our objective was to review CMS's oversight of MLR data reported to CMS, we did not verify the accuracy of the information in CMS's MLR data file by comparing it to the data in the MLR summary reports that States emailed to CMS for each plan. We also did not verify the accuracy of the information from CMS's Enrollment Reports.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

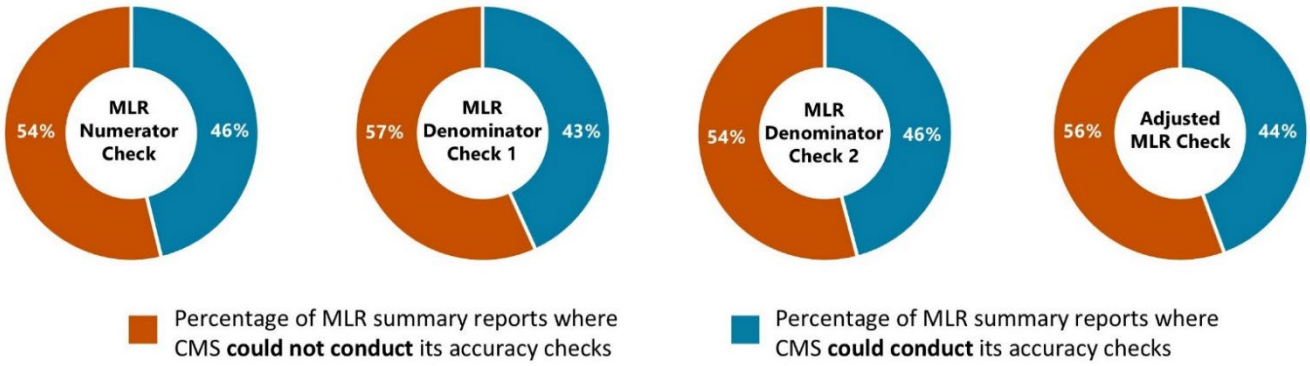
CMS's accuracy checks of State-submitted MLR data elements were limited and its completed checks indicated some potential inaccuracies

Accurate MLRs help States develop appropriate capitation rates for their plans so that their plans will reasonably achieve at least 85-percent MLRs. For the 2019 MLR reporting year, CMS identified a total of 57 MLR summary reports with potential inaccuracies submitted by 16 States. These MLR summary reports contained at least one potential inaccuracy identified by one of the five accuracy checks that CMS used to verify that States submitted accurate amounts for the four required MLR data elements.

For three of the four required MLR data elements included in the MLR calculation, CMS often could not conduct its accuracy checks because States did not submit optional MLR data elements

For three required MLR data elements, we found that CMS could not conduct its accuracy checks for more than half of the final MLR summary reports, as shown in Exhibit 3. To conduct the accuracy checks (i.e., the MLR Numerator Check, the MLR Denominator Checks 1 and 2, and the Adjusted MLR Check), CMS needed optional MLR data elements that States were not required to, and often did not, submit. Thus, CMS was prevented from conducting its accuracy checks.

Exhibit 3: CMS could not conduct each of its four accuracy checks for more than half of the 595 MLR summary reports



Source: OIG's analysis of CMS's 2019 MLR summary report data.

For the final MLR summary reports that contained the optional MLR data needed to conduct these accuracy checks, CMS identified the following potential inaccuracies:

- Twenty-three "MLR numerators" were potentially inaccurate among 275 MLR summary reports (MLR Numerator Check);
- Fifteen "MLR denominators" were potentially inaccurate among 258 MLR summary reports (MLR Denominator Check 1);
- Eighteen "MLR denominators" were potentially inaccurate among 273 MLR summary reports (MLR Denominator Check 2); and
- One "adjusted MLR" was potentially inaccurate among 264 MLR summary reports (Adjusted MLR Check).

If States had submitted more optional data, CMS could have checked the accuracy of more "MLR numerators," "MLR denominators," and "adjusted MLRs" using these accuracy checks, which might have identified additional potential inaccuracies.

For the fourth required MLR data element included in the MLR calculation, CMS identified potential inaccuracies on the basis of comparison with an alternate data source

In contrast to the other three required MLR data elements included in the MLR calculation, CMS does not rely on optional data elements to check the accuracy of the State-submitted "number of member months." Instead, CMS compares it to data in its Enrollment Report. However, CMS cannot always match the MLR summary reports to an Enrollment Report because these reports are submitted by States at different times of year for distinct purposes.

We found that CMS did not conduct its Member Months Check for 25 percent of 595 MLR summary reports because it could not match the two different reports. Specifically, this happened when certain plans were not included in the Enrollment Report or the information in the Enrollment Report was aggregated at a different level from that in the MLR summary report. For the 448 of 595 MLR summary reports that CMS could conduct its Member Months Check, CMS identified 25 with potentially inaccurate "numbers of member months."

The "number of member months" determines a plan's "credibility adjustment"—a defined percentage that a plan with fewer "member months" may add to its "unadjusted MLR" to account for its smaller size. Only plans at or below 380,000 member months should add "credibility adjustments" to their "unadjusted MLRs."[23] If the "number of member months" was inaccurately reported as lower than this, a plan may add a "credibility adjustment" when it was not small enough to be allowed to do so, and then the "adjusted MLR" would be too high.

CMS did not follow up with the States that submitted potentially inaccurate MLR data for their plans

According to CMS, potential inaccuracies need further evaluation and also possibly follow-up with States to determine if the MLR data are inaccurate. However, CMS did not follow up with the 16 States about the potential inaccuracies that it identified for the 2019 MLR reporting year. Thus, it missed the opportunity to obtain accurate MLR data for the potential inaccuracies that were, in fact, inaccurate. Further, by not following up with States, CMS also missed the opportunity to alert States about these potential inaccuracies so that the States could evaluate them and resolve any actual errors. These States might not have identified these potential inaccuracies in the MLR data that must be considered as part of developing plans' capitation rates.

In contrast to this lack of follow-up about potentially inaccurate MLR data, CMS does follow up with States to request submissions of missing MLR data. For the 2019 MLR reporting year, CMS successfully obtained 192 initial or resubmitted MLR summary reports from 19 States due to its follow-up. Notably, CMS's MLR summary report review procedures list the actions for following up with States about missing MLR data and other issues. However, these procedures do not list actions for following up about potential inaccuracies identified by CMS's accuracy checks.

Results of CMS's accuracy checks of MLR data were not communicated to CMS staff responsible for reviewing plans' future capitation rates

As of October 2025, CMS staff who review State-submitted MLR data did not share the results of their accuracy checks with the CMS staff involved in the capitation rate review process. To develop capitation rates, States must take into account plans' past MLRs and consider plans' expected MLRs for the future capitation rate.[24] The future capitation rates must allow plans to reasonably achieve MLRs of at least 85 percent.[25] CMS then reviews plans' future capitation rates and reviews and approves plans' contracts that include the final capitation rates. However, CMS missed the opportunity to use the results of its accuracy checks of State-submitted MLR data to inform its review of plans' capitation rates.

CONCLUSION AND RECOMMENDATIONS

MLRs are an important part of Medicaid managed care oversight. They show whether plans spent most of their revenue on medical costs rather than spending most of it on administrative costs or keeping it as profit. States must consider their plans' MLRs as part of developing capitation rates. Given their importance, whether they are being accurately reported by States is critical. However, we found that CMS's accuracy checks of required MLR data were limited, in part, because the checks relied on other optional MLR data elements that States did not always submit. For the five accuracy checks conducted on 2019 MLR summary reports in which CMS found potential inaccuracies, CMS missed opportunities to follow up with States and communicate internally.

We recommend that CMS:

Establish procedures that outline the steps to be taken to address potentially inaccurate Medicaid MLR data submitted by States and follow up with States, as needed

To better ensure the accuracy of State-submitted Medicaid MLR data, CMS should evaluate the potential inaccuracies identified by its five accuracy checks. CMS has MLR summary report review procedures that list the actions for following up with States to obtain submissions for missing MLR summary reports and resubmissions for incomplete MLR data. CMS should expand its MLR summary report review procedures to include actions related to its accuracy checks. Specifically, CMS should (1) define the size of a "material" difference to an MLR that results from a potential inaccuracy, (2) indicate how to use other available information to determine whether potential inaccuracies likely represent actual errors, and (3) specify when to follow up with States to alert them of potential inaccuracies and request resubmissions to correct any inaccurate MLR data. Then, CMS should implement these procedures and follow up with States, as needed to correct any inaccurate MLR data.

Ensure that insights from CMS's reviews of State-submitted Medicaid MLR data are communicated to CMS staff responsible for reviewing capitation rates

Inaccurate Medicaid MLR data could affect States' ability to evaluate their plans' past capitation rates and identify issues with capitation rate development. Therefore, CMS staff who check the accuracy of State-submitted MLR data should regularly communicate the results of these reviews with the CMS staff who review capitation

rates. After these results are communicated to the CMS staff who review capitation rates, they can determine whether to contact States.

Improve the efficiency and effectiveness of CMS's oversight of the accuracy of State-submitted Medicaid MLR data

To help ensure that States use accurate MLRs to inform capitation rate development, CMS should consider making improvements—in addition to the actions recommended above—to its oversight of State-submitted MLR data. Since the time of our review, CMS has improved the efficiency and effectiveness of its oversight of the completeness of MLR data by implementing a standardized web-based portal that has front-end automated completeness checks ensuring that States submit required MLR data elements. To improve the accuracy of State-submitted MLR data, CMS should consider leveraging this web-based portal to perform front-end automated accuracy checks.

Of the five accuracy checks that CMS conducts, four were limited by the amount of optional MLR data that States submitted. According to CMS, it lacks the regulatory authority to require these optional MLR data elements. In the absence of this regulatory authority, CMS could encourage States to submit optional MLR data through guidance to States. In this way, CMS could obtain more of the optional MLR data so that it can check more of the required MLR data for potential inaccuracies. For any additional potential inaccuracies identified, CMS should evaluate them using other available information, follow up with States as needed, and communicate internally about inaccurate MLRs.

AGENCY COMMENTS AND OIG RESPONSE

In its comments on our draft report, CMS affirmed its commitment to oversight of Medicaid managed care. CMS also described actions it has taken to support States in their efforts to comply with MLR requirements, including releasing an MLR Toolkit, creating an optional plan-to-State MLR reporting template, and implementing a standardized web-based portal for States to submit their MLR summary reports. In addition, to promote transparency, CMS now releases to the public MLR summary report data with plan-specific MLRs.

CMS concurred with our first recommendation. CMS stated that it will update its MLR summary report review procedures to clarify when additional CMS follow-up with States is needed to address potentially inaccurate MLR summary data.

CMS concurred with our second recommendation and stated that it will explore ways to share information about the accuracy of State-submitted MLR summary data with CMS staff who review capitation rates. CMS noted that any corrections to MLR data are usually made retroactively and, due to timing constraints of the rate review process, will be less likely to materially impact CMS's review of capitation rates. Nevertheless, if CMS staff who review capitation rates had information about potentially inaccurate MLR summary data, they could inform States. Then, States could use the information in meaningful ways, such as evaluating plans' past capitation rates and identifying issues with capitation rate development. As such, we look forward to information about how CMS staff who review MLR summary data will share the accuracy check results with CMS staff who review capitation rates.

Finally, CMS concurred with our third recommendation and stated that it will consider ways to incorporate into its web-based submission portal front-end, automated accuracy checks of the State-submitted MLR summary data. CMS has also taken some actions toward implementing this recommendation. After reviewing the draft of this report, CMS encouraged States to submit optional MLR data, during a technical advisory call with the States, and added instructions to the web-based MLR submission portal about the optional MLR data elements. In addition, CMS stated that it intends to continue, in forthcoming guidance, to encourage States to submit the optional MLR data elements.

We appreciate the steps that CMS has taken and additional actions it is planning to implement these recommendations, and we look forward to future updates on their progress.

For the full text of CMS's comments, see Appendix B.

APPENDICES

Appendix A: Recent and Ongoing HHS-OIG Work on Medicaid Managed Care MLRs

Information on OIG's work on managed care can be found on our Managed Care web page. Below is a list of recent and ongoing OIG work on Medicaid managed care MLRs.

Exhibit A-1: HHS-OIG's recent and ongoing work on Medicaid managed care MLRs

Recent HHS-OIG Evaluations	Report Number	Date Issued	Selected Findings and Recommendations
CMS Is Not Systematically Tracking Whether States Return Federal Shares of Medicaid Managed Care Remittances	OEI-03-23-00041	May 2025	OIG found that CMS was not tracking whether States returned the Federal shares of MLR remittances—at least half of $406 million in taxpayer dollars over 2 years. We made five recommendations to improve CMS's tracking.
CMS Has Opportunities to Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios	OEI-03-20-00231	September 2022	OIG found that plans had submitted incomplete annual MLR reports to States and that some States did not review selected MLR data elements for accuracy. CMS implemented OIG's recommendations that should improve the completeness and accuracy of plans' annual MLR reports.
Nationwide, Almost All Medicaid Managed Care Plans Achieved Their Medical Loss Ratio Targets	OEI-03-20-00230	August 2021	OIG found that States that established minimum MLRs with remittance requirements may recoup millions of dollars from plans that failed to meet minimum MLRs.
Ongoing HHS-OIG Audits	**Project Number**	**Date Announced**	**Objective**
Potential Cost Savings for the Medicaid Program if States Adopted a Minimum Medical Loss Ratio and Required Remittances From Managed Care Organizations	OAS-25-02-077	October 2025	OIG will determine the potential cost savings for Medicaid if select States had implemented minimum MLRs and required MLR remittances.
Medicaid Managed Care Organizations in States With Remittance Requirements	OAS-25-07-143	September 2024	OIG will determine whether plans correctly calculated required MLR remittances reported to select States and whether these States returned the Federal shares to CMS.

Appendix B: Agency Comments

Following this page are the official comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: August 19, 2026

TO: Ann Maxwell
Deputy Inspector General
for Evaluations and Inspections

FROM: Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General Draft Report: *Medicaid Managed Care: CMS Has Taken Limited Steps to Ensure the Accuracy of State-Submitted Medical Loss Ratio Data* (OEI-03-23-00040)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to strengthening the monitoring and oversight of Medicaid managed care programs.

As noted in the OIG's report, Medical Loss Ratios (MLRs) are an oversight tool that generally measure how much a managed care plan spends on the provision of covered services compared to the total revenue it receives in capitation payments. The calculation and reporting of MLRs provides states with the information necessary to understand how capitation payments made for people enrolled in managed care plans are expended. For contract rating periods starting on or after July 1, 2017, CMS regulations require that Medicaid managed care plans calculate and report their MLR according to the standards laid out in 42 CFR 438.8, which are similar to those used for calculating MLRs in Medicare Advantage and the private market. Medicaid managed care plans are required to submit to the state an annual MLR report that, at a minimum, includes the 13 data elements outlined in 42 CFR 438.8(k). States are then required in 42 CFR 438.74 to submit to CMS, with the rate certification required in 42 CFR 438.7, an annual summary description of the MLR report(s) received from their managed care plans. The summary report must include the amount of the numerator, the amount of the denominator, the MLR percentage achieved, the number of member months, and any remittances owed (if applicable) by each Medicaid managed care plan for that MLR reporting year.

CMS has taken a number of steps to support states in their efforts to comply with MLR requirements, and has provided states with guidance, FAQs, and individualized technical

assistance when needed.[1,2] CMS has also released an MLR Toolkit, which includes practical information that states can use to support the review, validation, and oversight of their Medicaid managed care plans' MLR reporting.[3] The MLR Toolkit also reminds states of their MLR monitoring responsibilities under 42 CFR 438.66, including reviewing MLR submissions received from their managed care plans for completeness and validating the accuracy of the information provided. While states have the flexibility to identify an approach to validating the MLR data submitted by their managed care plans, the MLR Toolkit provides states with suggested approaches and examples based on existing practices in selected states. In addition, CMS has created an optional plan-to-state reporting template that states may use with their managed care plans to gather the MLR data needed to fulfill their responsibility to submit summary MLR reports to CMS.[4]

Currently, CMS requires states to submit their required MLR summary reports through the Medicaid Data Collection Tool for Managed Care Reporting (MDCT-MCR). By having all states submit their MLR reports through the MDCT-MCR, CMS is able to generate and analyze state-specific and nationwide data across the universe of managed care programs and requirements. This data analysis allows CMS to identify areas for technical assistance, and to target efforts to assist states in improving their managed care programs, while also ensuring compliance with managed care statutes and regulations, such as ensuring access to care. Additionally, in order to promote transparency, CMS recently began publicly releasing state submitted MLR summary report data, which include plan-specific MLRs for Medicaid managed care programs.[5]

Lastly, it is important to note that the OIG's report analyzes MLR data from the 12-month rating period that ended in 2019, which was one of the earlier reporting periods for which states submitted MLR data to CMS. While the findings in the OIG's draft report are generally reflective of CMS's review process during that reporting period, CMS has made substantial efforts in recent years to improve oversight and state outreach related to potentially inaccurate MLR data. CMS is committed to strengthening the monitoring and oversight of Medicaid managed care programs. CMS also takes seriously its responsibilities to protect taxpayer funds by conducting thorough oversight of Medicaid. CMS looks forward to continuing to engage and collaborate with states in these areas.

The OIG's recommendations and CMS's responses are below.

[1] CMS, Medical Loss Ratio (MLR) Requirements Related to Third-Party Vendors, 2019, Accessed at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib051519.pdf
[2] CMS, Medicaid Managed Care Frequently Asked Questions (FAQs) – Medical Loss Ratio, 2020, Accessed at: https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib060520_new.pdf
[3] CMS, Medical Loss Ratio (MLR) Monitoring, Reporting, and Oversight: A Toolkit for States to Ensure Complete and Accurate MLR Reporting, 2024, Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/mlr-toolkit-sep-2024.pdf
[4] CMS, Optional Plan to State Template, Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/mlr-toolkit-template.xlsx
[5] CMS, MLR Summary Reports, 2026, Accessed at: https://data.medicaid.gov/dataset/743f9f04-4473-41e2-9da2-9a89db65ee55

OIG Recommendation

Establish procedures that outline the steps to be taken to address potentially inaccurate Medicaid MLR data submitted by States and follow up with States, as needed.

CMS Response

CMS concurs with this recommendation. As discussed in the OIG's report, CMS already has procedures detailing the process for following up with states to obtain submissions for missing MLR summary reports and resubmissions for incomplete MLR data. CMS will update these procedures to make clear when additional follow up is needed to address potentially inaccurate Medicaid MLR data submitted by states.

OIG Recommendation

Ensure that insights from CMS's reviews of State-submitted Medicaid MLR data are communicated to CMS staff responsible for reviewing capitation rates.

CMS Response

CMS concurs with this recommendation. As discussed in the OIG's report, the regulations at 42 CFR 438.4(b)(9) require that states develop managed care capitation rates in such a way that managed care plans can reasonably achieve an MLR of at least 85% for the rating period. States and their actuaries have the primary responsibility to review managed care plan-reported MLR data from previous years to inform the development of actuarially sound prospective capitation rates. States are then required in 42 CFR 438.74 to submit to CMS, with their rate certifications required in 42 CFR 438.7, an annual summary description of the MLR report(s) received from their managed care plans. In the 2026-2027 Medicaid Managed Care Rate Development Guide CMS makes clear to states that their actuaries must document how prior MLR reports informed rate development in the certification.[6]

CMS has already developed a shared document repository that allows the CMS staff responsible for reviewing state submitted capitation rates to view the accompanying MLR summary reports. CMS will explore how to best share information on the accuracy of the data included in the MLR summary reports with CMS staff responsible for reviewing state submitted capitation rates as well, however CMS notes that these corrections are usually made retroactively, and due to the timing constraints of the rate review process, it is less likely that these corrections will materially impact the capitation rate review

OIG Recommendation

Improve the efficiency and effectiveness of CMS's oversight of the accuracy of State-submitted Medicaid MLR data.

[6] CMS, 2026-2027 Medicaid Managed Care Rate Development Guide, Accessed at: https://www.medicaid.gov/medicaid/managed-care/downloads/2026-2027-medicaid-rate-guide-022026.pdf

CMS Response

CMS concurs with this recommendation. CMS has made substantial efforts in recent years to improve oversight and state outreach related to potentially inaccurate MLR data. For example, CMS has implemented front-end automated checks in the MDCT-MCR that prevent states from submitting their MLR summary reports to CMS if any of the required data elements are blank. CMS will consider ways to further leverage MDCT-MCR to perform front-end automated accuracy checks on MLR summary reports. Additionally, CMS recently encouraged states to submit optional data elements during a Managed Care Technical Advisory Group (MC-TAG) call, as well as through instructional text within MDCT-MCR. CMS intends to reiterate this strong encouragement to submit optional data elements in additional forthcoming guidance.

ENDNOTES

[1] 42 CFR § 438.8(a-b), (d-e), (f). According to 42 CFR § 438.8(e)(1), the MLR numerator includes expenditures for fraud prevention activities. However, this data element is not yet part of the Medicaid managed care MLR calculation. This data element will be added to the MLR calculation if and when the private market regulations define these types of expenses (85 Fed. Reg. 72754, 72792 (Nov. 13, 2020)).

[2] 42 CFR § 438.8(a-b), (k)(1-2).

[3] 42 CFR § 438.5. MACPAC, *Medicaid Managed Care Capitation Rate Setting*, March 2022. Accessed Apr. 29, 2026. Actuaries work on behalf of States to develop and certify plans' capitation rates. Qualified actuaries follow the practice standards created by the Actuarial Standards Board (see 42 CFR § 438.2).

[4] 42 CFR §§ 438.4, 438.5. CMS, *2024-2025 Medicaid Managed Care Rate Development Guide*, January 2024. Accessed on Sept. 3, 2025.

[5] 42 CFR § 438.5(b)(5). CMS, *2024-2025 Medicaid Managed Care Rate Development Guide*, January 2024. Accessed on Sept. 3, 2025.

[6] 42 CFR § 438.4(b)(9). CMS, *2024-2025 Medicaid Managed Care Rate Development Guide*, January 2024. Accessed on Sept. 3, 2025.

[7] CMS, *Medical Loss Ratio (MLR) Monitoring, Reporting, and Oversight: A Toolkit for States to Ensure Complete and Accurate MLR Reporting*, September 2024. Accessed on Dec. 2, 2025.

[8] 42 CFR § 438.7.

[9] CMS, *2024-2025 Medicaid Managed Care Rate Development Guide*, January 2024. Accessed on Sept. 3, 2025.

[10] 42 CFR § 438.74.

[11] CMS, "Open Data: MLR Summary Reports." Accessed on Dec. 2, 2025.

[12] 42 CFR §§ 438.3(a), (c) and 438.7(a).

[13] 42 CFR § 438.74(a).

[14] CMS, *Medicaid and CHIP Managed Care Monitoring and Oversight Tools*, July 6, 2022. Accessed on Dec. 1, 2025.

[15] CMS, Excel workbook, "mlr-reporting-template-11142024," downloaded from "Medical Loss Ratio (MLR) Report." Accessed on Dec. 2, 2025. We did not include two data elements from the State-to-CMS MLR summary reporting template in our count of data elements that make up the MLR calculation: "non-claims costs" and "remittance." As part of determining "incurred claims," plans must exclude "non-claims costs." These costs are not a distinct data element in the "MLR numerator." States may optionally submit the "non-claims costs" data element to CMS. In addition, the "remittance" data element is not part of the calculation that determines plans' MLRs.

[16] CMS, *Medicaid and CHIP Managed Care Monitoring and Oversight Tools*, Nov. 7, 2023. Accessed on Dec. 2, 2025.

[17] CMS, "MLR Compliance Review Procedures," October 2024. CMS conducted follow-up with States to request required MLR data elements that were missing based on a variety of checks of data completeness. As one

example, CMS followed up with States regarding missing "adjusted MLRs" for some plans. States had reported that these were non-credible plans and, therefore, "adjusted MLRs" were not required for these MLR summary reports. However, CMS reviewed the "number of member months" for these plans and found that the plans were either fully or partially credible plans. Therefore, CMS requested that these States resubmit their MLR summary reports. (For information about credibility adjustments, see CMS, *Medical Loss Ratio (MLR) Credibility Adjustments*, July 31, 2017. Accessed on Sept. 17, 2025.)

[18] Mathematica, "MLR Analytic File Data Dictionary, Version 1.3," November 2023. According to CMS, the MLR summary reports and the Enrollment Report collect different information about plan size at different times of the year. As such, these two sources of information cannot always be matched and when they do match, CMS does not expect them to match exactly.

[19] OIG, *CMS Has Opportunities To Strengthen States' Oversight of Medicaid Managed Care Plans' Reporting of Medical Loss Ratios* (OEI-03-20-00231), Sept. 22, 2022.

[20] CMS, *Medical Loss Ratio (MLR) Monitoring, Reporting, and Oversight: A Toolkit for States to Ensure Complete and Accurate MLR Reporting*, September 2024. Accessed on Dec. 2, 2025.

[21] CMS, Excel workbook, "mlr-toolkit-template," downloaded from "Medical Loss Ratio (MLR)," section "Medical Loss Ratio (MLR)—Optional Plan to State Template." Accessed on Dec. 2, 2025.

[22] According to CMS, the MLR data file contained the most recent State-submitted MLR data available at the time of OIG's request, due to the time needed for MLR reporting. This MLR data file represents one of the early MLR reporting periods for which States submitted their plans' MLR data to CMS for review.

[23] 42 CFR § 438.8(d), (h). CMS, *Medical Loss Ratio (MLR) Credibility Adjustments*, July 31, 2017. Accessed on Sept. 17, 2025. Plans that only cover long-term services and supports must be at or below 45,000 member months to add a "credibility adjustment."

[24] 42 CFR §§ 438.4(b)(9), 438.5(b)(5).

[25] 42 CFR § 438.4(b)(9).

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