Purpose of Medical Loss Ratio (MLR) Reporting Template

As described at 42 CFR 438.74, states are required to report summary Medical Loss Ratio (MLR) reports to the Centers for Medicare and Medicaid Services (CMS). Beginning on **[DATE]** this template will support standardized data submission by state Medicaid and CHIP programs to CMS. The data reported using this template will support state Medicaid and CHIP programs along with the CMS mandate to promote the transparency of Medicaid and CHIP managed care plan financial reporting.

Submission and Communications

- Completed forms should be submitted to **[INSERT INSTRUCTIONS RE: HOW TO SUBMIT FORM]**.
- Questions about this form may be directed to **managedcareTA@mathematica-mpr.com**

MLR Reporting Template Organization

Consistent with 42 CFR 438.74, this template provides space for states to report on the following reporting requirements: (1) the amount of the MLR numerator, (2) the amount of the MLR denominator, (3) the MLR percentage achieved, (4) the number of member months, (5) any remittances owed by each MCO, PIHP, or PAHP for the MLR reporting year, and (6) a description of the methodology used to determine the State and Federal share of remittances owed.

Within this template, states will find data elements with specific drop downs that CMS has pre-selected to standardize data across states, as well as places with instructions for states to report numerical values or free text. States shall report all data in the **BEIGE COLORED CELLS**. Tabs are organized as follows:

Tab topic:	Tab name:
Reporting instructions	Instructions
Primary contact & program reporting structure information	Program Information
Medicaid medical loss ratio (MLR) reporting & remittance calculations	MLR Reporting

Reporting Instructions

Consistent with 42 CFR 438.74, this template allows states to report on the five (5) required MLR summary components: (1) the amount of the MLR numerator, (2) the amount of the MLR denominator, (3) the MLR percentage achieved, (4) the number of member months, and (5) any remittances owed by each MCO, PIHP, or PAHP for the MLR reporting year. In addition to the 5 required requirements, fields marked as "Optional" are included to allow states to report additional MLR data that states currently collect from MCOs, PIHPs, or PAHPs.

Integrated plans (such as DSNPs and MMPs) are considered both Medicaid and Medicare managed care plans and are not exempt from Medicaid MLR reporting requirements at 42 CFR 438.74. Therefore, unless the state has authority to require their plans to calculate the MLR differently than as is required under 42 CFR 438.8, such as under a financial alignment demonstration approved under Section 1115A, the plan must calculate and report their MLR experience for Medicaid only.

MLR Reporting Template Organization

The data entry portion of the template is split between two (2) tabs, the "Program Information" tab and the "MLR Reporting" tab. States must first complete the "Program Information" tab before moving to the "MLR Reporting" tab. Data entered in the "Program Information" tab will be used to populate the reporting columns for the "MLR Reporting" tab. For both tabs, the reporting detail is by Program by MCO, PIHP, or PAHP, as detailed further below.

Additional details related to the structure and purpose of these data entry tabs are provided below

"Program Information" tab

Progress Indicators

Progress Indicators at the top of the worksheet note when all required information for each section is complete. When a requisite cell is blank, the indicator will say INCOMPLETE; when a requisite cell has been populated, the indicator will say COMPLETE. Indicators are provided for the following sections: Contract Information, Version Control, Program Reporting Structure, Eligibility Group Reporting Structure, MCO Name Reporting Structure, Reporting Period Reporting Structure. Data files with INCOMPLETE progress indicators should not be submitted to CMS.

Information for Primary Contact

A-D: States must enter the Name, Phone Number, Email Address, and Title of the Primary Contact related to this template. Follow-up communications related to this template will be made with the primary contact.
E-F: States must select the relevant state or territory name from the drop down for the name of the state/territory agency that is submitting this report.
G: States must indicate if this file is an updated version of an MLR Report--covering the same time period--that was previously submitted. States must select either Yes or No using the dropdown.
H: Free text response field that states must complete only if "Yes" was selected in section G (MLR resubmission). States should describe the differences between a previously submitted template, and the current version.

Program Reporting Information

States must provide summary MLR report data at the plan level. The summary reports are based on the plans' annual MLR reports to the state under 42 CFR 438.8(k). States have the option of reporting these data for each plan by program, statewide, or at another level of aggregation (e.g., eligibility groups). Program is defined by a specified set of benefits and eligibility criteria that are articulated in a contract between the state and managed care plans. Generally, MLR data should not be aggregated across multiple plans or across multiple programs; however, there is an exception if a managed care plan has more than one contract with the state—the state can report results for each contract separately or combine results for each plan. Further, if a state combines the reporting for plans with multiple contracts, the report must use a consistent MLR reporting year.

States must report credible and non-credible MLRs for all MCOs, PIHPs, and PAHPs. Under 42 CFR 438.8(l) a state may exclude a plan that is newly contracted with the state from this reporting for the first year of the plan's operation. These "new experience" plans must report MLRs during the next MLR reporting year in which the plan is in business with the state, even if the first year was not a full 12 months.

States can submit multiple MLR summary reporting forms (e.g., one per program) to CMS.

In this section of the report, states must describe the aggregation level used and any applicable program information. If a plan's data reflect all populations served across the state or all populations in a geographic region, a state should indicate "Statewide" or "Region" in the Program Name. If the state is reporting the MLR separately for specific eligibility group(s), the state must indicate this information in the "Eligibility Group" column. The MLR reporting period should be a period of 12 months consistent with the rating period. The MLR reporting period must not exceed 12 months. Note: The remittance reporting period may differ from the MLR reporting period. The remittance reporting period is the period of time used when determining the remittance amounts. If the remittance reporting period differs from the MLR reporting period, the remittance period should be entered separately on the MLR Reporting worksheet.

The information included in this section will be used to develop appropriate reporting columns for the "MLR Reporting" tab.

Data Element	Data Format	Instructions and Definition
I. Program Name	Free text (32,767 character limit)	Enter the name of the program(s) for which the state is reporting MLR data. A program is defined generally by a specified set of benefits and eligibility criteria that is articulated in a contract between the state and a managed care plan. If a state reports a plan's data on a statewide or regional basis, describe the Program Name as "Statewide " or "Region" and the state may provide additional details and descriptions in the Miscellaneous Notes field, such as the counties included. Leave unused fields blank.
J. Program Type	Set values (drop down)	Select from the drop down list the program type definition that best describes the program entered in the Program Name column.
K. Eligibility Group	Set values (drop down)	1. For States that intend to report MLRs for separate CHIP only programs, the state should select "CHIP only" from the drop down list in this column. These separate child health assistance programs are defined in 42 CFR 457.10. A state has the option to report the MLR for all populations (to include Medicaid and separate CHIP populations) served under the contract for the specified plan/program being reported, and in this case, the state should select "All Populations" as described in Option 4 below. 2. States that intend to qualify for the SUPPORT Act Section 4001 MLR provision must provide an MLR for the eligibility group described in section 1902(a)(10)(A)(i)(VIII) (referred to here as "the Expansion Group"). Indicate that an expansion-only MLR is being reported by using the drop-down list in this column to indicate Group VIII expansion only adult population. 3. For States that intend to report separate MLRs for eligibility groups that are served under the same program, select "Other" from the drop-down list in this column. Please see instructions in Data Element L for further instructions. 4. If neither 1, 2, nor 3 apply, select "All Populations", indicating that all Medicaid eligibility groups (and CHIP eligibility groups as applicable) covered under the contract for the specified plan/program are being reported.
L. If Other, Describe Eligibility Group	Free text (32,767 character limit)	If "Other" was selected in Data Element K (Eligibility Group), states must specify the eligibility group(s) reported in Data Element L. For example, a State may report separate MLRs for each eligibility group that is included in their "Comprehensive" program: Children <19 years; Aged, Blind, Disabled; Pregnant Women.
M. MCO, PIHP, or PAHP Name	Free text (32,767 character limit)	Enter the full name of each plan for which the state is reporting MLR data. Do not abbreviate plan names. All MCOs/PIHPs/PAHPs contracted in a specific program should be reported, including non-credible plans with small enrollment. Plan names should reflect those used in the Medicaid enrollment report: *"Managed Care Enrollment by Program and Plan"* (https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html) Leave unused fields blank. MLR data should not be aggregated across more than one plan and generally should not be aggregated across multiple programs unless states use the exception above.
N. MLR Reporting Period Start Date	Date (MM/DD/YYYY)	States must input the start date of the MLR Reporting Period as MM/DD/YYYY
O. MLR Reporting Period End Date	Date (MM/DD/YYYY)	States must input the end date of the MLR Reporting Period as MM/DD/YYYY
P. Explanation of Reporting Period Discrepancy	Free text (32,767 character limit)	For (A) Reporting Periods that are less than a 12-month period, or (B) for MCO/PIHP/PAHPs that have a different reporting period than other MCO/PIHP/PAHPs within the same program, include a qualitative response in this column. Examples include (but are not limited to) a new plan entering the market or state is re-aligning the reporting period from a state fiscal year to a calendar year. Responses may expand beyond the cell column widths.
Q. Misc. Notes	Free text (32,767 character limit)	Include any other notes/responses that the State wishes to report. Responses may expand beyond the cell column widths.

"MLR Reporting" tab

Based on the data entered in the "Program Information" tab, column K and onwards in the "MLR Reporting" tab will be populated with (an) appropriate reporting column(s) representing each Program-Plan combination. States must report the five required MLR summary elements. Note that the cells in this worksheet do not automatically calculate the MLR numerator, denominator, or MLR percentage. Each element must be entered manually. The applicable regulations for each element are provided in Column H.

Progress Indicators

Progress Indicators at the top of the worksheet note when all required information for each section is complete. When a requisite cell is blank, the indicator will say INCOMPLETE; when a requisite cell has been populated, the indicator will say COMPLETE. Indicators are provided for the following sections: MLR Numerator, MLR Denominator, Member Months, Adjusted MLR, Remittance (if applicable).

Note: States that are reporting non-credible plans should enter member month values in section 3.1 as described below. States should report all other required MLR reporting elements (sections 1.3, 2.3, 3.4) with the value 0, and answer "No" for section 4.1 when reporting non-credible plan information. Reporting in this way will ensure that the Progress Indicators result in a COMPLETE status.

Section	Data Format	Instructions and Definition
1.1 - 1.3 Medical Loss Ratio Nume	Dollar	- States may enter one or more of the optional MLR Numerator subcomponents in **sections 1.1 - 1.2** Note: if the optional subcomponents are reported, states must still report the total MLR Numerator (i.e., subcomponents will not automatically sum to Numerator). Optional elements include: Incurred Claims and Activities that improve health care quality. - Enter the required MLR Numerator dollar value in **section 1.3**
1.4 Non-Claims Costs	Dollar	- States may enter the optional non-claims costs value in **section 1.4**. This amount is not included in the MLR Numerator
2. Medical Loss Ratio Denominato	Dollar	- States may enter one or more of the optional MLR Denominator subcomponents in **sections 2.1 - 2.2**. Note: if the optional subcomponents are reported, states must still report the total MLR Denominator (i.e., subcomponents will not automatically calculate Denominator). Optional elements include: Premium Revenue; Federal, State, and local taxes and licensing; and regulatory fees - Enter the required MLR Denominator dollar value in **section 2.3**
3.1 MLR Calculation: Member Months	Count	- Enter the required Member Months value in **section 3.1**
3.2 - 3.4 MLR Calculation: Adjusted MLR Value	Percentage (enter exactly as the percentage should appear; i.e. entering '1' will result in 1% instead of 100%)	- Enter the required Adjusted MLR value in **section 3.4** - States may enter one or more of the optional subcomponents in **sections 3.2 - 3.3.** Note: if the optional subcomponents are reported, states must still report the total Adjusted MLR value (i.e., subcomponents will not automatically calculate Adjusted MLR). Optional elements include: Unadjusted MLR and Credibility adjustment. State may enter 0% if no credibility adjustment is needed. - For non-credible plans, the credibility adjustment should be rounded to the nearest tenth and entered up to 100%. For fully credible plans, the credibility adjustment should be entered as 0%.
4. Remittance		Complete the series of questions related to MLR Remittances via drop-downs and free form entry fields. Based on the state responses, cells may appear beige, indicating a response is required or "gray", indicating that a response is not required. States must answer these questions for each MLR reporting column. Enter amounts for either line 4.6.1 or 4.6.2; do not enter values in both lines. All amounts should be reported as absolute values. The following sections are required:
4.1: Does the contract include a remittance/payment requirement for being below/above a specified	Set values (drop down)	- Select one of the following: Yes or No. This element indicates if a remittance to the state or a payment to a plan is required in an MCO/PIHP/PAHP contract if a specific minimum MLR is not met.
4.6.1: Remittance dollar amount owed for MLR reporting period	Dollar	- Report the amount of remittances owed by each MCO/PIHP/PAHP in **section 4.6.1**. States should enter a zero (0) value if no remittance was owed by a plan. States should enter a positive value if a remittance was collected by the state. If states answered "No" in section 4.1, section 4.6.1 will appear "gray", indicating that a response is not required.
4.6.2: Payment dollar amount due to plan for MLR reporting period	Dollar	- Report the amount of the payment due to each MCO/PIHP/PAHP in **section 4.6.2** as a positive value, where applicable. This payment is specific to losses reimbursed under a minimum MLR arrangement; do not report the results of other risk corridors, reinsurance or other risk mitigation arrangements. If states answered "No" in section 4.1, section 4.6.2 will appear "gray", indicating that a response is not required. If states answered "Yes" in section 4.1, but do not make payments to plans for losses under a minimum MLR arrangement, states may enter $0.
4.9: Remittance Methodology Qualitative Response	Free text (32,767 character limit)	- Describe the methodology used to determine the State and Federal share of the remittance in the free entry text field in **section 4.9.** - States that intend to qualify for the SUPPORT Act Section 4001 MLR provision must provide a description of the methodology used to determine the State and Federal share of the remittance for the eligibility group described in section 1902(a)(10)(A)(i)(VIII).

Error Warnings

In sections 1, 2, 3 & 4 of the MLR Reporting tab, error warnings may appear indicating that data entered may have been entered incorrectly. The table below outlines the error warnings and their description. These messages are only warnings, and the MLR data may be submitted even if one or more of the warnings appear.

Section	Error Warning	Description

1. Medical Loss Ratio Numerator	*Warning: Numerator ≠ Subcomponents*	If the optional MLR numerator subcomponents were reported by a state, this error warning will appear when the sum of the optional numerator subcomponents do not equal the total reported MLR numerator amount in **section 1.3.**
2. Medical Loss Ratio Denominato	*Warning: Denominator ≠ Difference of Subcomponents*	If the optional MLR denominator subcomponents were reported by a state, this error warning will appear when the reported *Premium Revenue* less the reported *Federal, State, and local taxes and licensing and regulatory fees* does not equal the total reported MLR denominator amount in **section 2.3**.
3. MLR Calculation	*Warning: MLR is Outside of Typical Range*	This error warning will appear if the adjusted MLR reported by a state in **section 3.4** is greater than 110% or less than 70%.
3. MLR Calculation	*Warning: Unadj. MLR ≠ Numerator ÷ Denominator*	This error warning will appear if the *Unadjusted MLR* reported by a state in **section 3.2** does not equal the ratio of the reported MLR numerator over the reported MLR denominator (as reported in **sections 1.3 and 2.3** of the template)
3. MLR Calculation	*Warning: Adj. MLR ≠ Unadj. MLR + Credibility Adj.*	If the optional MLR calculation subcomponents were reported by a state (i.e. *Unadjusted MLR* & *Credibility Adjustment*) this error warning will appear when the sum of the optional MLR calculation subcomponents do not equal the reported adjusted MLR in **section 3.4**.
4. Remittance	*Warning: Enter amounts either in line 4.6.1 or 4.6.2; do not enter values in both lines*	This error warning will appear if a state has reported dollar amounts in both **sections 4.6.1 and 4.6.2**. Dollar amounts should be entered in one line or the other, not both lines.
Optional: Explanation of reporting errors	*N/A*	Free text fields are present for each reporting error flag. These fields allow states to explain why an error is present or to describe limitations the state may have had when reporting in the template. Responses may expand beyond the cell column widths and all responses are optional.

Primary Contact Information & Program Reporting Information

Progress Indicators

Contact Information (A-F):	INCOMPLETE	Program Reporting Structure (I-J):	INCOMPLETE	MCO Name Reporting Structure (M):	INCOMPLETE
Version Control Information (G-H):	INCOMPLETE	Eligibility Group Reporting Structure (K-L):	INCOMPLETE	Reporting Period Reporting Structure (N-P):	INCOMPLETE

Information for Primary Contact (Regarding Information Reported in this Template)

	Item	Data Format	Response
A	Contact Name:	*Enter free text*	
B	Contact Phone:	*Enter number as ###-###-####*	
C	Contact Email:	*Enter email address*	
D	Contact Title:	*Enter free text*	
E	State:	*Select from set values (drop down)*	
F	State Agency Name:	*Enter free text*	
G	Version Control: Is this template an updated version of a previously submitted summary MLR report covering the same time period?	*Select from set values (drop down)*	
H	Version Control Description: If "Yes" to question G above, please provide a description of the changes between this version and the prior version of the annual summary MLR Reporting template.	*Enter free text*	

Program Reporting Information

Reporting Structure:

Per 42 CFR 438.8(k)(xii) states must describe how MCO, PIHP, or PAHP data will be aggregated for Medicaid eligibility groups covered under the contract with the state. This section of the template allows states to describe the method by which data will be aggregated when reporting MLRs. The information included in the reporting structure table below will be used to develop appropriate reporting columns for the "MLR Reporting" tab.

I	J	K	L	M	N	O	P	Q
Program Name	**Program Type**	**Eligibility Group**	**If Other, Describe Eligibility Group**	**MCO, PIHP, or PAHP Name**	**MLR Reporting Period Start Date**	**MLR Reporting Period End Date**	**Explanation of Reporting Period Discrepancy**	**Misc. Notes**
Enter free text	*Select from set values (drop down)*	*Select from set values (drop down)*	*Free text for "other" response*	*Free text*	*Date (MM/DD/YYYY)*	*Date (MM/DD/YYYY)*	*Free text*	*Free text, optional*

Medicaid Medical Loss Ratio (MLR) & Remittance Calculations

Progress Indicators

MLR State Reporting Requirements per 42 CFR 438.74	Are required elements completed?	Are reporting errors present?	Optional: Explanation of reporting errors
1.3 MLR numerator	COMPLETE	NO ERRORS	
2.3 MLR denominator	COMPLETE	NO ERRORS	
3.1 Member Months	COMPLETE	N/A	
3.4 Adjusted MLR	COMPLETE	NO ERRORS	
4.1, 4.6.1 & 4.9 Remittance (if applicable)	COMPLETE	NO ERRORS	

Medicaid MLR and Remittance Calculations | Regulatory Definitions (42 CFR) | Data Format

1. Medical Loss Ratio Numerator

			Regulatory Definitions (42 CFR)	Data Format
Optional	*1.1*	Incurred Claims	§ 438.8(e)(2)	*Dollar*
Optional	*1.2*	Activities that improve health care quality	§ 438.8(e)(3)	*Dollar*
Required	***1.3***	**MLR numerator**	§ 438.8(e)(1)	*Dollar*
Optional	*1.4*	Non-Claims costs (not included in numerator)	§ 438.8(e)(2)(v)(A)	*Dollar*

2. Medical Loss Ratio Denominator

			Regulatory Definitions (42 CFR)	Data Format
Optional	*2.1*	Premium Revenue	§ 438.8(f)(2)	*Dollar*
Optional	*2.2*	Federal, State, and local taxes and licensing and regulatory fees	§ 438.8(f)(3)	*Dollar*
Required	***2.3***	**MLR denominator**	§ 438.8(f)(1)	*Dollar*

3. MLR Calculation

			Regulatory Definitions (42 CFR)	Data Format
Required	***3.1***	**Member Months**	§ 438.8(b)	*Count*
Optional	*3.2*	Unadjusted MLR		*Percentage (rounded to nearest tenth)*
Optional	*3.3*	Credibility adjustment	§ 438.8(h)	*Percentage (rounded to nearest tenth)*
Required	***3.4***	**Adjusted MLR**	§ 438.8(h)	*Percentage*

4. Remittance

			Data Format
Required	***4.1***	**Does the contract include a remittance/payment requirement for being below/above a specified MLR?**	*Set values (drop down)*
Optional	*4.2*	If yes, what is the state minimum MLR requirement?	*Percentage*
Optional	*4.3*	Does the state remittance MLR calculation align with the required components and methodology outlined in 438.8(c)?	*Set values (drop down)*
Optional	*4.4*	If no, please describe	*Free text for "No" response*
Optional	*4.5*	Calculated MLR for remittance purposes (please enter as a percentage)	*Percentage*
Required	***4.6.1***	**Remittance dollar amount owed for MLR reporting period**	*Dollar*
Optional	*4.6.2*	Payment dollar amount due to plan for MLR reporting period	*Dollar*
		MLR reporting period (autopopulated based on response in "Program Information" tab)	*Autopopulated*
Optional	*4.7*	Is the remittance period the same as the MLR reporting period?	*Set values (drop down)*
Optional	*4.8.1*	If no, please include remittance period start date	*MM/DD/YYYY for "No" response*
Optional	*4.8.2*	If no, please include remittance period end date	*MM/DD/YYYY for "No" response*
Required	*4.9*	**Remittance Methodology Qualitative Response** - Per 42 CFR 438.74(b)(2), if a remittance is owed, the state must describe the methodology used to determine the State and Federal share of the remittance. Please include in the text field to the right. - States that intend to qualify for the SUPPORT Act Section 4001 MLR provision must provide a description of the methodology used to determine the State and Federal share of the remittance for the eligibility group described in section 1902(a)(10)(A)(i)(VIII).	*Free text*