

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MASSACHUSETTS
MEDICAID MANAGED CARE
PROGRAM POTENTIAL SAVINGS
WITH MINIMUM MEDICAL LOSS RATIO**

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EXECUTIVE SUMMARY

The Medicaid program could have realized savings if Massachusetts required its Medicaid managed care plans to meet a minimum medical loss ratio standard, similar to those for private health insurers and Medicare Advantage plans, and if Massachusetts required remittances when managed care plans did not meet the standard.

WHY WE DID THIS REVIEW

A medical loss ratio (MLR) is the percentage of premium revenue an insurer spends to provide medical services and healthcare quality improvement activities for its members. This report is part of a series of Office of Inspector General reviews conducted to determine whether the Medicaid program could have achieved savings if States had required Medicaid managed care organizations (MCOs) to meet a minimum MLR standard and pay remittances if the MLR standard was not met.

Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to meet Federal minimum MLR standards. Medicare Advantage plans and Medicare Part D sponsors are required to pay remittances to the Centers for Medicare & Medicaid Services (CMS) if their MLR falls below 85 percent. Private health insurers, subject to the Patient Protection and Affordable Care Act's MLR standard, must provide rebates to their enrollees if their MLR falls below the appropriate percentage, whether that is 80 or 85 percent.

At the time of our review, CMS did not require States to have a minimum MLR standard for Medicaid MCOs. After our review but before the issuance of our report, CMS published a final rule that requires a minimum MLR for Medicaid MCOs for rate-setting purposes. The MLR formula required by the final rule is similar to the MLR requirements for most private health insurers, Medicare Advantage plans, and Part D sponsors. In the final rule, CMS also encourages States to adopt provisions that require Medicaid MCOs to pay remittances when they do not meet the MLR standard. Several States have applied MLR standards similar to those for private health insurers, Medicare Advantage plans, and Medicare Part D sponsors to their contracts with Medicaid MCOs, including some that require the MCOs to issue remittances to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards.

The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program.

The objective of this review was to determine the potential Medicaid program savings if the Massachusetts Executive Office of Health and Human Services (State agency) (1) required its Medicaid managed care plans to meet a minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances if that MLR standard was not met.

BACKGROUND

In the CMS final rule, the MLR calculation for Medicaid MCOs includes some variations to account for the differences in the Medicaid program and population (i.e., long-term services and supports or other services specific only to Medicaid and covered under the State plan). Under the final rule, States are required to use the 85 percent MLR as they develop capitation rates. According to CMS, an MLR is one tool that can be used to assess whether capitation rates are appropriately set. Appropriately set capitation rates help to ensure adequate payments are made to provide services to beneficiaries, rather than to pay for administrative expenses. MCOs are also required to calculate and report their MLR to the State Medicaid agencies.

The State agency manages the Massachusetts Medicaid (MassHealth) program. In calendar year (CY) 2014, about 815,000 Medicaid beneficiaries in Massachusetts were enrolled in Medicaid managed care plans. During this period, the State agency claimed Medicaid reimbursement from CMS, which administers the Medicaid program at the Federal level, for payments the State agency made to MCOs totaling \$4.7 billion (\$3.1 billion Federal share).

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for 10 MassHealth managed care plans. During this period, the total amount of Medicaid premium revenue earned by these plans was \$4 billion. The State agency makes payments to Massachusetts MCOs on the basis of (1) rating categories, which identify specific groupings of managed care enrollees based on a beneficiary's coverage type, also known as their assignment plan, and (2) their disability status as determined by the State agency or Social Security Administration. For each rating category within these plans, we determined the MLR for the same period and the amount the MCOs would have had to return to the State agency if the plans had been required to meet MLR standards similar to the Federal standards for certain private insurers and Medicare Advantage plans.

WHAT WE FOUND

We determined that the MassHealth program could have saved \$4.7 million (approximately \$3.5 million Federal share) in CY 2014 if the State agency (1) required its Medicaid managed care plans to meet the minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances when Medicaid managed care plans did not meet the MLR standard. Specifically, of the 10 managed care plans that we reviewed, we calculated MLRs for 2 plans (three rating categories) that were less than 85 percent (the minimum MLR standard for large private insurers) during CY 2014. However, MassHealth managed care contracts in general limited the amount plans were paid for administrative costs as a component of their capitated rate and contained risk-sharing arrangements between the State agency and the MCOs.

WHAT WE RECOMMEND

We recommend that the State agency:

- incorporate into its contracts with Medicaid MCOs the MLR standards adopted in the CMS final rule and
- consider implementing into its Medicaid MCO contracts a remittance requirement if appropriate (while the CMS final rule did not require States to collect remittances from MCOs, CMS encouraged States to implement this type of provision).

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency stated that it expects to include language that complies with the MLR standards adopted in the CMS final rule into its fiscal year 2017 contracts with Medicaid MCOs. The State agency also stated that it would consider implementing a remittance requirement into its Medicaid MCO contracts.

The State agency suggested that we change the number of plans we reviewed from 10 to 5 (to match the number of MCOs that the State agency contracts with). After consideration of the State agency's proposed clarifications to our draft report, we maintain that the presentation of our audit results by plan and rating category is appropriate.

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INTRODUCTION

WHY WE DID THIS REVIEW

A medical loss ratio (MLR) is the percentage of premium revenue an insurer spends to provide medical services and healthcare quality improvement activities for its members. This report is part of a series¹ of Office of Inspector General reviews conducted to determine whether the Medicaid program could have achieved savings if States had required Medicaid managed care organizations (MCOs) to meet a minimum MLR standard and pay remittances if the MLR standard was not met.

Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to meet Federal minimum MLR standards.² Medicare Advantage plans and Medicare Part D sponsors are required to pay remittances to the Centers for Medicare & Medicaid Services (CMS) if their MLR falls below 85 percent. Private health insurers, subject to the ACA's MLR standard, must provide rebates to their enrollees if their MLR falls below the appropriate percentage, whether that is 80 or 85 percent. At the time of our review, CMS did not require States to have a minimum MLR standard for Medicaid MCOs. After our review but before the issuance of our report, CMS published a final rule requiring a minimum MLR for Medicaid MCOs for rate-setting purposes. The MLR formula required by the final rule is similar to the MLR requirements for most private health insurers, Medicare Advantage plans, and Part D sponsors. In the final rule, CMS also encourages States to adopt provisions that require Medicaid MCOs to pay remittances when they do not meet the MLR standard. Several States have applied MLR standards similar to those for private health insurers, Medicare Advantage plans, and Medicare Part D sponsors to their contracts with Medicaid MCOs, including some that require the MCOs to issue remittances to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards.

The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program.

Massachusetts' Medicaid (MassHealth) managed care plan contracts with MCOs limit the amount that plans are paid for administrative costs and contain risk-sharing provisions between the State and the MCOs.

¹ To date, we have issued two reports: *The Medicaid Program Could Have Achieved Savings if New York Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act* ([A-02-13-01036](#)) and *The Medicaid Program Could Have Achieved Savings if Oregon Had Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act* ([A-09-15-02033](#)).

² Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to meet minimum MLR standards (Patient Protection and Affordable Care Act (ACA) (P.L. No. 111-148 (Mar. 23, 2010), and amending provisions of the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively known as the ACA).

OBJECTIVE

Our objective was to determine the potential Medicaid program savings if the Massachusetts Executive Office of Health and Human Services (State agency) (1) required its Medicaid managed care plans to meet a minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) require remittances if that MLR standard was not met.

BACKGROUND

The Medicaid Program

The Medicaid program pays for medical assistance for certain individuals and families with low income and resources (Title XIX of the Social Security Act). The Federal and State Governments jointly fund and administer the program. CMS administers the program at the Federal level. In Massachusetts, the State agency administers the Medicaid program.

Minimum Medical Loss Ratio for Medicaid Managed Care Organizations

CMS published a final rule on May 6, 2016, that requires Medicaid MCOs to achieve a minimum MLR of at least 85 percent, effective July 1, 2017.³ CMS implemented a MLR calculation for Medicaid MCOs similar to the Federal standards for most private health insurers, Medicare Advantage plans, and Medicare Part D sponsors. The MLR calculation for Medicaid MCOs includes some variations to account for differences in the Medicaid program and population (i.e., long-term services and supports or other services specific only to Medicaid and covered under the State plan). Under the final rule, States are required to use the 85-percent MLR as they develop capitation rates. According to CMS, an MLR is one tool that can be used to assess whether capitation rates are appropriately set. Appropriately set capitation rates help to ensure adequate payments are made to provide services to beneficiaries, rather than to pay for administrative expenses. MCOs are also required to calculate and report their MLR to the State Medicaid agencies. However, CMS did not require Medicaid State agencies to implement remittances for MCOs that fail to meet MLR standards. CMS did provide States the flexibility to require remittances from MCOs and encouraged States to implement contract provisions for remittances when the minimum MLR standard is not met.

Massachusetts' Medicaid Managed Care Program

Under the MassHealth managed care program, the State agency pays contracted MCOs fixed capitated payments to provide enrollees with Medicaid-covered services. The State agency makes payments to MCOs on the basis of rating categories,⁴ which identify specific groupings of

³ 81 Fed. Reg. 27498 (May 6, 2016).

⁴ Rating categories I and II include enrollees of traditional MassHealth and have average per-member, per-day capitation rates of \$9.89 and \$43.17, respectively. Rating categories IX and X include enrollees of MassHealth CarePlus and have average per-member, per-month capitation rates of \$426.66 and \$1,034.51, respectively.

managed care enrollees based on (1) a beneficiary's coverage type (e.g., MassHealth Standard or CarePlus), also known as their assignment plan, and (2) their disability status as determined by the State agency or Social Security Administration. In 2014, about 815,000 Medicaid beneficiaries in Massachusetts were enrolled in Medicaid managed care plans.⁵ Of this number, approximately 509,000 people were enrolled in five traditional MassHealth managed care plans, which offer comprehensive health services covered under the Medicaid State Plan, and approximately 270,000 people were enrolled in six MassHealth CarePlus managed care plans, which serve the majority of the newly eligible Medicaid ACA expansion population.

Appendix A contains a detailed description of the MassHealth managed care coverage types; Appendix B contains the MLR standards for private health insurers, Medicare Advantage plans, and Part D sponsors; and Appendix C contains the MLR standard for Medicaid MCOs.

Capitation payments to Massachusetts MCOs include both administrative and medical expense components. MassHealth managed care contracts limit the amount plans are paid for administrative costs as a component of their capitated payment rate⁶ and contain risk-sharing arrangements⁷ between the State agency and the MCOs, but the MassHealth managed care plan contracts do not contain MLR standards.

The State agency shares in any financial losses and gains experienced by the plan if actual medical expenses during the contract period are less than or exceed predetermined threshold amounts (risk corridors)⁸ defined in the contract. The medical expense portion of the capitation payments made to the MCO determines the threshold amounts. If the medical expenses are greater than the medical expense portion of capitation payments, a risk-share payment may be due from the State agency to the plan. If the medical expenses are less, a gain-share payment may be due from the plan to the State agency.

During calendar year (CY) 2014, the State agency claimed Medicaid reimbursement for payments made to MCOs totaling \$4.7 billion (\$3.1 billion Federal share). Of this amount,

⁵ MassHealth MCOs included traditional MassHealth managed care (MassHealth Standard, CommonHealth, and Family Assistance coverage types), MassHealth CarePlus, OneCare, Senior Care Options, and the Program of All Inclusive Care for the Elderly (PACE). We limited the scope of our review to traditional MassHealth managed care plans and MassHealth CarePlus plans.

⁶ Effective October 1, 2014, the State agency limited the amount traditional MassHealth managed care plans were paid for administrative costs as a component of their capitated payment rate to approximately \$1.91 per member, per day. During 2014, the State agency limited the amount MassHealth CarePlus plans were paid for administrative costs as a component of their capitated payment rate to approximately \$56.81 per member, per month.

⁷ The risk-sharing arrangements for traditional MassHealth plans became effective October 1, 2014, and MassHealth CarePlus plans became effective January 1, 2014.

⁸ Risk corridors are used to reduce the general uncertainty insurers face in the early years of implementation when the market is opened up to people with preexisting conditions who were previously excluded (e.g., ACA Medicaid expansion population.)

payments made to the five traditional MassHealth managed care plans and six MassHealth CarePlus managed care plans totaled approximately \$2.7 billion (\$1.4 billion Federal share) and \$1.4 billion (\$1.1 billion Federal share), respectively.

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for 10 MassHealth managed care plans⁹ (5 traditional plans and 5 CarePlus plans). During this period, the total amount of Medicaid premium revenue earned by these plans was \$4 billion. For each rating category within these plans, we determined the MLR for the same period and the amount the MCOs would have had to return to the State agency if the plans had been required to meet MLR standards similar to those for private insurers and Medicare Advantage plans. We used the MLR formula applicable to private health insurers and Medicare Advantage plans.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix D contains the details of our audit scope and methodology.

FINDING

We determined that the MassHealth program could have saved \$4.7 million (approximately \$3.5 million Federal share) in CY 2014 if the State agency (1) required its Medicaid managed care plans to meet the minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances when Medicaid managed care plans did not meet the MLR standard. Specifically, of the 10 managed care plans that we reviewed, we calculated MLRs for 2 plans (three rating categories) that were less than 85 percent (the minimum MLR standard for large private insurers) during CY 2014. However, MassHealth managed care contracts in general limited the amount plans were paid for administrative costs as a component of their capitated rate and contained risk-sharing arrangements between the State agency and the MCOs.

SOME PLANS HAD A MEDICAL LOSS RATIO OF LESS THAN 85 PERCENT

We determined that two MassHealth managed care plans had MLRs of less than 85 percent during CY 2014. Specifically, we calculated MLRs of less than 85 percent for one rating category for a traditional MassHealth managed care plan and both rating categories for one MassHealth CarePlus managed care plan.

We calculated that the Medicaid program could have saved \$4.7 million (approximately \$3.5 million Federal share) during CY 2014 if the State agency had required its Medicaid managed care plans to meet MLR standards for private health insurers and Medicare Advantage

⁹ We did not review the remaining plan because it had only 1 year of operational experience.

plans and had required the plans to issue remittances to the State agency when they did not meet the standards. These standards, with the exception of issuing remittances, have since been established for Medicaid MCOs in the CMS final rule with respect to rate setting.¹⁰

Appendix E contains the results of our calculation of the MLR for the selected plans using the formula applicable to private health insurers and Medicare Advantage plans, the results of our calculation of potential remittances if the plans did not meet an 85-percent minimum MLR standard, and potential Medicaid program savings if the State agency had required its Medicaid managed care plans to meet an 85-percent minimum MLR standard and issue remittances to the State agency if the standards were not met.

RECOMMENDATIONS

We recommend that the State agency:

- incorporate into its contracts with Medicaid MCOs the MLR standards adopted in the CMS final rule and
- consider implementing into its Medicaid MCO contracts a remittance requirement if appropriate (while the CMS final rule did not require States to collect remittances from MCOs, CMS encouraged States to implement this type of provision).

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency stated that it expects to include language that complies with the MLR standards adopted in the CMS final rule into its fiscal year (FY) 2017 contracts with Medicaid MCOs. Additionally, the State agency stated it has added MLR reporting and calculation requirements to its proposed FY 2016 MCO contract amendment. The State agency further stated that it would consider implementing a remittance requirement into its Medicaid MCO contracts.

The State Agency commented that all five MCOs¹⁰ exceeded the 85-percent MLR standard for 2014 and proposed some clarifications to our draft report. Specifically, the State agency suggested that we change the number of plans we reviewed from 10 to 5 (to match the number of MCOs that the State agency contracts with) and remove the reference to “plans” in Appendix A.

The State agency’s comments are included in their entirety as Appendix F, with the exception of the State agency’s proposed modifications to Appendix A.

¹⁰ The standards give States some flexibility in implementing the MLR requirements that may affect application of the formula.

¹⁰ Five MCOs administer the 10 managed care plans we reviewed. Each MCO has two types of plans (Traditional and Careplus). There are two rating categories within each plan.

OFFICE OF INSPECTOR GENERAL RESPONSE

Regarding the State agency's comment that all 5 MCOs exceeded the 85-percent MLR standard for 2014, we maintain that of the 10 managed care plans we reviewed, the MLRs for 2 of the plans (3 rating categories) were less than 85 percent during CY 2014. The State agency's calculation of the MLRs refers to the aggregate Medicaid population for each of the five MCOs rather than the population specific to each plan and rating category. Because the capitated payment rates and the nature of the related medical expenses differ significantly between plans and rating categories, the State agency should consider these differences for purposes of calculating the MLR and take them into account when setting capitation rates for future rating periods.

After consideration of the State agency's proposed clarifications to our draft report, we maintain that the presentation of our audit results by plan and rating category is appropriate.

APPENDIX A: MASSHEALTH MANAGED CARE COVERAGE TYPES

MASSHEALTH TRADITIONAL AND CAREPLUS MCO PROGRAMS

MassHealth’s traditional MCO program includes the following coverage types: MassHealth Standard, MassHealth CommonHealth, and MassHealth Family Assistance. MassHealth developed the Careplus managed care option for members who are eligible under the ACA. MassHealth Careplus members are eligible to enroll in Careplus MCOs.

Under their respective capitated payment agreements with the State agency, both traditional and Careplus MCOs provide a comprehensive set of healthcare services to covered enrollees. The benefits packages include care management, inpatient and outpatient hospital services, physician services, pharmacy services, and behavioral health services. MCOs are also required to coordinate the provision of some services that they are not contractually required to deliver. MassHealth pays for these additional services, commonly called “wrap services,” on a fee-for-service basis (i.e., MassHealth makes a separate payment to the provider for each individual service). Wrap services include services such as dental, vision care, and nonemergency transportation.¹¹

MassHealth Standard

Managed care plans that offer MassHealth Standard coverage provide services to pregnant women, children under age 19, and young adults aged 19 or 20; parents or caretaker relatives living with children under age 19, individuals who are HIV positive, and disabled adults; individuals with breast or cervical cancer; and former foster care children up to age 26. Beneficiaries generally do not pay a premium for MassHealth Standard coverage.

MassHealth CommonHealth

Managed care plans that offer MassHealth CommonHealth coverage provide services to certain disabled children and certain disabled adults with incomes that are too high to qualify for MassHealth Standard. CommonHealth has no income limit. Beneficiaries may pay a monthly premium based on household income.¹²

MassHealth Family Assistance

Managed care plans that offer MassHealth Family Assistance¹³ coverage provide services to children and young adults who are not eligible for MassHealth Standard. Family Assistance is

¹¹ Wrap services for MassHealth Standard and CommonHealth coverage types also include long-term services and supports at home. Examples of long-term care services and supports include personal care, adult day health, adult foster care, and durable medical equipment.

¹² MassHealth may charge a monthly premium to certain members who have incomes above 150 percent of the Federal poverty level (FPL).

¹³ Children are generally covered if gross family income is at or below 300 percent of the FPL. Young adults (aged 19 or 20) are covered if gross family income is at or below 150 percent of the FPL.

also for some low-income adults, as well as some people with HIV. Beneficiaries may pay a premium based on income.

MassHealth Careplus

Managed care plans that offer MassHealth CarePlus coverage provide services to adults aged 21 to 64 years old who are not otherwise eligible for MassHealth Standard. There are no premiums for CarePlus. CarePlus benefits are slightly more limited than those provided under MassHealth Standard.

ONECARE: MASSHEALTH PLUS MEDICARE

OneCare is a managed care option that provides coverage to disabled adults aged 21 to 64 years old who are eligible for MassHealth Standard or CommonHealth and are enrolled in Medicare Part A and Part B. Beneficiaries receive a comprehensive benefits package including inpatient and outpatient hospital services, pharmacy services, behavioral health services, physician services, long-term care services and supports, home health services, nursing facility services, durable medical equipment, and transportation services. (This plan was not included in the scope of our review.)

SENIOR CARE OPTIONS

Senior Care Options is a managed care plan that provides coverage to adults aged 65 or older who are eligible for MassHealth Standard and may also be eligible for Medicare. Beneficiaries receive a comprehensive benefits package including inpatient and outpatient hospital services, physician services, pharmacy services, home healthcare, long-term care services and supports (including nursing facility services), durable medical equipment, and transportation services. (This plan was not included in the scope of our review.)

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY

The PACE organization provides a comprehensive system of healthcare services for members age 55 and older who are otherwise eligible for nursing home admission. Beneficiaries receive a comprehensive benefits package, including care management, inpatient and outpatient hospital services, physician services, home health care, personal care, adult day care, durable medical equipment, and transportation services. PACE plans receive a capitated payment from both Medicaid and Medicare. (This plan was not included in the scope of our review.)

APPENDIX B: THE MEDICAL LOSS RATIO STANDARDS FOR PRIVATE HEALTH INSURERS, MEDICARE ADVANTAGE PLANS, AND PART D SPONSORS

The ACA, as amended,¹⁴ requires certain health insurers to submit data on the proportion of premium revenue spent on clinical services and activities that improve healthcare quality, also known as the MLR, and to issue rebates to enrollees if the percentage of premium revenue expended on costs for clinical services and activities that improve healthcare quality does not meet minimum standards.¹⁵

The MLR is the ratio of the numerator, consisting of the insurer's incurred claims plus the expenditures for activities that improve healthcare quality for the reporting year, to the denominator, which equals the insurer's premium revenue, excluding Federal and State taxes and licensing and regulatory fees, after accounting for payments or receipts related to the risk adjustment, risk corridors, and reinsurance programs (PHS Act § 2718(b)(1)(A)).¹⁶

The ACA-established formula for calculating the MLR is:

$$\frac{\text{(Incurred Claims + Expenditures for Activities that Improve Healthcare Quality)}}{\text{(Premium Revenue – Taxes – Licensing and Other Regulatory Fees)}}$$

If the applicable MLR standard is not met, the insurer must issue rebates to enrollees for the total amount of premium revenue (after subtracting Federal and State taxes and licensing or regulatory fees and, after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance),¹⁷ multiplied by the difference between the applicable MLR standard and the insurer's calculated MLR (PHS Act § 2718(b)(1)(B)).

¹⁴ ACA § 1001, added section 2718 to the Public Health Service (PHS) Act.

¹⁵ The ACA established a minimum MLR of 80 percent for individual and small markets (health insurance coverage offered to individuals other than in connection with a group health plan or group health plan maintained by a small employer with fewer than 100 employees) and 85 percent for large group markets (health insurance coverage through a group health plan maintained by a large employer with 101 or more employees) (PHS Act § 2718(b)(1)(A); ACA § 1304 (a)).

¹⁶ Federal regulations at 45 CFR part 158 contain the detailed methodology for calculating the MLR for certain private health insurers. Federal regulations at 42 CFR parts 422 and 423 contain the detailed methodology for calculating the MLR for Medicare Advantage plans and Part D sponsors, respectively.

¹⁷ The ACA's risk adjustment, risk corridors, and reinsurance programs are designed to work together to mitigate the potential effects of higher-than-average premiums and the denial of coverage to those who are in poor health and likely to require costly medical care. Specifically, risk adjustment is designed to mitigate any incentives for plans to attract healthier individuals and compensate those that enroll a disproportionately sick population. Risk corridors reduce the general uncertainty insurers face in the early years of implementation when the market is opened up to people with preexisting conditions who were previously excluded. Reinsurance compensates plans for their high-cost enrollees and, by the nature of its financing, provides a subsidy for individual market premiums generally over a 3-year period.

APPENDIX C: THE MEDICAL LOSS RATIO STANDARDS FOR MEDICAID MANAGED CARE ORGANIZATIONS

CMS published a final rule on May 6, 2016, that requires Medicaid MCOs to calculate, report, and use an MLR to develop capitation rates. The final rule requires that, effective July 1, 2017, the capitation rates for MCOs be set so as to achieve a minimum MLR of at least 85 percent.¹⁸ The MLR calculation for Medicaid MCOs is similar to the Federal standards for most private health insurers, Medicare Advantage plans,¹⁹ and Medicare Part D sponsors.²⁰

The MLR is the sum of an MCO's incurred claims, expenditures for activities that improve health care quality, and possibly limited expenditures for fraud prevention activities,²¹ divided by premium revenue adjusted for Federal or State taxes, licensing or regulatory fees, and after accounting for net adjustments for risk corridors or risk adjustment. According to CMS, the calculation is the same general calculation as the one established in 45 CFR § 158 for private insurers, with differences as to what is included in the numerator and the denominator to account for differences in the Medicaid program and population.

The formula for calculating the MLR under the final rule is:

$$\frac{(\text{Incurred Claims} + \text{Expenditures for Activities that Improve Healthcare Quality}^{22})}{(\text{Premium Revenue}^{23} - \text{Taxes} - \text{Licensing and Other Regulatory Fees})}$$

The CMS final rule proposes that States may impose a remittance requirement in accordance with State requirements if an MCO fails to meet the minimum MLR. While the rule does not require States to collect remittances from MCOs, CMS encourages States to implement these

¹⁸ 81 Fed. Reg. 27498, 27521 (May 6, 2016).

¹⁹ 42 CFR part 422.

²⁰ 42 CFR part 423.

²¹ CMS noted in the final rule that it was premature to adopt a standard for incorporating fraud prevention activities in the MLR for Medicaid since these expenses are not included in the current regulations on the MLR in the private insurance market. CMS further stated that fraud prevention activities should be aligned across programs. Therefore, the final rule stated that regulations related to incorporating fraud prevention activities in the MLR calculation will specify that MCO expenditures on activities related to fraud prevention as adopted for the private insurance market at 45 CFR part 158 would be incorporated into the Medicaid MLR calculation in the event the private insurance market MLR regulations are amended.

²² The definition of activities that improve health care quality encompasses activities related to service coordination, case management, and activities supporting States' goals for community integration of individuals with more complex needs, such as individuals using long-term services and supports.

²³ Payments by States to MCOs for one-time, specific life events of enrollees—events that do not receive separate payments in the private market or Medicare Advantage—would be included as premium revenue. Typical examples of these include maternity “kick-payments” where payments to MCO are made at the time of delivery to offset the cost of prenatal, postnatal, and labor and delivery costs for an enrollee.

types of financial contract provisions. Section 1.B.1.c.(3) of the final rule addresses the treatment of any Federal share of such remittances.²⁴

²⁴ 81 *Fed. Reg.* 27498, 27532 (May 6, 2016).

APPENDIX D: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the total amounts recorded on the MCOs' general ledgers for premium revenue, medical expenses, activities that improve healthcare quality, and Federal and State taxes and licensing and regulatory fees for 10 Medicaid managed care plans (5 traditional and 5 CarePlus) for CY 2014.²⁵ During this period, the total amount of Medicaid premium revenue earned by these plans was \$4 billion.

During CY 2014, the State agency claimed Medicaid reimbursement for payments made to five traditional MassHealth managed care plans and six MassHealth CarePlus managed care plans totaling approximately \$2.7 billion (\$1.4 billion Federal share) and \$1.4 billion (\$1.1 billion Federal share), respectively.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State's claim for reimbursement in the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64).

We did not review the overall internal control structure of the State agency or the MassHealth program. Rather, we reviewed only those controls related to our objective. We did not verify the accuracy of all cost and premium revenue information provided by the MCOs.

We performed fieldwork at the State agency's office in Boston, Massachusetts, and at MCOs' offices throughout Massachusetts from April through September 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- held discussions with CMS officials to obtain information regarding the MassHealth managed care program;
- held discussions with State agency officials to gain an understanding of the State agency's policies and procedures for overseeing and administering its Medicaid managed care program;
- reconciled Medicaid managed care payments included on Form CMS-64 to the State's MMIS for the quarter ended March 31, 2014;

²⁵ MCOs are required to file a statement of financial condition, including a balance sheet, a summary of receipts and disbursements, an income statement, and an analysis of utilization of all services covered by the MCO.

- obtained from the State agency a summary of capitated payments made to MCOs contracted with the State agency during CY 2014;
- obtained from the State agency quarterly revenue/expense reports for all Medicaid managed care plans; and
- selected for review 10 of the 11 Medicaid managed care plans (5 traditional plans and 5 CarePlus plans):
 - obtained from the MCOs total amounts recorded on their plans' general ledgers for cost and premium revenue;²⁶
 - obtained from the MCOs supporting documentation (e.g., general ledger account summaries and actuarial estimates and opinions) for the cost and premium revenue elements, as well as an explanation of how these amounts were derived;
 - verified a judgmental sample of incurred medical expenses;²⁷
 - verified earned premium revenue;²⁸
 - used the financial data obtained from the MCOs to compute the MLR for each rating category, using the formula applicable to private health insurers and Medicare Advantage plans;
 - calculated the remittance²⁹ that would have been issued to the State agency and determined the potential Medicaid program savings if the State agency had required the plan to meet a minimum MLR standard and issue a remittance to the State agency if the standard was not met; and
 - discussed our audit results with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

²⁶ Specifically, we obtained the total amounts recorded on the plans' general ledgers for premium revenue, medical expenses, activities that improve healthcare quality, and Federal and State taxes and licensing and regulatory fees.

²⁷ We selected 1 month during the audit period and verified certain medical expenses to the general ledger and supporting documentation (e.g., invoices).

²⁸ We obtained total capitated payments made to the plans by the State agency and compared those amounts to the plans' earned premium revenue.

²⁹ The ACA-established formula for calculating the rebate is (premium revenue – taxes – licensing and regulatory fees) × (the applicable MLR standard – the insurer's calculated MLR).

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**APPENDIX E: MEDICAL LOSS RATIOS FOR MASSHEALTH
MANAGED CARE PLANS AND POTENTIAL PROGRAM SAVINGS**

Traditional Plans	Rating Category³⁰	MLR³¹	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings³²
TMMC-1	I	101.5%	-	-
TMMC-1	II	94.0%	-	-
TMMC-2	I	89.3%	-	-
TMMC-2	II	97.8%	-	-
TMMC-3	I	107.4%	-	-
TMMC-3	II	84.1%	\$360,145	\$180,073
TMMC-4	I	105.0%	-	-
TMMC-4	II	100.2%	-	-
TMMC-5	I	98.3%	-	-
TMMC-5	II	87.0%	-	-
Subtotal			360,145	180,073
CarePlus Plans				
CMMC-1	IX	90.5%	-	-
CMMC-1	X	100.3%	-	-
CMMC-2	IX	78.0%	4,370,125	3,277,593
CMMC-2	X	84.8%	4,419	3,314
CMMC-3	IX	91.6%	-	-
CMMC-3	X	112.9%	-	-
CMMC-4	IX	110.9%	-	-
CMMC-4	X	111.3%	-	-
CMMC-5	IX	93.4%	-	-
CMMC-5	X	106.0%	-	-
Subtotal			4,374,544	3,280,907
Total			\$4,734,689	\$3,460,980

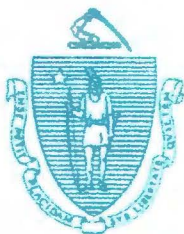
Note: Shaded areas indicate those plans and rating categories that did not meet a minimum MLR of 85 percent.

³⁰ The State agency uses rating categories to identify specific groupings of managed care enrollees based on assignment plan and disability status.

³¹ We rounded insurers' MLRs in accordance with Federal regulations (45 CFR § 158.221 and 42 CFR §§ 422.2400-2480).

³² The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program (section 1903(d)(3)(A) of the Social Security Act). To determine the approximate Federal share for traditional managed care plans, we multiplied the Medicaid potential program savings by the traditional Federal medical assistance percentage (FMAP) of 50 percent. For Careplus managed care plans, we used the enhanced FMAP of 75 percent for members considered "newly eligible" under the ACA. In future years, savings will likely be greater. The enhanced FMAP for Massachusetts was 80 percent in 2015, will gradually increase to 93 percent by 2019, and will then decrease to 90 percent in 2020, where it will remain indefinitely.

APPENDIX F: STATE AGENCY COMMENTS



The Commonwealth of Massachusetts
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Report Number: A-01-15-00505

September 23, 2016

Mr. David Lamir
Regional Inspector General for Audit Services
Office of Audit Services, Region I
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, MA 02203

Dear Mr. Lamir:

The Massachusetts Executive Office of Health and Human Services (EOHHS) is writing to respond to the U.S. Department of Health and Human Services, Office of Inspector General's draft report No. A-01-15-00505 ("the Draft Report") dated August 2016. The Draft Report pertains to an OIG Review of Massachusetts Medicaid Managed Care Program Potential Savings with Minimum Medical Loss Ratio. We welcome the opportunity to respond to the Draft Report, and greatly appreciate your efforts and your willingness to accept input from EOHHS in preparing your final report.

Attached please find Massachusetts' response to each of the recommendations in the draft report.

Sincerely,


Marylou Sudders



**OIG Review of MassHealth Managed Care Program Potential Savings with Minimum MLR
MassHealth Responses – September 23, 2016**

OIG Recommendations – Responses

- 1. *Incorporate into its contract with Medicaid MCOs the MLR standards adopted in the CMS final rule.***

MassHealth Response: As noted in the report, at the time of the OIG review, MassHealth was not required to have a minimum MLR standard in place for contracted managed care organizations (MCOs). MassHealth does, however, require its MCOs to submit their MLR calculation as well as other industry financial ratios as specified in the MCO contract. Based on our review of the MCOs MLR s, calculated using the traditional MLR formula, all 5 MCOs that were part of the OIG MLR review exceeded the 85% MLR standard for 2014.

In light of the final managed care rule issued by CMS in May 2016 which now requires a minimum MLR for Medicaid MCOs, MassHealth has already initiated a review of the managed care contracts and has drafted proposed language to comply with this rule. Given the July 2017 effective date, MassHealth expects to include this requirement in its 10/1/17 contracts resulting from its MCO and CarePlus program procurement. Additionally, as part of the proposed MCO contract amendment for 10/1/16, MassHealth has added MLR reporting and calculation requirements as well as a provision that states that the MCOs may be directed to maintain a minimum MLR and related requirements (this would be captured in a subsequent contract amendment).

- 2. *Consider implementing into its Medicaid MCO contracts a remittance requirement if appropriate (while the CMS final rule did not require States to collect remittances from MCOs, CMS encouraged States to implement this type of provision).***

MassHealth Response: As part of its overall review of the CMS final managed care rule and recommendations as well as required MassHealth programming changes to comply with the final rule requirements, MassHealth will continue to evaluate the benefit to the State using actual MCO financial performance data in upcoming contracts. To help with this evaluation, MassHealth will require Plans to provide additional data to more accurately capture all the elements included in the formula articulated in the final rule. Based on this assessment MassHealth will consider this proposal for future MCO contract modifications.

- 3. *MassHealth also proposes a couple of clarifications to the draft OIG report:***

- Page 3, How We Conducted This Review, 1st paragraph:** propose changing the number of managed care "Plans" reviewed from 10 to five (5) to prevent confusion with the number of managed care entities that were part of their evaluation. MassHealth currently contracts with six contracted managed care organizations (5 who supported both the Traditional MCO Program and CarePlus during the review period and one, Celticare, who participated only in the CarePlus program). OIG has noted that one MassHealth Plan (Celticare) was not reviewed because it only had one year of operational experience (see footnote #8).

- **Page 6, Appendix A: MassHealth Managed Care Coverage Types:** MassHealth recommends Appendix A be modified for clarity. For example the reference to Plans (i.e. **Managed care plans that offer...**) should be removed to clarify that certain coverage types are not supported by unique managed care entities. As noted above and referenced in the draft report, there are five MCOs (Boston Medical Center Health Net Plan, Fallon, Health New England, Neighborhood Health Plan and Tufts) that participate in the Traditional MCO Program (serves members with MassHealth Standard, MassHealth CommonHealth and MassHealth Family Assistance coverage types). In addition to Celticare, these same five MCOs also supported the CarePlus program in calendar year 2014. Please note that effective 2016, HNE no longer participates in the CarePlus Program. Please see attached for proposed modifications to Appendix A.