HMO Non-Covered Non-State Plan Expense Review

ASR # 2016-16

Department of Human Services

Table of Contents

Audit Participation

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

Health Maintenance Organizations

Denise Bergevin	Blue Plus, VP Finance and Corporate Controller
Kevin Brandt	HealthPartners, Corporate Controller
Karin Roberts	Medica, Sr. Manager Government Finance
Diane Tollefson	UCare, Assistant Controller, Accounting
Hue Danny Lee	Hennepin Health, Government Programs Manager
Sarah Duell	IMCare, Chief Financial Officer
Jon Hodgson	PrimeWest, Consulting Actuary, Cirdan Health
Scott Schufman	South County Health Alliance, CFO

Department of Human Services

Jeff Provance	Sr. Research Analysis Specialist
Chandra Breen	Managed Care Contract Management and Compliance

DHS Internal Audit

Gary L. Johnson	Audit Director
Ken Vandermeer	Deputy Audit Director, CPA, CFE
Titima To	Internal Auditor, CIA

January 5, 2018

Introduction

In 2015, the Legislature passed a bill[1] to involve the Department of Human Services (DHS) more directly in oversight of state-contracted Health Maintenance Organizations (HMOs) and County-based purchasing plans (CBPPs) that serve enrollees in publicly funded health plans. The new law requires DHS to conduct ad hoc audits of state public health care program administrative and medical expenses reported by HMOs and CBPPs.[2] In response, the Internal Audits Office and the DHS Health Care Administration collaborated on an initial risk assessment to identify gaps or weaknesses and provide a risk-based identification of priority audit areas.

This report is the second audit project outlined in the plan. It focuses on HMOs' and CBPPs' costs for non-state plan services in calendar year 2016. In our first project, we analyzed HMOs' administrative expenses for calendar year 2015.

Background

The publicly funded health care programs overseen by the Department of Human Services are known formally as Minnesota Health Care Programs (MHCP). 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 and CBPPs, depending on the program. DHS contracts with HMOs and CBPPs to provide covered services statewide to enrollees within MHCP.

In addition to HMOs and CBPPs, 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 plans (CBPPs) provide the same health care services as HMOs, and are overseen by both DHS, as payer, and the Department of Health (MDH), as licensor.

On a quarterly basis, HMOs and CBPPs must submit a financial statement to DHS. They must report the costs of all Medicaid-covered medical services and related administrative expenses. They must also report the dollar value of each specific service that is unallowable or is a non-state plan service. Both medical and administrative expenditures in the non-state plan category must be reported.[3]

This audit report focuses on HMOs and CBPPs costs for non-state plan services. Non-state plan services are medical costs and associated administrative costs not covered by the federal Medicaid program, including the following:

Examples of Non-Covered Medical Expenses:

- Waived cost sharing, such as co-pays and family deductibles
- Waiver services provided to patients that are non-waiver eligible

[1] 2015 Minn. Laws, Ch. 71, Art. 11, Section 36.
[2] Minn. Stat. Section 256B.69, Subd. 9d, Financial and Quality Assurance Audits, Para. (e).
[3] Minn. Stat. Section 256B.69, Subd. 9c, Managed Care Financial Reporting, Para. (d).

- Other medical services not covered by Medicaid (non-covered prescription and over-the-counter drugs, additional dental services, etc.)

Examples of Non-Covered Administrative Expenses:

- Allocated cost for administration of non-covered medical services (e.g. claims payment, authorization, staff time, etc.)
- Car seats
- Fitness programs and camps
- Member incentives and reward programs
- Consultant contracts that do not directly benefit Medicaid or MinnesotaCare enrollees
- Individual clinical licensure
- Grants not related to direct patient care or performance on patient outcome measures
- Tuition reimbursement to enrollees

Objectives

The objective of our audit was to determine if HMOs and CBPPs properly reported medical and administrative expenses for non-state plan services.

Scope

In this audit, we intended to review HMOs and CBPPs' costs for non-state plan services for the contract year January 1, 2016, to December 31, 2016, but limited our review to the available accounting transaction records, which spanned the period from January 1, 2016, through September 30, 2016. Although non-state plan services represent a small fraction of total medical costs (See Table 2 at the end of this report, for perspective), DHS Health Care staff asked us to examine this category of expenses because it has a medium to high potential for being reported inaccurately, and it has less federal regulatory control than most of the medical service categories with higher dollar amounts.

For this audit, we reviewed data provided by all HMOs and CBPPs, as follows:

- UCare (HMO)
- HealthPartners (HMO)
- Blue Plus (HMO)
- Medica (HMO)
- Itasca Medical Care (CBPP)
- South County Health Alliance (CBPP)
- Prime West (CBPP)
- Hennepin Health (HMO)

Methodology

To reach our objectives, we completed the following steps:

- For the period July 1, 2015, through September 30, 2016, we analyzed data reported by the HMOs and CBPPs via the Department's Financial Reporting Tool to identify any variances or other anomalies.
- For the accounting transaction data received, covering the period January 1, 2016, through September 30, 2016,
    - we reviewed items reported as non-state plan services and researched if they were in fact non-covered services. We also reviewed each line item for reasonableness and consistency of categorization.
    - we compared individual line item amounts to total expenditures for non-State plan services.
    - we analyzed their allocation methodology and consistency of approach for each category reported.
- We interviewed staff from the HMOs and CBPPs to gain an understanding of their reporting processes and operations.
- With assistance from DHS's Encounter Data Quality team, we reviewed accounting codes for calendar year 2016 by dollar amount for each HMO and CBPP.
- We discussed our results with Health Care Administration staff and obtained their confirmation to draw a conclusion.
- We reviewed reporting timelines to verify that HMOs and CBPPs reported their non-state plan costs in a timely manner per DHS deadlines.

Summary

State law requires that HMOs and CBPPs report to DHS the dollar value of unallowable and non-state plan services, including both medical and administrative expenditures.[4] Our analysis showed that non-state plan services accounted for 0.3% to 4.6% of total HMOs and CBPPs expenses. Many of these costs were for waived cost sharing for family deductibles and co-pays. HMOs and CBPPs use similar reporting categories for non-state plan service costs.

Our review of the methodologies HMOs and CBPPs' used to allocate non-state plan expenses found variations in how each HMO and CBPP categorized certain expenses such as car seats, rewards cards, and fitness programs. We also found that some were paid through the claims system utilizing procedure codes, which can be complex. For example, the code for Independent Living Skills (ILS) can be used to indicate any of the following covered or non-covered services:

- Covered services
    - Communication skills
    - Community living and mobility
    - Interpersonal skills
    - Reduction/elimination of maladaptive behavior
    - Self-care
    - Sensory/motor development involved in acquiring functional skills

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

- Non-covered services
    - ILS training provided in licensed settings that are not the person's home
    - Overnight supervision
    - Services duplicated with other Minnesota state plan or waiver services

Our review of accounting codes reported by the HMOs and CBPPs found no obvious or significant issues. Finally, our review of report submission dates found that all HMOs and CBPPs reported in a timely manner.

We also observed that the HMOs and CBPPs contract period is based on the calendar year, which also corresponds to their reporting periods or fiscal years. DHS has changed the HMOs and CBPPs reporting period to align with the state fiscal year (July through June) to ensure that rates are set using the most current financial data. This conflict between the reporting year ends for HMOs and CBPPS, and the data period used for rate setting requires more effort from the HMOs and CBPPS to prepare their financial statements for DHS rate setting purposes. Our evaluation of this timing difference found no reportable issues.

It is a best practice to use the same time period for a contract and all reporting on that contract so that all financial and outcome data reported align with the rates, requirements, and stipulations in effect during the contract period. Because DHS changed its reporting period, it now costs the HMOs and CBPPs more effort to prepare their financial statements for DHS. In addition, these fiscal year financial statements for DHS are more difficult to tie back to the HMOs and CBPPs' annual financial statements prepared for their own financial reporting period, typically calendar year.

Finding

1. Some HMOs and CBPPs reported inconsistently and provided unclear descriptions of non-state plan expenses itemized on the DHS Financial Reporting Tool.

HMOs and CBPPs did not provide a clear description of services included in each expense line item (See Table 1 below for examples). Furthermore, they did not utilize the "notes" area on the Financial Reporting Tool to further describe and explain their services and expenses.

Table 1: Examples of Unclear Description of Services

Accurate Description of Service	How Service Was Categorized on Report
• Car seat education • Fitness benefit & administration • Palliative care	• "Non-covered Services" • "Non-covered Services – Recovery Program" • "Additional Services"

Non-state plan services are defined as all medical costs and associated administrative costs not covered by Medicaid. According to the DHS Financial Reporting Tool, HMOs and CBPPs must provide a detailed list of non-state plan services and their dollar amount.[5]

We believe HMOs and CBPPs did not provide clear line item descriptions because DHS instructions were not specific enough. In addition, DHS did not follow up with HMOs and CBPPs in a timely manner after receiving the reports to clarify vague expense itemizations.

As a result, it is difficult for DHS program staff and auditors to understand exactly what is included in generic line item descriptions such as "non-covered service" or "additional service." This prevents DHS from gaining an accurate understanding of which HMOs and CBPPs expenses should properly have been excluded from the HMOs and CBPPs capitation rate.

Recommendations

- *HMOs and CBPPs should increase efforts to clearly identify unallowable costs to state health care programs.*

- *DHS should consider adding stronger and more specific guidance for HMOs and CBPPs to complete the DHS Financial Reporting Tool, including examples of how to meet specific criteria.*

- *DHS should require HMOs and CBPPs to provide more descriptive details or specific accounting codes that are used to exclude expenses from the capitation rate. This would assist DHS to verify that non-covered services were properly excluded from capitation.*

- *DHS should ensure HMOs and CBPPs list the specific non-state plan services included in each line item in order to comply with DHS guidance and Minnesota Statutes, Section 256B.69, Subdivision 9c.*

[5] DHS Financial Reporting Tool for MCOs, Schedule X.1, Non-State Plan / Non-Waiver Services guidance. See also Minn. Stat. Section 256B.69, Subd. 9c, Managed Care Financial Reporting, Para. (d).

Table 2: Top 10 (plus 2)* HMOs and CBPPs Medical Expenses Calendar Year 2015

Line	Description	HMO's	CCBPP's
11	Inpatient	$ 798,284,726	$ 81,584,946
20	Pharmacy	$ 697,215,045	$ 83,242,917
16	Physician - Primary Care	$ 669,455,363	$ 113,074,893
13	Outpatient (Non-ER)	$ 578,891,760	$ 57,547,920
46	Medicare Expenses	$ 517,205,211	$ 67,165,914
24	Mental Health/Substance Abuse Non-Facility	$ 279,873,346	$ 33,720,147
36	PCA	$ 248,482,026	$ 8,888,361
39	Elderly Waiver Services (excluding Care Coordination / Case Management)	$ 233,960,838	$ 30,666,574
23	Mental Health/Substance Abuse Facility	$ 148,110,962	$ 16,964,326
29	Transportation	$ 144,294,261	$ 12,063,864
43	Other Medical*	$ 68,705,924	$ 9,274,239
44	**Non-State Plan Expenses***	**$ (6,177,945)**	**$ (1,811,263)**

* We included "Other Medical" (services paid outside the claims process) and "non-state plan expenses" in this list, and in our audit plan, because they have a medium to high potential for being billed inaccurately. These costs also have less federal regulatory control than most of the high-dollar service categories in this list.