Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SOUTH CAROLINA'S MEDICAID MANAGED CARE PROGRAM POTENTIAL SAVINGS WITH MINIMUM MEDICAL LOSS RATIO

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INTRODUCTION

The Medicaid program would not have realized any savings if South Carolina had required its Medicaid managed care plans to meet minimum medical loss ratio standards similar to those for private health insurers and Medicare Advantage plans and if South Carolina had required remittances when managed care plans did not meet the standards.

WHY WE DID THIS REVIEW

A medical loss ratio (MLR) is the percentage of premium dollars an insurer spends to provide medical services and healthcare quality improvement activities for its members compared to the premium dollars it uses to pay for administrative expenses. This report is part of a series[1] of Office of Inspector General reviews conducted to determine whether the Medicaid program could achieve savings if States required Medicaid managed care organizations (MCOs) to meet minimum MLR standards and pay remittances if the MLR standards were 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 85 percent or 80 percent. At the time of our review, CMS did not require States to have minimum MLR standards for Medicaid MCOs. After our review, but prior to 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 encouraged States to adopt provisions that would require Medicaid MCOs to pay remittances when they do not meet MLR standards. 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.

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[1] To date, we have issued three 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), *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), *Review of Massachusetts Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio* (A-01-15-00505), and *Review of Massachusetts Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio* (A.01-15-00505).

[2] Private health insurers, Medicare Advantage plans, and Medicare Part D sponsors are required to meet minimum MLR standards pursuant to the 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 South Carolina Department of Health and Human Services (State agency) (1) required its Medicaid managed care plans to meet minimum MLR standards similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances if those MLR standards were 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 South Carolina, 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 an 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 variances to account for differences in the Medicaid program and population, for example, 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 utilize 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 minimum MLR standards are not met.

South Carolina's Medicaid Managed Care Program

Under the Healthy Connections 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 eligibility categories,[4] which identify specific

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[3] 81 Fed. Reg. 27498 (May 6, 2016).

[4] The eligibility categories are limited to certain Medicaid enrollees who do not also have Medicare, are under the age of 65, are not in a nursing home, limited benefit category, Home or Community Based Waiver program, Hospice, PACE program, do not have HMO third party coverage, and not enrolled in another Medicaid managed care plan.

groupings of managed care enrollees based on a beneficiary's eligibility type (e.g., low income families or SSI over 18), as determined by the State agency. In 2014, about 768,323 Medicaid beneficiaries in South Carolina were enrolled in Medicaid managed care plans. These people were enrolled in six Healthy Connections managed care plans, which offer comprehensive health services covered under the Medicaid State Plan.

Appendix A contains the MLR standards for private health insurers, Medicare Advantage plans, and Part D sponsors and Appendix B contains the MLR standards for Medicaid MCOs.

Capitation payments to South Carolina MCOs include both administrative and medical expense components. Healthy Connections managed care contracts are risk-based[5] between the State agency and the MCOs, but the Healthy Connections managed care plan contracts do not contain MLR standards. During calendar year (CY) 2014, the State agency claimed Medicaid reimbursement for payments made to MCOs totaling $2.5 billion ($1.8 billion Federal share).

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for six Healthy Connections managed care plans. During this period, the total amount of Medicaid premium revenue earned by these plans was $2.5 billion. For each MCO, 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 were 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 C contains the details of our audit scope and methodology.

RESULTS OF REVIEW

The Healthy Connections program would not have realized any Medicaid savings in CY 2014 if the State agency had (1) required its Medicaid managed care plans to meet minimum MLR standards 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 MLR standards. Specifically, all of the six managed care plans that we reviewed had MLRs greater than 85 percent (the minimum MLR standards for large private insurers) during CY 2014. This report therefore makes no recommendations.

[5] The MCO assumes the risk if the cost exceeds the capitation payment.

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

The ACA, as amended,[6] 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.[7]

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)).[8]

The ACA-established formula for calculating the MLR is:

(Incurred Claims + Expenditures for Activities that Improve Healthcare Quality) ÷
(Premium Revenue − Taxes − Licensing and Other Regulatory Fees)

If the applicable MLR standards are 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,[9] multiplied by the difference between the applicable MLR standards and the insurer's calculated MLR (PHS Act § 2718(b)(1)(B)).

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

[7] 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)).

[8] 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.

[9] 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 B: 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.[10] The MLR calculation for Medicaid MCOs is similar to the Federal standards for most private health insurers, Medicare Advantage plans,[11] and Medicare Part D sponsors.[12]

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,[13] 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 § 158.221 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:

(Incurred Claims + Expenditures for Activities that Improve Healthcare Quality[14]) ÷
(Premium Revenue[15] − Taxes − 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

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[10] 81 Fed. Reg. 27498, 27521 (May 6, 2016).

[11] 42 CFR part 422.

[12] 42 CFR part 423.

[13] 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.

[14] 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.

[15] 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.[16]

[16] 81 Fed. Reg. 27498, 27532 (May 6, 2016).

APPENDIX C: 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 six Medicaid managed care plans for CY 2014.[17] During this period, the total amount of Medicaid premium revenue earned by these plans was $2.5 billion.

During CY 2014, the State agency claimed Medicaid reimbursement for payments made to the six Healthy Connections managed care plans totaling approximately $2.5 billion ($1.8 billion Federal share).

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 Healthy Connections 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 Columbia, South Carolina, and at MCOs' offices throughout South Carolina from October 2015 through March 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- held discussions with CMS officials to obtain information regarding the Healthy Connections 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 September 30, 2014;

[17] 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 all six Medicaid managed care plans:

  - obtained from the MCOs total amounts recorded on their plans' general ledgers for cost and premium revenue;[18]

  - 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;[19]

  - verified earned premium revenue;[20]

  - 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; 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 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.

[18] 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.

[19] We selected and verified certain medical expenses to the general ledger and supporting documentation (e.g. claims data summary).

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