OLA
OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Managed Care Organizations' Administrative Expenses

MARCH 2015

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STATE OF MINNESOTA • James Nobles, Legislative Auditor

March 2015

Members of the Legislative Audit Commission:

At your request, we examined managed care organizations' expenses for administering Minnesota's public health care programs. We also examined the Department of Human Services' efforts to control administrative costs when setting managed care payment rates.

We found that the Department of Human Services (DHS) implemented important cost-savings initiatives for 2014, but will need to improve reporting directives to sufficiently address data complexity and variation among managed care organizations' accounting processes. DHS uses their administrative cost data for rate-setting analysis, and we found some discrepancies in their financial reports and documentation.

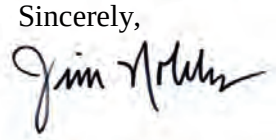
We recommend that the Legislature and the Department of Human Services be more directly involved in oversight of managed care administrative costs for Medical Assistance programs to help assure that the state does not pay for unreasonable costs. In particular, the Legislature should refine managed care reporting requirements and administrative spending limits specified in law.

This report also presents the results of our audits of managed care organizations' compliance with certain financial-related legal requirements for the year ended December 31, 2012. Our audit was conducted for the purpose of determining compliance with certain federal and state laws and rules for reporting administrative expenses and investment income. We emphasize that this has not been a comprehensive audit of all financial data of the managed care organizations, and that our work included testing their costs for the state's public programs only. Given the limited scope of our work, we do not express an overall opinion on the effectiveness of the managed care organizations' compliance with financial reporting. In addition, our work may not have identified all instances of noncompliance with legal requirements.

Our findings and recommendations for each of the four managed care organizations, including their responses, are contained in Appendices A through D of this report. The purpose of these reports is solely to describe the scope and results of our limited testing of the managed care organizations' compliance with certain financial reporting requirements. Accordingly, these reports are not suitable for any other purpose. We also did not audit the responses and we express no opinion on them.

We discussed the results of these audits with representatives of Blue Plus, HealthPartners, Medica, and UCare in December 2014. We received the cooperation of these organizations and the Department of Human Services while performing our work. Our evaluation and audits were conducted by Valerie Bombach (project manager), Tyler Billig, Carmen Marg-Patton, and Valentina Stone.

Sincerely,



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The Legislature and DHS should be more directly involved in oversight of managed care administrative costs for Medical Assistance programs.

Key Facts and Findings:

- Minnesota has relied on managed care organizations (MCOs) for decades to help administer its Medical Assistance (MA) program. Administrative spending by the four largest MCOs totaled about $278 million in 2012. (p. 8)

- The Department of Human Services (DHS) determines how much to pay MCOs for these services, and relies primarily on MCOs' financial data to set the administrative portion of payment rates. (p. 40)

- In our audits of MCOs' 2012 financial reports, we sampled administrative expense records and found a small number of miscategorized transactions. Total costs related to these discrepancies ranged from $1,702 to $3.0 million. (pp. 16-18)

- We identified some opportunities for MCOs to more directly allocate administrative expenses to specific lines of business. We also questioned some costs allocated to public programs and found that MCOs did not have adequate documentation to support some subcontracted services. (pp. 22-26)

- DHS implemented important cost-savings initiatives for 2014, but its technical execution of some rate-setting options for administrative expenses was sometimes lacking during 2013. (pp. 35-39)

- Minnesota statutes, rules, state contracts, and accounting principles do not ensure consistent reporting by MCOs and compliance with policymakers' intent. (pp. 26-30)

- During 2013, DHS directives and requests to MCOs were too general to sufficiently address data complexity, data integrity, and variations among MCOs' allocation and recordkeeping processes. (pp. 46-47)

Key Recommendations:

- The Legislature should amend statutes to clarify how MCOs must allocate administrative expenses and investment income on state-required financial reports, refine managed care administrative spending limits, and further define the types of unallowable expenses for state public programs. (pp. 28, 29, 46)

- The Legislature should amend statutes to specify requirements for MCOs' subcontracts for administrative services that are expensed to Minnesota's public programs, and DHS should incorporate such language into its contracts with MCOs. (p. 30, 46)

- DHS should enhance instructions, definitions, and technical guidance to facilitate MCO compliance with administrative expense reporting requirements. (p. 47)

- DHS should implement ad-hoc audits of financial data, unallowable expenses, and other information reported to the department by MCOs under state contracts and *Minnesota Statutes* 2014, 256B.69, subd. 9c. (p. 47)

Report Summary

In 2012, the Department of Human Services (DHS) contracted with managed care organizations (MCOs) to help administer Medical Assistance (MA) services for nearly 620,000 individuals. Administrative expenses for the four largest MCOs—Blue Plus, HealthPartners, Medica, and UCare—totaled about $278 million, or about 84 percent of all managed care administrative spending.

DHS must determine how much to pay MCOs for their services and ensure that payment amounts are within limits of law. The state's current "at-risk" payment method requires DHS to work with an actuary to develop reasonable and appropriate rates using data based on Medical Assistance services for MA enrollees.

Changes in DHS rate-setting practices and initiatives by state policymakers—including competitive price bidding and legislatively imposed caps on payment rate increases—likely have limited growth in managed care administrative costs in recent years. Managed care administrative expenses per member-month in 2013 were comparable to 2009 rates for some programs, and increased about 8 percent for others. Enhancements in the financial reporting relationship between DHS and managed care organizations should advance oversight and understanding of the costs of public health care programs.

DHS implemented important cost-savings initiatives for contract year 2014, but its technical execution was sometimes lacking.

DHS modified its rate-setting methods and used competitive price bids to determine 2014 managed care payment rates. For 2014 contracts, about 16 percent of the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare payments were set through competitive price bids. However, competitive price bids from contract year 2012 had a multi-year impact on rate-setting methodology.

DHS also modified its previous rate-setting methods with a goal of reducing trends in 2014 administrative costs by $47 million. For MCOs compensated through a prepaid capitation payment method, there are few statutory restrictions on the types of expenses they may incur for public programs. Any restrictions on administrative expenses are imposed when DHS renews contracts and determines new overall payment rates.

DHS did not execute some statutory provisions related to controlling managed care administrative expenses. State law imposes limits on growth in MCO administrative spending. DHS waived this restriction in 2013, noting a lack of clarity in the law and shifting coverage in populations. DHS staff also said that the statutory provision is technically incompatible with current rate-setting methods, competitive price bidding, and aggregate limits in managed care trends specified elsewhere in law.

DHS's use of some MCO financial reports for determining managed care payment rates has been a long-standing source of controversy.

For 2014 contracts, DHS and its actuary relied primarily on data reported and certified by the MCOs—data they consider comparable to data used by the federal government and other states. These data included the MCOs' 2012 annual statutory financial filings with the Minnesota Department

of Health (MDH). MCO representatives said that the financial information is correct for purposes of reporting to MDH and that the reports were not developed to be used for DHS rate setting. This controversy supports recent legislative work to expand the direct reporting relationship between DHS and MCOs.

MCOs generally complied with accounting standards when categorizing administrative expenses, with some exceptions.

We audited MCOs' 2012 accounting practices and financial reports. Among approximately 100 samples tested for each MCO, MCOs miscategorized a small number of administrative expense transactions. However, total costs related to these discrepancies ranged from $1,702 to $3.0 million. DHS used the MCOs' reports to determine their 2014 payment rates.

We identified some opportunities for MCOs to more directly allocate administrative expenses to specific products, but MCO representatives said that this practice would increase public program costs.

MCOs have complex processes to record and allocate their administrative expenses across numerous entities, products, and programs. MCOs process tens of thousands of transactions annually for such costs as general overhead, subcontractors, intercompany fees, and capital projects. For the majority of their 2012 administrative costs, MCOs consistently allocated at least some portion of each expense across state public programs. Some MCO costs for their subcontracted administrative services could have been more directly allocated to individual state programs or to commercial products that benefitted from the service.

MCOs' accounting and allocation practices did not sufficiently restrict some unreasonable expenses from the Medical Assistance programs on state-required reports in 2012.

Among our sample transactions, we questioned some expenses allocated to the state's public programs on reports used by DHS for rate setting for contract year 2014. For each MCO, we identified between one and four cost items that we considered unreasonable, unrelated to Medical Assistance services, or out of compliance with MDH rules. We estimated the total costs of these transactions allocated among state public programs ranged from $376 to $2,144, depending on the MCO.

We also questioned some other indirect marketing and charitable contribution expenses subject to DHS review for rate-setting purposes. In total, these types of transactions for each MCO ranged from $5,198 to $8.5 million. During 2013, DHS separately requested and received from the MCOs information about these types of expenses when determining payment rates.

MCO representatives said that their allocation practices comply with federal or state law, state contracts, reporting requirements, or accounting principles. More direction from state policymakers could diminish controversy about the types of managed care administrative expenses disallowed for Medical Assistance programs. DHS's use of these MDH reports will require ongoing reconciliation of disallowed expenses.

Managed care organizations did not have adequate documentation to support expenses for some administrative service subcontracts.

For some contract-related expenses we tested, MCOs did not have adequate documentation to verify whether their subcontractors were paid appropriately, assess the reasonableness of MCOs' allocations, or determine how the costs related to public programs. Some subcontracts were not fully signed or had expired, payments did not match the contract rates, or there was no statement of work. The number of these cost items ranged from two to four, depending on the MCO.

Minnesota statutes, rules, and state contracts do not ensure consistent reporting by MCOs and compliance with policymakers' intent.

Our examination of MCOs' detailed financial data, supporting documentation, and allocation practices revealed that reporting requirements could be improved. In particular, lack of definitions, details, and conflicting language in law and state contracts do not support recent efforts by policymakers. Insufficient guidance in accounting principles contributes to these inconsistencies, too. More direction in law regarding program-specific and cost allocation requirements, and the form and content of MCOs' subcontracts for administrative services, could reduce variation and misinterpretation.

In 2013, DHS directives and requests to MCOs were too general to sufficiently address data complexity, data integrity, and variations in MCOs' recordkeeping and allocation processes.

During our audit work, DHS staff were still refining new financial reporting templates for MCOs. We think the specifications for administrative expenses were too general and likely resulted in inconsistent or incomplete data, based on our audits of MCOs. DHS contracts with MCOs require them to submit and "certify" certain filings or other financial data as requested by DHS, but we found inconsistencies among federal law, contract language, and certification documents.

Enhanced financial reporting by MCOs may have minimal value for managed care payment rate setting without independent verification of the data.

DHS and its actuary accept the MCOs' data certifications but do not independently audit their summary-level data reports. Given the significant amount of information now compiled by DHS, more rigorous, ad-hoc verification of administrative expenses by DHS would be reasonable. Absent these actions, we question the extent to which state resources needed for oversight of additional MCO financial reporting will translate into cost savings. Such work also will help assure that MCOs costs are appropriately allocated to the state's public programs.

Introduction

Since 1982, the Department of Human Services (DHS) has contracted with managed care organizations (MCOs) to help administer Minnesota's public health care programs. The cost of their involvement is significant—in 2012, managed care organizations' reported administrative expenses for public programs totaled about $332.7 million.[1] On behalf of the state, the department determines the scope of services and negotiates how much to pay managed care organizations. However, the availability and use of certain financial data for setting payment rates has been a long-standing controversy among legislators, state administrators, managed care representatives, and others. It has been frequently suggested that the department should do more to ensure a better price for administrative services and reduce the likelihood of excess payments.

The Legislative Audit Commission in March 2013 directed the Office of the Legislative Auditor to evaluate managed care organizations' administrative expenses and the Department of Human Services' efforts to develop payment rates. This assignment incorporated components of a broader legislative directive to audit managed care organizations' financial and other information.[2] Our evaluation addressed the following questions:

- **How much do managed care organizations spend to administer Minnesota's publicly funded health care programs, and for what purposes?**

- **Do the administrative expenses reported by managed care organizations comply with state and federal laws? Are administrative expenses reported consistently?**

- **Does DHS adequately review and control administrative costs when developing payment rates for managed care organizations? Does the state pay for unreasonable or unnecessary administrative costs for managed care?**

Our audit work focused on the financial data of Blue Plus, HealthPartners, Medica, and UCare, and did not include audits of county-based purchasing organizations. We also evaluated the Department of Human Services' processes and practices for determining payments for administrative services for the Medical Assistance and MinnesotaCare programs for 2014. This work did not include evaluating rate-setting methods and processes for determining payments for medical services. We did not examine DHS's competitive procurement processes for obtaining managed care services, but we briefly discuss how this approach impacts rate setting for managed care payments.

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[1] Total includes general administrative and claims adjustment expenses reported by all managed care organizations under contract with the Department of Human Services. DHS payments and reimbursements to managed care organizations for all services for contract year 2012 totaled about $3.02 billion, including both state and federal monies.

[2] *Minnesota Statutes* 2014, 256B.69, subd. 9d.

We performed our audit work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[3] 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.

To provide context for our work, we spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of the four managed care organizations.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and partly relies on to determine payments to managed care organizations. We also reviewed select information required by the state's contracts for public health care programs or otherwise requested by DHS.

We interviewed management and employees of Blue Plus, HealthPartners, Medica, and UCare to gain an understanding of their procedures for recording and reporting administrative expenses and investment income, and how each entity allocates its costs across lines of business and programs. We obtained from each managed care organization detailed and summary financial transaction data, including general ledgers, accounts payable records, and other supporting documentation. We relied on this information to conduct our audit work.

From each entity, we selected an initial sample of more than 100 transactions to test against our objectives. We used a combination of purposive and stratified random sampling, and our sample universe generally included transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. We also selected a sample of each MCO's own contracts for administrative services and reviewed these expenses. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and supporting documentation, including purchase orders, invoices, bank statements, and other information.

We used federal and state laws, regulations, contracts, and the National Association of Insurance Commissioners (NAIC) statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for administrative services contracts.

To provide context for our evaluation, we reviewed current and historical state and federal laws and guidance for determining capitation payment rates. We also

[3] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision* (Washington, DC, 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

researched practice notes and actuarial standards promulgated by the American Academy of Actuaries, the Actuarial Standards Board, and the Society of Actuaries. To learn about alternative practices for determining capitation payment rates, we selected a sample of ten states and requested information from state agency representatives, and compiled pertinent statutes and regulations. To help with this work, we hired an actuarial consultant with expertise in this subject matter and experience working for state agencies in other states for their federal Medicaid programs.

To assess DHS's rate-setting activities, we reviewed documentation and data used to develop the administrative portion of managed care capitation payment rates. We also analyzed trends in spending using financial data and program enrollment reported by managed care organizations for 2009 and 2013.

Chapter 1 of this report provides an overview of the nature and costs of managed care administrative services for 2012 and describes background information about Minnesota's public health care programs. In Chapter 2, we briefly summarize the results of our audits of administrative expenses and financial reports for four managed care organizations and make recommendations to the Legislature. In Chapter 3, we assess how DHS determines payments for managed care administrative services and discuss recent initiatives by policymakers. We illustrate trends in managed care spending as one measure of these initiatives and of DHS's rate-setting practices. We also recommend refining state law and DHS technical guidance and contracts, based on our experience auditing managed care organizations. Lastly, Appendices A through D at the end of this report contain the findings and recommendations specific to each of the four managed care organizations we audited.

Chapter 1: Background

Minnesota's framework for providing public health care has undergone significant changes since the federal Patient Protection and Affordable Care Act of 2010 was enacted. These changes include redefining programs, benefits, and eligibility requirements, combined with alternative service arrangements, such as contracting directly with integrated health partnerships that are comprised of healthcare systems, hospitals, and providers.[1] What has not changed is the fact that the state has continued to contract with managed care organizations to help administer the state's federal Medicaid program—Medical Assistance—and MinnesotaCare programs.

In this chapter, we briefly describe the Department of Human Services' (DHS's) role in purchasing managed care services. We also present information about managed care organizations and their costs and services related to public programs. Our discussion focuses primarily on data and services for calendar year 2012 as these data were used to develop managed care payment rates for 2014.

OVERVIEW

The federal Centers for Medicare & Medicaid Services (CMS) in the U.S. Department of Health and Human Services oversees states' Medicaid programs. With CMS approval, states may obtain service arrangements with non-state entities to administer federally funded health care programs.[2] In Minnesota, the Department of Human Services has partially or fully delegated certain functions to managed care organizations (MCOs) as specified in federal regulations.[3]

Managed care organizations—also referred to as health maintenance organizations—are nonprofit entities that must participate in public programs as a condition of certification in Minnesota.[4] The Minnesota Department of Health (MDH) has primary regulatory authority over these entities and is responsible for ensuring their compliance with state-mandated reporting, certification, and solvency requirements.[5] As part of its oversight, MDH conducts periodic assessments of the quality of their services, including management of their provider networks. Today, each of the managed care organizations we audited—

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[1] *Minnesota Statutes* 2014, 256B.0755. See http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441, accessed March 5, 2015.

[2] *42 CFR*, sec. 438.6 (2014).

[3] *42 CFR*, secs. 438.207-438.210 (2014).

[4] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644. Pursuant to the Internal Revenue Code, Section 501(c)(4), these organizations are generally exempt from federal income taxes. Throughout this report, we refer to health maintenance organizations (HMOs) as managed care organizations (MCOs).

[5] *Minnesota Statutes* 2014, 62D.01, subd. 2b; 62D.04; and 62D.041.

Blue Plus, HealthPartners, Medica, and UCare—offer commercial products to Minnesota residents, in addition to serving public health care programs.

Managed care organizations are regulated by MDH, but also are subject to state and federal requirements through their contracts for public programs with the Department of Human Services. Minnesota law requires MDH and DHS to work together to identify and collect data on managed care administrative spending for state public health care programs.[6] Recent changes in state law also enhanced the reporting relationship between MCOs and DHS for managed care programs.[7] We discuss these requirements later in Chapter 3.

In addition to managed care organizations, Minnesota allows counties to purchase or provide health care services for the state's public programs.[8] Through their contracts with DHS, these publicly owned "county-based purchasing organizations" provide the same administrative services as health maintenance organizations and also are subject to oversight by MDH.

MANAGED CARE PROGRAMS

In 2012, Minnesota had several Medical Assistance (MA) programs that served different populations. These programs included: the Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), Special Needs Basic Care (SNBC), and Preferred Integrated Networks (PINS). These programs are largely the same MA programs provided today. Throughout this report, we refer to these programs as the state's public programs or Medical Assistance programs.

First, PMAP served families and children, pregnant women, and adults without children that met federal Medicaid eligibility requirements. Under a federal waiver in place during 2012, expanded MA coverage and federal funding also was available for Minnesota's optional state program, called MinnesotaCare.[9] MinnesotaCare provided services to adults, parents, and caretakers with incomes higher than those covered by MA.

Other MA programs covered enrollees who typically required additional services, including enhanced care coordination and long-term care services. MSC+ and MSHO served MA recipients age 65 and over. MSHO coordinated or integrated Medicaid with Medicare services together as a way to control costs or improve access to care. Both MSHO and MSC+ provided the same services as PMAP and some added benefits that were administered under managed care, such as home and community-based services and limited nursing home care. People eligible for both Medicare and Medicaid could choose MSHO so that their

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[6] *Minnesota Statutes* 2014, 256B.69, subd. 9a.

[7] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 63.

[8] *Minnesota Statutes* 2014, 256B.692. In 2012, DHS contracted with three county-based organizations—South Country Health Alliance, PrimeWest, and Itasca Medical Care—and one other health maintenance organization (HMO)—Metropolitan Health Plan dba Hennepin Health.

[9] The federal waiver for "PMAP+" covered a 2.5 year period.

benefits for the two programs were administered by the same health plan. MSC+ members eligible for Medicare could use Medicare fee-for-service or enroll in a separate federal Medicare plan for Medicare parts A and B and obtain separate Medicare prescription drug coverage.

Lastly, the SNBC program provided basic health care services to persons with disabilities, including those who were eligible for both Medicaid and Medicare. The SNBC program contracted with Medicare health plans to coordinate Medicaid and Medicare services for eligible enrollees. Most long-term care services for SNBC enrollees are not administered under managed care. As part of SNBC contracts with certain managed care organizations, DHS implemented PINS. The PINS program integrated physical and mental health services within one managed care organization and coordinated this care with social services.[10]

DHS determines which managed care organizations to contract with for each of these programs, and contracts and payment rates typically have been for one-year terms.[11] For contract year 2012, DHS used a competitive price bid process to obtain managed care services for the seven-county metro area. For the remaining 80 counties, DHS set the managed care payment rates. For contract year 2014, DHS again used a competitive bid process to obtain services for 27 other counties in other areas of the state, and set the managed care payment rates in the remaining counties, including the seven-county metro area. In Chapter 3, we briefly describe how competitive price bidding has affected DHS rate setting for managed care administrative costs for the state's public programs.

Service Areas and Costs

For 2012, DHS contracted with eight managed care entities to administer public programs across Minnesota. The great majority of managed care services were provided by Blue Plus, HealthPartners, Medica, and UCare. State reimbursement to these four entities for 2012 services totaled about $2.69 billion (out of $3.02 billion for all MCOs), including both medical and administrative costs.[12] These four MCOs accounted for about 84 percent of all administrative expenses reported for the state's public programs.[13]

In 2012, the scope and costs of managed care administrative services varied, depending on the managed care organization and specific program being administered.

[10] The PINS program is implemented through one MCO in Dakota County only.

[11] *Minnesota Statutes* 2014, 256B.69, subd. 5.

[12] State reimbursement represents DHS total payments—including both state and federal monies—for all services to these managed care organizations for contract year 2012.

[13] Services by one other MCO and the three county-based purchasing organizations comprised the remaining 16 percent of administrative costs reported for the state's public programs.

In 2012, managed care administrative expenses for Blue Plus, HealthPartners, Medica, and UCare totaled about $214.7 million, as shown in Exhibit 1.1.[14] Administrative expenses per member-month enrollment ranged from $35 per member-month (Blue Plus) to $31 per member-month (HealthPartners and Medica). When considering MCO expenses for medical and all administrative costs, the share of total expenses attributed to administrative services ranged from 6.0 percent (Medica) to 7.6 percent (UCare).

Exhibit 1.1: Managed Care Enrollment and Administrative Expenses, by Managed Cared Organization, Contract Year 2012

Managed Care Organization and Programs it Administers	Total Member-Months (in thousands)	Total Administrative Expenses (in thousands)[a]	Administrative Expenses per Member-Month (All Programs)	Administrative Expenses as Share of Total Administrative and Medical Expenses	
				Excluding Premium Taxes and Surcharges	Including Premium Taxes and Surcharges
Blue Plus (PMAP, MNCare, MSHO, MSC+)	1,602	$ 55,427	$35	6.0%	7.4%
HealthPartners (PMAP, MNCare, MSHO, MSC+)	1,001	30,625	31	5.9%	7.5%
Medica (PMAP, MNCare, MSHO, MSC+, SNBC-MA only, PINS)	1,627	49,709	31	4.5%	6.0%
UCare (PMAP, MNCare, MSHO, MSC+, SNBC-MA only)	2,366	78,919	33	6.1%	7.6%
Total	6,596	$214,680	$33	5.6%	7.1%

NOTES: Acronyms represent the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), Special Needs Basic Care (SNBC), and Preferred Integrated Networks (PINS).

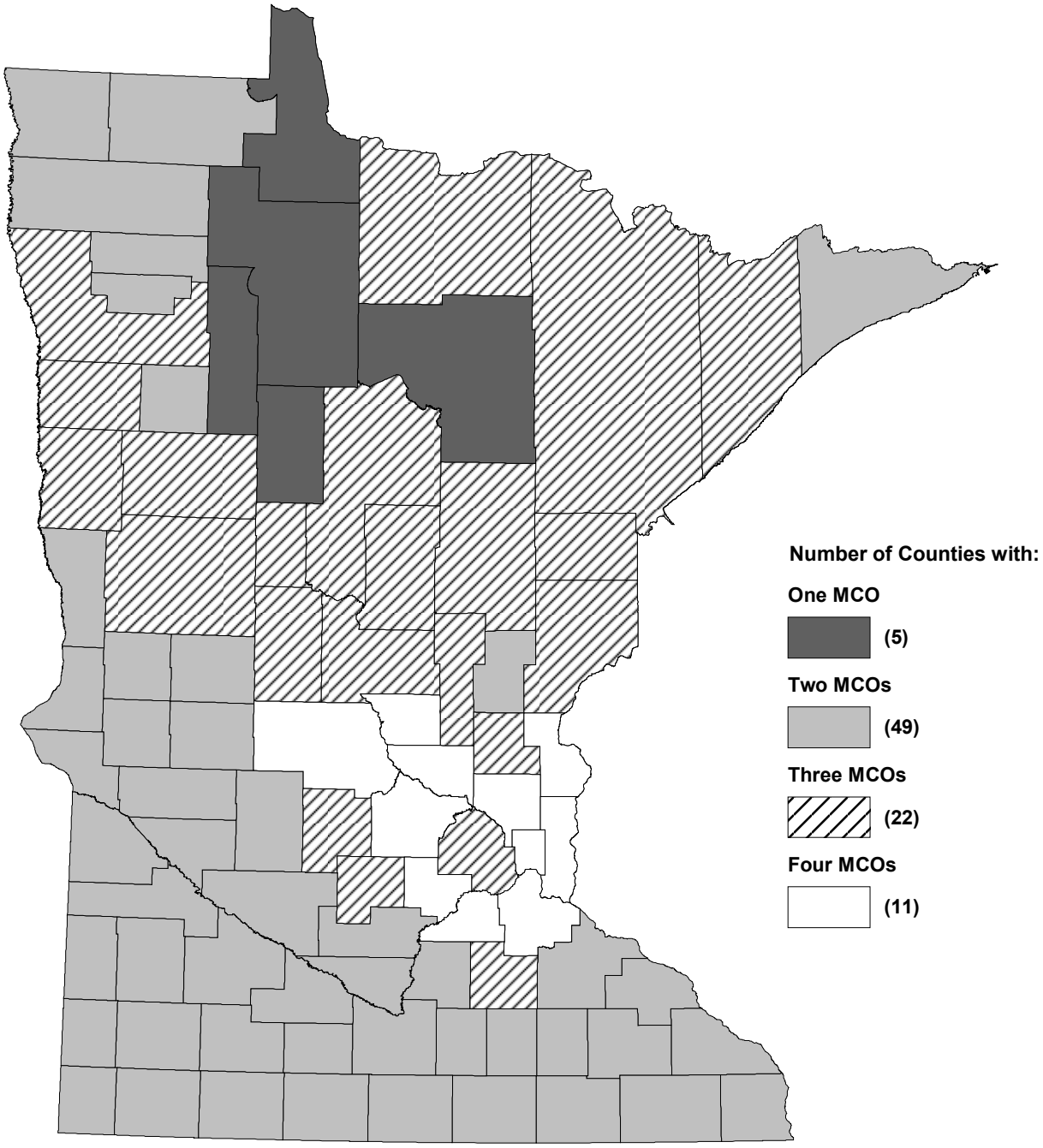
[a] Represents general administrative and claims adjustment expenses, and excludes estimated state premium taxes and surcharges on health maintenance organizations (HMOs) pursuant to *Minnesota Statutes* 2014, 297I.05, subd. 5; and 256.9657, subd. 3. Including such taxes and surcharges, 2012 administrative expenses for these four MCOs totaled about $278 million.

SOURCE: Office of the Legislative Auditor, analysis of 2012 Minnesota Supplement Report(s) #1, Statement of Revenue, Expenses, and Net Income, reported by Blue Plus, HealthPartners, Medica, and UCare.

The differences among MCOs' costs are due to a variety of factors; for example, some types of populations—such as those with special needs—require additional services and resources. Some MCOs administered more types of public programs than others. Administrative costs per program also can be affected by how an MCO estimates and allocates costs to individual programs or products, an issue we discuss in Chapter 2. Lastly, each entity's service area varied, depending on the programs it administered. Exhibit 1.2 illustrates the county service areas for these four entities during 2012, by number of managed care organizations.

[14] Totals exclude estimated state premium taxes and surcharges on HMOs pursuant to *Minnesota Statutes* 2014, 297I.05, subd. 5; and 256.9657, subd. 3. Including these taxes, reported administrative expenses totaled about $278 million.

Exhibit 1.2: Service Areas of Four Largest Managed Care Organizations Administering Minnesota Public Health Care Programs, Contract Year 2012



NOTES: Map represents counties served by Blue Plus, HealthPartners, Medica, or UCare and includes administrative services for all Medical Assistance and MinnesotaCare programs. The number and types of programs administered in each county varied by managed care organization.

SOURCE: Office of the Legislative Auditor, summary of managed cared organization service areas based on Department of Human Services' 2012 data.

Types of Administrative Services

In its contracts with MCOs, the Department of Human Services specifies the scope and nature of administrative services each MCO must provide; for example, claims processing and billing services. Federal law prescribes performance standards for certain administrative functions—for example, timely processing of claims for payment—and the department must include these requirements in its contracts.[15] DHS also specifies certain activities that the MCOs must undertake to receive performance incentive monies. DHS holds back a portion of each MCO's payments and the monies are distributed based on the MCO's performance on various standards.

Exhibit 1.3 illustrates the types of services provided for public programs by these four MCOs, collectively, and the share of total administrative costs for each service.[16] In 2012, about 26 percent of all administrative expenses was for general administrative and finance-related services. About 25 percent was for billing, enrollment, and claims processing services, and 16 percent was for medical management, quality assurance, and utilization management. Each of the remaining service categories accounted for 8 percent or less of all administrative expenses.[17]

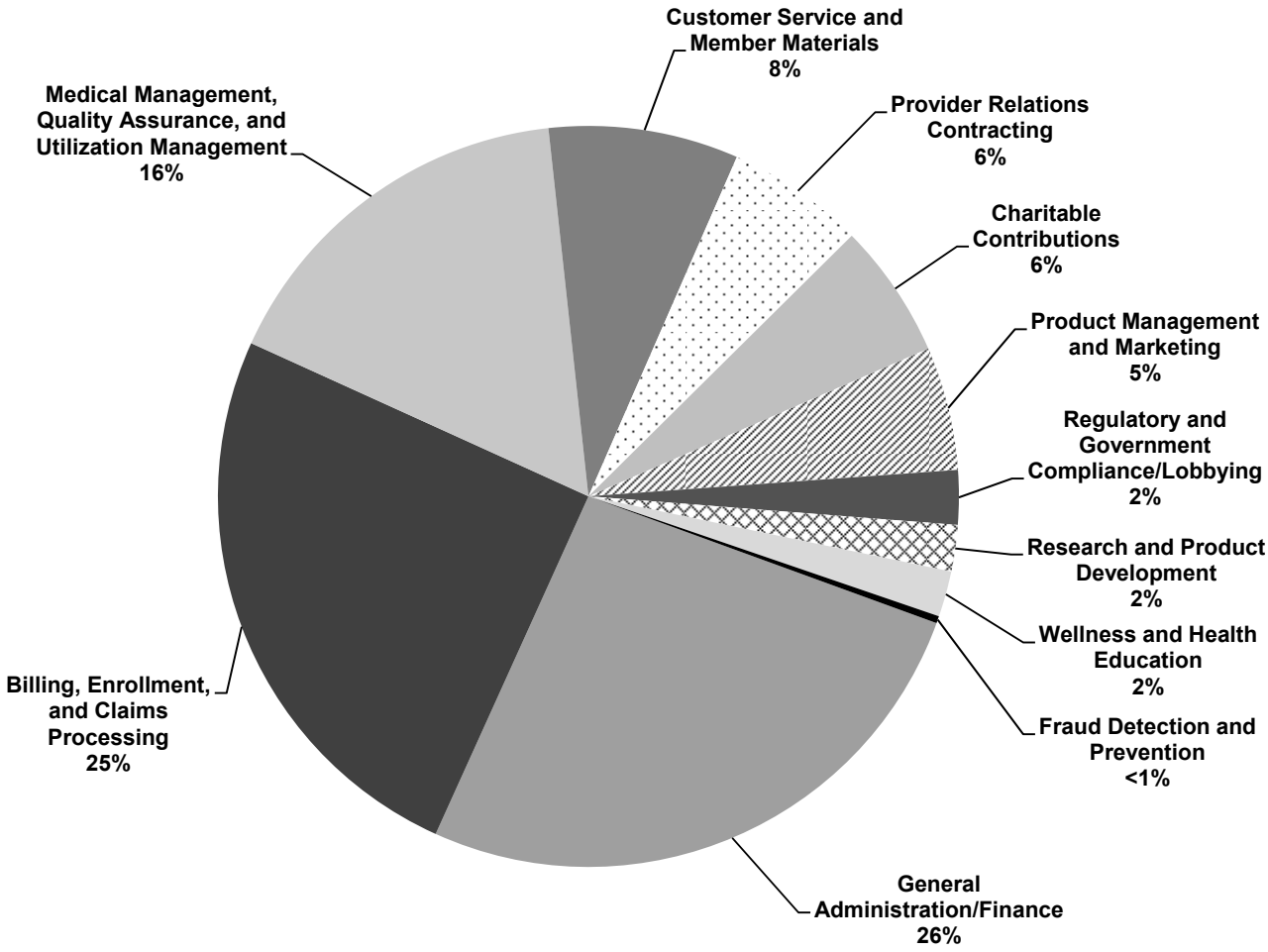
Managed care organizations can and do structure their internal functions, departments, and recordkeeping systems according to their own business models. Later in this report, we explain how state and federal law provide limited detail on the types of administrative expenses MCOs may incur to deliver services for Minnesota's federal Medicaid program. In Chapter 2, our discussion and recommendations result from our audit work at these four largest MCOs.

[15] *42 CFR*, sec. 447.46 (2014).

[16] These data exclude state premium taxes and surcharges reported by these four MCOs.

[17] The categories presented here do not necessarily align with each MCO's organizational framework, but represent common, state-mandated expense groups for reporting purposes.

Exhibit 1.3: Managed Care Administrative Expenses, by Expense Category, Calendar Year 2012



NOTES: Data exclude state premium taxes and surcharges on HMOs. Percentages do not total 100 percent due to rounding.

SOURCE: Office of the Legislative Auditor, analysis of Blue Plus, HealthPartners, Medica, and UCare financial data.

Chapter 2: Managed Care Administrative Expenses

Minnesota has long required managed care organizations (MCOs) to report their administrative expenses to the state. More recently, the state has imposed additional reporting requirements in order to help the Department of Human Services (DHS) set reasonable and appropriate managed care payment rates. State regulations refer mostly to insurance industry accounting standards as guidance for MCOs to record administrative expenses in state-required reports. In this chapter, we summarize findings about MCOs' accounting practices, compliance with certain reporting requirements, and allocation of administrative costs to state public programs for 2012. We recommend legislative actions to enhance MCO financial reporting, understanding of MCO administrative expense data, and future state audits of managed care programs. We discuss DHS rate setting and its use of MCOs' financial data later in Chapter 3.

REPORTING REQUIREMENTS

The State of Minnesota contracts with Blue Plus, HealthPartners, Medica, and UCare to help administer its public health care programs. These four MCOs have complex business models that include relationships with other health insurance or health care entities.[1] The MCOs administer numerous other products and services, such as commercial health insurance for private citizens, federal and state employees, and federal health care programs.[2] These MCOs' business models also involve complex processes to estimate, track, and record financial data, such as general operating, capital, and program-specific costs.

MCOs have filed financial information about their operations with the state for more than four decades.[3] Today, some of these financial documents are not available for the public to see, but many are accessible through websites of the departments of Commerce and Health. State oversight has expanded over the years to help verify the information presented in these financial reports and assure regulators and the public about their content.

In particular, MCOs must have certain financial information certified annually by an independent public accountant.[4] The Department of Commerce oversees a

[1] These other entities may include or be referred to as an affiliate, parent, subsidiary, related entity or party, or other type of organization, depending on the nature of the business relationship.

[2] For example, a managed care organization may contract with a related entity to provide accounting and claims processing services in exchange for a fixed payment amount.

[3] See *Laws of Minnesota* 1973, chapter 670, sec. 8, "The Health Maintenance Act of 1973"; and *Minnesota Statutes* 2014, chapter 62C, "The Nonprofit Health Service Plan Corporation Act."

[4] *Minnesota Statutes* 2014, 62D.08.

periodic "financial examination" of each managed care organization.[5] These examinations are broad in scope and look at the financial condition of the entity, review their business affairs and insurance operations, and assess compliance with certain regulations.

To help state regulators assess their business operations and financial condition, managed care organizations must follow accounting principles that require consistent reporting and presentation of their finances in annual statements.

Minnesota law requires managed care organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions.[6] MDH requires MCOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. To complete this form, MCOs must interpret and consistently apply accounting standards codified as the NAIC Statements of Statutory Accounting Principles (SSAPs).[7] The NAIC provides guidance in the form of statements, instructions, issue papers, and other references.

One of the fundamental concepts of the NAIC accounting principles is to facilitate consistent reporting of meaningful, comparable financial information in order to help regulators determine an MCO's financial condition.[8] Although these principles are a primary authority for MCOs to record and report their finances, the NAIC also defers to other accounting principles.[9] Further, the NAIC SSAPs are not intended to preempt state legislative and regulatory authority.[10]

Minnesota requires MCOs to complete and submit to MDH two additional reports—Minnesota Supplement Report #1 and #1A—that present financial data of each MCO's revenues, medical and administrative expenses, and other data, summarized for each product.[11] These two reports are publicly available online at the MDH website.

MCOs participating in the state's public programs also must submit to DHS their financial statements and other information, including their MDH annual financial

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[5] *Minnesota Statutes* 2014, 62D.14. The Department of Health maintains an agreement with the Department of Commerce to oversee financial examinations, to be conducted at least once every three years. The Department of Commerce has authority to conduct financial examinations of insurance companies doing business in this state. *Minnesota Statutes* 2014, 60A.031.

[6] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 2007.

[7] The NAIC annually publishes its *Accounting Practices & Procedures Manual*, Volumes I-III.

[8] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, vol. 1 (Washington, DC, 2013) P-6.

[9] *Ibid*., P-8.

[10] *Ibid*.

[11] *Minnesota Statutes* 2014, 62D.08, subd.7; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 2007. The categories are: commercial, Medicare, each of the Minnesota public programs, dental, "Other," and "Non-Minnesota" (business provided outside of Minnesota and unrelated to Minnesota products).

filings and expenses and revenues, by product.[12] DHS collects and views this and other financial data provided by MCOs for purposes of determining managed care payment rates for state public programs. The accuracy of these financial reports is important because if they are used for determining managed care payment rates, DHS must ensure compliance with federal rate-setting requirements. Further, state statutes impose limits on growth in MCOs' administrative spending for public programs.[13]

AUDIT METHODS

In the next sections, we summarize the results of our audits of MCOs' compliance with certain financial reporting requirements for reports submitted to both MDH and DHS. Specifically, we tested and relied on data the MCOs used to complete: the NAIC *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; NAIC *Exhibit of Net Investment Income*; *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *2012 Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.

For our audit work, we used a narrower, more targeted approach than typically used for either an independent annual audit or a financial examination. We tested the accuracy and reliability of 2012 general administrative, claims adjustment, and investment data contained in these three financial documents filed by each MCO. We audited each MCO's detailed financial data; however, our work was limited to transactions for which at least some part of an administrative expense was apportioned to the state's public programs, and did not include testing commercial-only or Medicare-only transactions, or transactions for medical expenses. Generally, we sampled transactions greater than $500, and some work required examining additional, related transactions.

Appendices A through D contain findings and conclusions specific to each managed care organization, along with their responses. We frame our discussion in the remainder of this report to comply with data privacy requirements. All four managed care organizations classified the majority of their data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

ADMINISTRATIVE EXPENSES AND ALLOCATION

We reviewed how MCOs classified and categorized their administrative expenses on three financial reports, and how they allocated their costs to the state's public programs. For 2012, each MCO's total administrative expenses varied greatly, depending on the number of enrollees served and programs it administered. For these four MCOs, the total 2012 administrative expenses reported for the state's

[12] *Minnesota Statutes* 2014, 256B.69, subd. 9c(b). See Minnesota Department of Human Services, *2012 Families and Children Model Contract* (St. Paul, 2012), secs. 9.10.1-9.10.2; and Minnesota Department of Human Services, *2013 Families and Children Model Contract* (St. Paul, 2013), secs. 9.10.1-9.10.3. DHS contracts for other MA programs contain similar language.

[13] *Minnesota Statutes* 2014, 256B.69, subd. 5i.

public programs were: $70.1 million (Blue Plus), $39.5 million (HealthPartners), $67.7 million (Medica), and $99.7 million (UCare).[14]

These four MCOs' reported administrative expenses represent tens of thousands of accounting transactions. During our work, we observed that accounting processes varied among the MCOs, depending on the type and amount of the expense. To the extent possible, we framed our sampling methodology to account for such differences and still meet our audit objectives.

Categorization of Administrative Expenses

As part of the Health Annual Statement filed with the state, each MCO must complete the Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses. On this exhibit, each MCO must summarize and report its total administrative expenses for all products—that is, commercial and public programs combined—by type of expense. For our work, our sample population included only expenses in which at least some portion was allocated to the state's public programs. We tested approximately 100 individual financial transactions from each MCO's data and verified whether these costs were correctly classified as "administrative" expenses on this exhibit.[15] We also tested whether these expenses were recorded to the appropriate administrative expense line (such as Rent, Salaries and Benefits, or Taxes, for example). Exhibit 2.1 illustrates certain administrative expense classes and categories on the NAIC Underwriting and Investment Exhibit, Part 3.

Among the samples we tested, managed care organizations generally complied with accounting principles when classifying transactions as administrative expenses for 2012, with one exception.

We found that each MCO had appropriately classified our sample transactions as "administrative," with one exception. One MCO classified up to $2.8 million in management and claims adjustment expenses as "medical" expenses and did not include these cost items on its 2012 Underwriting and Investment Exhibit, Part 3; in our opinion, these cost items should have been reported as administrative expenses.[16] The correct classification of these types of expenses is important because DHS handles administrative expenses differently than medical expenses when determining managed care payment rates for the state's public programs.

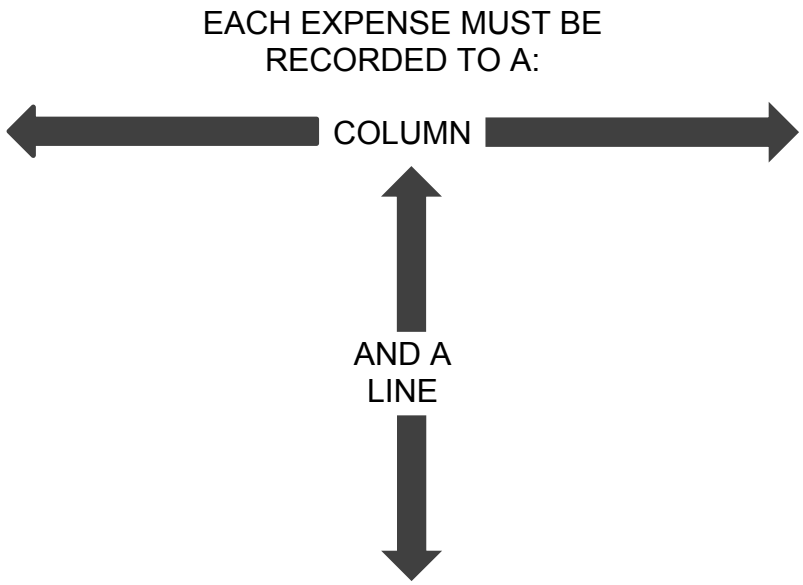
[14] Totals include state premium taxes and surcharges on HMOs. Total MA enrollment for each MCO during 2012 was: Blue Plus (1.6 million member-months), HealthPartners (1.0 million member-months), Medica (1.6 million member-months), and UCare (2.4 million member-months).

[15] We selected samples from MCO data sets containing general ledger and accounts payable data. We also looked for expenses we expected to be classified as "administrative." For purposes of our audit work, we considered "administrative" expenses to include "claims adjustment expenses," "general administrative expenses," and "investment expenses." For more detailed descriptions about these expenses, see NAIC *Statements of Statutory Accounting Principles*, No. 70 and No. 55.

[16] The total reported here represents an upper-bound estimate; we were unable to determine the precise amount in question without testing and verification of individual transactions. These expenses also were not included in the total administrative expenses reported on the MCO's 2012 Minnesota Supplement Reports #1 and #1A.

Exhibit 2.1: Types of Managed Care Organizations' Administrative Expenses, Summarized by Expense Class, 2012

Expense Classification	Claim Adjustment Expenses: Cost Containment Expenses	Claim Adjustment Expenses: Other Claim Adjustment Expenses	General Administrative Expenses	Investment Expenses	Total
Rent	$	$	$	$	$
Salary, wages, and other benefits					
Commissions					
Legal fees and expenses					
Certifications and accreditation fees					
Auditing, actuarial, and other consulting services					
Traveling expenses					
Marketing and advertising					
Postage, express and telephone					
Printing and office supplies					
Occupancy, depreciation, and amortization					
Equipment					
Cost or depreciation of EDP equipment and software					
Outsourced services: EDP, claims, and other services					
Boards, bureaus, and association fees					
Insurance, except on real estate					
Taxes					
Investment expenses					
Aggregate write-ins for expenses					
Total expenses	$	$	$	$	$



NOTES: Each managed care organization (MCO) must summarize its total administrative expenses for all products and programs, collectively, on this Exhibit. MCOs complete and file this exhibit each year as part of their Health Annual Statement. The expense classifications listed here do not include all categories included on the actual National Association of Insurance Commissioners form. Minnesota Supplement Reports #1 and #1A show how these total expenses are allocated across lines of business and state public programs.

SOURCE: Office of the Legislative Auditor, summary of some categories included on the National Association of Insurance Commissioners 2012 Annual Statement—*Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*.

Based on the data we were provided by each MCO, we also reconciled each entity's detailed 2012 administrative expenses for state public programs to its internal accounting documents and its 2012 Underwriting and Investment Exhibit, Part 3. We did not observe any reportable differences in *total* expenses among these key documents and data.[17]

[17] For administrative expense allocated to the state's public programs, we tested and reconciled each MCO's 2012 data contained in general ledgers, accounts payable data, year-end trial balances, and other accounting documentation, against our three sample financial documents.

Among the samples we tested, managed care organizations miscategorized a small number of administrative expense transactions—the total costs related to each of these discrepancies ranged from $549 to $3 million.

We tested whether MCOs' administrative expense transactions were correctly categorized on our sample three financial reports; again, these expenses included transactions in which at least some portion of the expense was allocated to the state's public programs. Among approximately 100 samples tested for each MCO, the number of transactions miscategorized—that is, recorded to the incorrect line—on each MCO's Underwriting and Investment Exhibit, Part 3, ranged from 2 to 7. When including all costs likely related to these sample transactions, total miscategorized expenses for each MCO ranged from $1,702 to $3.03 million. For three MCOs, between one and four sample transactions were miscategorized on either Minnesota Supplement Report #1 or #1A. For these two supplement reports, the total discrepancies for each MCO ranged from $703 to $2.3 million. The discrepancies discussed here represented miscategorization *within* each report and did not affect the total administrative expenses reported.

For purposes of reporting financial information for the state's public programs, correct categorization or disclosure of certain administrative expenses—such as taxes—is important because some categories of data may be handled differently than others when setting managed care payment rates. Most of the MCO reporting discrepancies pertained to the following categories: Salaries, Wages, and Other Benefits; Taxes, Licenses, and Fees; Cost or Depreciation of EDP Equipment and Software; and Cost Containment. In response to our findings, some MCO representatives said that NAIC accounting principles do not sufficiently describe how to record some of the transactions we questioned. As such, the lack of specific instructions may have contributed to some inconsistencies in reporting.

Allocation Requirements

In recent years, Minnesota law imposed additional reporting requirements to enhance understanding of the costs of individual health insurance products and programs, and to develop consistency in reporting among MCOs. In response to a report by the Office of the Legislative Auditor, the 2008 Legislature directed MDH to develop guidelines to ensure that MCOs have consistent procedures for allocating administrative expenses and investment income across their commercial and public lines of business and across individual public programs.[18]

[18] The 2008 law also required the commissioner of human services to work with the commissioner of health to identify and collect data on administrative spending for state health care programs reported to the commissioner of health by MCOs under *Minnesota Statutes* 62D.08. See *Laws of Minnesota* 2008, chapter 364, secs. 5 and 12; Minnesota Department of Health, *Administrative Expenses and Investment Income for Health Plans and County-Based Purchasers: Guidelines and Recommendations, Report to the Minnesota Legislature 2009* (St. Paul, 2009); Minnesota Department of Health, *Advisory Group on Administrative Expenses: Report to the Minnesota Legislature 2012* (St. Paul, 2012), 2; and Minnesota Office of the Legislative Auditor, *Financial Management of Health Care Programs* (St. Paul, 2008).

The 2010 Legislature extended this effort by requiring in law that every managed care organization "must directly allocate administrative expenses to specific lines of business or products when such information is available."[19] The law also required MCOs to report this information to the state on a template developed by MDH. MDH did develop and require MCOs to file by April 1, 2013, this new report—Minnesota Supplement Report #1A—for the year ending December 2012.[20] Each MCO did complete and file this report with MDH mid-year 2013.

With the new reporting requirement, MCOs now must report administrative expenses and other financial information for each product, program, or line of business on two separate reports: Minnesota Supplement Report #1 and Minnesota Supplement Report #1A. (Blank copies of these two documents are contained in Appendix E of this report.) Generally accepted accounting principles provide guidance for determining how costs may be attributed to an individual product, program, or entity. Such guidance varies, depending on the authoritative source. In general, accounting principles present three scenarios for apportioning the cost of a unique transaction: (1) direct costs, (2) direct allocation, and (3) indirect allocation. Exhibit 2.2 on the next page summarizes these accounting concepts and related key NAIC accounting principles.

Depending on whether and how consistently MCOs implement this practice, more direct allocation of administrative expenses could mean that the overall cost of each state program increases or decreases from year to year. To examine how each MCO allocated administrative expenses across its lines of business in Minnesota Supplement Reports #1 and #1A for 2012, we first reviewed each MCO's accounting practices and processes.

MCO Allocation Processes

Each MCO processes tens of thousands of transactions related to their administrative costs each year. These transactions are for many types of expenses, such as general overhead, services by subcontractors, intercompany fees, and payments for capital projects. Further, managed care organizations can and do structure their internal functions, departments, and accounting according to their own business models and services.

Managed care organizations have complex allocation processes to record and apportion their administrative expenses across numerous entities, products, and programs.

[19] Further, remaining expenses that cannot be directly allocated must be allocated based on other methods, as recommended by the Advisory Group on Administrative Expenses. See *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2, effective January 1, 2013; and *Minnesota Statutes* 2014, 62D.08, subd. 7.

[20] The new Minnesota Supplement Report #1A reallocates general administrative expenses and investment income from Minnesota Supplement Report #1 and groups MCO "general administrative" expenses into seven general categories. Three other key requirements include: (1) each MCO must break out direct expenses from indirect expenses, (2) total indirect expenses must be reallocated across lines of business by dollars of premium income (or premium–equivalent for certain business); and (3) each MCO must allocate its investment gain by the prior five years of net income.

Exhibit 2.2: Accounting Terms and Principles for Allocating Administrative Costs, 2012

Terms	Description of Accounting Principle
Direct Cost	All costs for an item can be easily and specifically identified with or benefit a single program, product, or entity (or "cost objective"), and can be assigned with a high degree of accuracy.
Direct Allocation	Costs are considered to benefit two or more specific products, programs, or entities, and can be easily assigned. Costs are apportioned based on the relative benefits received. Direct allocation method requires some rigor of analysis—such as studies of employee activities, salaries, or claim counts—and must be "fair and reasonable."
Indirect Allocation	The allocation of costs incurred for a common or joint purpose benefitting more than one product, program, or entity, but costs are not readily assignable without effort disproportionate to the results achieved. Indirect allocation methods should still be appropriate for the type of expense allocated.
National Association of Insurance Commissioners Key Accounting Principles for Allocating Expenses	
SSAP No. 70	Any allocation of costs must be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salaries, or similar analyses.
Appendix A-440	Within a holding company system, transactions shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.
Issue Paper 94	Allocation should be based on the method that yields the most accurate results. Any basis of allocation which is found to be inappropriate should be discounted.

NOTES: These terms and principles are not always interpreted or applied in a mutually exclusive way. For example, the terms "direct cost" and "direct allocation" are sometimes used interchangeably. Some principles refer to "direct" cost and "indirect" allocation only, and do not reference "direct allocation." These definitions are for descriptive purposes only. Minnesota managed care organizations under contract for Medical Assistance programs are not subject to these federal standards.

SOURCES: Office of the Legislative Auditor, summary of National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, vol. I-III; Statements of Statutory Accounting Principles No. 70; Appendix A-440; and Issue Paper 94. See also U.S. Office of Management and Budget, *Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A; and *48 CFR*, secs. 9904.402-30—9904.402-50 (2014).

In 2012, MCOs mostly relied on accounting systems or software programs to apportion costs across their lines of business. Generally, an MCO can preprogram into its accounting system an allocation formula or metric for each type of cost or department. Expenses then are allocated automatically to one or more specific entities, products, programs, or departments when they are entered into the system. Some of these systems are quite complicated, with multiple allocation steps or formulas. Some MCOs also manually allocate certain expense items on a case-by-case basis.

As shown in Exhibit 2.2, NAIC accounting principles require that any allocation of costs be based on a method that yields the most accurate results. Where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios, such as studies of employee activities, salaries, or similar analyses. Further, NAIC concepts require that each MCO is consistent in how it treats expenses.

Most of the allocation formulas used by each MCO in 2012 were predetermined by management, and were part of an "allocation model" that accounted for all types of administrative expenses or functions, such as legal, billing, or cost containment. Depending on the expense type, costs were allocated based on number of staff, square footage, member-months, premium revenues, claim counts, or other formulas.[21] MCOs relied on formal analysis—such as time tracking—to develop some formulas; however, for particular types of expenses or departments, management often subjectively estimated an allocation percentage. For example, management might set the percentage of marketing costs allocated to each line of business based on estimates of workload during the past year. MCO representatives told us that they periodically modify these formulas, or add cost centers or categories for new programs or expense types.

During our audit work, MCO representatives said that the Department of Commerce had reviewed and approved their allocation models as part of the department's financial examinations. Our audit work did not include evaluating each MCO's allocation model. Rather, we examined whether certain expenses could be more directly allocated to a specific product—in accordance with new state requirements—using each MCO's description of its allocation methods.

Direct Allocation

Each MCO's methods for allocating its administrative expenses across commercial and government programs in 2012 varied greatly, depending on the expense type, department, function, or entity. These methods also did not align exclusively with state public program needs as each MCO also offered commercial products or other administrative services, either within or outside of Minnesota.

For the majority of their 2012 administrative costs, managed care organizations consistently allocated at least some portion of each expense item to state public programs.

Managed care organization representatives told us that they most often spread administrative expenses across all lines of business to gain efficiencies in business operations. For more than 50 percent of all MCO administrative expense items in 2012, between 0.1 percent and 100 percent of each transaction was allocated to the state's programs on their Minnesota Supplement Reports #1 and #1A.[22] MCOs were mostly consistent in that they often treated all state

[21] For their allocation "metrics," management of some MCOs sometimes modified basic values—such as number of staff—by some factor before allocating costs (for example, number of full-time-equivalent staff X 1.2).

[22] Estimate is based on 2012 detailed financial data provided by the managed care organizations.

public programs as a single "product," and rarely tracked and directly assigned expenses solely to one individual program—such as PMAP, MSHO, or SNBC.[23] Depending on the expense type or dollar amount, some MCOs did individually review and directly allocate some expenses for one-time or specialized services.

We identified opportunities for managed care organizations to more directly allocate administrative expenses to specific products, although managed care representatives said that this practice is time-consuming and would increase costs for public programs.

Among approximately 100 transactions tested for each MCO, we identified some types of services that could have been expensed more directly to one or more state programs in each MCO's 2012 Minnesota Supplement Report #1A.[24] These items did not include day-to-day general overhead and operating expenses. Rather, these costs resulted from subcontracts for services unique to one or more lines of business. Within the contract documents, the MCO had specified products—commercial or public program—that benefitted from the service. For some of these expenses, the contract services required tracking by member eligibility, by program. As such, the MCO had information available for more direct allocation of costs.

For each MCO, the number of these contract-related services that could have been directly allocated ranged from two to five. The total sample transactions we tested ranged from $14,478 to $66,896, and we estimated the amounts allocated among the state's public programs ranged from $7,152 to $14,208.[25] When including all costs likely related to these transactions, we estimated the total costs allocated among state programs ranged from $14,068 to $206,572.

In response to the new requirements for directly allocating costs, some MCO representatives said that increased tracking of expenses would require additional administrative resources and, thus, increase the costs of the state's public programs. MCO representatives also informed us that their current allocation processes and methods are similar to those used during 2012.

Costs Allocated to Public Programs

Minnesota managed care organizations have broad discretion regarding the type of costs they may incur for their business. Generally, an MCO is paid a fixed, prepaid amount—or capitation payment—and MCO net earnings must be devoted to the nonprofit purposes of the MCO in providing comprehensive health care.[26] Minnesota law also authorizes MCOs to make payments to any

[23] Acronyms represent the Prepaid Medical Assistance Program (PMAP), Minnesota Senior Health Options (MSHO), and Special Needs Basic Care (SNBC).

[24] *Minnesota Statutes* 2014, 62D.08, subd. 7(a).

[25] For more information, see Appendices A through D at the end of this report.

[26] *Minnesota Statutes* 2012, 62D.02, subd. 4, generally defines health maintenance organizations as entities that are paid a fixed, prepaid amount to provide comprehensive health maintenance services without regard to the frequency or extent of services furnished to any particular enrollee. See also *Minnesota Statutes* 2014, 62D.12, subd. 9.

organization(s) which are operated for charitable, education, religious, or scientific purposes, and they may not incur costs or pay for expenses that are unreasonably high in relation to the value of the services.[27]

For MCOs under contract for the Medical Assistance programs, any restrictions or limits on spending occur through the DHS rate-setting process to determine managed care payments for the upcoming contract year. This process relies in part on historical data and reports submitted to DHS by each MCO. (We discuss how DHS sets managed care payment rates later in Chapter 3.)

Managed care organizations allocated some unreasonable expenses to the Medical Assistance programs on their 2012 state-required financial reports.

Among our sample transactions we tested, we questioned some administrative expenses allocated by the MCOs to the state's public programs on their 2012 Department of Health Minnesota Supplement Reports #1 and #1A. In our opinion, these cost items were: (1) unreasonable and did not reflect the actions a prudent person would take in the circumstances, (2) unrelated to the provision of services under the state's Medical Assistance plan for Medical Assistance enrollees, or (3) did not comply with MDH rules.[28] In particular, Department of Health rules required MCOs to identify and separately report services for business outside of Minnesota and unrelated to Minnesota products.

Based on our review of MCOs' internal policies and practices, we concluded that the MCOs' accounting and allocation processes did not sufficiently identify and restrict these types of expenses from the Medical Assistance programs on their 2012 MDH supplement reports. The expenses we questioned varied for each MCO and were incurred for alcohol beverages, travel, entertainment, or activities or services outside of Minnesota and unrelated to the state's public programs. For each MCO, the number of these transactions tested ranged from one to three. The total value of the transactions ranged from $2,664 to $26,000, and we estimated total costs allocated among state public programs ranged from $376 to $2,144. As a result of our sampling methodology, these expenses were mostly small; however, we consider these transactions to be indicators of an MCO's allocation practices.

We also questioned other administrative expenses allocated by the MCOs to the state's public programs on their MDH 2012 supplement reports. These expenses were for indirect marketing activities or charitable contributions. Minnesota laws in effect at the time the MCOs filed their annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific

[27] *Minnesota Statutes* 2014, 62D.12, subd. 9a; and 62D.19.

[28] We used the following criteria as the basis for our findings: U.S. Office of Management and Budget, *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations*, subp. A, sec. 105. (We used this OMB "prudent person" standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this OMB standard.) See also *Minnesota Statutes* 2014, 62D.19; *42 CFR*, secs. 438.6(c)(4)(ii)(A) and 438.6e (2014); and *Minnesota Rules*, 4685.1930, subps. 2 and 6, posted October 2007.

purposes.[29] However, charitable contributions were included in the financial data and supplement reports submitted to DHS, and they were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[30]

Some of the costs we questioned may have benefitted individuals who happen to be enrolled in Medical Assistance, but the services were not part of the federally approved services for Minnesota's MA programs. In some cases, the MCO did not provide us with sufficient documentation to determine the details of the expense. For each MCO, the total indirect marketing and contribution transactions discussed here ranged from $47,569 to $10 million, and we estimated the amount allocated among the state's public programs ranged from $5,198 to $8.5 million. These expenses were for: marketing videos, trinkets, training for sales staff for commercial products, newspaper and television advertisements, tickets to a sporting event, promotional charity events, grants for research or employment opportunities, contributions to other nonprofit organizations, website development, and other types of expenses.[31]

Absent restrictions in state law or rule, disagreements over managed care organizations' allocation of costs to the state's public programs will persist.

Managed care representatives mostly disagreed with our findings about their allocation of costs on MDH-required reports, and our characterization of such costs as unreasonable for purposes of determining payment rates for public programs. For some costs we questioned, some representatives said that their allocation practices comply with federal and state law, state contracts, reporting requirements, and accounting standards. Some MCO representatives also said that: (1) Minnesota Supplement Reports #1 and #1A are financial reports required by MDH and were not developed nor were intended to be used for other purposes, such as by DHS for determining capitation payment rates for the state's public programs; (2) directly allocating these types of expenses exclusively to products other than the state's public programs would not be appropriate; (3) the expenses were small, benefit their organization overall, and are standard for their industry; or (4) the audit firms they employ to conduct their independent audits would not certify their financial reports if they used different allocation methods.

We questioned MCOs' indirect marketing and charitable contribution expenses because the MCOs allocated these expenses to the public programs on their MDH supplement reports, and we do not view these expenses as related to approved services under the state's Medical Assistance program. As we described earlier in this chapter, Minnesota Supplement #1A was developed to facilitate understanding of the costs for public health care programs, and DHS views the MDH supplement reports when developing payment rates for 2014.

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[29] *Minnesota Statutes* 2012, 62D.12, subd. 9a.

[30] *Minnesota Statutes* 2012, 256B.69, subd. 5i.

[31] Regarding the marketing expenses we questioned, MCO representatives said that these cost items were for indirect marketing or "branding" and were not for direct marketing that would have required DHS approval.

Laws passed during the 2013 legislative session defined indirect marketing and charitable contributions as "unallowable" for purposes of determining managed care capitation payments; however, this law was passed *after* the MCOs completed and filed their 2012 annual financial filings and supplement reports.[32] Under the new law, these unallowable expenses are: fines or penalties assessed against the MCO; indirect marketing or advertising expenses; charitable contributions; and any portion of an individual's compensation in excess of $200,000. During 2013, DHS requested from MCOs and they submitted separate financial data regarding these unallowable expenses, and we attempted to reconcile these data with the MCO annual reports submitted to DHS for purposes of determining managed care payment rates. We were able to verify that some of these expenses were sufficiently disclosed to DHS. We discuss the results of our efforts and make recommendations later in Chapter 3.

Subcontract Administrative Expenses

Managed care organizations may subcontract with outside entities or individuals for the provision of services, including administrative services.[33] The state's contracts with the MCOs for public programs specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all subcontracts must be in writing.[34] During 2012, managed care organizations did subcontract for many types of administrative services, and these expenses were among the transactions we sampled.

Managed care organizations did not have adequate documentation to support costs related to some subcontracts for administrative services expensed to public programs in 2012.

For some contract-related sample transactions we tested, MCOs did not have adequate documentation to validate whether the subcontractors were paid appropriately, assess the reasonableness of the MCO's allocation, or determine how these expenses related to the state's public programs.[35] We found that invoices for subcontracted professional services sometimes lacked descriptive information. (In contrast, invoices for purchased goods generally contained descriptive data—such as price, product type, and number of units.) Under these circumstances, written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in

[32] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21, amended *Minnesota Statutes* 2012, 256B.69, subd. 5i.

[33] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[34] Department of Human Services, *2012 Families and Children, Model Contract* (St. Paul, 2012), secs. 9.1, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6 (2014). Minnesota law defines a "contract" as any written instrument or electronic document containing the elements of offer, acceptance, and consideration. *Minnesota Statutes* 2014, 16C.02, subd. 6.

[35] We defined questioned costs to include "a cost that is questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation." OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

question are related to the contract and are not for other services.[36] And written amendments document any changes to the agreement between the MCO and contractor.

When verifying these expenses, we found that some MCOs' subcontracts were not signed by both parties or had expired, or payments did not match the vendor rates in the documents provided by the MCO. Some contracts had conflicting provisions or the payments we tested did not align with terms for amending the contract. In some instances, the MCO did have a general master contract, but did not execute an individual work order contract or statement of work describing payment terms and the nature of work or expected final product. For each MCO, the number of contract-related transactions that lacked adequate documentation ranged from two to four, the total transactions we tested ranged from $28,109 to $219,086, and we estimated the total costs allocated among the state's public programs ranged from $2,893 to $31,736.[37]

DISCUSSION AND RECOMMENDATIONS

Policymakers recently expanded financial reporting requirements for MCOs to improve transparency and understand costs for managed care administrative services. We focused our work to help assess implementation of these changes, and we identified issues for state policymakers and administrators to consider. The following discussion provides context for our recommendations and, if implemented, would enhance future audit work for the state's public programs.

Minnesota statutes, rules, and state contracts do not ensure consistent reporting by managed care organizations and compliance with policymakers' intent.

Our examination of managed care organizations' detailed financial data, supporting documentation, and allocation practices revealed that state financial reporting requirements should be improved. In particular, lack of detail and conflicting language in law and state contract provisions do not sufficiently support recent efforts by policymakers. Insufficient guidance in accounting principles may contribute to inconsistencies in reporting, too.

[36] We tested our contracts and samples transactions to verify: (1) the MCO had a written agreement signed by an authorized MCO representative and subcontractor, with details about the parties to the contract, duration, and terms of payment; (2) the invoice or transaction tested aligned with the terms of the contract; and (3) an amendment to the contract—as necessary—was executed to ensure the contract documents supported the transaction tested. For recommended best practices and guidelines for contracting, we referred to Minnesota Department of Administration, *State Contracting, Policies and Procedures* (St. Paul, 2000, modified May 2012), sec. 5.

[37] These totals do not include all likely related costs. Specifically, identifying all likely related costs when there is no controlling reference document—such as a contract—was too difficult to sufficiently verify. For more information, see Appendices A through D at the end of this report.

Reporting Instructions and Definitions

Some Minnesota statutes now require MCOs to report certain financial data for each individual program or product. We found that MCOs differed in their interpretation of "program" or "product," depending on the reporting requirement. As part of reviewing MCO practices for directly allocating expenses to specific lines of business or product when such information is available (as required by state statute), we considered each state public program to be a separate product.[38] Our interpretation aligns with laws passed during the 2008 legislative session, which requires direct allocation to *individual* public programs.[39] This approach also recognizes that DHS executes separate contracts and uses different methods for determining managed care payment rates, depending on the public program.[40] However, we found that MCOs most often treated all state public programs as a single "product" when directly allocating costs on Minnesota Supplement Report #1A, or otherwise allocated individual administrative expenses across all commercial and public programs (including Medicare).

We also observed that managed care representatives differed in their interpretation of terms "direct allocation" and "indirect allocation." Some considered directly allocate to mean "direct expense"; that is, 100 percent of the expense is attributed to a single entity or program.[41] One MCO representative said that because the Minnesota law does not define "directly allocate," MCOs may record costs according to internal definitions. Some said that the law does not specify the types of expenses to directly allocate (such as for items above a certain dollar amount, or for one-time projects, general operations, or contracts). Finally, one representative disagreed with the Department of Health instructions to allocate indirect costs by premium income as "there is no [relationship] between premium revenues and administrative expenses."

Several managed care representatives told us that more tracking and direct allocation of costs would be time-consuming and not cost-effective. This could be true for some types of general overhead costs; however, for contract-related expenses, MCOs already invest time in hiring subcontractors and developing a scope of work. For the sample transactions we identified as appropriate for more direct allocation, we think any measurable increase in resources needed to trace these costs more often results from a subcontractor's billing practices. Based on our review of sample transactions, subcontractors often combined costs—such as for legal services—for multiple projects into a single invoice, rather than submit a separate invoice for each project or program. Further, some higher dollar value invoices contained few references about the nature and amount of services provided.

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[38] *Minnesota Statutes* 2014, 62D.08, subd. 7(a).

[39] *Laws of Minnesota* 2008, chapter 364, sec.12.

[40] DHS combines PMAP and MinnesotaCare in a single contract, MSC+ and MSHO in a single contract, and SNBC is a standalone contract.

[41] An allocation formula which *allocates* 0 percent of costs to program A and 100 percent of costs to program B has the same effect of a *direct expense* to program B.

As directed by the Legislature, MDH developed Minnesota Supplement Report #1A and accompanying instructions. However, *Minnesota Statutes* 2014, 62D.08, does not define the term "directly allocate" or "lines of business or product," or specify types of expenses to allocate. More explicit language and definitions could help address differences in MCOs' interpretation and reporting of administrative expenses on Supplement Report #1A. To facilitate this process, the Legislature could refer to existing definitions of these terms in federal standards and regulations when defining these terms in state law.[42] Other states—such as Texas—have adopted federal definitions or specified how some types of expenses must be allocated.[43]

RECOMMENDATION

The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to include Department of Health instructions and to further specify how managed care organizations must allocate administrative expenses for Minnesota Supplement Report #1A.

State statutes and rules also do not ensure that MCOs consistently allocate and report investment income on Minnesota Supplement Report #1A. Specifically, instructions in *Minnesota Statutes* 2014, 62D.08, are very brief and require MCOs to "allocate investment income based on cumulative net income over time by business line or product" on a form required by MDH. MDH instructions are also very brief and state that MCOs "must allocate investment gain by the prior five years of net income."

Notwithstanding these differences, we found that some MCOs did not precisely comply with MDH requirements and used their own methodology. Managed care representatives interpreted these instructions differently, or said that the instructions do not ensure reported values that accurately reflect recent investment experience.

We think that *Minnesota Statutes* 2014, 62D.08, should be amended to ensure consistency in reporting requirements and compliance with policymakers' intent. In particular, reporting requirements for Minnesota Supplement #1A rely on data reported in Minnesota Supplement Report #1, and there are minimal state instructions for Minnesota Supplement Report #1. This means that each MCO could compute net income based on its internal methodology for each product; in turn, this approach can affect how much investment income is allocated to each public program on Supplement Report #1A.

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[42] *48 CFR*, sec. 9904 (2014); U.S. Office of Management and Budget, *Circular A-87, Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004); *48 CFR,* sec. 31 (2014); and U.S. Office of Management and Budget, *Circular A-122, Cost Principles for Non-Profit Organizations* (Washington, DC, 2004). We cite these standards for reference purposes only. Minnesota managed care organizations under contract for Medical Assistance programs are not subject to these federal standards.

[43] Texas Health and Human Services Commission, *Uniform Managed Care Manual, Cost Principles for Expenses*, v. 2.2 (July 20, 2013).

RECOMMENDATION

The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to further specify how managed care organizations must allocate investment income on Minnesota Supplement Report #1A.

Requirements for Subcontracts

Managed care organizations may subcontract with other entities or individuals for administrative services for public programs; this arrangement is allowed under the state's contracts with the MCOs, as well as state law.[44] DHS contracts also require that the MCOs comply with all federal laws and regulations—including federal contract laws. Both federal law and state contracts specify that subcontracts must be in writing.

MCOs pay vendors and professional consultants for administrative services. We found that the scope of these professional services and payment terms were not always adequately documented, payments did not always align with the contract terms, and the subcontractors' invoices lacked descriptive information. For one sample without a fully signed contract, MCO total payments to its subcontractor exceeded $200,000 and the majority of costs were allocated to state public programs.

In response to our findings, some managed care representatives said that they were not required under law or through their state contracts to maintain current, fully executed contracts for the transactions we questioned. In their view, management approval of the expense is sufficient documentation, or the services were "not significant or material" to the MCO's obligation under its contract with the state and, thus, did not require a written contract.

Managed care organizations participate in administering public health care programs, a service that involves the handling of sensitive and personal information. For administrative services outsourced by the MCOs and expensed to the public programs, tight contracting requirements represent sound business practice and facilitate transparency in program costs. DHS contracts with MCOs contain more explicit provisions for some types of MCO subcontracts for health care services than for administrative services. The Legislature and DHS should directly specify that MCOs must maintain fully executed, current, written subcontracts for administrative services expensed to the public programs, including the required form and content of these documents. At a minimum, such provisions should explicitly address subcontracted administrative services that involve access to not public data.

[44] *Minnesota Statutes* 2014, 62D.05, subd. 4; and DHS, *2012 Families and Children Model Contract*, secs. 9.3.1 and 9.3.5.

RECOMMENDATIONS

The Legislature should specify in law requirements regarding managed care organizations' subcontracts for administrative services that are expensed to Minnesota's public health care programs.

In its contracts with managed care organizations, the Department of Human Services should further specify requirements regarding subcontracts for administrative services, including the required form and content.

Chapter 3: Department of Human Services Rate Setting

The relationship between managed care administrative spending and health outcomes is complicated. Absent requirements for quality of care and service performance, a lower price may, or may not, result in better value for services. Nonetheless, the state's processes and practices for determining Minnesota's costs for Medical Assistance should help ensure that payment rates for managed care administrative services are appropriate and reasonable, and neither inadequate nor excessive.

In this chapter, we make observations about the Department of Human Services' (DHS's) efforts to control managed care administrative costs through the payment rate-setting process.[1] We identify areas of concern based on our audits of managed care organizations' (MCOs') 2012 administrative expense data. We also offer recommendations to policymakers and the department to improve state oversight. Much of the analysis and data used for rate setting has been classified as not public, and we frame our discussion accordingly.

MANAGED CARE TRENDS 2009-2013

Our audits of managed care organizations' 2012 financial reports found that MCOs' overall administrative expense totals were correct, with some larger reporting exceptions that may have had an effect on DHS's rate-setting analysis for 2014. For the data we tested, MCOs generally complied with the National Association of Insurance Commissioners (NAIC) accounting principles when completing reports required by the Department of Health. However, we found that the administrative expenses that MCOs allocated to the state's public programs included some questionable or unallowable costs for purposes of determining managed care payment rates.

Our findings support recent actions by policymakers to establish a more direct reporting relationship between the MCOs and the Department of Human Services. DHS must determine how much to pay managed care organizations for administering the state's public health care programs, and ensure that payment amounts are within limits of law.[2] DHS also is responsible for controlling state expenditures for Medical Assistance—this includes ensuring against excess payments.[3]

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[1] We did not retain an actuary to review the analyses and certifications by DHS or its actuary, or to calculate a better payment rate. We also did not verify whether the 2014 managed care payment rates were "actuarially sound."

[2] *42 CFR*, sec. 438.6(c) (2014); and *Minnesota Statutes* 2014, 256B.69, subd. 5.

[3] *42 CFR*, sec. 456.3(a) (2014); and *Minnesota Statutes* 2014, 256B.69, subd. 5k.

Managed care administrative costs per member-month in 2013 were comparable to 2009 rates for some state public health care programs, but increased for others.

We examined DHS rate-setting activities during 2013 for contract year 2014, but we also considered that some state initiatives preceded this time period. For context, Exhibit 3.1 summarizes recent trends in MCO expenses, revenues, and member-months for the four largest MCOs.[4] Compared with 2009 financial data, MCO administrative expenses per member-month were about 0.5 percent lower in 2013 for the Prepaid Medical Assistance Program (PMAP) and MinnesotaCare, but about 8.0 percent higher in 2013 for Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+).[5] These differences may be due to several factors, including program requirements, care management activities, changes in MCOs' service arrangements, rate-setting methods, contract negotiations, or competitive price bids. These trends also could reflect changes in MCOs' allocation methods. In Chapter 2, we described how MCOs most often allocated administrative expenses across all public programs during 2012.

Exhibit 3.1: Minnesota Public Health Care Programs, Expenses and Enrollment, Four Managed Care Organizations, Contract Years 2009 and 2013

Programs[a]	Contract Year 2009	Contract Year 2013	Percentage of Change
Administrative Expenses (in thousands)			
PMAP, GAMC, MinnesotaCare	$156,274	$201,274	28.8%
MSHO, MSC+	$ 52,840	$ 67,843	28.4%
Total Member-Months (in thousands)			
PMAP, GAMC, MinnesotaCare	4,609	5,966	29.4%
MSHO, MSC+	401	476	18.9%
Administrative Expenses per Member-Month			
PMAP, GAMC, MinnesotaCare	$ 34	$ 34	-0.5%
MSHO, MSC+	$132	$142	8.0%
Medical Expenses per Member-Month			
PMAP, GAMC, MinnesotaCare,	$405	$408	0.6%
MSHO, MSC+	$2,189	$2,169	-0.9%

NOTES: Acronyms used in this exhibit represent the Prepaid Medical Assistance Program (PMAP), General Assistance Medical Care (GAMC), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+)

[a] General Assistance Medical Care was a state public program in 2009, but the program was discontinued. This population was covered under other MA programs during 2013.

SOURCE: Office of the Legislative Auditor, analysis of Blue Plus, HealthPartners, Medica, and UCare financial data reported in 2009 and 2013 Minnesota Supplement Report(s) #1, Statement of Revenue, Expenses, and Net Income.

[4] Data reported in Exhibit 3.1 does not include MCOs' financial experience for contract year 2014 as these data will not be available until April 2015.

[5] Total administrative expenses for all four MCOs—Blue Plus, HealthPartners, Medica, and UCare combined—decreased from about $278 million in 2012 to $269 million in 2013.

PAYMENT METHODOLOGIES

DHS's managed care payment rates and methodology must be approved by the federal Centers for Medicare & Medicaid Services (CMS) in order for Minnesota to receive federal Medicaid funds. CMS also must approve the state's Medical Assistance (MA) plan, the scope and level of health care services, and populations covered. Federal regulations and guidelines provide the framework for developing payment rates for these services, but these directives largely defer to states and their actuaries to select payment methods and execute the details. As of March 2015, CMS approved Minnesota's 2014 managed care payment rates—including the certifying actuary's methodologies and assumptions for administrative costs—for MSHO, MSC+, and Special Needs Basic Care (SNBC). CMS's approval of PMAP and MinnesotaCare rates was still pending

Minnesota has used an "at-risk" capitation payment method for managed care services for many years. Under this approach, the price for administrative and medical services—and any additional monies for the MCO to contribute to its financial reserves—are bundled together and treated as a single payment. This means each MCO is paid a fixed, prepaid amount for each enrollee without regard to the level or amount of health care provided to any individual enrollee.[6] Under a capitation payment method, the MCO assumes the risk for paying for all services—even if the costs exceed the capitation payment amount—but also retains all monies not spent.

Under a capitation payment method, DHS must assure and provide documentation to CMS that MA payment rates are "actuarially sound."[7] That is, the rates must be:

- Developed in accordance with generally accepted actuarial principles and practices.
- Appropriate for the populations to be covered, and based only upon services covered under the state plan to Medicaid-eligible individuals (or costs directly related to providing these services, including MCO administration).
- Certified as meeting federal requirements by actuaries who meet the qualification standards of the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

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[6] *Minnesota Statutes* 2014, 62D.02, subd. 4.

[7] *42 CFR*, sec. 438.6(c)(1)-(4) (2014). For contract year 2014, actuarial standards suggest that Medicaid benefit premium rates are "actuarially sound" if, for business in the state for which the certification is being prepared and for the period covered by the certification, the projected premiums—including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income—provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital. See American Academy of Actuaries, *Medicaid Rate Certification Work Group, Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs* (Washington, DC, 2005), 8-9.

Minnesota supplements federal law with general provisions that rates must satisfy federal requirements and be developed in accordance with generally accepted actuarial principles and practices.[8] In essence, DHS must work with and rely on an actuary to ensure compliance with Medicaid regulations. As in previous years, DHS contracted with an actuary firm during 2013 to fulfill these requirements for contract year 2014.

DHS and its certifying actuary have broad discretion to select rate-setting methods for managed care administrative costs.

Under federal Medicaid guidelines, DHS must include an adjustment to the overall capitation payment rate to account for administrative expenses, but DHS is allowed flexibility in how it determines this amount.[9] Actuarial methods to develop the administrative portion of the rate include: (1) percentage of all premium revenues; (2) fixed payment per member-month; or (3) combination of fixed payment for certain services, combined with a percentage for remaining service costs that may vary.[10] Broadly, DHS must assure that only administrative costs directly related to the provision of federally approved Medical Assistance services for MA enrollees are built into the administrative portion, and explain any incentive or risk-sharing arrangements.[11]

CMS also allows reasonable amounts for risk margin or profit levels, but has not established standards that define "reasonable" or how profit must be computed into the payment rate.[12] For Minnesota's MA program in 2014, the capitation rates did not include an explicit "profit" component, but did include a factor for "contribution to surplus"—0.75 percent for PMAP and Minnesota Care, for example—for managed care organizations' reserves.

Federal Medicaid guidelines and actuary standards require that the certifying actuary document all assumptions and methods used, including projections in future expenditures, enrollment, and utilization.[13] For example, forecasted trends

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[8] *Minnesota Statutes* 2014, 256B.69, subd. 5k.

[9] Centers for Medicare & Medicaid Services, *Appendix A. PAHP, PIHP, and MCO Contracts, Financial Review Documentation for At-risk Capitated Contracts Ratesetting* (Washington, DC, 2003), sec. AA.3.2.

[10] Wakely Consulting Group, *Review of Medicaid MCO Administrative Rate Setting Methodology* (Minneapolis, 2014), 26.

[11] *42 CFR*, sec. 438.6(c)(3) (2014). The actuary also should include an adjustment for taxes, assessment, or fees that the MCOs must pay out of the capitation rates. Other factors considered appropriate for determining the administrative portion include: overall size, lines of business covered by the rate, age of the MCO or years of participation in Medical Assistance, organizational structure, demographic mix of enrollees, member services, interpreter services, and expenditures for marketing, claims processing, medical management, and staff overhead. Wakely, *Review of Medicaid MCO Administrative Rate Setting Methodology*, 24-26.

[12] CMS, *Appendix A. Financial Review Documentation*, sec. AA.3.2. For Minnesota's MA program, any contribution to surplus is determined separate from the administrative and medical components of the payment rate.

[13] *42 CFR*, sec. 438.6(c)(3) (2014); and Wakely, *Review of Medicaid MCO Administrative Rate Setting Methodology*, 29.

in administrative spending may be computed based on national indices or other measures of the health insurance industry. Minnesota statutes impose limits on future overall trend increases to MA rates paid to managed care organizations.[14] Most of these limits apply to the overall capitation payments and are not necessarily specific to administrative expenses. For example, DHS was required to limit the maximum annual trend increases in managed care payment rates to 2.0 percent for the 2014 MCO contracts for families and children.

For Minnesota managed care organizations compensated through a prepaid capitation payment method, federal and state law provide few specific restrictions on MCOs regarding the types of expenses they may incur to administer the state's Medical Assistance programs.[15] Generally, an MCO must fulfill its contractual obligations, but may use its capitation payment monies as it chooses throughout the year. Any restrictions regarding administrative expenses are imposed when DHS renews contracts and determines new overall payment rates.

2014 PAYMENT RATES

For contract year 2014, DHS determined capitation payment rates for managed care services through two separate competitive procurement processes: (1) competitive price bid, a process previously implemented through 2011 legislative session laws for contract year 2012;[16] and (2) state-set base rates (that is, DHS sets the rate and contracts with each MCO). These rate-setting processes differed depending on the Medical Assistance program, population, and geographic area. Rates for PMAP were developed separately using different data and methods than for MSHO, for example. Medical needs for these populations vary, and rate-setting methods must account for these variances. DHS's expectations for administrative services also differ for each program, which affect MCO administrative spending.

The Department of Human Services implemented important cost-savings initiatives for contract year 2014, but the department's technical execution during 2013 was sometimes lacking.

Prior to 2011, the state's actuary developed a single base rate for each program. Through a competitive price bid approach, the capitation rate-setting process is more complex but offers more flexibility for finalizing payment amounts. CMS requires that the state's actuary calculate rate ranges; that is, lower and upper

[14] *Minnesota Statutes* 2014, 256B.69, subd. 31. State law allows DHS to use competitive price bidding, payment reductions, or other methods to achieve the specified reductions and limits on an aggregate, statewide basis.

[15] *Minnesota Statutes* 2014, 62D.12, subd. 9, 9a. Federal laws impose restrictions on certain marketing by MCOs under Medicaid contracts and, thus, related administrative expenses. See *42 U.S. Code*, 1396u-2 (2012); and Department of Human Services, *2012 Model Contract*, sec. 3.2.4.

[16] *Minnesota Statutes* 2014, 256B.69, subd. 33; and *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 96.

bound rates.[17] The actuary must certify that any and all rates within the range are actuarially sound. This means that all rates in the range represent a cost reimbursement for an *average* MCO, and any single rate may be sufficient for one MCO, but perhaps not others. DHS can select any rate within the range when negotiating contracts, and the rate ranges provide parameters for evaluating competitive price bids from MCOs.

Competitive Price Bid

For contract year 2012, DHS used a competitive price bid process to procure managed care services for PMAP and MinnesotaCare for the seven-county metro area.[18] DHS again used this approach for the 2014 PMAP and MinnesotaCare contracts for 27 other counties: a "North" region comprised of 21 counties, and a "South" region comprised of 6 counties.[19] Although DHS used these processes in two different regions in two different years, the value of this approach affected payment rates for MA programs overall.

Competitive price bids for the Medical Assistance programs had a multi-year impact on DHS's managed care payment rate-setting methods.

More specifically, in its request for proposals, DHS asked each MCO to submit separate medical and administrative cost components for their bids. This included estimated prices for general cost categories, but not detailed financial records to detect unreasonable or unnecessary administrative costs. Rather, each MCO's bids were compared with the actuary's rate ranges and against other MCOs' bids. Following a DHS request for best and final offers, DHS staff scored the MCOs' final bid proposals based on cost and quality criteria (including a section scored by county representatives) and awarded the contracts.[20]

Exhibit 3.2 shows that three MCOs were awarded at least 1 county service area through competitive price bid; each award ranged from 4 to 27 counties. Capitation payment rates for these 27 counties represented MCOs' best and final offer for both administrative and medical services; actual payment rates varied for each MCO and the populations covered.[21] These payments account for about 16 percent of all capitation payments for PMAP and MinnesotaCare. As a share of all Medical Assistance payments, PMAP and MinnesotaCare represent about 88 percent of all MA enrollment, 73 percent of MA managed care payment dollars, and 73 percent of MA managed care administrative expenses.[22]

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[17] CMS, *Appendix A. Financial Review Documentation*, sec. AA.1.3.

[18] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 96.

[19] *Minnesota Statutes* 2014, 256B.69, subd. 33. These 27 counties were scheduled for procurement.

[20] County representatives did not review or score the bids, and DHS awarded the final contracts.

[21] Schedules of final payment rates are contained with the managed care contracts posted to the DHS website: mn.gov/dhs/.

[22] Estimates are based on MCOs' 2012 administrative expenses and 2012 and 2013 enrollment.

Exhibit 3.2: Managed Care Organizations' Service Areas, PMAP and MinnesotaCare, Contract Year 2014

	Service Areas, by Number of Counties			Total Service Areas: Rates Set via Competitive Price Bid	
Organization	PMAP	MinnesotaCare	Total PMAP and MinnesotaCare	Number of Counties	Percentage of Total
Blue Plus	30	55	55	0	0%
HealthPartners[a]	12	14	14	4	29
Medica[a]	22	38	38	13	34
UCare[a]	63	72	72	27	38

NOTES: "Service Area" is a county. PMAP represents the Prepaid Medical Assistance Program.

[a] Managed care organization awarded some service areas through competitive price bid.

SOURCE: Office of the Legislative Auditor, summary of Department of Human Services documents.

For 2014, competitive price bids from 2012 impacted the rates set for all MCOs and county-based purchasing organizations. In 2012, 54 percent of managed care capitation payments for PMAP and MinnesotaCare were determined by competitive price bid. When setting the 2014 payment rates, the DHS actuary incorporated assumptions about efficiencies that should have been gained in a competitive price bid environment over the previous two years. That is, the actuary applied a downward adjustment to forecasted trends when calculating the rate ranges.

The impact of competitive price bids on individual MCO's 2014 administrative spending is yet unknown as MCOs do not report 2014 financial data until later in 2015. MCO representatives told us that their time and resources devoted to the competitive price bid process during 2013 for contract year 2014 were significant and added to their administrative costs. In particular, responding to some DHS technical data requests was challenging under the department's timelines and instructions. Some MCO representatives also questioned whether the state would realize the cost-savings that policymakers anticipated.

State Set Rates

Outside of the competitive price bid process, payments for the remaining PMAP and MinnesotaCare service areas were determined by DHS through direct negotiations with MCOs. DHS used the rate ranges developed for the competitive price bid process when it contracted with MCOs for the remaining PMAP and MinnesotaCare service areas. For the remaining 60 counties, DHS set and contracted for payment rates at the lower end of the 2014 rate range. For MSHO, MSC+, and SNBC, the actuary developed separate, single base rates for each program that included adjustments for the populations served, such as medical needs (or "risk" adjustment), demographics, geographic region, and enrollment for each MCO.

In 2013, the Department of Human Services modified its capitation payment rate-setting methods with the goal of limiting growth in 2014 managed care administrative costs.

For contract year 2014, DHS departed from past practices and incorporated new analysis to compute the administrative cost portion of the payment rates.[23] DHS and policymakers sought savings through the 2013 legislative session, and a 2013 law mandated a $47 million reduction in otherwise projected trend increases for administrative expenses.[24] To achieve the intended reduction in trends, DHS used a combination of methods—including analysis of costs per member-month—blended with assumptions about enrollment for 2014.[25] The intended savings were tied to estimates for certain costs classified as "unallowable" for the Medical Assistance program. (We discuss MCO reporting of these types of expenses later in this chapter.)

For contract year 2014, the trend factors applied by the DHS actuary to the administrative portion of the managed care capitation payment rates also fell within certain limits specified in state statutes.[26] Specifically, DHS must limit maximum annual trend increases to rates paid to managed care plans and county-based purchasing plans for calendar years 2014 and 2015. The trend rate limits apply to the overall capitation payment rate and vary by state program; for example, the trend limit is 2.0 percent for medical assistance families and children. Minnesota law also requires that DHS limit aggregate administrative costs paid to managed care plans under contract for the MA programs to an overall average of 6.6 percent of total payments.[27] When considering payment rates for all programs, DHS rate-setting methods for contract year 2014 generally recognized the 6.6 percent limit for administrative expenses.

During 2013, DHS did not execute some options for controlling managed care administrative expenses.

DHS and its actuary have three other mechanisms with which to adjust their estimates for administrative expenses. First, state law requires that DHS treat MCO investment expenses in the same manner as investment income when setting capitation payments rates.[28] That is, if DHS includes MCOs' investment expenses when calculating rates, the department also must consider MCOs' investment income. However, DHS and its actuary waived this requirement for contract year 2014 in lieu of the projected $47 million required reduction in overall trend, combined with lowering the target contribution to surplus margin

[23] Based on documentation provided by DHS and its actuary.

[24] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 23.

[25] Detailed information about the methodology referenced here is classified as trade secret under *Minnesota Statutes* 2014, 13.37.

[26] *Minnesota Statutes* 2014, 256B.69, subd. 31. We did not verify whether the overall capitation payment trend rates complied with the statutory limit.

[27] *Laws of Minnesota* 2008, chapter 363, art. 18, sec. 3, subd. 5. The limit on administrative costs does not include state premium taxes and assessments.

[28] *Minnesota Statutes* 2014, 256B.69, subd. 5j.

to 0.75 percent. DHS representatives also said that a three-month delay in payments imposed by the legislature and administratively by DHS diminished the MCOs' ability to earn investment income on capitation payments received and before claims were paid.[29]

Second, DHS and its actuary did not exclude administrative costs for "non-state plan" services—services not included in the state Medical Assistance plan submitted to CMS for approval—when developing 2014 rates. Each MCO must identify and report to DHS any non-state plan costs that are otherwise included in its annual statutory financial filing.[30] This helps DHS and its actuary attest whether the new rates are based only on costs for administrative services to be furnished under the Medical Assistance plan for MA enrollees. One DHS representative said the amounts reported and certified by MCOs as non-state plan administrative costs were small.

Lastly, DHS in 2012 and 2013 did not determine MCOs' compliance with statutory limits on increases in administrative spending when determining payment rates. State statutes mandate that each MCO's administrative costs for Medical Assistance programs—as a percentage of total revenue—cannot exceed by more than 5 percent its costs for the previous year.[31] DHS must impose a penalty equal to the amount in excess of the limit, but may waive the penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.

DHS staff said that this statutory provision to limit growth in MCOs' administrative spending is technically incompatible with current rate-setting methods, competitive price bidding, and aggregate limits in managed rate trends specified elsewhere in state law. Further, they said that the state's Medicaid expansion and shifting coverage of populations affected program enrollment, and the law is unclear whether the limit applies to an MCO's individual program or aggregate administrative spending. We make recommendations regarding this statute later in this chapter.

Data Sources

Determining payment rates for administrative services requires data; in particular, data determined to have the highest degree of reliability relative to other sources, and which represents costs directly related to providing services under the state's MA plan for program-eligible individuals.[32] Actuarial standards require that the certifying actuary consider and use available data that, in the actuary's professional judgment, is sufficiently current, appropriate for the intended purpose, and will

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[29] *Laws of Minnesota* 2011, First Special Session, chapter 9, art. 6, sec. 94.

[30] See Department of Human Services, *2013 Families and Children Model Contract*, secs. 9.10.1-9.10.3.

[31] *Minnesota Statutes* 2014, 256B.69, subd. 5i.

[32] *42 CFR*, sec. 438.6(c) (2014); CMS, *Appendix A. Financial Review Documentation*, secs. AA.2.0 and AA.3.2.

allow the actuary to perform the desired analysis.[33] Further, actuaries must determine and disclose whether there are any known, material limitations to the data, but are not required to audit the data.[34] Federal guidance suggests that both the state agency and actuary are responsible for deciding which sources of data to use for rate setting.[35] DHS must document for CMS the state's compliance with rate certification requirements and actuarial standards.

DHS and its actuary relied mostly on financial data provided and certified by managed care organizations to develop 2014 administrative rate ranges; however, we found inconsistencies among data certification requirements and documentation.

Through DHS's actuary, the department defined general requirements for data analysis and work product, while any additional analyses occurred through ongoing interaction among DHS staff, its actuary, and MCO representatives. To develop the administrative rate ranges, DHS generally relied on its actuary to determine what data were appropriate, what was required from each MCO, and if there were any material limitations to the data.

According to DHS and its actuary, the primary data used to develop the administrative portion of the base rate ranges for 2014 was comparable to data used by the federal government and other states. These data included annual financial filings submitted to the departments of Health and Commerce, independent data inquiries to the MCOs, as well as national data on Medicaid and Medicare costs and trends. In considering "unallowable costs," DHS also considered findings from previous audits mandated by the Governor in 2011.

An important step in rate development and data acquisition pertains to a federal requirement for "certifying" the data used by the state. Specifically, DHS contracts with MCOs require the entities to submit certain filings or other financial data as requested by DHS, and the MCOs must complete forms in which they attest to the accuracy, completeness, and truthfulness of the data and documents.[36] DHS 2013 contracts also required that:

> The MCO shall either certify to the State that its annual statutory financial filing with the Minnesota Department of Health (MDH) represents only costs related to services covered under the State

[33] Wakely, *Review of Medicaid MCO Administrative Rate Setting Methodology*, 26-27. The Actuarial Standards Board recommends practices for the selection and use of data. Other considerations include: the reasonableness and comprehensiveness of the necessary data elements, with particular attention to internal and external consistency; the costs and feasibility of obtaining alternative data; the benefit to be gained from an alternative data set or data sources; and sampling methods. Actuarial Standard Board, *Actuarial Standards of Practice No. 23* (Washington, DC, 2011), 3.

[34] Actuarial Standard Board, *Actuarial Standards of Practice No. 23*, 3-5.

[35] CMS, *Appendix A. Financial Review Documentation*, secs. AA.2.0 and AA.3.2.

[36] *42 CFR*, sec. 438.604-606 (2014), subp. H, *Certifications and Program Integrity*. The law requires DHS to require that certification must attest to the (1) accuracy, completeness and truthfulness of the data and (2) accuracy, completeness and truthfulness of the documents specified by the state. DHS, *2013 Families and Children Model Contract*, sec. 9.10.

> Plan including the MCO's administrative costs; or the MCO must certify and report the dollar value of each specific service that is a Non-State Plan service.[37]

Managed care organizations did submit certifications of their 2012 annual financial filings to DHS in 2013. However, the language contained in the forms used for some certifications aligned with language in federal law, but did not include the additional language in DHS contracts. That is, the MCOs submitted two separate certifications. We found that the MCOs interpretation of the certification requirements varied and did not always align with the requirements under the DHS contracts. As part of our audit work, one MCO reported that in its certification of some reports, it was only certifying to its costs for non-state plan services. One MCO representative said that in its report on non-state plan service costs, the MCO only reported and certified *medical* costs not covered by the state plan, and not administrative costs.

In Chapter 2, we questioned some administrative costs allocated by MCOs to state public programs on their financial reports. Some MCO representatives said that DHS has not explicitly instructed them on which costs are non-state plan administrative costs and, thus, they did not separately disclose these expense items to DHS.

DHS's use of some MCO financial reports for rate setting has been a long-standing source of controversy.

In particular, some individuals have expressed concern that there may be deficiencies in the data presented in MCOs' annual financial filings for purposes of determining payment rates. Audits required by the Governor in 2011 raised questions about MCO costs allocated to the state's public programs on their Department of Health supplement reports, which summarizes each MCO's revenues, expenses, and net income, by product and public program. The public also views these reports assuming that the costs reported under each Medical Assistance program are for Medical Assistance enrollees, and readers are not aware that the reported amounts include other items not necessarily specific or related to Medical Assistance.

Other state-mandated audits or financial examinations do not audit the MCOs' reported administrative expenses in detail; rather, they are examined in the context of ensuring financial solvency of the MCO or the materiality of error relative to their overall financial statements. For our audit work, we found some examples of miscategorized or misclassified expenses large enough that they may have affected capitation payment rate-setting analysis. We also questioned some types of expenses—such as charitable contributions—because the MCOs allocated these expenses to the public programs on their 2012 MDH supplement reports, and we considered these costs unrelated to the MA programs.

Currently, MCOs follow NAIC accounting principles to complete the MDH supplement reports, and there are minimal instructions in state statutes or rule for

[37] The MCO must provide this certification no later than May 1st of the Contract Year.

how they must complete and allocate costs to programs on Minnesota Supplement Report #1. We found that the NAIC accounting principles provide methods and guidance to MCOs on how to allocate their costs; however, some MCO representatives said that restricting unallowable expenses from certain lines of business conflicts with NAIC allocation guidance. Further, MCO representatives assert that the Department of Health reports were not developed for DHS rate-setting purposes (an issue we discussed in Chapter 2).

Prior to 2013, there were limited alternative data sources collected by the state to inform policymakers about MCOs' detailed administrative data for public programs. Generally, there may be some MA program-specific information contained in independent audits and financial examination reports filed with the Department of Commerce; however, such data may not be pertinent to rate-setting needs. Other data sources are important checks against self-reported data and can help guide the technical execution of rate setting. Accurate data and rigorous rate-setting methods are essential for oversight of the Medical Assistance program, but there may be limits on the extent to which rate setting can control administrative costs under a capitation payment method. Other factors may have a broader impact on how much the state pays for managed care administrative services.

OTHER FACTORS AFFECTING COSTS

Reliable data and appropriate methodologies are critical for determining actuarially sound payment rates, as is the technical execution of this work. The state's use of a capitation payment method for managed care administrative services requires continued efforts towards improving financial data used for this purpose. However, actuarial rate setting represents just one element among other, complementary dynamics that influence the costs of public health care programs.

Rigorous state oversight requires sound rate-setting practices, but competitive price bids, contract negotiations, statutory requirements, expanded program needs, and involvement by state policymakers affect managed care administrative costs, too.

In recent years, initiatives by state policymakers and administrators have helped advance oversight and understanding of the costs of public health care programs. This work includes unique audits of managed care expenses, expanded data collection, specifications in state law for allocating or excluding MCO costs, and competitive price bid.

Beginning January 2014, managed care organizations must now report extensive financial data directly to DHS about all aspects of their operations—not just administrative expenses—as shown in Exhibit 3.3. The changes are intended to help address the perceived inadequacies in other data sources used for capitation payment rate setting. In the past, there has been a limited formal reporting process for MCOs to disclose, or for DHS to identify, other unallowable or unreasonable costs for Medical Assistance. These changes enhanced the reporting relationship between DHS and the MCOs.

Exhibit 3.3: Managed Care Organization Statutory Reporting to the Department of Human Services, 2014

Description of Information that Must Be Reported to the Department of Human Services

- Income statement by program
- Financial statement footnotes
- Quarterly profitability by program and population group
- Medical liability summary by program and population group
- Received but unpaid claims report by program
- Services versus payment lags by program for hospital, outpatient, physician, and other medical services, and pharmaceutical benefits
- Utilization reports that summarize utilization and unit cost information by program for hospital, outpatient, physician, and other medical services
- Pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services
- Subcapitation expenses by population group
- Third-party payments by program
- All new, active, and closed subrogation cases by program
- All new, active, and closed fraud and abuse cases by program
- Medical loss ratios by program
- Administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies
- Revenues by program, including investment income
- Nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan…to providers and vendors for administrative services under contract with the plan, including but not limited to:
  - Individual-level provider payment and reimbursement rate data
  - Provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process
  - Data on implementation of legislatively mandated provider rate changes
  - Individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process
- Data on the amount of reinsurance or transfer of risk by program
- Contribution to reserve, by program

NOTE: Managed care organizations and county-based purchasing organizations participating in Minnesota's public health programs must provide this information to DHS.

SOURCE: Office of the Legislative Auditor, summary of *Minnesota Statutes* 2014, 256B.69, subd. 9c(b).

Assessing the outcomes of any one of these recent initiatives on public programs would be complicated. Competitive price bid for managed care services brings additional data into the rate-setting analysis for payments; however, the impact on 2014 and 2015 administrative expenses is not yet known. Legislatively imposed caps on spending also lay out parameters for administrative costs, but program expansion also affects costs. DHS's change in rate-setting methods is intended to help set reasonable and appropriate payment rates, but the effectiveness of actuarially sound rate ranges in controlling costs also depends on the outcomes of contract negotiations.

Collectively, these efforts have likely contributed to the reduced trends in managed care costs illustrated earlier in Exhibit 3.1. Engagement by policymakers also has been important for maintaining oversight of public health care costs. Continued work in this area should extend these results, and some refinements are needed.

ISSUES AND RECOMMENDATIONS

From our audit of managed care organizations' administrative expenses and review of DHS rate-setting documentation and processes, we identified several issues that require policymakers' attention. We also recommend ways to improve financial information provided by MCOs to the department.

Enhanced administrative expense reporting by managed care organizations may have minimal value for rate setting without explicit statutory requirements, improved DHS technical specifications and definitions, and independent verification of rate-setting data.

In particular, without improvements in how financial information is defined, recorded, and compiled, we think the value of collecting additional managed care data will be limited. Also, without such improvements, future audits of detailed financial data may not yield useful information for administering state public programs.

Statutory Requirements

Minnesota law requires DHS to set uniform criteria, definitions, and standards for data submitted to the department, and requires MCOs to comply with these criteria.[38] To support this work, we think language in Minnesota statutes and rules regarding managed care reporting and unallowable administrative costs should be more explicit to ensure consistent data and the capture of all intended information. Managed care organizations process tens of thousands of administrative expense transactions annually, and their accounting structures and allocation models vary greatly.

When verifying managed care organizations' data, we encountered differences in how the organizations defined various terms and recorded administrative expenses.

In particular, MCO representatives interpreted the term "program" or "plan" differently; for example, it could mean one program—such as PMAP—or all Medical Assistance programs, collectively. Newly implemented law disallows certain expenses for rate-setting purposes, but we observed differences in how MCOs construed requirements for reporting compensation limits and charitable contributions. MCOs also must now report payments to "vendors for administrative services under contract with the plan." However, MCOs varied in their contracting practices and definitions as to what constitutes an acceptable

[38] *Minnesota Statutes* 2014, 256B.69, subd. 9c(a).

contract. Further, state contracts contain provisions that require MCOs to define when a subcontractor's services are "significant and material" to its contractual obligations for public programs. Some MCOs interpret and apply this provision more broadly than is specified in the DHS contracts.

More direction from state policymakers could diminish controversy about the types of managed care administrative expenses disallowed for Medical Assistance programs, and help assure that the state does not pay for unreasonable costs.

Federal regulations impose few specifics regarding administrative expenses, and generally require that only costs for services not covered by the state plan—or costs relating to providing such services—be excluded from the development of managed care capitation rates.[39] In contrast, Minnesota laws passed in 2013 identified four types of unallowable expenses: charitable contributions, fines and penalties, indirect marketing and advertising, and any portion of an individual's compensation in excess of $200,000.[40]

For contract year 2014, DHS asked the MCOs for information on these unallowable expenses as part of rate setting and competitive price bids, and we attempted to verify the data the MCOs submitted to DHS. Our ability to audit these reported costs was affected by each MCO's business model, number of products, and allocation model. In addition, the MCOs' accounting structures for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. The MCOs' allocation models are very complex, and this made it difficult to retrospectively trace and quantify these expenses. While we were able to verify that one MCO significantly disclosed these unallowable costs, verifying the other three MCOs' data would have required considerably more time. More importantly, MCO representatives said they currently use the same complex processes for recording, allocating, and reporting such costs.

Through our audit work we identified other questionable costs allocated to public programs by MCOs that were unrelated to state plan-approved services. These included costs for alcohol beverages, travel, entertainment, and activities or services outside of Minnesota and unrelated to the Medical Assistance programs. For these types of questioned costs, we also examined the MCOs' underlying policies and procedures for allocating costs. We concluded that the state does pay for unreasonable expenses for the Medical Assistance programs. MCOs disagreed with our findings and asserted that such expenses do not violate law.

If policymakers want to further exclude other types of expenses from the development of payment rates, such expenses and the reporting mechanism should be explicitly codified in statute. Any statutory language excluding certain categories of expenses should be enhanced with more precise definitions, and require direct classification and recording of expenses to specific categories in

[39] CMS, *Appendix A. Financial Review Documentation*, sec. AA.2.4.

[40] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21, amended *Minnesota Statutes* 2012, 256B.69, subd. 5i.

order to help audit efforts. To facilitate this process, the Legislature could refer to existing definitions of these terms in federal standards, regulations, and cost principles, or other states' definitions, when defining these terms in state law.[41]

Lastly, Minnesota law imposes limits on growth in managed care administrative spending; however, current language does not sufficiently specify whether the caps pertain to individual MA programs or all MA programs, collectively. Expectations for administrative services vary for each program, and some MCOs contract with DHS for more Medical Assistance programs than others. Further, the measure specified in law—administrative spending as a percent of total revenues—does not align with current DHS rate-setting methods. DHS staff told us that it would be difficult to operationalize this mandate as currently defined.

RECOMMENDATIONS

The Legislature should:

- **Amend *Minnesota Statutes* 2014, 256B.69, subd. 5i, to clarify limits on managed care administrative spending for state public programs, and to further define the terms and types of unallowable expenses for Medical Assistance rate-setting purposes.**

- **Amend *Minnesota Statutes* 2014, 256B.69, subd. 9c, to define "by program," and to further specify the types of payments that must be reported for MCOs' subcontracts for administrative services expensed to state public programs.**

Department of Human Services Reporting Requirements

As part of the rate-setting and procurement process, DHS makes numerous requests for information to the managed care organizations. To more directly address data needs specific to public health care programs, DHS also implemented new reporting requirements, shown previously in Exhibit 3.3.

DHS directives and requests to managed care organizations were too general to sufficiently address data complexity, data integrity, and variations among MCOs' recordkeeping and allocation processes.

During 2014, DHS staff were still refining the new MCO financial reporting templates, and this work required several iterations of data requests to managed care organizations. We did not evaluate all aspects of the new MCO reporting template. However, we think the specifications regarding administrative expenses were too general and likely resulted in inconsistent or incomplete data, based on our audits of MCOs' accounting data and allocation processes.

[41] *48 CFR*, sec. 9904 (2014). U.S. Office of Management and Budget, *Circular A-87, Cost Principles for State, Local and Indian Tribal Governments* (Washington, DC, 2004); *48 CFR*, sec. 31 (2014); and U.S. Office of Management and Budget, *Circular A-122, Cost Principles for Non-Profit Organizations* (Washington, DC, 2004). See also California Code of Regulations, 28 CCR, sec. 1300.78 (2014); 10 CRR New York, parts 1002.1-1002.3 (2014); and Texas Health and Human Services Commission, *Uniform Managed Care Manual, Cost Principles for Expenses*, v. 2.2 (July 20, 2013).

DHS's contracts with MCOs require the entities to submit certain filings or other financial data as requested by DHS, and attest to the accuracy, completeness, and truthfulness of the data and documents. For some 2012 data used for rate setting, MCO certification documents addressed language in federal law, but did not precisely align with DHS contract language. On the other hand, language contained within other certifications aligned with DHS contract requirements. During our audit work, MCO representatives reported different interpretations of the intent and purpose of their certifications. There also was disagreement from some MCO representatives regarding instructions on "non-state plan" administrative services and expenses. More comprehensive, documented guidance by DHS on these requirements could reduce misinterpretation and help assure that payment rate setting is based only on data representing approved services for the Medical Assistance programs and related administrative costs.

RECOMMENDATIONS

The Department of Human Services should enhance instructions, definitions, and technical guidance to managed care organizations to facilitate compliance with reporting instructions.

The Legislature should amend state law to require that managed care organization certifications align with federal law and the Department of Human Services (DHS) contract language. DHS should develop and require managed care organizations to use such templates with certifying their data.

Data Verification

The value of enhanced data collection by DHS will depend on complete and consistent reporting, both within and among managed care organizations. DHS can rely solely on the audit or examination work of others for insight into the quality of the data it receives. For our audit samples, we found that MCOs mostly complied with accounting principles for classifying administrative expenses, but we also found opportunities for more direct allocation of expenses, a lack of documentation for some contract expenses, and some questioned costs allocated to public programs. Without unique requests by DHS, it is unlikely audits by other entities—such as the departments of Health and Commerce—will sufficiently incorporate data verification needs specific to rate setting or competitive procurement for Medical Assistance programs.

RECOMMENDATION

The Department of Human Services should implement ad-hoc audits of data reported by managed care organizations; in particular, data reported pursuant to *Minnesota Statutes* 2014, 256B.69, subd. 9c.

Currently, DHS and its actuary accept but do not independently audit the summary-level administrative expense data reported and certified by the MCOs. During 2013, their review of MCO administrative expense data involved questioning discrepancies in high-level summary data. Given the vast amount of

information now compiled by DHS, more rigorous, ad-hoc verification of administrative expense data by DHS would be reasonable. This work should directly target data analysis needed for controlling administrative spending and to support its contracting processes. In particular, DHS should be more directly involved in verifying data classified in state statutes as unallowable for rate-setting purposes. Such efforts would help enhance DHS's understanding of the data and its own reporting instructions to MCOs, and also ensure against overpayment in the development of managed care payment rates. Absent these actions, we question the extent to which state resources devoted to additional reporting of MCO administrative expenses will translate into cost savings for the Medical Assistance programs.

List of Recommendations

- The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to include Department of Health instructions and to further specify how managed care organizations must allocate administrative expenses for Minnesota Supplement Report #1A. (p. 28)

- The Legislature should amend *Minnesota Statutes* 2014, 62D.02 and 62D.08, to further specify how managed care organizations must allocate investment income on Minnesota Supplement Report #1A. (p. 29)

- The Legislature should specify in law requirements regarding managed care organizations' subcontracts for administrative services that are expensed to Minnesota's public health care programs. (p. 30)

- In its contracts with managed care organizations, the Department of Human Services should further specify requirements regarding subcontracts for administrative services, including the required form and content. (p. 30)

- The Legislature should:

  - Amend *Minnesota Statutes* 2014, 256B.69, subd. 5i, to clarify limits on managed care administrative spending for state public programs, and to further define the terms and types of unallowable expenses for Medical Assistance rate-setting purposes. (p. 46)

  - Amend *Minnesota Statutes* 2014, 256B.69, subd. 9c, to define "by program," and to further specify the types of payments that must be reported for MCOs' subcontracts for administrative services expensed to state public programs. (p. 46)

- The Department of Human Services should enhance instructions, definitions, and technical guidance to managed care organizations to facilitate compliance with reporting instructions. (p. 47)

- The Legislature should amend state law to require that managed care organization certifications align with federal law and the Department of Human Services (DHS) contract language. DHS should develop and require managed care organizations to use such templates with certifying their data. (p. 47)

- The Department of Human Services should implement ad-hoc audits of data reported by managed care organizations; in particular, data reported pursuant to *Minnesota Statutes* 2014, 256B.69, subd. 9c. (p. 47)

Minnesota Department of **Human Services**

March 5, 2015

James R. Nobles, Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review the findings and recommendations from your audit of *Managed Care Organization (MCO) Administrative Expenses* for public health care programs. We appreciate the diligent and professional work of your staff on this important issue.

As you are aware, the Department of Human Services has focused for the last four years on getting better value for in our managed care contracts. The report recognizes the progress we have made on containing costs and improving the oversight and transparency in our managed care contracting process. However, the report findings also highlight the need for continued improvements in reporting and oversight of MCOs expenses. We support the recommendations, which we believe will help provide the tools for DHS to continue its progress on this effort.

DHS began its efforts to reform the managed care contracting process in 2011 by implementing competitive bidding for public health care program contracts, starting January 1, 2012 in the seven-county metropolitan area. This was the first time DHS placed its contracts out for bid and resulted in substantial savings to the state budget. DHS was also successful in reducing costs in the existing 2011 contracts by negotiating a one percent cap on MCO profits. DHS has continued this successful procurement process by competitively bidding an additional 27 counties for calendar year 2014 referenced in the audit and recently released a statewide procurement for managed care for calendar year 2016.

As the audit documents, in addition to the reforms made to the procurement process, DHS has also implemented significant changes to its rate-setting practices and worked closely with the Legislature to pass meaningful financial reporting, quality assurance and independent audit requirements to provide more detailed financial data directly to DHS. DHS conducted an independent audit of past rate-setting practices that informed these administrative and legislative changes.

Some of these changes have just begun implementation and were after the time period of the audit. Specifically, DHS implemented the enhanced quarterly and annual financial reporting in mid-2014 that requires detailed breakdown of medical and administrative expenses. DHS has already made revisions to this requirement for 2015 reporting to require additional information and instruction. DHS has also clarified the definition of "allowable expenses" in the current statewide procurement for the 2016 contract year. We will continue to monitor the implementation, results, and identify additional areas for improvement.

Our responses to specific recommendations in the audit report are included below.

Audit Findings

The audits of the 2012 MCO financial reports found a small number of miscategorized transactions. Total costs related to these discrepancies ranged from $1,702 to $3.0 million, and some exceptions may have affected DHS managed care payment rate-setting analysis.

The audits identified opportunities for MCOs to more directly allocate administrative expenses to specific lines of business. Findings indicated that MCOs did not have adequate documentation to support some subcontracted services.

DHS' technical execution of some rate-setting options for administrative expenses was lacking during 2013.

Minnesota statutes, rules, state contracts, and accounting principles do not ensure consistent reporting by MCOs and compliance with policymakers' intent.

2013 DHS directives to the MCOs were too general to sufficiently address data complexity, data integrity, and variations among MCOs' allocation and recordkeeping processes.

Audit Recommendation

The Legislature should amend statutes to specify requirements for MCOs' subcontracts for administrative services that are expensed to Minnesota's public programs, and DHS should incorporate such language into its contracts with MCOs.

Response to Audit Recommendations

The Department supports legislative efforts that would define MCO requirements for subcontracts that allocate administrative services to Minnesota's public health care programs. Upon enactment of new legislation, DHS would incorporate any new requirements into the MCO contracts.

Responsible Person:	Nathan Moracco
Estimated Completion Date:	Contingent on new legislation

Audit Recommendations

DHS should enhance instructions, definitions, and technical guidance to facilitate MCO compliance with administrative expense reporting requirements.

DHS should implement ad-hoc audits of data reported to the department by MCOs under state contracts and required by Minnesota Statutes 2014, 256B.69, subd. 9c.

Response to Audit Recommendation

In January of 2015, the Department issued an improved financial reporting template for collection of financial information and provided further detailed guidance and instructions to the MCOs in the price bid instructions for the 2016 statewide procurement referenced above. For example, the Department is working to better standardize the definition of managed care "product" and "program" to improve the allocation of administrative expenses, such as compensation above $200,000, and provide further definition to specific categories of unallowable expenses such as charitable contributions.

The Department will continue to refine the financial reporting template to incorporate administrative expense information at a more granular level and provide further guidance and definition on unallowable expenses in response to the findings of this audit. Revised instructions will be clearly documented in the financial reporting template and in the contract and future procurements.

The Department supports the recommendations and will develop a process to perform ad-hoc audits of the MCOs' financial data to ensure compliance with legislation, existing state and federal law, and contract requirements. DHS will develop a process between its Internal Audits and Health Care Administration staff to identify audit requirements and incorporate audit findings into contract requirements, rate-setting analyses, and financial reporting. Additional program and audit staff resources will be needed for the department to fully implement this recommendation in a timely manner.

Responsible Person:	Nathan Moracco, DHS; Gary Johnson, DHS
Estimated Completion Date:	December 31, 2014

Thank you again for the professional and dedicated efforts of your staff during this audit. The Department of Human Services policy is to follow up on all audit findings to evaluate the progress being made to resolve them. Progress is monitored until full resolution has occurred. Moving forward, the Department is committed to be more directly involved in the oversight of managed care administrative costs for Minnesota Health Care Programs.

If you have any further questions, please contact Gary L. Johnson, Internal Audit Director, at (651) 431-3623.

Sincerely,

Lucinda E. Jesson
Commissioner

Appendix A: Blue Plus

Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

Conclusions

Blue Plus generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, Blue Plus either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- Blue Plus generally complied with certain requirements for reporting administrative expenses on its 2012 annual financial reports, with some exceptions.
- Blue Plus did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- Blue Plus did not have adequate documentation to support expenses related to two Blue Plus contracts for administrative services.
- Blue Plus allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of Blue Plus' administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

BLUE PLUS

BACKGROUND

Blue Plus is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] Blue Plus is an affiliate of Blue Cross Blue Shield of Minnesota (BCBSM), and Blue Plus sustains its operations through management agreements with BCBSM. Specifically, BCBSM provides and charges Blue Plus for general and administrative services necessary for its operations, including its accounting systems and processes for recording and allocating expenses across products.

Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[2] The Minnesota Department of Human Services (DHS) contracted with Blue Plus to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+). Blue Plus also provided other health insurance products and services unrelated to these programs during this period.[3]

Blue Plus' reported expenses to administer the state's programs in 2012 totaled approximately $70.1 million.[4] These expenses represented managed care general administrative and claims adjustment services for one or more programs in 82 counties statewide. Blue Plus' program enrollment for this period totaled about 1.6 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with Blue Plus also specify that the entity is subject to audits by OLA.[5] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

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[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(4), Blue Plus is generally exempt from federal income taxes.

[2] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[3] Blue Plus also provided commercial products and contracted directly with the Centers for Medicare & Medicaid Services to provide coverage for Medicare programs.

[4] Blue Plus, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include general administrative and claims adjustment expenses.

[5] Minnesota Department of Human Services, *2012 Families and Children Contract, HMO Minnesota, DBA Blue Plus* (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of Blue Plus' administrative expenses and investment income focused on the following audit objectives, for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by Blue Plus to the State of Minnesota for Minnesota public health care programs?

- Did Blue Plus report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by Blue Plus for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[6] 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.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[7]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who conduct audits of health insurance entities to gain an understanding of their scope

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[6] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision*, (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[7] U.S. Office of Management and Budget (OMB), *Circular A-133: Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of Blue Plus.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[8] Specifically, we used the following documents from Blue Plus' 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expense*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenues, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[9]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for expenses for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[10]

We interviewed management and employees of Blue Plus to gain an understanding of Blue Plus procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

From Blue Plus' financial data, we selected an initial sample of 103 transactions to test against our objectives.[11] We used a combination of random and purposive

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[8] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[9] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. The NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[10] DHS, *2012* and *2013 Families and Children Contract, HMO Minnesota, DBA Blue Plus*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5i. A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

[11] The total number of transactions we actually reviewed exceeded 103 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on Blue Plus' *2012 Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses;* our sample design included a stratified random sample using the line item categories of this exhibit.

sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of Blue Plus' own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, bank statements, contracts, and other supporting information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for Blue Plus' administrative services contracts. We also examined the extent to which certain "unallowed" expenses were disclosed to DHS for purposes of determining managed care capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled Blue Plus' 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against Blue Plus' publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by Blue Plus at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. Blue Plus classified the great majority of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

Blue Plus generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, Blue Plus either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

FINDINGS AND RECOMMENDATIONS

Finding 1

Blue Plus generally complied with certain requirements for reporting administrative expenses on its 2012 annual financial reports, with some exceptions.[12]

Among 103 samples we tested, Blue Plus generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Annual Statement, Underwriting and Investment Exhibit, Part 3, with some exceptions.[13] Blue Plus recorded certain tax-related expenses totaling $919,748 on this exhibit, but it did not fully disclose the nature of these expenses. Instead of categorizing these tax-related expenses as "Taxes, Licenses, and Fees," Blue Plus categorized these costs as "Other Expenses" on the line "Aggregate Write-ins."

Blue Plus miscategorized expenses for seven transactions totaling at least $87,784 on this exhibit.[14] Specifically, Blue Plus miscategorized expenses related to four of these transactions as "Equipment"; in our opinion, these expenses should be categorized as "Cost or Depreciation of EDP Equipment and Software." Blue Plus miscategorized two transactions that should have been recorded as "Outsourced Services," but were recorded on different lines of this exhibit. Blue Plus misclassified one transaction as "Other Claims Adjustment," instead of "General Administrative." Blue Plus' miscategorization of these items did not impact the sum total of administrative expenses reported on this exhibit. For three of these samples totaling $8,759, the discrepancies affected the totals reported for the corresponding category—but not the overall totals—on Blue Plus' 2012 Minnesota Supplement Report #1A.

Minnesota law requires managed care organizations to complete and file with the state the NAIC Health Annual Statement.[15] NAIC instructions for the Underwriting and Investment Exhibit, Part 3, direct entities to record taxes and assessments to the line "Taxes, Licenses, and Fees."[16] Disclosure of these types of expenses informs regulators and others about the MCO's actual service costs and expenses required by federal and state authorities. For transparency

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[12] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[13] In its instructions for recording expenses on this Part 3 exhibit, NAIC most often refers to individual lines as "expense classification items," but sometimes refers to individual lines as "categories." Instructions for other reports we tested refer to individual expense lines as "categories." For purposes of this report, we refer to groupings of types of expenses to individual exhibit lines as "categories."

[14] These totals represent a lower-bound estimate based on information provided by Blue Plus. Calculating the precise amount related to these samples is difficult due to the complexity of the BCBSM/Blue Plus accounting system.

[15] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, chapter 4685, subparts 1910-1980, posted October 11, 2007.

[16] National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*, (Washington, DC, 2012), 80-92.

purposes, entities reporting items as "Aggregate Write-Ins" should provide more detailed description of major expenses at the bottom of this exhibit. NAIC instructions also define the types of expenses to record to "Outsourced Services" and "Cost or Depreciation of EDP Equipment and Software."[17]

NAIC accounting principals define claims adjustment expenses as "costs expected to be incurred in connection with the adjustment and recording of managed care claims."[18] The sample transaction we discuss here does not meet the NAIC criteria.

Recommendation

Blue Plus should report administrative expenses, taxes, and assessments in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

Finding 2

Blue Plus did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.[19]

Expenses for Blue Plus' administrative services—including contract-related expenses—are allocated across Blue Plus product lines through the Blue Cross Blue Shield accounting system and allocation model. Blue Plus uses an allocation model with numerous statistics to apportion costs, depending on the type of administrative expense. For some larger transactions, Blue Plus does not process expenses through its allocation model, but directly designates the items to specific programs or products.

Among the samples we tested, we identified two cost items for which Blue Plus could have allocated expenses more directly to individual products that benefitted from the services. In 2012, Blue Plus paid one contractor for work performed on behalf of two state programs, and paid a different contractor for work specific to its commercial and Medicare-related products; however, Blue Plus used an "indirect" approach to allocate these expenses across these products and additional programs, too. In its directives to its contractors, Blue Plus specified which programs were within the scope of work. For these samples, the transactions we tested totaled $66,896, and we estimated $14,209 was allocated

[17] NAIC, *Official NAIC Annual Instructions—Health*, 81-84. Outsourced services include expenses for administrative services, claim management services, new programming, membership services, and other similar services. Costs for EDP equipment and software include depreciation and amortization expense for electronic data processing equipment, operating software, and nonoperating software.

[18] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, Vol. 1 (Washington, DC, 2012) *Statements of Statutory Accounting Principles, No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses*; and NAIC *Official NAIC Annual Instructions—Health*, 80-92.

[19] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

among all state public programs on Blue Plus' Minnesota Department of Health supplement reports.[20]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project or service.[21] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[22] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[23] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[24]

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[25] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. Blue Plus could use its contract documents and statements of work as resources to discern costs incurred for specific lines of business and, thus, more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, Blue Plus should directly allocate administrative expenses to specific lines of business or products when such information is available.*

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[20] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Blue Plus' allocation model.

[21] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A, secs. E and F. We cite this standard for definition purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[22] *Ibid*. Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

[23] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70.

[24] *Ibid*., Appendix A-440.

[25] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2.

Finding 3

Blue Plus did not have adequate documentation to support expenses related to two Blue Plus contracts for administrative services.[26]

Among the samples we tested, Blue Plus paid one contractor for work in 2012, but for one project did not have a written schedule or statement of work that detailed the scope and duration of work, payment terms, and signatures by both parties. Blue Plus' payments to a different contractor exceeded the amount specified in the contract.[27] For these two samples, the transactions we tested totaled $60,558; we estimated $5,789 was allocated among all state public programs.[28]

Without adequate supporting documentation, we were unable to validate whether Blue Plus' contractors were paid appropriately, assess the reasonableness of Blue Plus' allocation, or determine how these expenses related to the state's public programs. Specifically, we defined questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[29]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[30] Blue Plus' contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[31] NAIC directs that transactions within a holding company system be recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[32] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence

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[26] For Finding 3, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[27] Blue Plus representatives advised us that they reconciled these expenses against the contracted amount with the contractor, after we detected the issue during our field audit work.

[28] Totals reported here represent OLA estimates of expenses allocated to the state's public programs using Blue Plus' allocation model. Estimating the precise amount allocated is very difficult due to the complexity of the Blue Cross Blue Shield/Blue Plus cost allocation processes and accounting system.

[29] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[30] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[31] DHS, *2012 Families and Children Contract, Blue Plus*, secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6. DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. Minnesota law defines a "contract" as any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[32] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, Appendix A-440.

that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

Blue Plus should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. Blue Plus' payments should be in accordance with the terms of such contracts.

Finding 4

Blue Plus allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.[33]

Among 103 samples tested, Blue Plus allocated unreasonable costs for three transactions to Minnesota's Medical Assistance programs on its 2012 Minnesota Supplement Reports #1 and #1A. The value of these three sample transactions totaled $53,896. We estimated the allocated value totaled $2,144, and the transactions were for alcohol beverages ($13), and activities or services that occurred outside of Minnesota and were unrelated to services for the state's public programs ($2,131).[34] In our view, Blue Plus did not sufficiently consider and restrict these types of expenses from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[35] We defined questioned costs to include: …where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[36] Minnesota Department of Health administrative rules direct MCOs to identify and separately record administrative expenses for operations or other business outside of Minnesota.[37]

In its contracts with DHS, Blue Plus must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO

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[33] For Finding 4, we considered a single questioned cost to be a finding.

[34] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Blue Plus' allocation model. These cost items represent the individual transactions we tested only.

[35] Some of these types of expenses would be considered "unallowable" expenses based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 3; and *48 CFR*, sec. 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

[36] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[37] *Minnesota Rules*, 4685.1930, subparts 2 and 6, posted October 11, 2007.

must certify and report the dollar value of each specific service that is a non-state plan service.[38] Blue Plus did not consider these cost items to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by Blue Plus to the state's public programs on its financial reports. These eight sample transactions totaled $188,938 and were for marketing activities and contributions. We estimated the allocated costs totaled $18,528. Minnesota laws in effect at the time Blue Plus filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[39] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[40]

During 2013, DHS separately requested and Blue Plus provided DHS and its actuary with 2012 summary financial data regarding the types of unallowable expenses specified in the 2013 law—including marketing and contribution expenses—and how much was allocated to state public programs. We tested but were unable to sufficiently verify the extent to which Blue Plus fully disclosed these expenses to DHS, for several reasons. First, the BCBSM/Blue Plus accounting structure used for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. Second, the BCBSM/Blue Plus allocation model is very complex; this made it difficult to retrospectively trace and quantify these expenses. Lastly, verifying these financial records against the data Blue Plus submitted would have required significantly more time beyond the scope of this audit.

NAIC accounting principles for MCOs direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary

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[38] *42 CFR*, sec. 438.604, subp. H (2014) Program Integrity and Certification; and DHS, *2012 Families and Children Contract, Blue Plus*, sec. 9.10. (Other DHS contracts with Blue Plus contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR*, secs. 438.6(c)(4)(ii)(A) and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO…"

[39] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

[40] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expenses, charitable contributions, and any individual's compensation in excess of $200,000.

ratios, or similar analyses.[41] Blue Plus should implement a more rigorous process to calculate the underlying basis for allocating administrative expenses, in order to identify and disclose unreasonable and unallowable costs to DHS for purposes of determining managed care payments for state programs. Blue Plus also could implement accounting practices that identify such expenses—perhaps by specific type or account code—and: (1) directly expense such costs to a non-state plan product, either manually or through its allocation model; or (2) separately identify such costs in when reporting and certifying its data to DHS in accordance with DHS contracts and state law. These approaches would help assure Blue Plus costs are appropriately allocated to the state's public programs.

Recommendation

Blue Plus should fully identify and segregate administrative expenses that are classified as unallowable for rate-setting purposes, or unreasonable or unrelated to services for the Medical Assistance programs, when reporting and certifying financial data to the Department of Human Services.

[41] NAIC, *Accounting Practices & Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; and *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these federal standards for reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

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BlueCross BlueShield Minnesota

February 19, 2015

VIA ELECTRONIC MAIL

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Re: Blue Plus, Audit of Compliance with Financial Reporting
January 1, 2012 to December 31, 2012

Dear Ms. Bombach:

HMO Minnesota d/b/a Blue Plus ("Blue Plus") appreciates the opportunity to provide comments on the report dated February 16, 2015 in which the Office of the Legislative Auditor made certain conclusions, findings and recommendations regarding its review of the administrative expenses and investment income reported by Blue Plus on its 2012 annual financial reports and the allocation of certain administrative expenses to Minnesota's public programs.

The report found that Blue Plus generally complied with legal requirements and accounting standards for reporting administrative expenses on its annual report. However there were limited exceptions and Blue Plus' responses to those items are contained herein. This document should be read in conjunction with the Final Report to give a complete and comprehensive understanding of the observations and findings.

The report states that "Blue Plus' reported expenses to administer the state's programs in 2012 totaled approximately $70.1 million." As noted in footnote 4, this amount is from Blue Plus' 2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses and Net Income. The report state that "administrative expenses reported here include general administrative and claims adjustment expenses." Blue Plus notes that the administrative expenses reported also include estimated premium taxes and surcharges.

Findings and Blue Plus Responses:

Finding 1: Blue Plus generally complied with certain requirements for reporting administrative expenses on its 2012 annual financial reports, with some exceptions.

Brief description

The report states that Blue Plus "generally complied with legal requirements and accounting standards for reporting administrative expenses on its 2012 Annual Statement, Underwriting and Investment Exhibit, Part 3." However the report identifies two exceptions to this conclusion. The first exception involves the recording of certain tax-related expenses and the second involves the miscategorization of certain other expenses. The report notes that "Blue Plus' miscategorization of these items did not impact the sum total of administrative expenses reported on this exhibit." Three of the samples tested affected the totals reported for the corresponding categories on Minnesota Supplement Report #1A, "but did not affect the overall total expenses recorded."

Blue Plus response:

Blue Plus follows Statutory Accounting Principles and state law. Under Finding 1, regarding the recording of certain tax-related assessments, Blue Plus believes that the recording of $919,748 in the "Other" Category was a reasonable interpretation of the NAIC instructions. This amount related to the Minnesota Comprehensive Health Association (MCHA) Assessment pursuant to Minnesota Statutes section 62E.11, subd. 6. Regarding the recording of Equipment instead of Cost or Depreciation of EDP Equipment and Software (the four transactions referenced on page 12), Blue Plus provided an explanation of its interpretation of the instructions relative to SSAP 16.

Regarding the miscategorization of the remaining three transactions sampled, Blue Plus notes that these items did not impact the total overall expenses reported.

Finding 2: Blue Plus did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial reports.

Brief description

This finding relates to two out of 103 transactions tested in which the auditor identified two cost items for which Blue Plus could have allocated expenses more directly to individual products that benefitted from the services. These two samples totaled $66,896 and the auditor estimated that $14,209 was allocated across all public programs on the supplement reports in lieu of being allocated directly to the individual products.

Blue Plus response:

Blue Plus follows Statutory Accounting Principles and its internal corporate allocation policies. When possible, specific identification of expenses is recorded and in all cases a reasonable methodology is employed.

Finding 3: Blue Plus did not have adequate documentation to support expenses related to two Blue Plus contracts for administrative services

Brief description

The auditor's threshold for Finding 3 constitutes two or more exceptions, or any single exception greater than $10,000 to be a finding. In this case, the report identifies two contracts in which one was not properly documented in scope, payment terms and signature and the second in which the payment to the contractor exceeded the amount specified. The two transactions tested totaled $60,558, of which $5,789 was allocated among state public programs.

Blue Plus response:

The lack of documentation to support expenses was inadvertent and is inconsistent with Blue Plus' standard business practices to maintain documentation to support contracts for administrative services.

Finding 4: Blue Plus allocated some unreasonable costs to Minnesota's Medical Assistance programs in its 2012 financial report.

Brief description

In this section of the report, the auditor states that a single questioned cost is considered to be a finding. The report states that of the 103 samples tested, "Blue Plus allocated unreasonable costs for three transactions to Minnesota's Medical Assistance programs in its 2012 Minnesota Supplement Reports #1 and #1A." The report lists the total value of the three sample transactions at $53,896, of which the auditor estimated $2,144 was allocated to public programs.

The report states that the auditor also questioned some other costs allocated by Blue Plus to state public programs. Of the eight sampled transactions, the auditor estimated that $18,528 were allocated to public programs. The costs questioned included payments to charitable, educational, religious or scientific purposes. As the report notes, it is permissible for health maintenance organizations to make these payments.

Blue Plus response:

The report states that Blue Plus did not report these identified costs to the Department of Human Services as part of its annual statutory financial certification to DHS. Blue Plus provided documentation to the auditor regarding the non-allowable 2012 costs and administrative expenses that it had reported to DHS as required by its contracts with DHS during the time period at issue. As also noted in the report, laws later passed in 2013 classified several expenses including charitable contributions as unallowable for rate-setting purposes, and subsequent changes in reporting requirements have clarified the reporting of these expenses.

Blue Plus is committed to compliance with requirements relating to reporting of administrative expenses for managed care rate-setting purposes. Blue Plus has policies and procedures in place to identify and report administrative expenses to DHS that are not allowable for rate-setting purposes as required by its contracts with DHS.

Blue Plus' Summary Comments

The OLA performed specific tasks under its April 2013 Managed Care Organizations' Administrative Expenses Topic Selection Background Paper and as provided in applicable Minnesota Statutes. The OLA found that Blue Plus generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports with some limited exceptions. Blue Plus appreciates the opportunity to provide these comments and is committed to serving all of the members enrolled in its programs.

Thank you for the opportunity to comment.

Sincerely,

Frank Fernandez
President & Chief Executive Officer
HMO Minnesota d/b/a Blue Plus

Appendix B: HealthPartners, Inc.
Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

CONCLUSIONS

HealthPartners generally complied with certain financial-related legal requirements for reporting its administrative expenses and investment income on its 2012 annual financial reports, with exceptions. In addition, for several sample transactions, HealthPartners either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- HealthPartners did not fully comply with some requirements for reporting administrative expenses and investment income on its 2012 annual financial reports.
- HealthPartners did not adequately identify administrative expenses for five samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- HealthPartners did not have adequate documentation to support expenses related to four HealthPartners contracts for administrative services.
- HealthPartners allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of HealthPartners' administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

HEALTHPARTNERS, INC.

BACKGROUND

HealthPartners, Inc., (HealthPartners) is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] HealthPartners conducts its operations and is supported through service agreements with numerous other affiliates and related entities under the HealthPartners system of companies. In particular, Group Health Plan, Inc.—a wholly owned subsidiary of HealthPartners—provides administrative and management services to HealthPartners. HealthPartners' administrative expenses as reported in its financial statements are initially allocated from Group Health Plan, Inc.

Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[2] The Minnesota Department of Human Services (DHS) contracted with HealthPartners to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+). HealthPartners also provided other health insurance products and health care services unrelated to these programs during this period.[3]

HealthPartners' reported expenses to administer the state's programs in 2012 totaled approximately $39.5 million.[4] These expenses represented managed care general administrative and claims adjustment services for one or more programs in 14 counties statewide. HealthPartners' program enrollment for this period totaled about 1.0 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with HealthPartners also specify that the entity is subject to audits by OLA.[5] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

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[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(4), HealthPartners is generally exempt from federal income taxes.

[2] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[3] HealthPartners also provided commercial insurance products and contracted directly with the Centers for Medicare & Medicaid Services to provide coverage for Medicare programs.

[4] HealthPartners, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include both general administrative and claims adjustment expenses.

[5] Minnesota Department of Human Services, *2012 Families and Children Contract, HealthPartners, Inc*. (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of HealthPartners' administrative expenses and investment income focused on the following audit objectives for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by HealthPartners to the State of Minnesota for Minnesota public health care programs?

- Did HealthPartners report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by HealthPartners for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[6] 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.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[7]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who

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[6] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision*, (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[7] U.S. Office of Management and Budget (OMB), *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of HealthPartners.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[8] Specifically, we used the following documents from HealthPartners' 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[9]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for expenses for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[10]

We interviewed management and employees of HealthPartners to gain an understanding of HealthPartners' procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

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[8] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[9] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. The NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[10] DHS, *2012* and *2013 Families and Children Contract, HealthPartners, Inc.*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5i. A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

From HealthPartners' financial data, we selected an initial sample of 104 transactions to test against our objectives.[11] We used a combination of random and purposive sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of HealthPartners' own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, contracts, bank statements, and other information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for HealthPartners' administrative services contracts. We also examined the extent to which certain "unallowed" expenses were disclosed to DHS for purposes of determining managed care capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled HealthPartners' 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against HealthPartners' publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by HealthPartners at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. HealthPartners classified the great majority of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

HealthPartners generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with exceptions. In addition, for several sample transactions, HealthPartners either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota's public health care programs.

[11] The total number of transactions we actually reviewed exceeded 104 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on HealthPartners' *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses;* our sample design included a stratified random sample using the line item categories of this exhibit.

FINDINGS AND RECOMMENDATIONS

Finding 1

HealthPartners did not fully comply with some requirements for reporting administrative expenses and investment income on its 2012 annual financial reports.[12]

Among 104 sample transactions we tested, HealthPartners generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3, with exceptions.[13] For three transactions, HealthPartners misclassified expenses totaling $34,586 as "Cost Containment"; in our opinion, these transactions should be classified as "General Administrative."[14] HealthPartners also miscategorized employer-paid federal payroll taxes totaling about $3 million to the line item "Salaries, Wages, and Benefits," rather than to the correct line (Taxes, Licenses, and Fees). The discrepancies discussed here did not affect the sum total of administrative expenses reported on this exhibit.

Minnesota law requires managed care organizations to complete and file with the state the NAIC Health Annual Statement.[15] NAIC statements of statutory accounting principles provide guidance to managed care organizations for recording expenses on their annual financial statements. NAIC defines cost containment expenses as "expenses that actually serve to reduce the number of health services provided or the cost of such services."[16] The three sample transactions we tested do not meet the NAIC criteria for cost containment expenses. NAIC instructions for the Underwriting and Investment Exhibit, Part 3, also direct entities to record payroll taxes to the category "Taxes, Licenses, and Fees."[17] HealthPartners' employer-paid taxes discussed here meet the definition of a payroll tax.

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[12] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[13] In its instructions for recording expenses on this Part 3 exhibit, NAIC most often refers to individual lines as "expense classification items," but sometimes refers to individual lines as "categories." Instructions for other reports we tested refer to individual expense lines as "categories." For purposes of this report, we refer to groupings of types of expenses to individual exhibit lines as "categories."

[14] One of these transactions also could have been classified as "Other Claims Adjustment." HealthPartners also categorized these three transactions as "claims adjustment" expenses for purposes of reporting its data on 2012 Minnesota Supplement Report #1 and Supplement Report #1A.

[15] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, chapter 4685, subparts 1910-1980, posted October 11, 2007.

[16] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, Vol.1, (Washington, DC, 2012); *Statements of Statutory Accounting Principles, No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses*; and National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health*, *Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses* (Washington, DC, 2012).

[17] NAIC, *Official NAIC Annual Instructions—Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses.*

HealthPartners did not fully comply with requirements for reporting administrative expenses and investment experience (or gains and losses) on its 2012 Minnesota Supplement Report #1A. HealthPartners miscategorized "Board, Bureau, and Association Fees" totaling $419,000 as "General Business/Office Expense," rather than to the correct line (Consulting and Professional Fees). HealthPartners also miscategorized federal payroll taxes totaling $1.9 million as "Employee Benefit Expenses," rather than to the line "General Business and Office Type Expenses." These discrepancies did not affect the sum total of administrative expenses, or the expenses allocated to individual product lines, on this report. When allocating net investment income across its lines of business, HealthPartners used a method that differed from state requirements and factored in the MCO's long-term investment experience for each product. The discrepancies discussed here did not affect the total investment experience stated on this report.

Minnesota Department of Health (MDH) instructions for completing Supplement Report #1A specify the types of expenses to record in each of seven categories. Minnesota also has two separate instructions for reporting investment income and gains for each product or program on this financial report. *Minnesota Statutes* 2014, 62D.08, subd. 7(b) requires that:

> Every health maintenance organization must allocate investment income *based on cumulative net income over time* by business line or product and must submit this information…using the reporting template provided by the commissioner of health.

The Minnesota Department of Health's instructions for completing Minnesota Supplement #1A state that "investment gain must be allocated *by the prior five years of net income*."[18]

Recommendations

HealthPartners should report administrative expenses and payroll taxes in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

HealthPartners should report administrative expenses and investment income and gains in accordance with Minnesota Statutes *2014, 62D.08, subd. 7.*

Finding 2

HealthPartners did not adequately identify administrative expenses for five samples that could have been directly allocated to specific programs on its 2012 annual financial report.[19]

HealthPartners uses a complex allocation model to apportion administrative expenses to specific departments (or accounting units) within the organization.

[18] See http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm.

[19] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

Most of HealthPartners' administrative departments support all product lines and are not unique to one particular product. If HealthPartners has a department whose only function is to provide services for a particular product, HealthPartners directly allocates those expenses to the particular product. For example, all state and federal public programs are supported by HealthPartners' "government programs" accounting unit. With some exceptions, HealthPartners does not further discern among the state's government programs to directly allocate costs. Under this model, HealthPartners classified all general administrative expenses as "directly" allocated its 2012 Minnesota Supplement Report #1A submitted to the Minnesota Department of Health in 2013.

Among the samples we tested, we identified five cost items for which HealthPartners could have allocated expenses more directly to individual products that benefitted from the services. In 2012, HealthPartners paid one of its contractors for work performed on behalf of its Medicare-related products, and paid a different contractor for work related to its commercial and government programs. HealthPartners also sponsored and paid for two other initiatives that required verifying member eligibility for just two state programs. In directives to its contractors, HealthPartners specified which products were within the scope of work; however, HealthPartners allocated some costs from each of these five samples to all government programs. For these cost items, the transactions we tested totaled $45,039; we estimated $7,153 was allocated across all state public programs on HealthPartners' Minnesota Department of Health supplement reports.[20]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project or service.[21] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[22] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[23] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[24]

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[20] We estimated that these transaction expenses and likely related costs allocated to the state's public programs totaled $69,844. These estimates were developed based on information provided by HealthPartners about its allocation model.

[21] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A, secs. E and F. We cite this standard for definition purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[22] *Ibid*. Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

[23] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70.

[24] *Ibid*., Appendix A-440.

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[25] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. HealthPartners could use its contract documents, statements of work, and member eligibility, as resources to discern costs incurred for specific lines of business and, thus, more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, HealthPartners should directly allocate administrative expenses to specific lines of business or products when such information is available.*

Finding 3

HealthPartners did not have adequate documentation to support expenses related to four HealthPartners contracts for administrative services.[26]

Among the samples we tested, HealthPartners did not have adequate contracts or current work orders that detailed the scope and duration of work, payment terms, and signatures by both parties, for three contracts for administrative services. HealthPartners also paid another contractor a rate that differed from the payment terms of the contract. The transactions we tested totaled $28,109; we estimated $2,893 was allocated among all state public programs.[27]

Without adequate supporting documentation, we were unable to validate whether HealthPartners' contractors were paid appropriately, assess the reasonableness of HealthPartners' allocation, or determine how these expenses related to the state's public programs. We defined questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[28]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[29] HealthPartners'

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[25] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2.

[26] For Finding 3, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[27] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using HealthPartners' allocation model. We estimated these transactions and all likely related costs allocated to the state's public programs totaled $19,327.

[28] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[29] *Minnesota Statutes* 2014, 62D.05, subd. 4.

contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[30] NAIC directs that transactions within a holding company system be recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[31] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

HealthPartners should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. HealthPartners' payments should be in accordance with the terms of such contracts.

Finding 4

HealthPartners allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.[32]

Among 104 samples we tested, HealthPartners allocated unreasonable costs for three items to Minnesota's Medical Assistance programs on its 2012 Minnesota Supplement Reports #1 and #1A. These three sample transactions totaled $5,129, and were for entertainment, and for activities or services occurring outside of Minnesota and unrelated to services for the state's public programs.[33] We estimated the costs allocated to the state's public programs totaled $578. In our view, HealthPartners did not sufficiently consider and restrict these types of expenses from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[34] We considered questioned costs to include: …where the costs incurred appear

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[30] DHS, *2012 Families and Children Contract, HealthPartners, Inc.*, secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6 (2014). DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. A "contract" is any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[31] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, Appendix A-440.

[32] For Finding 4, we considered a single questioned cost to be a finding.

[33] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using HealthPartners' allocation model. We estimated these transactions and all likely related costs allocated to the state's public programs totaled $3,351.

[34] Some of these expenses would be considered unallowable based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 14; and *48 CFR*, sec. 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

unreasonable and do not reflect the actions a prudent person would take in the circumstances.[35] Minnesota Department of Health administrative rules direct MCOs to identify and separately record administrative expenses for operations or other business outside of Minnesota.[36]

In its contracts with DHS, HealthPartners must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO must certify and report the dollar value of each specific service that is a non-state plan service.[37] HealthPartners did not consider these cost items to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by HealthPartners to the state's public programs on its financial reports. These seven sample transactions totaled $47,569 and were for marketing and contributions. We estimated the allocated costs totaled $5,198. Minnesota laws in effect at the time HealthPartners filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[38] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[39]

During 2013, DHS separately requested and HealthPartners provided DHS and its actuary with 2012 summary financial and other data regarding the types of unallowable expenses specified in the 2013 law—including the marketing and contribution expenses—and the amount allocated to state public programs. We tested but were unable to sufficiently verify the extent to which HealthPartners fully disclosed these expenses to DHS, for several reasons. First, HealthPartners'

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[35] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[36] *Minnesota Rules*, 4685.1930, subparts 2 and 6, posted October 11, 2007.

[37] *42 CFR*, sec 438.604, subpart H (2014), Program Integrity and Certification; and DHS, *2012 Families and Children Contract, HealthPartners*, sec. 9.10. (Other DHS contracts with HealthPartners contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR,* secs. 438.6(c)(4)(ii)(A) and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO..."

[38] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

[39] *Laws of Minnesota* 2013, chapter 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expenses, charitable contributions, and any individual's compensation in excess of $200,000.

accounting structure used for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. Second, HealthPartners' processes for allocating costs are quite complex; this made it difficult to retrospectively trace and reconcile these expenses. Lastly, verifying these financial records against the data HealthPartners submitted to DHS would have required significantly more time beyond the scope of this audit.

NAIC accounting principles direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[40] HealthPartners should implement a more rigorous process to calculate the underlying basis for allocating administrative expenses, in order to identify and disclose unreasonable and unallowable costs to DHS for purposes of determining managed care payments for state programs. HealthPartners also could implement accounting practices that identify such expenses—perhaps by specific type, account code, or amount—and: (1) directly expense such costs to a non-state plan product, either manually or through its allocation model; or (2) separately identify such costs when reporting and certifying its data in accordance with DHS contracts and state law. These approaches would help assure that HealthPartners costs are appropriately allocated to the state's public programs.

Recommendation

HealthPartners should fully identify and segregate administrative expenses that are classified as unallowable for rate-setting purposes, or unreasonable or unrelated to services for the Medical Assistance programs, when reporting and certifying financial data to the Department of Human Services.

[40] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; and *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these standards for general references purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

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February 19, 2015

James Nobles
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Saint Paul, MN 55101

Dear Mr. Nobles:

Thank you for the opportunity to respond to the report *HealthPartners, Inc., Audit of Compliance with Financial Reporting* ("Report"), completed by the Office of the Legislative Auditor ("OLA"). We appreciate the thoroughness and professionalism of the OLA team members who conducted the audit. Moreover, we recognize the helpful role that a thorough review, like that conducted by the OLA, can play in highlighting opportunities for improvement. We believe this audit affirms our effective processes and controls.

As you may know, we provide extensive financial reporting to many different regulators at the state, federal, and accreditation levels for commercial plans as well as state and federally funded programs, and the requirements we are subject to can be inconsistent or in conflict. We work hard to comply with all of these requirements while keeping in mind the need to minimize administrative costs and complexity so that our focus can be on improving the health of our members and patients. That's the expectation Minnesotans have of our organization, and we take that responsibility seriously.

Again, thank you for the opportunity to respond your Report. Before providing specific responses to individual findings, I would like to share some general points about our administrative allocation model:

- HealthPartners allocates costs across product lines using an administrative allocation model (Model) that was developed over 25 years ago and is continually updated for changes in our organization and products.
- The Model uses multiple cost drivers to allocate the administrative costs for our different departments. Examples of these cost drivers are direct allocations, FTEs, square footage, numbers of members, effort certification and claims. HealthPartners always attempts to allocate costs directly to specific product lines when practical.
- The Model has been audited by numerous regulators including the Minnesota Department of Commerce, Minnesota Department of Health, Internal Revenue Service, Centers for Medicare and Medicaid Services, Office of Personnel Management, and our independent auditors.
- In each of those audits the Model was closely examined and determined to be an acceptable approach to allocate costs between organizations and products within HealthPartners.

Finally, it's important to note that none of the findings made by OLA pertained to issues that would have a material effect on the accuracy of our overall financial reporting or on the amounts paid by the State of Minnesota for its public health care programs. This demonstrates that we have instituted effective controls and systems to assure reasonable compliance with financial reporting requirements. Our allocation method provides an accurate and reliable portrayal of our finances. This method not only directly reduces administrative expense, but, we believe, also reduces cost of care by allowing staff who work in cost containment areas, such as medical management and case management, to maximize the time they spend assuring our members receive appropriate and effective care by minimizing the time staff are required to devote to administrative paperwork.

Our responses to each of the individual findings follow.

Finding 1:

We are pleased that the Report noted that the observations leading to this finding had no impact on either the amount of our administrative expenses or their allocation among product lines. While we acknowledge and are grateful that the OLA has looked so closely at the subcategorization of several of our administrative expenses, we question the need for a formal finding on an issue with no impact. Moreover, HealthPartners does not agree with all elements of Finding 1.

HealthPartners reports administrative expenses in accordance with National Association of Insurance Commissioners ("NAIC") instructions for the Health Annual Statement. We report them under the proper breakout classification on the Statement of Revenue, Expenses, and Net Income, whether they are Cost Containment expenses, Claims Adjustment expenses or General Administrative expenses. Because certain of HealthPartners' departments are engaged solely in activities properly classified as Cost Containment, HealthPartners does not agree that certain expenses within those departments should be allocated to General Administrative expenses.

HealthPartners agrees and will change the line item where employer-paid FICA tax is recorded on the Health Annual Statement, Underwriting and Investment Exhibit Part 3 from the Salaries and Benefits line to the Payroll Taxes line. HealthPartners will also make the same change on Supplemental Report #1A. This change, as noted by the OLA, would not have had any impact on the administrative expenses charged to any HealthPartners product lines.

HealthPartners disagrees with Finding 1 as it relates to reporting of investment income. HealthPartners allocates investment income across product lines in accordance with Minnesota Statutes, section 62D.08, subdivision 7, paragraph (b), which provides that investment income must be allocated based on "cumulative net income over time by business line or product." HealthPartners acknowledges that the instructions for Supplement 1A say investment income must be allocated based on net income for the past five years. If we were to prepare Report 1A using the past-five-year method, the net incomes for all product lines, including State-funded products, would be different between the two reports. The amounts reported on Supplemental Report 1A are required to tie back to Supplemental Report 1. Therefore, we follow Minn. Stat. § 62D.08, subd. 7(b) for the allocation of investment income so that net income by product lines will be consistent between the reports.

Finding 2:

HealthPartners sells multiple products that cross all lines of businesses—whether commercial, Medicare or Medicaid; fully or self-insured; group or individual; medical or dental. Most administrative departments of HealthPartners support all product lines and are not unique to one particular product. If HealthPartners has a department whose only function is to provide services for one particular product line, HealthPartners' administrative allocation model, as described above, directly allocates those expenses to the particular product it is supporting in accordance with Minn. Stat. § 62D.08, subd. 7(a). If a department provides services to multiple lines of businesses, the Model properly allocates the costs of the whole department to each product line it supports based on the cost driver that provides the most reasonable allocation for that department. While this approach may result in a particular invoice that related, for example, to commercial-only to be allocated across all products, it is balanced out by other invoices that may have related only to the State's public programs being similarly allocated.

HealthPartners will continue to evaluate its allocation model as well as how it sets up its departments to facilitate allocating directly to lines of business or products when information is available to directly allocate expenses.

Finding 3:

HealthPartners has processes and procedures in place to support all contracted services that are provided to HealthPartners. However, contract management is a complex process and one that HealthPartners will continue to work on improving. In the specific instances where the OLA found deficiencies, we would note that all expenses were supported by invoices and documentation of approval for the expenses by department leaders. Also, in the instance where the rate paid did not match that in the contract, it should be noted that, due to an increase in volume, the vendor had agreed to discount its services below the contracted rate, so that the cost of services was actually lower.

Finding 4:

HealthPartners files Supplemental Report 1 and Supplemental Report 1A in accordance with instructions for filing these reports with the Minnesota Department of Health. In submitting these reports, we are also required to follow NAIC, SSAP, and GAAP accounting principles. These two reports are designed to show how each product line within HealthPartners is performing and require us to allocate all costs incurred by HealthPartners to each product. These two reports are not intended to break apart or exclude any costs from product lines that may be classified for rate setting purposes by DHS as unallowable costs. DHS's understanding of this is clear as they require separate reports of unallowable costs so that they can be backed out of rate setting processes. HealthPartners has complied with all DHS requests and instruction for reports to show the costs within Report 1 and Report 1A that would be classified as unallowable costs for rate setting purposes. Moreover, when using these reports for other rate reporting or submission of bids to, for example, CMS or the federal employee health benefit program, we make adjustments to remove unallowable cost, such as lobbying, charitable contributions, marketing, etc. It would be inconsistent with accepted financial reporting protocols to not allocate these costs to Reports 1 and 1A in the first place.

HealthPartners complies with all contractual certification requirements with respect to the data it submits to DHS. Section 9.10.2 of our 2012 Families and Children Contract requires that we either (1) certify

that the statutory filing only reflects State Plan services or (2) "certify and report the dollar value of each specific service that is a non-State Plan service." In 2012 and for 2012 in 2013, HealthPartners has complied with this section of the contract by certifying and reporting on each specific non-State Plan service in the manner requested and specified by DHS. In addition, HealthPartners has responded fully and accurately to all requests for further information from DHS concerning administrative costs, including those that break out costs related to lobbying, charitable contributions, marketing, and others.

Conclusion

Once again, we appreciate the efforts of OLA and the auditing team to closely examine our financial reporting as it relates to Minnesota's public health care programs. While there are some very minor opportunities to improve, overall we believe this report affirms that we are an effective administrator of medical assistance and MinnesotaCare managed care programs for the State of Minnesota. We strongly support making these programs as robust and sustainable as possible, but this must be undertaken in the context of the programs' ultimate goal of providing the best health care and experience to program recipients in an efficient and cost-effective manner. HealthPartners has sound financial practices in place to help the State of Minnesota achieve these goals. We are proud to serve public program members, and look forward to continuing to work with the State to improve the system for the good of all Minnesotans.

Sincerely,

David A. Dziuk
Senior Vice President and Chief Financial Officer

Appendix C: Medica Health Plans
Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

CONCLUSION

Medica generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with exceptions. In addition, for several sample transactions, Medica either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- Medica did not fully comply with some requirements for reporting administrative expenses on its 2012 annual financial reports.
- Medica did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- Medica did not have adequate documentation to support expenses related to four Medica contracts for administrative services.
- Medica allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of Medica's administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

MEDICA

BACKGROUND

Medica Health Plans (Medica) is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] Medica is an affiliated entity of Medica Holding Company (MHC), and provides and charges for administrative services to other MHC affiliates as specified through management agreements. Medica also contracts with and pays United Health Group (UHG) for administrative services, including accounting, billing, claims processing, network, and general administration.[2]

Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[3] The Minnesota Department of Human Services (DHS) contracted with Medica to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), and Special Needs Basic Care (SNBC). Medica also provided other health insurance products unrelated to these programs during this period.[4]

Medica's reported expenses to administer the state's programs in 2012 totaled approximately $67.7 million (including management fees paid to UHG).[5] These expenses represented managed care general administrative and claims adjustment services for two or more programs in 33 counties statewide. Medica's program enrollment for this period totaled about 1.6 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with Medica also specify that the entity is subject to audits by OLA.[6] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

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[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(4), Medica is generally exempt from federal income taxes.

[2] Medica's payments to UHG in 2012 totaled $14.5 million.

[3] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[4] Medica contracted directly with the Centers for Medicare & Medicaid Services to provide services for Medicare programs. Medica also provided commercial insurance products, and administrative and management services.

[5] Medica Health Plans, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include both general administrative and claims adjustment expenses.

[6] Minnesota Department of Human Services, *2012 Families and Children Contract, Medica Health Plans* (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of Medica's administrative expenses and investment income focused on the following audit objectives, for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by Medica to the State of Minnesota for Minnesota public health care programs?

- Did Medica report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by Medica for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[7] 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.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[8]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who

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[7] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision*, (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[8] U.S. Office of Management and Budget (OMB), *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of Medica.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[9] Specifically, we used the following documents from Medica's 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[10]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[11]

We interviewed management and employees of Medica to gain an understanding of Medica's procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

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[9] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[10] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[11] DHS, *2012* and *2013 Families and Children Contract, Medica Health Plans*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5(i). A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

From Medica's financial data, we selected a sample of 103 transactions to test against our objectives.[12] We used a combination of random and purposive sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of Medica's own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, contracts, bank statements, and other supporting information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for Medica's administrative services contracts. We also examined the extent to which certain "unallowable" expenses were disclosed to DHS for purposes of determining capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled Medica's 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against Medica's publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by Medica at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. Medica classified most of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

Medica generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 financial reports, with exceptions. In addition, for several sample transactions, Medica either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota's public health care programs.

[12] The total number of transactions we reviewed exceeded 103 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on Medica's *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses*; our sample design included a stratified random sample using the line item categories of this exhibit.

FINDINGS AND RECOMMENDATIONS

Finding 1

Medica did not fully comply with some requirements for reporting administrative expenses on its 2012 annual financial reports.[13]

Among 103 sample transactions we tested, Medica generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3, with some exceptions. Medica did not include in this exhibit certain management and claims adjustment expenses; rather, Medica classified these expenses elsewhere in its annual statement as "medical" expenses. These expenses may have totaled up to $2.8 million.[14] Similarly, these administrative expenses were not included in the total general administrative and claims adjustment expenses on its 2012 Minnesota Supplement Reports #1 and #1A.

Minnesota law requires managed care organizations to complete and file with the state the NAIC Health Annual Statement.[15] In its instructions and accounting principles, NAIC instructs MCOs to record management and claims adjustment expenses as "General Administrative" or "Claims Adjustment," and not as "medical."[16] (Federal reporting requirements for the Affordable Care Act also classify these expenses as administrative.[17]) Medica incurs other costs for similar types of services, but Medica correctly classifies these transactions as administrative expenses in its financial reports. These reporting discrepancies represent inconsistent interpretation and application of accounting principles, contrary to NAIC guidance.[18]

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[13] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[14] This finding is based on supporting documentation provided by Medica during the audit. Verifying the precise impact of this reporting discrepancy was not possible without extensive testing and review of all transactions related to this service. Some of these expenses may have been appropriately classified as "medical."

[15] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted Oct. 11, 2007.

[16] National Association of Insurance Commissioners, *Accounting Practices & Procedures Manual*, Vol.1 (Washington, DC, 2012), *Statements of Statutory Accounting Principles, No. 55, Unpaid Claims, Losses and Loss Adjustment Expenses*; and National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health*, *Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses* (Washington, DC, 2012). NAIC, *Accounting Practices & Procedures Manual*, Vol. 1, *Statements of Statutory Accounting Principles, No. 70, Allocation of Expenses*, classifies expenses within principal groupings as claims adjustment expenses and general administrative expenses.

[17] *45 CFR,* secs. 158.150(c) and 158.160 (2014).

[18] Consistency in the application of statutory accounting practices is a fundamental concept on which NAIC standards are based. NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, *Preamble*: P-5.

Recommendation

Medica should report administrative expenses in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

Finding 2

Medica did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs in its 2012 annual financial report.[19]

Medica allocates expenses for administrative services—including contract-related expenses—across product lines and among its affiliates using both direct and indirect allocation methods. Medica uses an allocation model with numerous statistics to apportion costs, depending on the types of administrative expense. For some larger transactions, Medica does not record expenses through its allocation model, but directly designates the items to specific products.

Among the samples we tested, we identified two cost items for which Medica could have allocated the expenses more directly to individual products that benefitted from the services. During 2012, Medica paid one of its contractors for work specific to two state programs; however, Medica used an "indirect" approach to allocate these expenses across all state programs based on a combination of statistics. Medica also paid a different contractor for work on behalf of commercial lines of business through Medica's affiliates, but Medica indirectly allocated the expenses across commercial and all state programs. In its directives to its contractors, Medica specified which programs were within the scope of work. For these samples, the amount of transactions tested totaled $14,478, and we estimated $14,068 was allocated among all state public programs on Medica's Minnesota Department of Health supplement reports.[20]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project or service.[21] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[22] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or

[19] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[20] The totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Medica's allocation methods.

[21] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004) attach. A, secs. E and F. We cite this standard for definition purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[22] *Ibid*. Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

similar analyses.[23] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[24]

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[25] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. Medica could use its contract documents and statements of work as resources to discern costs incurred for specific lines of business and, thus, to more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, Medica should directly allocate administrative expenses to specific lines of business or products when such information is available*.

Finding 3

Medica did not have adequate documentation to support expenses related to four Medica contracts for administrative services.[26]

Among the samples we tested, Medica paid two different contractors rates that did not align with the payment terms in its contracts. One consultant was paid less than the contract payment rate, and one consultant was paid more than the contract payment rate. For these two samples, the transactions tested totaled $2,200, and we estimated $326 was allocated among all state public programs.[27]

Medica also paid two other contractors for administrative services in 2012, but did not provide us with adequate contracts or current work orders detailing the full scope and duration of work, payment terms, and signatures by both parties. For these contracts, the transactions tested totaled $216,886, and we estimated $31,410 was allocated among all state public programs.

Without adequate supporting documentation, we were unable to validate whether the contractors were paid appropriately, assess the reasonableness of Medica's allocation, or determine how these expenses related to public programs. We defined questioned costs to include:

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[23] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70.

[24] *Ibid*., Appendix A-440.

[25] *Laws of Minnesota* 2010, First Special Session, chapter 1, art. 20, sec. 2.

[26] For Finding 3, we considered two or more exceptions of any single exception greater than $10,000 to be a finding.

[27] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Medica's allocation methods. We estimated the amount of these transactions and likely related expenses as allocated to the state's public programs totaled $7,298.

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[28]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[29] Medica's contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[30] NAIC directs that transactions within a holding company system be recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[31] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

Medica should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. Medica's payments should be in accordance with the terms of such contracts.

Finding 4

Medica allocated some unreasonable costs to Minnesota's Medical Assistance programs on its 2012 financial reports.[32]

Among 103 samples we tested, Medica allocated unreasonable costs for three transactions to Minnesota's Medical Assistance programs in its 2012 Minnesota Supplement Reports #1 and #1A. These three transactions totaled $18,306. We estimated the allocated costs totaled $1,340, and included expenses for alcohol beverages ($19), travel ($1,236), and activities or services occurring outside of Minnesota and unrelated to the state's public programs ($86).[33] In our view,

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[28] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[29] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[30] DHS, *2012 Families and Children Contract, Medica Health Plans*, secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR*, sec. 434.6 (2014). DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. A "contract" is any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[31] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, Appendix A-440.

[32] For Finding 4, we considered a single questioned cost to be a finding.

[33] Totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using Medica's allocation methods. Due to the complexity of Medica's allocation model, we could not more precisely estimate the amount reported here. We estimated all known and likely related costs as allocated to the state's programs totaled $3,813.

Medica did not sufficiently consider and restrict these types of expenses from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[34] We defined questioned costs to include: …where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[35] In its guidance for completing financial reports, Minnesota Department of Health administrative rules direct MCOs to identify and separately record administrative expenses for operations or other business outside of Minnesota.[36]

In its contracts with DHS, Medica must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO must certify and report the dollar value of each specific service that is a non-state plan service.[37] Medica did not consider these cost items to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by Medica to the state's public programs on its financial reports. These nine transactions we tested totaled $6,988,488, and were for marketing expenses and charitable contributions. We estimated the allocated costs totaled $6,135,701.[38] Minnesota laws in effect at the time Medica filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner

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[34] Some of these expenses would be considered unallowable based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 3; and *48 CFR*, sec. 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

[35] OMB, *Circular A-133*, subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[36] *Minnesota Rules*, 4685.1930, subparts 2 and 6, posted October 11, 2007.

[37] *42 CFR,* sec. 438.604, subpart H (2014), Program Integrity and Certification; and DHS, *2012 Families and Children Contract, Medica Health Plans*, sec. 9.10. (Other DHS contracts with Medica contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR,* secs. 438.6(c)(4)(ii)(A) and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO..."

[38] For two transactions we tested, Medica allocated 100 percent of the costs ($609,575) to the state's public programs. In our view, a share of these costs should have been allocated to Medica commercial products as they also would have benefitted from the intended purpose of these costs.

of human services.[39] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[40]

During 2013, DHS separately requested and Medica provided DHS and its actuary with 2012 summary financial and other data regarding the types of unallowable expenses specified in the 2013 law—including marketing and contribution expenses—and the amount that was allocated to state public programs. We tested but were unable to sufficiently verify the extent to which Medica fully disclosed these expenses to DHS, for several reasons. First, Medica's accounting structure used for recording expenses during 2012 did not precisely align with the expense categories later disallowed by the 2013 law. Second, Medica's processes for allocating costs are very complex; this made it difficult to retrospectively trace and reconcile these expenses. Lastly, verifying these financial records against the data Medica submitted would have required significantly more time beyond the scope of this audit.

NAIC accounting principles for MCOs direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[41] Medica should implement a more rigorous process to calculate the underlying basis for allocating administrative expenses, in order to identify and disclose unreasonable and unallowable costs to DHS for purposes of determining managed care payments for state programs. Medica also could implement accounting practices that identify such expenses—perhaps by specific type, account code, or amount—and: (1) directly expense such costs to non-state plan products, either manually or through its allocation model; or (2) separately identify such costs when reporting and certifying its data to DHS in accordance with DHS contracts and state law. These approaches would help assure Medica costs are appropriately allocated to the state's public programs.

Recommendation

Medica should fully identify and segregate administrative expenses that are classified as unallowable for rate-setting purposes, or are unreasonable or unrelated to services for the Medical Assistance programs, when reporting and certifying financial data to the Department of Human Services.

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[39] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

[40] *Laws of Minnesota* 2013, chap. 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expense, charitable contributions, and any individual's compensation in excess of $200,000.

[41] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these federal standards for reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

MEDICA.

February 19, 2015

Mr. James Nobles
Legislative Auditor
Centennial Office Building, Room 140
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to submit a letter for inclusion in your Audit of Compliance with Financial Reporting. We appreciate the attention your staff gave to the comments we have provided throughout the process. A number of them were taken into account in finalizing the findings. Some of them were not and are noted here for the record.

Finding 1

Medica files a number of standard and custom reports for our various regulators. The guidance we rely on is not always clear or consistent. For example, NAIC guidance does not specify the classification between the administrative and medical expenses cited here. We rely on instruction from the Minnesota Department of Commerce in determining these classifications. Our filings have been built using a consistent methodology over the years, and have been reviewed and audited quarterly by the Department of Commerce.

It is worth noting that the classification we have used, if relied upon for setting rates, would likely have the effect of lowering our premiums rates from the state.

Finding 2

The invoice cited in this finding for approximately $14,000 was appropriately allocated to State Public Programs. However, the finding notes that details within the invoice would have allowed us to further directly allocate expenses to specific programs. While the statute states that expenses should be allocated directly when such information is available – and our guiding principle is to allocate directly when practicable – we believe that a standard of reasonableness needs to apply. The items in the invoice that could have been allocated directly ranged from $27 to $1,700. If there is no standard of reasonableness, we would need to increase both staff and administrative expense – with the promise of little or no benefit to the state.

Finding 3

Medica has a robust contract management system that ensures the expenditures are appropriately authorized and that written contracts are in place prior to receiving services. Occasionally, changes to contracts, including contract extensions, are not reflected in contract extensions on a timely basis, as this audit has shown. We will strive to ensure current documentation is in place for all contracts.

Finding 4

The finding points to three invoices with allocations totaling $1,340 that are considered unreasonable. We continue to believe that these expenses were appropriately allocated. For example, the largest portion of this expense was for travel to an out-of-state location to oversee operations that directly affect our public programs business. There will always be an element of judgment in determining reasonableness. More importantly, the salient point here is that this disagreement is not material.

We will continue to work with DHS to provide any and all information needed for rate setting.

We value our partnership with the state, and the coverage and service we are able to provide for our members. To that end, we are dedicated to following all regulatory requirements for financial reporting and in producing filings that are accurate and complete. Given the complexity of this work, we know that small errors will occur and that there will be areas of disagreement. We view this audit, and all those we participate in, as an opportunity to improve our performance and strengthen our partnerships.

Sincerely,

Glenn Andis
Senior Vice President
Medica Government Programs

Appendix D: UCare Minnesota

Audit of Compliance with Financial Reporting
January 1, 2012, to December 31, 2012

REPORT SUMMARY

Conclusions

UCare generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, UCare either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

Key Findings

- UCare generally complied with certain requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions.
- UCare did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.
- UCare did not have adequate documentation to support expenses related to two UCare contracts for administrative services.
- UCare allocated unreasonable costs for one sample transaction to Minnesota's Medical Assistance programs on its 2012 financial reports.

Audit Scope

Our audit of UCare's administrative expenses and investment income focused on compliance with requirements for financial reporting for the period January 1, 2012, through December 31, 2012.

UCARE

BACKGROUND

UCare Minnesota (UCare) is a managed care organization licensed as a nonprofit health maintenance organization in Minnesota.[1] Minnesota requires nonprofit health maintenance organizations to participate in its public health care programs as a condition of licensure.[2] The Minnesota Department of Human Services (DHS) contracted with UCare to provide managed care services and health care coverage in 2012 for the Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), Special Needs Basic Care (SNBC), Minnesota Senior Health Options (MSHO), and Minnesota Senior Care Plus (MSC+). UCare also provided other health insurance products and services unrelated to these programs during this period.[3]

UCare's reported expenses to administer the state's programs in 2012 totaled approximately $99.7 million.[4] These expenses represented managed care general administrative and claims adjustment services for one or more programs in 80 counties statewide. UCare's program enrollment for this period totaled nearly 2.4 million member-months.

This compliance audit was conducted by the Office of the Legislative Auditor (OLA) pursuant to *Minnesota Statutes* 2014, 3.971, and 256B.69, subd. 9d. The 2013 Legislative Audit Commission directed OLA to conduct an evaluation of managed care organizations' administrative expenses. State of Minnesota contracts with UCare also specify that the entity is subject to audits by OLA.[5] In the remainder of this report, we use the terms health maintenance organization (HMO) and managed care organization (MCO) interchangeably.

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[1] *Minnesota Statutes* 2014, chapter 62D. Pursuant to the Internal Revenue Code, Section 501(c)(3), UCare is generally exempt from federal income taxes.

[2] *Minnesota Statutes* 2014, 62D.04, subd. 5; and 256B.0644.

[3] UCare contracted directly with the Centers for Medicare & Medicaid Services to provide coverage for Medicare programs. UCare also provided administrative and management services via an agreement with UCare Wisconsin, a UCare subsidiary.

[4] UCare Minnesota, *2012 Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*. Administrative expenses reported here include both general administrative and claims adjustment expenses.

[5] Minnesota Department of Human Services, *2012 Families and Children Contract, UCare Minnesota* (St. Paul, 2011), sec. 9.4.4.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our audit of UCare's administrative expenses and investment income focused on the following audit objectives, for the period January 1, 2012, through December 31, 2012:

- How accurate, complete, and reliable are the administrative expenses and investment income reported by UCare to the State of Minnesota for Minnesota public health care programs?

- Did UCare report its administrative expenses and investment income in compliance with certain state and federal laws and its contracts with the State of Minnesota?

- Are the administrative expenses and investment income reported by UCare for Minnesota public health care programs reasonable, appropriate, and likely related to services under the State of Minnesota contracts for Medical Assistance programs for Medical Assistance-eligible members?

To answer these questions, we considered the risk of noncompliance with financial reporting legal requirements and DHS contract provisions, and the risk of questioned costs going undetected or unreported to DHS. We performed our work in accordance with generally accepted government standards for conducting audits of compliance with financial reporting requirements.[6] 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.

For this audit, we partly relied on standards of the U.S. Office of Management and Budget, which defines questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation; or (3) where the costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[7]

We spoke with representatives from the Minnesota departments of Commerce, Health, and Human Services to identify state and federal laws, regulations, and contract requirements to use as evaluation criteria for compliance. We also spoke with state regulators, examiners, and certified public accountants who

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[6] U.S. Government Accountability Office, *Government Auditing Standards, 2011 Revision* (Washington, DC: December 2011), Standards 2.10, 2.11(c), A2.02(j)(o), and A2.04(c).

[7] U.S. Office of Management and Budget (OMB), *Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations* (Washington, DC, as revised June 26, 2007), subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

conduct audits of health insurance entities to gain an understanding of their scope of work and audit methodology. We reviewed the findings and recommendations from previous audits and examinations of UCare.

Based on our background work, we focused our testing on the administrative expenses and investment income data contained within reports the Department of Human Services collects and also partly relies on for determining payment rates for managed care organizations.[8] Specifically, we used the following documents from UCare's 2012 financial reports: the National Association of Insurance Commissioners (NAIC) *Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expense*; and NAIC *Exhibit of Net Investment Income*; *Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income*; and *Minnesota Supplement Report #1A, Reallocation of Expenses and Investment Income*.[9]

We also reviewed select financial information and documents required by the state's contracts for public health care programs or otherwise requested by the Department of Human Services. This included financial data for expenses for services not covered by the state's federal Medicaid plan and expenses classified in state law as unallowable for purposes of setting capitation payment rates for managed care organizations.[10]

We interviewed management and employees of UCare to gain an understanding of its procedures for recording and reporting administrative expenses and investment income, and how the entity apportions its costs across lines of business and programs. We obtained detailed and summary financial transaction data, including general ledgers, journal entries, trial balances, and accounts payable records. We relied on this information to conduct our audit work and reconcile data across and within our sample financial reports. We also looked for expenses we expected to see recorded as administrative expenses (as opposed to medical expenses), and for expenses that should not have been recorded as administrative expenses.

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[8] *Minnesota Statutes* 2014, 256B.69, subd. 9c.

[9] Minnesota requires health maintenance organizations to report their finances in accordance with Minnesota Department of Health (MDH) instructions. MDH requires HMOs to complete and file an annual report and other financial documents, including the National Association of Insurance Commissioners (NAIC) Health Annual Statement. The NAIC instructions for completing this form require interpretation and application of NAIC Statements of Statutory Accounting Principles. See: *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[10] DHS, *2012* and *2013 Families and Children Contract, UCare Minnesota*, sec. 9.10.1; and *Minnesota Statutes* 2014, 256B.69, subd. 5i. A capitation payment is a fixed, prepaid sum paid to an MCO for providing health care services without regard to frequency of services for any particular enrollee.

From UCare's financial data, we selected an initial sample of 103 transactions to test against our objectives.[11] We used a combination of random and purposive sampling, and our sample universe generally included all transactions greater than $500 in which at least some portion of the transaction was expensed to a state public program. For each transaction we tested, we considered the type and purpose of the expense and method for apportioning the costs. We selected a sample of UCare's own contracts for administrative services and reviewed expenses incurred through these contracts. As needed to fully understand the circumstances for some transactions, we obtained written representations from management and related documentation, including purchase orders, invoices, bank statements, contracts, and other supporting information.

We used federal and state laws, regulations, contracts, and NAIC statements of statutory accounting principles (SSAPs) as criteria for testing expenses. We relied on NAIC SSAPs, DHS contract requirements, definitions in state law, and Minnesota Department of Administration guidelines for contracts as criteria for verifying expenses for UCare's administrative services contracts. We also examined the extent to which certain "unallowed" expenses were disclosed to DHS for purposes of determining managed care capitation payment rates for the public programs.

For administrative expenses allocated to the state's public programs, we tested and reconciled UCare's 2012 data contained in general ledgers, accounts payable detailed data, and other accounting documentation against UCare's publicly reported financial documents. In the next sections, we present our findings—or "exceptions"—in which the samples or data tested did not meet our criteria, based on the information provided by UCare at the time of the audit. All other samples not reported here complied with our testing criteria or standards. We frame our discussion in the remainder of this report to comply with data privacy requirements. UCare classified much of its data and supporting documents as not public under *Minnesota Statutes* 2014, 13.37.

CONCLUSIONS

UCare generally complied with certain financial-related legal requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions. In addition, for several sample transactions, UCare either did not have adequate supporting documentation or allocated unreasonable costs to Minnesota public health care programs.

[11] The total number of transactions we actually reviewed exceeded 103 as testing of some random samples and contract-related expenses required examining separate, related transactions. Our population consisted of all transactions related to the administrative expenses reported on UCare's *2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses;* our sample design included a stratified random sample using the line item categories of this exhibit.

FINDINGS AND RECOMMENDATIONS

Finding 1

UCare generally complied with certain requirements for reporting administrative expenses and investment income on its 2012 annual financial reports, with some exceptions.[12]

Among 103 sample transactions we tested, UCare generally complied with certain legal requirements and accounting standards for reporting administrative expenses on its 2012 Health Annual Statement, Underwriting and Investment Exhibit, Part 3, with two exceptions.[13] UCare miscategorized expenses for one transaction to "Printing and Office Supplies," instead of to the correct line (Cost or Depreciation of EDP Equipment and Software). UCare also miscategorized expenses for a second transaction to "Traveling Expenses"; in our opinion, these expenses should be categorized as "Outsourced Services." These two transactions totaled $1,702. UCare's miscategorization of these items did not impact the sum total of administrative expenses on this exhibit.

Minnesota requires managed care organizations to complete and file the National Association of Insurance Commissioners (NAIC) Health Annual Statement.[14] NAIC instructions for the Underwriting and Investment Exhibit, Part 3, direct where to record expenses on this exhibit.[15]

UCare did not fully comply with requirements for reporting investment experience (or gains and losses) on its 2012 Minnesota Supplement Report #1A. UCare used a method for allocating net investment income and gains across its lines of business that differed from state reporting requirements and factored in recent earnings generated relative to current lines of business. UCare's allocation method did not impact the total amount of investment income reported on its 2012 Minnesota Supplement Report #1A.

Minnesota has two separate instructions for reporting investment income and gains for each product or program on Supplement Report #1A. *Minnesota Statutes* 2014, 62D.08, subd. 7(b) requires that:

> Every health maintenance organization must allocate investment income *based on cumulative net income over time* by business

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[12] For Finding 1, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[13] In its instructions for recording expenses on this Part 3 exhibit, NAIC most often refers to individual lines as "expense classification items," but sometimes refers to individual lines as "categories." Instructions for other reports we tested refer to individual expense lines as "categories." For purposes of this report, we refer to groupings of types of expenses to individual exhibit lines as "categories."

[14] *Minnesota Statutes* 2014, 62D.08; and *Minnesota Rules*, 4685.1910-4685.1980, posted October 11, 2007.

[15] National Association of Insurance Commissioners, *Official NAIC Annual Instructions—Health, Underwriting and Investment Exhibit, Part 3 – Analysis of Expenses* (Washington, DC: September 2012).

> line or product and must submit this information…using the reporting template provided by the commissioner of health.

The Minnesota Department of Health's instructions for completing Minnesota Supplement Report #1A state that "investment gain must be allocated *by the prior five years of net income*."[16]

Recommendations

UCare should report administrative expenses in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

UCare should report investment income and gains in accordance with Minnesota Statutes *2014, 62D.08, subd. 7.*

Finding 2

UCare did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.[17]

UCare uses both direct and indirect allocation methods to record and allocate administrative costs across its lines of business. Generally, expense transactions are reviewed for attributing costs to a specific product or program. UCare directly allocates certain expenses to specific products. Expenses related to more than one product are most often indirectly allocated across products based on premium revenue.

Among the samples we tested, we identified two cost items for which UCare could have allocated expenses more directly to individual programs that benefitted from the services. During 2012, UCare sponsored and paid for two health care cost containment initiatives that required direct tracking of member eligibility, by state program. UCare contracted with outside vendors for these services and specified in each statement of work the state programs that would benefit from these efforts. UCare did not directly allocate these costs to the designated state programs. Instead, UCare indirectly allocated these expenses across all products. These sample transactions totaled $16,289; we estimated $10,046 was allocated among all state public programs on UCare's Minnesota Department of Health supplement reports.[18]

The U.S. Office of Management and Budget defines direct costs as those that can be specifically identified with a particular final cost objective, such as a project

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[16] See http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm.

[17] For Finding 2, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

[18] The totals reported in this paragraph represent OLA estimates of expenses allocated to the state's public programs using UCare's allocation methods. We estimated these transactions and all likely related costs allocated to the state's public programs totaled $206,572.

or service.[19] Further, a cost may be distributed—or allocated—across projects or programs in accordance with the relative benefits received.[20] In its accounting principles for allocating costs, NAIC directs that any allocation of costs be based on a method that yields the most accurate results; where specific identification among entities is not feasible, allocation of expenses should be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[21] Also, transactions within a holding company system shall be fair and reasonable, in conformity with statutory accounting practices consistently applied, and recorded in a manner as to clearly and accurately disclose the nature and detail of the transactions.[22]

Minnesota laws contain explicit directives to MCOs for allocating costs. *Minnesota Statutes* 2014, 62D.08, subd. 7(a), requires that managed care organizations must directly allocate administrative expenses to specific lines of business or products when such information is available. The 2010 Legislature imposed this requirement, effective January 1, 2013.[23] The Minnesota Department of Health required MCOs to complete and file Minnesota Supplement Report #1A in mid-2013 for year 2012. UCare could use its contract documents and statements of work as resources to discern costs incurred for specific programs and, thus, more directly allocate expenses.

Recommendation

Pursuant to Minnesota Statutes *2014, 62D.08, subd. 7, UCare should directly allocate administrative expenses to specific lines of business or products when such information is available.*

Finding 3

UCare did not have adequate documentation to support expenses related to two UCare contracts for administrative services.[24]

Among the samples we tested, UCare paid a contractor for one project in 2012, but did not have an executed contract or statement of work that detailed the scope and duration of work, payment terms, and signatures by both parties. UCare's total payments to a different contractor exceeded the agreed upon amount in the contract. These two sample transactions totaled $38,291, and we estimated the

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[19] See, for example, U.S. Office of Management and Budget, *Circular A-87: Cost Principles for State, Local, and Indian Tribal Governments* (Washington, DC, 2004), attach. A, secs. E and F. We cite this standard for definition purposes, only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to this federal standard.

[20] *Ibid.* Costs that may be *indirectly* allocated are those: (a) incurred for a common or joint purpose benefiting more than one cost objective, and (b) not readily assignable to the cost objectives specifically benefitted, without effort [to allocate] disproportionate to the results achieved.

[21] National Association of Insurance Commissioners, *Accounting Practices and Procedures Manual*, Vol. 1, *Statements of Statutory Accounting Principles, SSAP No. 70.* (Washington, DC, 2012).

[22] *Ibid.*, Appendix A-440.

[23] *Laws of Minnesota* 2010, First Special Session, Chapter 1, art. 20, sec. 2.

[24] For Finding 3, we considered two or more exceptions or any single exception greater than $10,000 to be a finding.

costs that lacked adequate documentation and allocated to the state's public program totaled $4,408.[25]

Without adequate supporting documentation, we were unable to validate whether UCare's contractors were paid appropriately, assess the reasonableness of UCare's allocation, or determine how these expenses were related to the state's public programs. We defined questioned costs to include:

> …costs that are questioned by the auditor because of an audit finding…(2) where the costs, at the time of the audit, are not supported by adequate documentation.[26]

Managed care organizations may contract with individuals or vendors for the provision of services, including administrative services.[27] UCare's contracts with DHS specify the MCO must comply with federal regulations regarding general requirements for all contracts and subcontracts, and that all contracts must be in writing.[28] Written, signed contracts that specify the scope of work, contract terms and duration, and payment rates are supporting evidence that payments in question are related to the contract and not for other services. Similarly, written amendments document any changes to the agreement between the MCO and contractor.

Recommendations

UCare should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed contracts and statements of work that specify the scope, duration, and payment rates. UCare's payments should be in accordance with the terms of such contracts.

Finding 4

UCare allocated unreasonable costs for one transaction to the Medical Assistance programs on its 2012 financial reports.[29]

Among 103 samples, we identified one sample in which UCare allocated about $376 for alcohol beverages and related costs to Minnesota's Medical Assistance

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[25] Totals reported in this section represent OLA estimates of allocated expenses to the state's public programs using UCare's allocation methods.

[26] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[27] *Minnesota Statutes* 2014, 62D.05, subd. 4.

[28] DHS, *2012 Families and Children Contract, UCare, Minnesota,* secs. 9.3, 9.3.1, and 9.3.5; and *42 CFR,* sec 434.6 (2014). DHS contracts for the MSHO and MSC+ programs require that all MCO subcontracts must be in writing and include a specific description of payment arrangements. A "contract" is any written instrument or electronic document containing the elements of offer, acceptance, and consideration. See, for example, *Minnesota Statutes* 2014, 16C.02, subd. 6.

[29] For Finding 4, we considered a single questioned cost to be a finding.

programs on its 2012 Minnesota Supplement Reports #1 and #1A.[30] In our view, UCare did not sufficiently consider and restrict this type of expense from being allocated to state public programs on its financial reports.

We think such costs are unreasonable and not related to the provision of approved services for Minnesota's Medical Assistance programs.[31] We considered questioned costs to include: …where costs incurred appear unreasonable and do not reflect the actions a prudent person would take in the circumstances.[32]

In its contracts with DHS, UCare must certify to DHS that the financial data in its annual financial filings represent only costs related to services covered under the state plan, including administrative service costs; otherwise, the MCO must certify and report the dollar value of each specific service that is a non-state plan service.[33] UCare did not consider this cost item to be services in addition to state plan services for the public programs and, thus, did not separately report these expenses when certifying its financial data.

We questioned some other costs allocated by UCare to the state's public programs. These seven sample transactions totaled $10,044,568, and included expenses for marketing and contributions. We estimated the costs allocated to the state's public programs totaled about $8,512,112. Minnesota laws in effect at the time UCare filed its annual financial reports specified that MCOs could make payments to charitable, education, religious, or scientific purposes; however, these types of expenses were not allowed for purposes of DHS determining managed care payment rates unless approved by the commissioner of human services.[34] Laws later passed during the 2013 Legislative Session classified indirect marketing, charitable contributions, and some other types of expenses as

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[30] The totals reported in this section represent OLA estimates of expenses allocated to the state's public programs using UCare's allocation methods. The transaction tested totaled $2,664.

[31] These expenses would be considered unallowable based on criteria for other federal programs. See, for example, OMB, *Circular A-87,* attach. B, sec. 3; and *48 CFR*, sec 31.703 (2014). We cite these standards for general reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

[32] OMB, *Circular A-133,* subp. A, sec. 105. We used this standard pursuant to *Minnesota Statutes* 2014, 3.971. Minnesota managed care organizations under contract for the Medical Assistance programs are not otherwise subject to this federal standard.

[33] *42 CFR*, sec. 438.604, subp. H (2014), Program Integrity and Certification; and DHS, *2012 Families and Children Contract, UCare*, sec. 9.10. (Other DHS contracts with UCare contain similar language.) Federal regulations require that DHS set rates that are appropriate and based on services to be furnished under the state plan for Medicaid-eligible enrollees. *42 CFR* secs. 438.6(c)(4)(ii)(A), and 438.6(e) (2014). MCOs may cover for enrollees services in addition to the state plan, although the cost of these services cannot be included when determining capitation payment rates. DHS requests and uses the MCOs' Health Annual Statements and Minnesota Supplement Reports #1 and #1A when it determines managed care capitation payment rates—including payments for administrative services. One DHS certification document states that the certifier acknowledges that "the data\information submitted…may directly affect the calculation of the payments to the MCO..."

[34] *Minnesota Statutes* 2012, 62D.12, subd. 9a; and 256B.69, subd. 5i.

not allowable for purposes of setting capitation payment rates for the Medical Assistance Program.[35]

During 2013, DHS separately requested and UCare provided DHS and its actuary with 2012 summary financial data regarding the types of unallowable expenses specified in the 2013 law—including the marketing and contribution expenses. We tested documentation supplied by both UCare and DHS regarding these types of expenses, and the amount allocated to state public programs. We found that UCare did substantially disclose these expenses to DHS and its actuary as part of the rate-setting process for contract year 2014.

NAIC accounting principles for MCOs direct that any allocation of costs be based on a method that yields the most accurate results, or otherwise be based upon pertinent factors or ratios such as studies of employee activities, salary ratios, or similar analyses.[36] UCare should identify and disclose all unreasonable costs to DHS for purposes of determining managed care payments for state programs. UCare should implement accounting practices that identify such expenses—perhaps by specific type or account code—and: (1) directly expense such costs to a non-state plan product, either manually or through its allocation model; or (2) separately identify such costs when reporting and certifying its data to DHS in accordance with DHS contracts and state law. These approaches would help assure UCare costs are appropriately allocated to the state public programs.

Recommendation

UCare should fully identify and segregate administrative expenses that are unreasonable or otherwise unrelated to providing services for the Medical Assistance programs when reporting and certifying financial data to the Department of Human Services.

[35] *Laws of Minnesota* 2013, chap. 108, art. 6, sec. 21 amended *Minnesota Statutes* 2012, 256B.69, subd. 5i. Currently, the unallowable expenses are: fines or penalties assessed against the MCO, indirect marketing or advertising expenses, charitable contributions, and any individual's compensation in excess of $200,000.

[36] NAIC, *Accounting Practices and Procedures Manual*, Vol. 1, SSAP No. 70. Federal regulations and standards provide more explicit definitions, guidance, and cost principles for identifying and handling *unallowable* costs, such as those discussed here. See, for example, OMB, *Circular A-87*; and *48 CFR*, secs. 31.703 and 9904.405 (2014). We cite these federal standards for reference purposes only. Minnesota managed care organizations under contract for the Medical Assistance programs are not subject to these federal standards.

February 18, 2015

Mr. James Nobles, Legislative Auditor
Office of the Legislative Auditor
Room 140, Centennial Building
658 Cedar Street
St. Paul, MN 55155-1603

Re: Response to Appendix D of the OLA Audit of Compliance with Financial Reporting

Dear Mr. Nobles:

UCare appreciates the opportunity to respond to the Office of the Legislative Auditor's review of UCare's administrative and investment expenses for 2012 and related financial reporting. Although the report shows we can always improve our documentation and reporting, we are pleased by the minor findings and high level of compliance described in the report. Over 98% of the audited transactions in each finding area were compliant. In addition, the net financial impact of the findings on UCare's financial reporting is only $1,459 in under-reported expenses out of a total $99.7 million in UCare administrative expenses for state public health care programs.

We note below specific responses to the findings which will provide readers helpful context for understanding the report. Before proceeding to these detailed responses, we believe it is important to emphasize that UCare shares the Legislature's interest in ensuring we as a State are cost-effectively providing coverage and care to our most vulnerable individuals and families. Although audits constitute one necessary approach for confirming managed care's value and compliance, we hope that they do not distract policy makers and stakeholders from richer discussions about how managed care can strengthen performance, accountability, and quality in the delivery of public health care program services.

Finding 1: UCare generally complied with certain requirements for administrative expenses and investment income on its 2012 annual financial reports, with some exceptions.

Recommendations

UCare should report administrative expenses in accordance with NAIC instructions for the Health Annual Statement, Underwriting and Investment Exhibit, Part 3, and NAIC Statements of Statutory Accounting Principles.

UCare should report investment income and gains in accordance with Minnesota Statutes 2014, 62D.08, subd. 7.

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As recommended in the report, we will continue to report administrative expenses in accordance with applicable NAIC requirements. We acknowledge that the two identified exceptions (totaling $1,702) out of the 103 sampled transactions could have been categorized more precisely. We appreciate that the report noted that the less refined categorization did not affect the sum total of reported administrative expenses.

We accept the report's clarification of how investment income should be reported under Minnesota Statutes, section 62D.08, subdivision 7(b), and look forward to implementing the recommended approach for 2014 annual reporting. We also appreciate that the report noted our prior method did not affect the total amount of reported investment income.

Finding 2: UCare did not adequately identify administrative expenses for two samples that could have been directly allocated to specific programs on its 2012 annual financial report.

Recommendation: Pursuant to Minnesota Statutes 2014, 62D.08, subd. 7, UCare should directly allocate administrative expenses to specific lines of business or products when such information is available.

Although we would have preferred to learn that all of the 103 tested transactions reflected the most accurate possible allocation, we accept that two of the transactions could have been directly allocated to a product or program. It is worth highlighting here that the transactions in question resulted in **under-allocation** of administrative expenses to state public programs in the amount of $6,243. We will take greater care in reviewing potential costs for direct allocation of administrative expenses when information is available.

Finding #3: UCare did not have adequate documentation to support expenses related to two UCare contracts for administrative services.

UCare should retain adequate documentation to support its contracts for administrative services that are expensed to the state's public programs; such documentation includes fully-executed (sic) contracts and statements of work that specify the scope, duration, and payment rates. UCare's payments should be in accordance with the terms of such contracts.

We agree that in one of the 103 tested transactions we could not produce a signed statement of work, and we regret this lack of documentation. However, we respectfully disagree that we lacked documentation for the other transaction described in this finding. We produced documentation showing that the UCare business leader for the contract approved the relatively small amount of expenses that exceeded the contracted amount. This is consistent with our policy, and we do not understand the basis for the

apparent implication that a contract amendment would have been required. In any event, we will continue to strive for appropriate contract documentation and we have instituted even more robust contracting review processes since 2012.

Finding #4: UCare allocated unreasonable costs for one transaction to the Medical Assistance programs on its 2012 financial reports.

Recommendation

UCare should fully identify and segregate administrative expenses that are unreasonable or otherwise unrelated to providing services for the Medical Assistance programs when reporting and certifying financial data to the Department of Human Services.

In this finding, the report describes $376 in alcohol and related expenses that UCare spent as part of a recognition dinner for physicians who demonstrated high-quality care for our members. We do not understand how this expense should have been segregated in our financial reports. Neither the Department of Human Services nor the Department of Health has provided any direction or imposed any restrictions about how such expenses should be reported. We reported such expenses in compliance with applicable laws and contract requirements, and will continue to follow any revised or clarified standards issued by our government partners and regulators.

At UCare, we take our mission as a nonprofit organization seriously, and are proud of our efforts to provide community benefit. We appreciate that the report confirmed that UCare appropriately reported our charitable contributions and fully complied with the specific reporting requirements for these expenses recently implemented by the Department of Human Services.

Thank you for your office's professional efforts in this audit and report.

Sincerely,

Nancy J Feldman

Nancy J. Feldman
President & CEO

Appendix E: Sample Financial Reports

Managed care organizations must complete and file with the Minnesota Department of Health two reports that summarize their revenues, health care expenses, administrative expenses, and other information, by lines of business. Blank copies of these two reports—*Minnesota Supplement Report #1, Statement of Revenue, Expenses, and Net Income;* and *Minnesota Supplement Report #1A, Reallocation of Administrative Expenses*—are provided in the following pages. For a sample of administrative expense transactions, we tested the accuracy of each managed care organization's financial data recorded on their 2012 reports. The results of our audit work are summarized in Chapter 2. Our findings and recommendations for each of the managed care organizations are contained in Appendices A through D.

<Name of HMO>
Minnesota Supplement Report #1
STATEMENT OF REVENUE, EXPENSES AND NET INCOME
For the year ending December 31, 2012
Public Information, Minnesota Statutes § 62D.08

NAIC #	NAIC Description	1	2	3	4
	As found on page 4 of the Annual Statement	NAIC Totals	Non-Minnesota Products (Eliminations)	Total Minnesota Products	Commercial
1	Member Months				
REVENUES:					
2	Net Premium Income (including $ [redacted] non-health premium income)				
3	Change in unearned premium reserves and serve for rate credits				
4	Fee-for-service (net of $ [redacted] medical expenses)				
5	Risk revenue				
6	Aggregate write-ins for other health care related revenues (Line 699)	NR	NR	NR	NR
7	Aggregate write-ins for other non-health revenues (Line 799)	NR	NR	NR	NR
8	TOTAL REVENUES (Lines 2 through 7)	NR	NR	NR	NR
EXPENSES:					
9	Hospital/medical benefits				
10	Other professional services				
11	Outside referrals				
12	Emergency room and out-of-area				
13	Prescription drugs				
14	Aggregate write-ins for other hospital and medical expenses (Line 1499)	NR	NR	NR	NR
15	Incentive Pool and Withhold Adjustments				
16	TOTAL EXPENSES (Lines 9 through 15)	NR	NR	NR	NR
LESS					
17	Net reinsurance recoveries				
18	Total hospital and medical (Lines 16 minus 17)	NR	NR	NR	NR
19	Non-health claims				
20	Claims adjustment expenses				
21	General administrative expenses				
22	Increase in reserves for life, accident and health contracts (including $ [redacted] increase in reserves for life only)				
23	Total underwriting deductions (Lines 18 through 22)	NR	NR	NR	NR
24	Net underwriting gain or (loss) (Lines 8 minus 23)	NR	NR	NR	NR
25	Net investment income earned				
26	Net realized capital gains or (losses)				
27	Net investment gains or (losses) (Lines 25 plus 26)	NR	NR	NR	NR
28	Net gain or (loss) from agents' or premium balances charged off				
29	Aggregate write-ins for other income or expenses (Line 2999)	NR	NR	NR	NR
30	Net income or (loss) before federal income taxes (Lines 24 plus 27 plus 28 plus 29)	NR	NR	NR	NR
31	Federal and foreign income taxes incurred				
32	Net income (loss) (Lines 30 minus 31)	NR	NR	NR	NR

Minnesota Supplement Report #1 (Continued)

5	6	7	8	9	10	11	12	13	14
Medicare + Choice	Medicare Cost	Minnesota Senior Health Options (MSHO)	SNBC (MA Only)	SNBC (Integrated)	Prepaid Medical Assistance Program (PMAP)	MNCare	Dental	Other Please Specify	Administrative Services Only
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR
NR	NR	NR	NR	NR	NR	NR	NR	NR	NR

SOURCE: Minnesota Department of Health, http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm, accessed March 2, 2015.

<Name of HMO>
Minnesota Supplement Report #1A
REALLOCATION OF EXPENSES AND INVESTMENT INCOME
For the year ending December 31, 2012
Public Information, Minnesota Statutes § 62D.08

		1	2	3	4
Line	**Direct Non-Claim Expenses**	**Total**	**Non MN**	**Total MN**	**Commercial**
1	Employee benefit expenses	0		0	
2	Sales expenses	0		0	
3	General business/office expense	0		0	
4	State premium taxes and assessments	0		0	
5	Consulting and professional fees	0		0	
6	Outsourced services	0		0	
7	Other expenses	0		0	
8	**Total Direct Expenses**	**0**	**0**	**0**	**0**

		1	2	3	4
Line	**Reallocated Indirect Non-Claim Expenses**	**Total**	**Non MN**	**Total MN**	**Commercial**
9	Employee benefit expenses	0		0	
10	Sales expenses	0		0	
11	General business/office expense	0		0	
12	State premium taxes and assessments	0		0	
13	Consulting and professional fees	0		0	
14	Outsourced services	0		0	
15	Other expenses	0		0	
16	**Total Indirect Expenses**	**0**	**0**	**0**	**0**

		1	2	3	4
Line	**Direct plus Indirect Non-Claim Expenses**	**NAIC Total**	**Non MN**	**Total MN**	**Commercial**
17	Employee benefit expenses	0	0	0	0
18	Sales expenses	0	0	0	0
19	General business/office expense	0	0	0	0
20	State premium taxes and assessments	0	0	0	0
21	Consulting and professional fees	0	0	0	0
22	Outsourced services	0	0	0	0
23	Other expenses	**0**	**0**	**0**	**0**
24	**Total Non-Claim Expenses = Sum of Lines 17 to 23**	**0**		**0**	
25	**Claims Adjustment Expenses**	0		0	
26	**Revenues (Supp Report #1, Line 8)**	0		0	
27	**Incurred Claims (Supp Report #1, Line 18 + Line 22)**	0		0	
28	**Net Investment Gain/(Loss) (Allocated)**	0		0	
29	**Aggregate Write Ins for Other Income or (Expenses)**	0		0	
30	**Federal and Foreign Income Taxes Incurred**	0		0	
31	**Net Income = Lines 26+28+29-24-25-27-30**	**0**	**0**	**0**	**0**

Minnesota Supplement Report #1A (Continued)

5	6	7	8	9	10	11	12	13	14
M+C	Medicare	MSHO	SNBC MA	SNBC	PMAP	MNCare	Dental	Other	Admin
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

5	6	7	8	9	10	11	12	13	14
M+C	Medicare	MSHO	SNBC MA	SNBC	PMAP	MNCare	Dental	Other	Admin
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

5	6	7	8	9	10	11	12	13	14
M+C	Medicare	MSHO	SNBC MA	SNBC	PMAP	MNCare	Dental	Other	Admin
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	0	0	0	0	0	0	0	0	0
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
0	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

SOURCE: Minnesota Department of Health, http://www.health.state.mn.us/divs/hpsc/mcs/forms.htm, accessed March 2, 2015.

Forthcoming OLA Evaluations

Mineral Taxation
Minnesota Film and TV Board

Recent OLA Evaluations

Agriculture
Agricultural Commodity Councils, March 2014
"Green Acres" and Agricultural Land Preservation Programs, February 2008
Pesticide Regulation, March 2006

Criminal Justice
Health Services in State Correctional Facilities, February 2014
Law Enforcement's Use of State Databases, February 2013
Public Defender System, February 2010
MINNCOR Industries, February 2009
Substance Abuse Treatment, February 2006

Education, K-12, and Preschool
Special Education, February 2013
K-12 Online Learning, September 2011
Alternative Education Programs, February 2010
Q Comp: Quality Compensation for Teachers, February 2009
Charter Schools, June 2008

Education, Postsecondary
Preventive Maintenance for University of Minnesota Buildings, June 2012
MnSCU System Office, February 2010
MnSCU Occupational Programs, March 2009

Energy
Renewable Energy Development Fund, October 2010
Biofuel Policies and Programs, April 2009
Energy Conservation Improvement Program, January 2005

Environment and Natural Resources
Recycling and Waste Reduction, February 2015
DNR Forest Management, August 2014
Sustainable Forest Incentive Program, November 2013
Conservation Easements, February 2013
Environmental Review and Permitting, March 2011
Natural Resource Land, March 2010
Watershed Management, January 2007

Government Operations
Minnesota Board of Nursing: Complaint Resolution Process, March 2015
Councils on Asian-Pacific Minnesotans, Black Minnesotans, Chicano/Latino People, and Indian Affairs, March 2014
Helping Communities Recover from Natural Disasters, March 2012

Government Operations (continued)
Fiscal Notes, February 2012
Capitol Complex Security, May 2009
County Veterans Service Offices, January 2008

Health
Minnesota Health Insurance Exchange (MNsure), February 2015
Financial Management of Health Care Programs, February 2008
Nursing Home Inspections, February 2005

Human Services
Managed Care Organizations' Administrative Expenses, March 2015
Medical Assistance Payment Rates for Dental Services, March 2013
State-Operated Human Services, February 2013
Child Protection Screening, February 2012
Civil Commitment of Sex Offenders, March 2011
Medical Nonemergency Transportation, February 2011
Personal Care Assistance, January 2009

Housing and Local Government
Consolidation of Local Governments, April 2012

Jobs, Training, and Labor
State Protections for Meatpacking Workers, 2015
State Employee Union Fair Share Fee Calculations, July 2013
Workforce Programs, February 2010
E-Verify, June 2009
Oversight of Workers' Compensation, February 2009
JOBZ Program, February 2008
Misclassification of Employees as Independent Contractors, November 2007

Miscellaneous
The Legacy Amendment, November 2011
Public Libraries, March 2010
Economic Impact of Immigrants, May 2006
Liquor Regulation, March 2006
Gambling Regulation and Oversight, January 2005

Transportation
MnDOT Selection of Pavement Surface for Road Preservation, March 2014
MnDOT Noise Barriers, October 2013
Governance of Transit in the Twin Cities Region, January 2011
State Highways and Bridges, February 2008

OLA reports are available at www.auditor.leg.state.mn.us or by calling 651-296-4708.