

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MINNESOTA MEDICAID MANAGED CARE
ENTITIES USED A MAJORITY OF
MEDICAID FUNDS RECEIVED FOR
MEDICAL EXPENSES AND QUALITY
IMPROVEMENT ACTIVITIES**

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Deputy Inspector General
for Audit Services**

**September 2021
A-05-18-00018**

Office of Inspector General

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Report in Brief

Date: September 2021

Report No. A-05-18-00018

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

The Secretary of Health and Human Services received multiple letters expressing concerns regarding the oversight of the Minnesota Medicaid managed care program. The concerns included the lack of transparency of the managed care program, the payments made to managed care entities, and the lack of requirements for meeting medical loss ratios (MLRs). An MLR is the percentage of premium dollars spent to provide medical services and health care quality improvement activities.

Our objective was to examine how Minnesota managed care entities use Medicaid funds they receive to provide services to enrollees.

How OIG Did This Audit

We reviewed calendar year (CY) 2017 cost and premium revenue data for eight Minnesota Medicaid managed care entities. Medicaid managed care entities are required to calculate and report an MLR for contracts starting on or after July 1, 2017. For each managed care entity's Medicaid contract, we determined the MLR for the same period and the amount the managed care entities would have had to return to Minnesota if the managed care entities' Medicaid programs were required to meet a minimum MLR of 85 percent.

Minnesota Medicaid Managed Care Entities Used a Majority of Medicaid Funds Received for Medical Expenses and Quality Improvement Activities

What OIG Found

During CY 2017, Minnesota managed care entities used the majority of funds received for medical expenses and quality improvement activities. Specifically, of the eight Medicaid managed care entities that we reviewed, we calculated MLRs for their contracted Medicaid programs and found one entity that had an MLR less than 85 percent during CY 2017 for one of its contracts. We determined that the Minnesota Medicaid program could have saved \$82,427 (approximately \$41,213 Federal share) in CY 2017 if Minnesota: (1) required its Medicaid managed care entities to meet the minimum 85-percent MLR standard for each Medicaid managed care contract and (2) required remittances when Medicaid managed care entities did not meet the MLR standard.

What OIG Recommends and Minnesota Comments

During CY 2017, Minnesota managed care entities used the majority of funds received for medical expenses and quality improvement activities. Further, Minnesota has incorporated a remittance requirement for contracts beginning CY 2018 if MCOs do not meet an MLR of at least 85 percent; therefore, we have no recommendations. Minnesota provided comments on the draft report.

TABLE OF CONTENTS

INTRODUCTION..... 1

 Why We Did This Audit..... 1

 Objective..... 1

 Background..... 1

 The Medicaid Program..... 1

 Minimum Medical Loss Ratio for Medicaid Managed Care Entities 2

 Minnesota’s Medicaid Managed Care Program 2

 How We Conducted This Audit..... 3

RESULTS OF AUDIT 3

CONCLUSION 4

MINNESOTA COMMENTS 4

APPENDICES

 A: Audit Scope and Methodology..... 5

 B: Minnesota’s Medicaid Managed Care Programs 7

 C: Medical Loss Ratio Standards for Medicaid Managed Care Entities..... 8

 D: Medical Loss Ratios for Minnesota’s Medicaid Managed Care Entities and
 Potential Program Savings 10

 E: State Agency Comments..... 11

INTRODUCTION

WHY WE DID THIS AUDIT

The Secretary of Health and Human Services has received multiple letters expressing concerns regarding the oversight of the Minnesota Medicaid managed care program. The concerns included the lack of transparency of the managed care program, the payments made to managed care entities, and the lack of requirements for meeting medical loss ratios (MLRs). An MLR is the percentage of premium dollars an insurer spends to provide medical services and health care quality improvement activities for its members. Determining the managed care entities' MLRs helps demonstrate how the managed care entities are spending Medicaid funds.

At the time of our audit, the Centers for Medicare & Medicaid Services (CMS) did not require States to have a minimum MLR standard for Medicaid managed care entities. For contracts starting on or after July 1, 2017, the State must ensure that each managed care entity calculates and reports an MLR.¹ The MLR formula is similar to the MLR requirements for most private health insurers, Medicare Advantage plans, and Medicare Part D sponsors. If a State elects to mandate a minimum MLR for its managed care entities, that minimum MLR must be equal to or higher than 85 percent.² States are not required to adopt provisions that mandate Medicaid managed care entities to pay remittances that do not meet the MLR standard.

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

OBJECTIVE

Our objective was to examine how Minnesota managed care entities use Medicaid funds they receive to provide services to enrollees.

BACKGROUND

The Medicaid Program

The Medicaid program provides 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 Minnesota, the Department of Human Services (State agency) administers the Medicaid program.

¹ 42 CFR § 438.8(a).

² 42 CFR § 438.8(c).

Minimum Medical Loss Ratio for Medicaid Managed Care Entities

The State must ensure, through its contracts starting on or after July 1, 2017, that each managed care entity calculates and reports an MLR. CMS implemented an MLR calculation for Medicaid managed care entities similar to the Federal standards for most private health insurers, Medicare Advantage Plans, and Medicare Part D sponsors. The MLR calculation for Medicaid managed care entities includes some variations to account for differences in the Medicaid program and population, for example, long-term services and supports or other services specific to Medicaid and covered under the State plan. If a State elects to mandate a minimum MLR for its managed care entities, that minimum MLR must be equal to or higher than 85 percent (the standard used for projecting actuarial soundness). 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. CMS did not require Medicaid State agencies to implement remittances for managed care entities that fail to meet MLR standards. However, CMS provided States the flexibility to require remittances from managed care entities and encouraged States to implement contract provisions for remittances when the minimum MLR standard is not met.

Minnesota's Medicaid Managed Care Program

Under Minnesota's Medicaid managed care program, the State agency pays contracted managed care entities fixed monthly capitation payments to make Medicaid-covered services available to enrollees. In calendar year (CY) 2017, 1,144,444 Medicaid beneficiaries in Minnesota were enrolled in 4 Medicaid managed care programs,³ which offer comprehensive health services to low-income individuals and families, as well as to seniors and people with disabilities.

Appendix B contains a detailed description of Minnesota's Medicaid managed care programs, and Appendix C contains the MLR standards for Medicaid managed care entities. Starting with contract year 2018, Minnesota required the managed care entities to calculate MLRs for Federal reporting purposes on a per contract basis.

For CY 2017, the State agency claimed Medicaid reimbursement for payments made to managed care entities totaling \$5.7 billion (\$3.5 billion Federal share) for the four programs.

³ The four Minnesota Medicaid managed care programs included Prepaid Medical Assistance Program, Minnesota Senior Health Options, Minnesota Senior Care Plus, and Special Needs BasicCare. Minnesota Senior Health Options and Minnesota Senior Care Plus programs are under one contract.

HOW WE CONDUCTED THIS AUDIT

We reviewed CY 2017 cost and premium revenue data for eight Minnesota Medicaid managed care entities.⁴ For this period, the total amount of Medicaid premium revenue earned by these entities was \$5.6 billion.⁵ For each managed care entity's Medicaid contract, we determined the MLR for the same period and the amount the managed care entities would have had to return to the State agency if the managed care entities' Medicaid programs were required to meet MLR standards similar to those for private insurers and Medicare Advantage plans. We used the MLR formula applicable to the Medicaid managed care entities for contracts starting on or after July 1, 2017.

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 A contains the details of our audit scope and methodology.

RESULTS OF AUDIT

During CY 2017, Minnesota managed care entities used the majority of funds received for medical expenses and quality improvement activities. Specifically, of the eight Medicaid managed care entities that we reviewed, we calculated MLRs for their contracted Medicaid programs and found one entity that had an MLR less than 85 percent during CY 2017 for the Minnesota Senior Care Plus and Minnesota Senior Health Options contract. We determined that the Minnesota Medicaid program could have saved \$82,427 (approximately \$41,213 Federal share) in CY 2017 if the State agency: (1) required its Medicaid managed care entities to meet the minimum 85-percent MLR standard for each Medicaid managed care contract and (2) required remittances when Medicaid managed care entities did not meet the MLR standard.

Appendix D contains the results of our calculation of the MLR for each Medicaid managed care contract with the 8 entities (21 MLRs in total⁶), the results of our calculation of potential remittances if the entities did not meet an 85-percent minimum MLR standard, and potential

⁴ The audit period encompassed the most current data available at the time we initiated our audit.

⁵ The State agency claimed Medicaid reimbursement for pass-through payments of \$45.5 million (\$28.2 million Federal share). Pass-through payments are amounts paid to Medicaid managed care entities as supplemental payments that the entities are required to pass through to designated contracted providers and are defined in 42 CFR § 438.6(a). They are not considered premium revenue earned by the managed care entities for the MLR calculation.

⁶ Three of the eight managed care entities did not have one of the three contracts we reviewed.

Medicaid program savings if the State agency had required its Medicaid managed care entities to meet an 85-percent minimum MLR standard for each Medicaid managed care contract and issue remittances to the State agency if the standard were not met.

CONCLUSION

During CY 2017, Minnesota managed care entities used the majority of funds received for medical expenses and quality improvement activities. Further, Minnesota has incorporated a remittance requirement for contracts beginning CY 2018 if MCOs do not meet an MLR of at least 85 percent; therefore, we have no recommendations.

MINNESOTA COMMENTS

The Minnesota Department of Human Services Deputy Commissioner provided comments on the draft report, which are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the total amounts recorded by the managed care entities for premium revenue, medical expenses, activities that improve health care quality, fraud prevention activities, and Federal and State taxes and licensing and regulatory fees for four Medicaid managed care programs for CY 2017. For this period, the total amount of Medicaid premium revenue earned by these entities was \$5.6 billion. For CY 2017, the State agency claimed Medicaid reimbursement for payments made to the eight managed care entities totaling \$5.7 billion (\$3.5 billion Federal share).

Our audit allowed us to establish reasonable assurance of the authenticity, accuracy, and completeness of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We established reasonable assurance of the data provided by the State by reconciling payments made to the managed care entities with the amounts recorded by the managed care entities and then reconciling payment totals to the State's claim for reimbursement on 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 Minnesota Medicaid 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 managed care entities.

We performed audit work at the State agency's office in St. Paul, Minnesota, and at managed care entities' offices in Minnesota as well as in our office in Madison, Wisconsin.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- 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 to the amounts included on Form CMS-64 for the quarter ended March 31, 2017;
- obtained from the State agency a summary of capitated payments made to managed care entities contracted with the State agency during CY 2017;

- selected for review all eight Medicaid managed care entities, and, for each contracted Medicaid program:
 - obtained from the managed care entities total amounts recorded for cost and premium revenue;⁷
 - obtained from the managed care entities supporting documentation (e.g., general ledger account summaries and actuarial estimates) 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;⁸
 - verified earned premium revenue;⁹ and
 - used the financial data obtained from the managed care entities to compute the MLR;
- calculated the remittance¹⁰ that would have been issued to the State agency and determined the potential Medicaid program savings if the contract with the MCOs had required the managed care entity to meet a minimum MLR standard and issue a remittance to the State agency if the standard were not met; and
- discussed our audit results with State agency officials.

We provided the State agency with a draft audit report for review. The State agency provided comments that we included in their entirety as Appendix E.

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.

⁷ Specifically, we obtained the total amounts recorded for premium revenue, medical expenses, activities that improve health care quality, fraud prevention activities, and Federal and State taxes and licensing and regulatory fees.

⁸ We verified certain medical expenses to the general ledger and supporting documentation (e.g., invoices).

⁹ We obtained total capitated payments made by the State agency to the entities for their contracted Medicaid programs and compared those amounts to the entities' earned premium revenue.

¹⁰ We used the Affordable Care Act-established formula for calculating the rebate, which is (premium revenue – taxes – licensing and regulatory fees) × (the applicable MLR standard – the insurer's calculated MLR).

APPENDIX B: MINNESOTA'S MEDICAID MANAGED CARE PROGRAMS

[Also called Medical Assistance]

PREPAID MEDICAL ASSISTANCE PROGRAM

The Prepaid Medical Assistance Program is a managed care program for people eligible for Medicaid who are pregnant women, children under 21, adults with children and relative caretakers age 21 to 64, or adults without children age 21 to 64.

MINNESOTA SENIOR HEALTH OPTIONS

Minnesota Senior Health Options (MSHO) is a voluntary managed care program that combines Medicare and Medicaid financing and acute and long-term care service delivery systems for people age 65 or older into one managed care plan. Known as a Medicare Advantage Special Needs Plan federally, MSHO is only available to people 65 or over who are enrolled in Medicaid and Medicare. In addition to all the benefits under Medicare and Medicaid, MSHO provides a dedicated care coordinator to help members navigate through their Medicare and Medicaid health care benefits.

MINNESOTA SENIOR CARE PLUS

Minnesota Senior Care Plus is Minnesota's mandatory managed care program for people who are age 65 or older, either dually eligible for Medicare and Medicaid or only eligible for Medicaid, and not enrolled in MSHO. It provides a care coordinator to help members navigate Medicaid benefits.

SPECIAL NEEDS BASIC CARE

Special Needs BasicCare (SNBC) is a voluntary managed care program for people with disabilities ages 18 through 64 who have Medicaid. Enrollees may have a care coordinator or navigator to help them get health care and support services. Some SNBC health plans coordinate with other payers, including Medicare Parts A, B, and D for enrollees who have that coverage. Some health plans are contracted with CMS to integrate Medicare and Medicaid benefit sets.

APPENDIX C: MEDICAL LOSS RATIO STANDARDS FOR MEDICAID MANAGED CARE ENTITIES

FEDERAL LAWS

The State must ensure, through its contracts starting on or after July 1, 2017, that each managed care entity calculates and reports an MLR.¹¹ If a State elects to mandate a minimum MLR for its managed care entities, that minimum MLR must be equal to or higher than 85 percent (the standard used for projecting actuarial soundness).¹² The MLR calculation for Medicaid managed care entities is similar to the Federal standards for most private health insurers, Medicare Advantage plans,¹³ and Medicare Part D sponsors.¹⁴

The MLR is the sum of a managed care entity's incurred claims, expenditures for activities that improve health care quality, and expenditures for fraud prevention activities divided by premium revenue adjusted for Federal or State taxes and licensing or regulatory fees and 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 is:

$$\frac{\text{(Incurred Claims + Expenditures for Activities That Improve Health Care Quality}^{15} \\ \text{+ Fraud Prevention Activities)}}{\text{(Premium Revenue}^{16} \text{ – Taxes – Licensing and Other Regulatory Fees)}}$$

A credibility adjustment is also added to the MLR before calculating any remittance for a partially credible managed care entity to account for the difference between the actual and

¹¹ 42 CFR § 438.8(a).

¹² 42 CFR § 438.8(c).

¹³ 42 CFR part 422.

¹⁴ 42 CFR part 423.

¹⁵ 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.

¹⁶ Payments by States to managed care entities 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 managed care entities are made at the time of delivery to offset the cost of prenatal, postnatal, and labor and delivery costs for an enrollee.

target MLRs that may be due to random statistical variation. On an annual basis, CMS will calculate and publish base credibility factors for managed care entities.

**APPENDIX D: MEDICAL LOSS RATIOS FOR MINNESOTA’S MEDICAID
MANAGED CARE ENTITIES AND POTENTIAL PROGRAM SAVINGS**

Program/Managed Care Entity	MLR¹⁷	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings¹⁸
Prepaid Medical Assistance Program			
MCE-1	95.3%		
MCE-2	100.8%		
MCE-3	87.6%		
MCE-4	90.0%		
MCE-5	109.7%		
MCE-6	95.9%		
MCE-7	96.3%		
MCE-8	91.3%		
Minnesota Senior Health Options and Minnesota Senior Care Plus (Combined)			
MCE-1	93.2%		
MCE-2	87.2%		
MCE-3	N/A		
MCE-4	102.6%		
MCE-5	98.7%		
MCE-6	89.5%		
MCE-7	84.8%	\$82,426.71	\$41,213.36
MCE-8	102.2%		
Special Needs Basic Care			
MCE-1	N/A		
MCE-2	111.9%		
MCE-3	85.4%		
MCE-4	N/A		
MCE-5	97.1%		
MCE-6	101.7%		
MCE-7	97.0%		
MCE-8	93.0%		

Note: The shaded area indicates the entity’s contract that did not meet a minimum MLR of 85 percent.

¹⁷ We rounded insurers’ MLRs in accordance with Federal regulations (45 CFR § 158.221 and 42 CFR §§ 422.2400-2480). An MLR of N/A indicates that the managed care entity did not have a contract for that specific program.

¹⁸ 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). We used Minnesota’s regular FMAP rate of 50 percent, as Congress has allowed States to calculate the Federal share of the remittance at the lower regular FMAP rather than the enhanced FMAP rate.

APPENDIX E: STATE AGENCY COMMENTS



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August 17, 2021

Department of Health and Human Services
Office of Audit Services, Region V
Sheri L. Fulcher, Regional Inspector General for Audit Services
233 North Michigan, Suite 1360
Chicago, Illinois 60601

Dear Ms. Fulcher:

Thank you for providing an opportunity to comment on draft audit report A-05-18-00018 entitled *Minnesota Medicaid Managed Care Entities Used a Majority of Medicaid Funds Received for Medical Expenses and Quality Improvement Activities*. We appreciated the opportunity to work with your staff as they conducted this work.

The state of Minnesota works hard to ensure that managed care capitation rates set for our public health care programs are efficient and actuarially sound. Funds paid by the state to contracted managed care organizations are used to provide services to enrollees and improve the quality of care enrollees receive, as confirmed by your review of medical loss ratios (MLRs).

Minnesota elected to incorporate a remittance to the state if a managed care organization has an MLR lower than the federal standard of 85%. This applies to contracts beginning January 1, 2018 and after, which was our state's earliest opportunity in accordance with federal managed care regulations.

We appreciate your review and if you have any questions, comments or concerns about our response, please contact Gary L. Johnson, Director of Internal Audits, at 651 431-3623 or through e-mail at Gary.L.Johnson@state.mn.us.

Sincerely,

/Charles E. Johnson/

Charles E. Johnson
Deputy Commissioner