HMO Data Analysis

ASR # 2016-15

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Audit Participation

The following persons were interviewed for or contributed to the preparation of this report.

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January 5, 2018

Introduction

In 2015, the Minnesota Legislature passed a bill to involve the Department of Human Services (DHS) more directly in oversight of state-contracted Health Maintenance Organizations (HMOs) that serve enrollees in publicly funded healthcare programs. The new law requires DHS to conduct ad hoc audits of state public health care program administrative and medical expenses reported by the HMOs.[1] In response, the Internal Audits Office worked with the DHS Health Care Administration (HCA) to develop an audit plan. This plan involved conducting an initial risk assessment to identify gaps or weaknesses and provide a risk-based identification of priority audit areas. This report is the result of the first audit project outlined in the plan.

Background

In March 2015, the Office of the Legislative Auditor (OLA) released a report on HMO administrative expenses.[2] The report included the following key findings:

1) Financial Reporting:
   - Using 2012 financial reporting from the four HMOs, the OLA found miscategorized administrative expenses. Total costs related to these discrepancies ranged from $1,702 to $3 million.

2) Allocation Method and Oversight:
   - OLA identified some opportunities for the HMOs to allocate administrative expenses more directly to specific lines of business. The OLA also questioned some costs allocated to public programs and found that the HMOs did not have adequate documentation to support some subcontracted services.

3) Enhanced Instruction, Definition, and Technical Guidance:
   - DHS implemented important cost-saving initiatives for 2014, but the technical execution of some rate-setting options for administrative expenses was sometimes lacking because the department's guidance or instructions were incomplete, not sufficiently detailed, or unclear. During 2013, DHS directives and requests to HMOs were too general to sufficiently address data complexity, data integrity, and variations among the HMOs' allocation and recordkeeping processes.

The OLA report recommended that the Minnesota Legislature and DHS clarify statutes for HMO allocation methods, strengthen financial reporting requirements, further clarify terms and types of unallowable expenses, and be more directly involved in oversight of HMOs and county-based purchasing plans.

After the OLA report was released, the Legislature passed a bill in 2015 that included the following language:

[1] Minn. Stat. Section 256B.69, Subd. 9d, Para. (e), Financial and Quality Assurance Audits.

[2] State of Minnesota, Office of the Legislative Auditor, Program Evaluation Report, *Managed Care Organizations' Administrative Expenses*, March 2015.

> "The commissioner [of Human Services], to the extent of available funding, shall conduct ad hoc audits of state public health care program administrative and medical expenses reported by managed care plans and county-based purchasing plans. This includes: financial and encounter data reported to the commissioner under subdivision 9c, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public health care programs. These audits also must monitor compliance with data and financial report certification requirements established by the commissioner for the purposes of managed care capitation payment rate-setting. The managed care plans and county-based purchasing plans shall fully cooperate with the audits in this subdivision. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2016, and each February 1 thereafter, the number of ad hoc audits conducted in the past calendar year and the results of these audits."[3]

The publicly funded health care programs overseen by the Department of Human Services are known formally as Minnesota Health Care Programs (MHCPs). These programs provide health care coverage to eligible families with children, adults, people with disabilities and seniors. MHCP members receive health care services either on a fee-for-service basis or through contracted HMOs, depending on the program. DHS contracts with HMOs to provide covered services statewide to enrollees within MHCP programs.

In addition to HMOs, Minnesota allows counties to purchase or provide health care services for the state's public programs. Through their contracts with DHS, these publicly owned "county-based purchasing organizations" provide the same health care services as HMOs, with both receiving oversight by DHS, as payer, and the Department of Health (MDH) as licensor.

This report focuses solely on the HMOs, and not the county-based purchasing plan organizations, because that was the focus of the OLA audit, and the HMOs represent the highest risk in terms of financial volume. The four HMOs examined in this audit are HealthPartners, Medica, BluePlus and UCare.

Objectives

We reviewed and assessed the OLA report to understand their approach as well as understand the HMOs processes.

During our audit, we focused on the following objective:

[3] Minn. Stat. Section 256B.69, Subd. 9d, Para. (e), Financial and quality assurance audits.

- Analyzing and assessing the most current available contract year (calendar year 2015) administrative expenses to identify potential for unallowable expense allocation, as well as under or over allocation of expenses to state public programs, according to current applicable federal/state laws, regulations and technical guidance.

Scope

The review was limited to the HMOs' 2015 transaction level detail data obtained by DHS. This data was only from the four largest HMOs: HealthPartners, Medica, BluePlus and UCare, and did not include a review of the county-based purchasing plans.

Methodology

We reviewed the OLA samples for calendar year 2012 administrative expenses and supporting documentation that the four HMOs provided to the OLA, and applied that knowledge to our 2015 analysis. We assessed the validity of exceptions identified by the OLA, and determined if any items might have been overlooked. We assessed each exception in terms of whether or not subsequent laws, regulations or actions by DHS had been put in place to correct the issue. We also determined if the HMOs made any policy or process changes to address the issues.

Our sample included all calendar year 2015 transactions that comprised line item totals within the annual DHS Financial Reporting Tool administrative expense categories. Using auditor judgment, we selected a sample for each HMO of specific transactions to verify against applicable supporting documentation. The sample selection included sorting the general ledger transaction detail from high to low, and selecting transactions greater than $5,000. Our review focused on identifying and determining if sampled items were in compliance with current state or federal law, regulation, or DHS technical guidance.

We reviewed the administrative expense allocation methodologies for each HMO to understand how HMOs allocated expenses to state programs. This general understanding provided an opportunity to identy the potential for other ways that administrative costs not applicable to state programs might get charged.

We also tested the HMOs' methodology and practice for adhering to the $200,000 limit for individual salaries allocated to Minnesota Health Care Program (MHCP). This required obtaining a reconciliation of the original general ledger data to ensure that salary allocations did not exceed the $200,000 threshold by aggregating the costs or spreading them across multiple categories.

Beginning in calendar year 2014, the DHS Health Care Administration (HCA) required HMOs to report their administrative expense data using an Excel workbook template called the DHS Financial Reporting

Tool. HCA has revised this tool routinely to provide additional guidance to HMOs on how and what to report when issues arise.

Minnesota law also prescribes 18 specific data sets that HMOs must report to DHS using the DHS Financial Reporting Tool specified by the DHS commissioner.[4] However, business structures within each HMO are different, and the corresponding allocation methods they each practice are complex. Therefore, in order for DHS to obtain reliable financial information through the DHS Financial Reporting Tool, the HMOs need specific guidance about the level of detail required to report every expense item, especially the following:

A. Compensation of individuals within the organization in excess of $200,000:

The DHS Financial Reporting Tool only requires the HMOs to report a total amount of salary for any employee making more than $200,000. This does not include a detailed summary or reconciliation explaining how many employees, what their salary is, and what amount was actually allocated. For the purpose of this audit, we requested that the HMOs submit a detailed reconciliation spreadsheet.This reconciliation spreadsheet explained all salary data being allocated to state programs for each individual that earned more than $200,000 and provided support that HMOs did not allocate more than $200,000 to state health care programs. Subsequently, DHS provided additional guidance to clarify the detail HMOs must submit with the DHS Financial Reporting Tool.

B. Outsourced services:

The DHS Financial Reporting Tool only requires that HMOs report the total amount of cost attributed to outsourced services. This does not include a detailed breakdown explaining what type of service, the amount, and public program they are for. We requested that HMOs provide more general ledger information about outsourced services. Upon further testing, we found no issues.

C. State premium taxes:

The instructions within the DHS Financial Reporting Tool do not specify whether state premium taxes, surcharges, and assessments should be reported in total on line 51 or line 56. As a result, reporting of payments made for these premium taxes varies because HMOs could separate or include in either line 51 or line 56.

[4] Minn. Stat. Section 256B.69, Subd. 9c, Para. (b), Managed Care Financial Reporting.

Findings

1. **Health Maintenance Organizations allocated costs to state programs that did not directly benefit state programs.**

Three of the four HMOs allocated over $174,000 in administrative costs that did not directly benefit clients enrolled in MHCP programs. These costs were for activities such as travel, training, regulatory fees, legal costs, internships, and investment consulting. These costs were allocated by the HMOs indirectly across all of their programs. The amounts listed were the amounts found for the MHCP programs. The total amount of these questioned costs are listed in Table 1.

Minnesota law identifies certain administrative expenses that are not allowable for rate-setting purposes. These expenses include: charitable contributions; penalties and fines; indirect marketing or advertising; lobbying and political activities, including events or contributions; membership in any social, dining, or country club or organizations; entertainment including amusement, diversion and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities.[5]

The Legislature and DHS should expand the list and be more specific about which administrative costs are unallowable. The MHCP's costs might be allocated to HMO activities that do not benefit state program enrollees. Our testing found the following unallowable or questionable costs:

Table 1: Unallowable Cost Allocations

Description	Allocation to State Public Programs
Travel Outside MN	$ 3,982.00
Regulatory Fee	$ 2,000.00
Litigation Cost	$ 6,800.00
Other Legal Matters	$ 298.00
Solar Garden Subscription	$ 7,565.00
Corporate Internship Program	$ 60,000.00
Legal and Media support	$ 18,000.00
Training Out-of-State	$ 60,000.00
Investment Consulting	$ 15,360.00
	$ 174,005.00

[5] Minn. Stat. Section 256B.69, Subd. 5i, Para. (b), Administrative Expenses.

For the amounts and items listed above, it is difficult to discern if they are related to public programs, non-public programs, or both. Through additional information received, it is our opinion that they are not related to public programs. For example:

- Travel Costs include travel outside MN, including International travel.
- Litigation cost identified above relate to UCare vs. MDHS. At a hearing, the court granted the request of Blue Plus, Medica, Hennepin County and HealthPartners to intervene in this action and to present arguments relating the UCare's temporary injunction motion. All four intervenors objected to the request and submitted briefs and affidavits supporting their arguments. This is a cost to intervene in this litigation.

Recommendations

- *DHS should increase its efforts and diligence to ensure HMOs allocate and report only costs allowable to public health care programs.*

- *DHS Health Care Administration should assess, determine and clarify which additional administrative expenses should be declared unallowable to ensure that indirect costs are applicable to state programs and would benefit enrollees.*

2. **Health Maintenance Organizations often have not provided financial data in sufficient detail to enable DHS to gain a full understanding of administrative expenses.**

The DHS Financial Reporting Tool does not have adequate structure or guidance to facilitate effective review of administrative expenses, such as compensation of individuals in excess of $200,000, outsourced services, and state premium taxes.

The purpose of analyzing HMO financial reporting is to examine past and current data so DHS can identify, evaluate, and mitigate potential areas of risk. To do this effectively, DHS needs to see additional supporting data from the HMOs that clarifies individual line items in their financial reports, aids reconciliation of reported total costs, and helps explain how costs were allocated.

Furthermore, the Minnesota Legislature stated that the Commissioner shall collect detailed data regarding financial statements, provider payments, provider rate methodologies, and other data as determined by the Commissioner.[6] While the HMOs generally responded in a timely fashion to our data requests, we did not receive data from all HMOs in a timely manner; we consistently

[6] Minn.Stat. Section 256B.69, Subd. 9c. Managed Care Financial Reporting.

encountered delays with our data requests to UCare. State law explicitly requires the HMOs to "provide the Commissioner [of DHS]. access to all data required" to complete financial and quality assurance audits, and to "fully cooperate" with such audits.[7]

Without more detailed, accurate, and timely data from the HMOs, it will be difficult for DHS to accurately assess their cost allocations, cost trends, and expenditures. Furthermore, it will also be difficult for the Legislature to evaluate the return on state and federal investment. All of this, potentially, has implications for DHS's ability to set accurate capitation rates.

Recommendations

- *DHS Health Care Administration should continue to add more worksheets to the DHS Financial Reporting Tool to increase the validity and usefulness of financial information submitted by HMOs (i.e. List of employees who received more than $200,000 and how amounts were allocated to the state public program). Subsequent to the period covered by this report, DHS has provided additional guidance on compensation to clarify details HMOs must submit with the DHS Financial Reporting Tool.*

- *DHS Health Care Administration should strengthen the language in their HMO contracts to require that HMOs comply with audit information requests within a specified amount of time, such as within 2 weeks unless otherwise agreed upon by both parties.*

[7] Minn. Stat. Section 256B.69, Subd. 9d, Financial and Quality Assurance Audits.