Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CALIFORNIA MEDICAID MANAGED-CARE PROGRAM POTENTIAL SAVINGS WITH MINIMUM MEDICAL LOSS RATIO

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

For the nine Medicaid managed-care organizations we reviewed, the Medicaid program would not have realized savings in 2014 if California had (1) required the organizations to meet a minimum medical loss ratio standard similar to the Federal standards for private health insurers and Medicare Advantage plans and (2) required remittances when that standard was not met.

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 health care quality improvement activities for its members. This review is part of a series of Office of Inspector General (OIG) 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.[1] (See Appendix A for a list of related OIG reports.)

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.[3]

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 its final rule requiring States to set capitation rates that target a minimum MLR for Medicaid MCOs. 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 the MLR standard. Several States have already awarded contracts to Medicaid MCOs with MLR standards similar to those for private health insurers, Medicare Advantage plans, and Medicare Part D sponsors. Some of these contracts require MCOs to issue remittances to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards.

[1] Remittances in this context represent a partial refund of premiums.

[2] Patient Protection and Affordable Care Act, 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.

[3] 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 100 or fewer 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) (Public Health Service (PHS) Act § 2718(b)(1)(A); ACA § 1304(a)).

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 determine the potential Medicaid program savings if the California Department of Health Care Services (State agency) had (1) required its Medicaid MCOs to meet a minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances when 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 California, 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.[4] 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 (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, and an MLR is one tool that can be used to assess whether capitation rates are appropriately set. Appropriately set capitation rates help to ensure that adequate payments are made to provide services to beneficiaries rather than for administrative expenses. MCOs are also required to calculate and report their MLR to State Medicaid agencies. CMS did not require Medicaid State agencies to implement remittances for MCOs that fail to meet MLR standards. However, CMS provided 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.

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

[4] 81 Fed. Reg. 27498, 27521 (May 6, 2016).

California's Medicaid Managed-Care Program

Under California's Medicaid managed-care program, the State agency pays its Medicaid MCOs fixed, monthly capitated payments to provide enrollees with Medicaid-covered services. The capitation payments include administrative and medical expense components.
The State agency's contracts with its Medicaid MCOs placed a limit on the administrative expenses that an MCO could incur in accordance with State regulations.[5] Additionally, the contracts required an MCO to achieve a minimum MLR for its adult members enrolled as part of the ACA's Medicaid expansion.[6] However, the State agency's contracts did not contain MLR standards for any other beneficiaries, which, for the purpose of this report, we refer to as "non-expansion members."

In December 2014, approximately 8.9 million Medicaid beneficiaries in California were enrolled in Medicaid managed-care plans. During calendar year (CY) 2014, the State agency claimed Federal Medicaid reimbursement for capitated payments that it made to MCOs totaling $27.4 billion ($16.8 billion Federal share).

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for Medicaid non-expansion members for the nine highest paid Medicaid MCOs in California.[7] For each of the nine MCOs, we determined the MLR for CY 2014 and whether the MCO would have had to issue remittances to the State agency if the MCO 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.

[5] An established plan with administrative costs exceeding 15 percent of its earned revenue may be called upon by the State agency to demonstrate that its administrative costs are not excessive and are justified under the circumstances, or that it has instituted procedures that have effectively reduced its administrative costs (California Code of Regulations, Title 28, § 1300.78(b)).

[6] Effective January 1, 2014, the ACA gave States the choice to expand their Medicaid coverage for nearly all individuals under the age of 65 with incomes up to 133 percent of the Federal poverty level. California chose to participate in the Medicaid expansion. Individuals enrolled in managed-care plans through California's Medicaid expansion program are known as adult expansion members.

[7] During this period, the State agency made approximately $19.9 billion of capitation payments to these nine MCOs. We excluded cost and premium revenue data for adult expansion members and members of nonfederally funded programs because an MLR was already applied to them or their services were not federally funded.

RESULTS OF REVIEW

For the nine Medicaid MCOs that we reviewed, the State agency would not have realized Medicaid program savings in CY 2014 if the State agency had (1) required the MCOs to meet a minimum MLR standard similar to the Federal standards for certain private health insurers and Medicare Advantage plans and (2) required remittances when that MLR standard was not met. Although the State agency did not require its MCOs to achieve a minimum MLR standard, the State agency achieved savings similar to the savings it would have achieved with an MLR requirement by placing limits on the administrative costs that MCOs could incur. Because the MLRs we calculated for the nine MCOs were greater than 85 percent during CY 2014, the MCOs would not have had to issue remittances to the State agency. Consequently, this report does not include any recommendations.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Review of South Carolina's Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio	A-04-16-06191	12/21/2016
Review of Massachusetts Medicaid Managed Care Program Potential Savings With Minimum Medical Loss Ratio	A-01-15-00505	11/30/2016
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	4/12/2016
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	10/20/2015

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

The ACA, as amended,[8] requires certain health insurers to submit data on the proportion of premium revenue spent on clinical services and activities that improve health care 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 health care quality does not meet minimum standards.[9]

The MLR is the ratio of the numerator, consisting of the insurer's incurred claims plus the expenditures for activities that improve health care 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)).[10]

The ACA-established formula for calculating the MLR is:

(Incurred Claims + Expenditures for Activities That Improve Health Care Quality) ÷
(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)[11] multiplied by the difference between the applicable MLR standard and the insurer's calculated MLR (PHS Act § 2718(b)(1)(B)).

[8] Section 1001 of the ACA added section 2718 to the PHS Act.

[9] 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 100 or fewer 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)).

[10] 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.

[11] 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.[12] The MLR calculation for Medicaid MCOs 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 an MCO's incurred claims, expenditures for activities that improve health care quality, and possibly limited expenditures for fraud prevention activities[15] divided by premium revenue adjusted for Federal or State taxes and 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:

$$\frac{\text{(Incurred Claims + Expenditures for Activities That Improve Health Care Quality}^{16}\text{)}}{\text{(Premium Revenue}^{17}\text{ − Taxes − Licensing and Other Regulatory Fees)}}$$

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. Although the final rule does not require States to collect remittances from MCOs, CMS encourages States to implement

[12] 81 Fed. Reg. 27498, 27521 (May 6, 2016).

[13] 42 CFR part 422.

[14] 42 CFR part 423.

[15] CMS noted in the final rule that it was premature to adopt a standard for incorporating fraud prevention activities in the MLR for Medicaid because 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 into 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.

[16] 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.

[17] 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," in which payments to an MCO are made at the time of delivery to offset the cost of prenatal, postnatal, and labor and delivery costs for an enrollee.

these 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.[18]

[18] 81 Fed. Reg. 27498, 27534 (May 6, 2016).

APPENDIX D: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed CY 2014 cost and premium revenue data for Medicaid non-expansion members for the nine highest paid Medicaid MCOs in California.[19] For each of the nine MCOs, we determined the MLR for CY 2014 and whether the MCO would have had to issue remittances to the State agency if the MCO 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 did not review the overall internal control structure of the State agency or the California Medicaid program. Rather, we reviewed only those controls related to our objective. We did not verify the accuracy of all cost and premium revenue data provided by the MCOs.

We performed fieldwork at the State agency's office in Sacramento, California, and at MCOs' offices throughout California from July 2015 to May 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements and the State agency's Medicaid managed-care plan contracts;

- held discussions with CMS officials to obtain information on California's Medicaid 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;

- obtained from the State agency a summary of capitated payments made to Medicaid MCOs contracted with the State agency during CY 2014;

- judgmentally selected for review nine MCOs on the basis of the total capitation payments that the State agency made to the MCOs and, for each of these MCOs:

[19] During this period, the State agency made approximately $19.9 billion of capitation payments to these nine MCOs. We excluded cost and premium revenue data for adult expansion members and members of nonfederally funded programs because an MLR was already applied to them or their services were not federally funded.

- obtained the amounts recorded on its general ledger for cost and premium revenue,[20]
- obtained supporting documentation (e.g., general ledger account summaries) for the cost and premium revenue elements and an explanation of how these amounts were derived,

- compared the amounts recorded in the general ledger with the amounts in the annual financial statements and supporting documentation, and

- used the financial data to compute the MLR 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.

[20] Specifically, we obtained the amounts recorded on the MCO's general ledger for premium revenue, medical expenses, activities that improve health care quality, and Federal and State taxes and licensing and regulatory fees.