

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**THE MEDICAID PROGRAM
COULD HAVE ACHIEVED SAVINGS IF
OREGON HAD APPLIED
MEDICAL LOSS RATIO STANDARDS
SIMILAR TO THOSE ESTABLISHED
BY THE AFFORDABLE CARE ACT**

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Gloria L. Jarmon
Deputy Inspector General
for Audit Services

April 2016
A-09-15-02033

Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

The Medicaid program could have saved \$10.1 million (\$6.4 million Federal share) during 2014 if Oregon had required its contracted Medicaid coordinated-care organizations to meet medical loss ratio standards similar to those established by the Affordable Care Act.

WHY WE DID THIS REVIEW

The objective of this review was to determine potential Medicaid program savings if the Oregon Health Authority, Division of Medical Assistance Programs (State agency), had required its Medicaid coordinated-care organization (CCO) plans to meet medical loss ratio (MLR) standards for its non-expansion population similar to those standards established by the Patient Protection and Affordable Care Act (ACA).

The ACA established standards for the amount of premium revenue that certain commercial health insurers and Medicare Advantage plans can spend on costs other than health-care-related expenses. These standards are known as the MLR. Insurers that do not meet these standards must pay rebates to their enrollees or the U.S. Department of Health and Human Services (the Department).

Although the MLR standards do not apply to Medicaid spending, some States have applied similar standards to their contracts with Medicaid managed-care organizations (MCOs) and require the MCOs to issue rebates to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards. The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program. A recent Office of Inspector General review found that Medicaid could have achieved further savings if New York had required its Medicaid MCOs to meet MLR standards similar to those established by the ACA.

In Oregon, CCO plans serve beneficiaries enrolled in the State's Medicaid managed-care program. Effective January 1, 2014, the ACA gave States the choice to expand their Medicaid coverage for nearly all individuals under the age of 65 with incomes up to 133 percent of the Federal poverty level. Oregon chose to participate in the Medicaid expansion. Individuals enrolled in CCO plans through Oregon's Medicaid expansion program are known as the expansion population; for the purpose of this report, we refer to the remaining individuals enrolled in these plans as "the non-expansion population." Although Oregon applied MLR standards to its contracts with Medicaid CCO plans for its expansion population and required those plans to issue rebates to the State if these standards were not met, it did not apply the standards for its non-expansion population.

BACKGROUND

The ACA, as amended, established standards for certain commercial health insurers and Medicare Advantage plans to meet minimum MLR standards and provide rebates to enrollees or the Department if the minimum standards are not met. The MLR is the percentage of premium dollars an insurer spends to provide medical services and health care quality improvement

activities for its members. The ACA-established minimum MLR for large group insurers and Medicare Advantage plans is 85 percent. In general, the higher an insurer's MLR, the more value an enrollee receives; that is, a larger portion of each premium dollar paid goes toward health benefits, not administrative costs and profits. On June 1, 2015, the Centers for Medicare & Medicaid Services issued a proposed rule in the *Federal Register* to require Medicaid MCOs to achieve a minimum MLR of at least 85 percent for rate setting.

In calendar year (CY) 2014, Oregon's 16 CCO plans served approximately 850,000 Medicaid beneficiaries. During this period, the State agency claimed Federal Medicaid reimbursement for payments that the State agency made to CCO plans totaling \$4.2 billion (\$3.3 billion Federal share).

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for 11 of Oregon's Medicaid CCO plans for the non-expansion population on the basis of our preliminary assessment of plans' financial information. During this period, the total amount of Medicaid premium revenue earned by these plans was \$1.8 billion. For each plan, we determined the MLR for the same period and the amount that the plan would have had to return to the State agency if the plan had been required to meet MLR standards similar to those established by the ACA.

WHAT WE FOUND

Although the State agency applied MLR standards to its contracts with Medicaid CCO plans for its expansion population, the Federal Medicaid program could have achieved further savings during CY 2014 if the State agency had required those plans to (1) meet MLR standards for its non-expansion population similar to those standards established by the ACA and (2) issue rebates to the State agency if those standards were not met. Specifically, the MLRs for 3 of the 11 CCO plans that we reviewed were less than 85 percent (the ACA's minimum MLR standard for large group insurers and Medicare Advantage plans) for the non-expansion population. We determined that the Medicaid program could have saved \$10.1 million (\$6.4 million Federal share) during CY 2014 if the State agency had required its Medicaid CCO plans to meet MLR standards for its non-expansion population similar to the ACA-established standards.

WHAT WE RECOMMEND

We recommend that the State agency incorporate MLR standards into its contracts with Medicaid CCO plans for its non-expansion population. If the State agency had incorporated standards similar to those established by the ACA into its contracts for the 11 CCO plans we reviewed, the Medicaid program could have saved \$10.1 million (\$6.4 million Federal share) during CY 2014.

STATE AGENCY COMMENTS

The State agency concurred with our recommendation and described actions that it planned to take to address our recommendation.

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INTRODUCTION

OBJECTIVE

Our objective was to determine potential Medicaid program savings if the Oregon Health Authority, Division of Medical Assistance Programs (State agency), had required its Medicaid coordinated-care organization (CCO) plans to meet medical loss ratio (MLR) standards for its non-expansion population similar to those standards established by the Patient Protection and Affordable Care Act (ACA).

WHY WE DID THIS REVIEW

The ACA¹ established standards for the amount of premium revenue that certain commercial health insurers and Medicare Advantage plans can spend on costs other than health-care-related expenses. These standards are known as the MLR. Insurers that do not meet these standards must pay rebates to their enrollees or the U.S. Department of Health and Human Services (the Department).

Although the MLR standards do not apply to Medicaid spending, some States have applied similar standards to their contracts with Medicaid managed-care organizations (MCOs) and require the MCOs to issue rebates to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards.² The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program. A recent Office of Inspector General review found that Medicaid could have achieved further savings if New York had required its Medicaid MCOs to meet MLR standards similar to those established by the ACA.³

In Oregon, CCO plans serve beneficiaries enrolled in the State's Medicaid managed-care program. Effective January 1, 2014, the ACA gave States the choice to expand their Medicaid coverage for nearly all individuals under the age of 65 with incomes up to 133 percent of the Federal poverty level. Oregon chose to participate in the Medicaid expansion. Individuals enrolled in CCO plans through Oregon's Medicaid expansion program are known as the expansion population; for the purpose of this report, we refer to the remaining individuals enrolled in these plans as "the non-expansion population." Although Oregon applied MLR standards to its contracts with Medicaid CCO plans for its expansion population and required those plans to issue rebates to the State if these standards were not met, it did not apply the standards for its non-expansion population.

¹ P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

² In July 2012, the Centers for Medicare & Medicaid Services (CMS) required Florida to implement a similar standard as part of a Medicaid demonstration project waiver program that mandated Medicaid beneficiaries residing in five counties to enroll in a Medicaid managed-care plan. As a condition of the waiver program extension, CMS required that MCOs in the demonstration counties meet an 85-percent MLR standard.

³ *The Medicaid Program Could Have Achieved Savings if New York Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act* ([A-02-13-01036](#)), issued October 20, 2015.

BACKGROUND

The Medicaid Program

The Medicaid program pays for medical assistance for certain individuals and families with low income and resources (Title XIX of the Social Security Act). The Federal and State Governments jointly fund and administer the program. The Centers for Medicare & Medicaid Services (CMS) administers the program at the Federal level. In Oregon, the State agency administers the Medicaid program.

Oregon's Medicaid Managed-Care Program

In Oregon, the State agency uses a coordinated-care model to serve beneficiaries enrolled in Oregon's Medicaid managed-care program. Before the development of the coordinated-care model (and under the traditional managed-care model), the State agency paid health care providers separately, and providers managed a specific element of a beneficiary's health (e.g., physical or behavioral care).

In 2011, Oregon established CCO plans under the coordinated-care model to improve health care and lower costs. CCO plans are networks of health care providers that work together to provide physical, mental, and dental care to Medicaid beneficiaries. The State agency pays CCO plans to provide care to Medicaid beneficiaries on the basis of a budget that grows at a fixed rate for each CCO.

In calendar year (CY) 2014, 16 CCO plans served approximately 850,000 Medicaid beneficiaries. During this period, the State agency claimed Federal Medicaid reimbursement for payments made to these CCO plans totaling \$4.2 billion (\$3.3 billion Federal share).

The Medical Loss Ratio Standards Established by the Affordable Care Act

The ACA, as amended, established standards for certain commercial health insurers and Medicare Advantage plans to meet minimum MLR standards and provide rebates to enrollees or the Department if the minimum standards are not met.⁴ The MLR is the percentage of premium dollars an insurer spends to provide medical services and health care quality improvement activities for its members. The ACA-established minimum MLR for large group insurers and Medicare Advantage plans is 85 percent.⁵ Insurers that do not meet the MLR standards must pay rebates to their enrollees or the Department. In general, the higher an insurer's MLR, the more value an enrollee receives; that is, a larger portion of each premium dollar paid goes toward health benefits, not administrative costs and profits. On June 1, 2015, CMS issued a proposed

⁴ Section 1001 of the ACA added section 2718 to the Public Health Service Act (PHS Act). The MLR standards do not apply to long-term-care, dental, vision, or retiree health insurance.

⁵ The ACA established a minimum MLR of 80 percent for individual and small markets (health insurance coverage offered to individuals other than in connection with a group health plan or group health plan maintained by a small employer with fewer than 100 employees) and 85 percent for large group markets (health insurance coverage through a group health plan maintained by a large employer with 101 or more employees) (PHS Act § 2718(b)(1)(A); ACA § 1304(a)).

rule in the *Federal Register* to require Medicaid MCOs to achieve a minimum MLR of at least 85 percent for rate setting.⁶

Although the State agency applied MLR standards to its contracts with Medicaid CCO plans for its expansion population and required those plans to issue rebates to the State agency if those standards were not met, it did not apply the standards for its non-expansion population.

For details regarding the MLR standards established by the ACA and how rebates are calculated, see Appendix A.

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2014 cost and premium revenue data for 11 of Oregon’s Medicaid CCO plans for the non-expansion population on the basis of our preliminary assessment of plans’ financial information. During this period, the total amount of Medicaid premium revenue earned by these plans was \$1.8 billion. For each plan, we determined the MLR for the same period and the amount that the plan would have had to return to the State agency if the plan had been required to meet MLR standards similar to those established by the ACA.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix B contains the details of our audit scope and methodology.

FINDING

Although the State agency applied MLR standards to its contracts with Medicaid CCO plans for its expansion population, the Federal Medicaid program could have achieved further savings during CY 2014 if the State agency had required those plans to (1) meet MLR standards for its non-expansion population similar to those standards established by the ACA and (2) issue rebates to the State agency if those standards were not met. Specifically, the MLRs for 3 of the 11 CCO plans that we reviewed were less than 85 percent (the ACA’s minimum MLR standard for large group insurers and Medicare Advantage plans) for the non-expansion population. We determined that the Medicaid program could have saved \$10.1 million (\$6.4 million Federal share) during CY 2014 if the State agency had required its Medicaid CCO plans to meet MLR standards for its non-expansion population similar to the ACA-established standards.

⁶ 80 Fed. Reg. 31098, 31107 (June 1, 2015).

SOME PLANS DID NOT MEET MEDICAL LOSS RATIO STANDARDS SIMILAR TO THOSE ESTABLISHED BY THE AFFORDABLE CARE ACT

The ACA established standards for certain commercial health insurers and Medicare Advantage plans to achieve a minimum MLR of 85 percent. However, the MLR standards do not apply to Medicaid managed care.

We determined that some of Oregon's Medicaid CCO plans did not meet a minimum MLR standard of 85 percent during CY 2014. Specifically, of the 11 CCO plans that we reviewed, the MLRs for the non-expansion population for 3 CCO plans were less than 85 percent.

We calculated that the Medicaid program could have saved \$10,117,645 (\$6,388,281 Federal share) during CY 2014 if the State agency had required its CCO plans to meet MLR standards for its non-expansion population that were similar to those standards established by the ACA.

Appendix C contains the results of our calculations of the MLRs for the selected CCO plans using the formula described in the ACA, the potential Medicaid program savings if the State agency had required its CCO plans to meet MLR standards for its non-expansion population similar to the ACA-established standards, and the Federal share of the potential Medicaid program savings.

RECOMMENDATION

We recommend that the State agency incorporate MLR standards into its contracts with Medicaid CCO plans for its non-expansion population. If the State agency had incorporated standards similar to those established by the ACA into its contracts for the 11 CCO plans we reviewed, the Medicaid program could have saved \$10,117,645 (\$6,388,281 Federal share) during CY 2014.

STATE AGENCY COMMENTS

The State agency concurred with our recommendation and stated that it intends to amend its CCO contracts effective for CY 2017 to incorporate an MLR standard of 85 percent for the entire population served by the CCOs. The State agency's comments are included as Appendix D.

APPENDIX A: THE MEDICAL LOSS RATIO STANDARDS ESTABLISHED BY THE AFFORDABLE CARE ACT

The ACA, as amended,⁷ requires certain health insurers to submit data on the proportion of premium revenues spent on clinical services and activities that improve health care quality, also known as the MLR, and to issue rebates to enrollees if the percentage of premium revenues expended on costs for clinical services and activities that improve health care quality does not meet minimum standards.⁸

The MLR is the ratio of the numerator, consisting of the insurer's incurred claims plus the expenditures for activities that improve health care quality for the reporting year, to the denominator, which equals the insurer's premium revenue, excluding Federal and State taxes and licensing and regulatory fees, after accounting for payments or receipts related to the Risk Adjustment, Risk Corridors, and Reinsurance programs (PHS Act § 2718(b)(1)(A)).⁹

The ACA-established formula for calculating the MLR is as follows:

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

If the applicable MLR standard is not met, the insurer must issue rebates to enrollees for the total amount of premium revenue, after subtracting Federal and State taxes and licensing and regulatory fees as provided in and after accounting for payments or receipts for Risk Adjustment, Risk Corridors, and Reinsurance,¹⁰ multiplied by the difference between the applicable MLR standard and the insurer's calculated MLR (PHS Act § 2718(b)(1)(B)).

⁷ Section 1001 of the ACA added section 2718 to the PHS Act.

⁸ The ACA established a minimum MLR of 80 percent for individual and small markets (health insurance coverage offered to individuals other than in connection with a group health plan or group health plan maintained by a small employer with fewer than 100 employees) and 85 percent for large group markets (health insurance coverage through a group health plan maintained by a large employer with 101 or more employees) (PHS Act § 2718(B)(1)(A); ACA § 1304(a)).

⁹ Federal regulations at 45 CFR part 158 contain the detailed methodology for calculating the MLR.

¹⁰ The ACA's Risk Adjustment, Risk Corridors, and Reinsurance programs are designed to work together to mitigate the potential effects of higher-than-average premiums and the denial of coverage to those who are in poor health and likely to require costly medical care. Specifically, Risk Adjustment is designed to mitigate any incentives for plans to attract healthier individuals and compensate those that enroll a disproportionately sick population. Risk Corridors reduce the general uncertainty that insurers face in the early years of implementation when the market is opened up to people with preexisting conditions who were previously excluded. Reinsurance compensates plans for their high-cost enrollees and, by the nature of its financing, provides a subsidy for individual market premiums generally over a 3-year period.

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the total amounts reported by 11 of Oregon's Medicaid CCO plans for premium revenue, medical expenses, activities that improve health care quality, and Federal and State taxes and licensing and regulatory fees for CY 2014.¹¹ During this period, the total amount of Medicaid premium revenue earned by these plans was \$1.8 billion.

During CY 2014, the State agency claimed Medicaid reimbursement for payments made to 16 Medicaid CCO plans totaling \$4.2 billion (\$3.3 billion Federal share).

We did not review the overall internal control structure of the State agency or the Oregon Medicaid program. Rather, we reviewed only those controls related to our objective. We did not verify the accuracy of all costs and premium revenue information provided by the CCOs.

We performed fieldwork at the State agency's office in Salem, Oregon, and at the CCOs' offices throughout Oregon from July through September 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State requirements;
- held discussions with CMS officials to obtain information on Oregon's Medicaid managed-care program;
- held discussions with State agency officials to gain an understanding of the State agency's policies and procedures for overseeing and administering its Medicaid managed-care program;
- reconciled the State agency's Medicaid managed-care payments included on CMS Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, for CY 2014 with the Medicaid managed-care payments in the State agency's statewide financial management application reports for CY 2014;
- obtained from the State agency a summary of capitated payments made to CCO plans that contracted with the State agency during CY 2014;
- obtained from the State agency audited financial statements and financial reports for all Medicaid CCO plans;

¹¹ CCO plans were required to submit financial reports to the State agency for financial stability evaluation.

- performed a preliminary calculation of the MLR on the basis of cost and premium revenue elements identified in the financial reports for all Medicaid CCO plans;
- judgmentally selected for review 11 Medicaid CCO plans on the basis of our preliminary assessment of plans' financial information obtained from the State agency and for each of these plans:
 - obtained the total amount reported for cost and premium revenue,¹²
 - obtained supporting documentation (e.g., general ledger account summaries and actuarial estimates) for the cost and premium revenue elements and an explanation of how these amounts were derived,
 - verified incurred medical expenses,¹³
 - verified earned premium revenue,¹⁴
 - used the financial data obtained to compute the MLR for the non-expansion population by using the formula described in the ACA, and
 - calculated the rebate¹⁵ that would have been issued to the State agency to determine the potential Medicaid program savings if the State agency had required the plan to meet MLR standards for the non-expansion population similar to those standards established by the ACA; and
- discussed our audit results with State agency officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

¹² We obtained the total amounts reported for premium revenue, medical expenses, activities that improve health care quality, and Federal and State taxes and licensing and regulatory fees.

¹³ We selected and verified certain medical expenses incurred by each CCO. For medical expenses incurred and paid, we obtained detailed underlying support, such as the claims data summary. For medical expenses incurred but not reported, we obtained a description of the actuarial methodology used to determine the actuarial estimates.

¹⁴ We obtained total capitated payments made to each plan by the State agency and compared that amount with the plan's earned premium revenue.

¹⁵ The ACA-established formula for calculating the rebate is as follows: (premium revenue – taxes – licensing and regulatory fees) × (the applicable MLR standard – the insurer's calculated MLR).

**APPENDIX C: PLAN MEDICAL LOSS RATIOS
AND POTENTIAL MEDICAID PROGRAM SAVINGS**

| Plan | MLR¹⁶ | Potential Medicaid Program Savings | Federal Share of Potential Medicaid Program Savings¹⁷ |
|--------------|-------------------------|---|---|
| CCO 1 | 92.1% | – | – |
| CCO 2 | 73.2% | \$7,753,552 | \$4,895,592 |
| CCO 3 | 91.1% | – | – |
| CCO 4 | 91.8% | – | – |
| CCO 5 | 87.0% | – | – |
| CCO 6 | 83.9% | 2,139,310 | 1,350,761 |
| CCO 7 | 87.5% | – | – |
| CCO 8 | 88.6% | – | – |
| CCO 9 | 84.7% | 224,783 | 141,928 |
| CCO 10 | 97.7% | – | – |
| CCO 11 | 87.9% | – | – |
| Total | | \$10,117,645 | \$6,388,281 |

Note: Shaded areas indicate those plans that did not meet a minimum MLR of 85 percent.

¹⁶ We rounded insurers' MLRs in accordance with Federal regulations (45 CFR § 158.221).

¹⁷ The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program (the Social Security Act § 1903(d)(3)(A)). To determine the approximate Federal share of potential program savings, we multiplied the Medicaid potential program savings by 63.14 percent (the Federal Medicaid assistance percentage applied to payments to Medicaid CCO plans in Oregon for CY 2014).

APPENDIX D: STATE AGENCY COMMENTS



OREGON HEALTH AUTHORITY

Kate Brown, Governor

Oregon
Health
Authority

500 Summer Street NE, E-20
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March 9, 2016

Report Number: A-09-15-02033

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
Department of Health and Human Services - Region IX
Office of Inspector General
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San Francisco, CA 94103

Dear Ms. Ahlstrand:

Thank you for the opportunity to review and provide comment on the draft report entitled *The Medicaid Program Could Have Achieved Savings if Oregon Had Applied Medical Loss Ratio Standards Similar to Those Established by the Affordable Care Act* (Report Number A-09-15-02033). Below we have provided our response to the report's recommendation. We would also like to thank you for the work of your staff in completing this report.

BACKGROUND

Since 2012, the State of Oregon through the Oregon Health Authority (OHA) has contracted with Coordinated Care Organizations (CCOs) to provide coordinated care to its Medicaid-eligible population; there are currently 16 CCOs that cover the population. The goal of the CCO program is to achieve the triple aim of better health, better health care, and lower per capita cost. Today, OHA provides services to over 1 million Medicaid beneficiaries primarily through its' CCOs.

As part of the Affordable Care Act expansion in 2014, OHA implemented a MMLR standard for the expansion population only.

RECOMMENDATION / RESPONSE

The Office of Inspector General's (OIG) report recommends OHA expand the MMLR requirement to include the non-expansion population served by the CCOs; based on an 85% MMLR threshold. As described in the report, this is consistent with the Notice of Proposed Rulemaking (NPRM) CMS-2390-P that was published in the Federal Register on June 1, 2015.

OHA concurs with OIG's recommendation and intends to amend its CCO contracts effective for calendar year 2017 to incorporate a MMLR standard of 85% for the entire population served by the CCO. This will replace the current MMLR standard that applies to the expansion population only.

1

Thank you again for the opportunity to review and provide comments to the draft report. Should you have any questions related to our planned actions, please contact David Lyda, Chief Audit Officer, at [REDACTED]

Respectfully,

/Mark Fairbanks/

Mark Fairbanks
Chief Financial Officer
Oregon Health Authority

cc: Lynne Saxton, Director

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Office of Inspector General Note—The deleted text has been redacted because it is personally identifiable information.