NEW YORK STATE OF OPPORTUNITY. Department of Health

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January 10, 2017

Ms. Andrea Inman
Audit Director
New York State Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2014-S-55 entitled, "Mainstream Managed Care Organizations-Administrative Costs Used in Premium Rate Setting."

Please feel free to contact Amy Nickson, Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Howard Zucker M.D.

Howard A. Zucker, M.D., J.D.
Commissioner of Health

Enclosure

cc: Ms. Nickson

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2014-S-55 entitled,
Medicaid Program - Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2014-S-55 entitled, "Medicaid Program - Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting".

Background:

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1

Modify the rate-setting methodology to ensure that franchise taxes and MTA surcharges are properly factored into the methodology.

Response #1

The Department agrees that the rate setting methodology should ensure that franchise and Metropolitan Transportation Authority (MTA) surcharges are not factored twice. The Department has subsequently updated its methodology to incorporate this change beginning in State Fiscal Year (SFY) 2015-16.

Recommendation #2

Determine the extent to which the MCOs' (including Fidelis') reported facilitated enrollment expenses include non-allowable marketing expenses, and assess whether the intent of the MRT-related policy change – and the intended cost savings – can be achieved given current MCO reporting practices.

Response #2

The Department does not reimburse plans for marketing expenses. MRT initiative #10, which was implemented on April 1, 2011, eliminated Direct Marketing of Medicaid Recipients from the Managed Care Organization (MCO) premium, generating $45 million in savings to the NYS Medicaid program. Accordingly, the Department, effective State Fiscal Year (SFY) 2011-12, has not been reimbursing plans for their marketing expenses. More specifically, and as illustrated in the chart below, Medicaid Managed Care total dollars decreased by $33 million from 2010 to 2012

for Marketing, Advertising & Facilitated Enrollment (FE) combined, despite an increase in enrollment of 15.3 percent. If 2010 enrollment was held constant, the savings from 2010 to 2012 would have been $47.3 million. Thus, the Department not only achieved, but surpassed its original savings estimates specific to MRT #10.

MEDICAID MANAGED CARE All Plans
Marketing, Advertising & Facilitated Enrollment (FE)

YEAR	MMs	TOTAL DOLLARS
2010	32,914,425	$ 138,361,964
2011	34,959,311	$ 127,269,132
2012	37,955,113	$ 105,059,033

YEAR	MMs	TOTAL PMPM
2010	32,914,425	$ 4.20
2011	34,959,311	$ 3.26
2012	37,955,113	$ 2.77

Source: 2010, 2011, & 2012 MMCOR Reports

MMs	PMPM		TOTAL DOLLARS
32,914,425	$	4.20	$ 138,361,964
32,914,425	$	2.77	$ 91,106,504
			$ 47,255,460

Savings from 2010 to 2012 if MMs held constant at 2010 level.

Additionally, the Medicaid MCO Model Contract has been updated to more explicitly remove references to any marketing costs. The revised Medicaid Managed Care Operating Report (MMCOR) instructions clearly state that effective April 1, 2011 Medicaid marketing activities are ceased and, therefore, should not be reported. It should be noted that commercial lines of business are not subject to this limitation. Lastly, MMCOR instructions clearly state that effective March 31, 2011 advertising costs are not reimbursed in the premium, and must be reported as non-allowable administrative expenses.

Recommendation #3

Revise the MMCOR instructions to ensure adequate guidance is given for reporting marketing and facilitated enrollment expenses, fines, and legal costs.

Response #3

As the Department stated in its preliminary response, the MMCOR instructions are a living document that is updated and amended each and every time new populations and/or benefits are carved into Managed Care. Instructions are also modified on a quarterly basis to reflect revisions in reporting tables as deemed necessary by program and policy changes impacting MCOs.

Revisions may also occur when there are changes impacting State and Federal statute, regulation or policies specific to the provision of medical services.

Since the preliminary response to this audit, the Department along with the NYS Office of Information Technology Services has completed the process of cost report conversion and modernization of the MMCOR software to a new web based operating platform. This upgrade allows the Department to make changes and modifications to the MMCOR in an efficient manner reflecting programmatic and policy changes impacting the MCOs in real time.

As part of the software conversion, the Department has implemented a thorough revision of the MMCOR instructions and organized the instructions in a manner making it easier to navigate, as well as correlate to each table contained within the reporting software. The new instructions offer clear guidance for standard issues and more specificity for various reporting categories that previously might have been deemed unclear or insufficient. New tables and corresponding instructions were also added to reflect inclusion of new benefits and populations as well as to provide further breakout and detail specificity for certain high cost services.

Recommendation #4

Recalculate the administrative cost cap and the base administrative premium rate based on our findings and apply the recalculations to the premiums paid for the State fiscal year 2014-15 and forward.

Recommendation #5

Recover overpayments from all mainstream MCOs based on the recalculated premiums.

Response #4 and #5

The Department will assess whether the MMCOR findings associated with the reporting of facilitated enrollment will impact the rates in a substantive manner. The Department believes that in the context of a Medicaid Managed Care program that totals approximately $18 billion gross annually in Medicaid expenditures, these findings would have an immaterial impact. It should be noted that for the period in question, the Department has the flexibility (based on Centers for Medicare & Medicaid Services (CMS) policy[1]) to pay within the actuarially certified premium rate ranges produced by the State's actuary, Mercer. Correcting the MMCOR reporting errors identified by the Office of the State Comptroller for this finding would not likely move rate ranges or premium rates in a substantive manner one way or the other towards the lower or upper bounds of the actuarially certified rate range. Additionally, the cost of engaging Mercer in a complete recertification of the rates should be taken into account in relation to this recommendation. It is estimated that the recertification cost would range between $28,000 and $35,000. Finally, any recalculation of these premiums would need the approval of CMS and the New York State Division

[1] Note that while there was no specific rule granting the authority to use rate ranges "historically, [CMS} considered any capitation rate paid to a managed care plan that was within the certified range to be actuarially sound regardless of where it fell in the range." (See Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions to Third Party Liability Final Rule; Fed. Reg. Vol. 81, No. 88, 5/6/2016, at pg. 7567). Through the final rule, CMS has changed this policy.

of the Budget. The Department would need to remit the Federal share (roughly 50 percent) of any recoveries to CMS.

It should also be noted that when compared to actual MCO administrative costs, the Department's reimbursement as a percentage of premium for Mainstream MCOs is much lower at 7%, when compared to the actual MCO reported administrative cost of 8%. Furthermore, although the Mainstream Managed Care premium is actuarially sound and falls within the certified rate ranges, the Department's administrative component of premium as a percentage of total premium, 8.5%, is less than Mercer due to the Department's incorporation of administrative caps.

Recommendation #6

Assess the cost of the current actuary contract, and any future contracts and amendments, against all MCOs, as appropriate.

Response #6

The Department is currently determining the annual actuarial contract costs to potentially be assessed on MCOs. It should be noted that the Department currently receives roughly 50 percent of total cost in Federal funding on Medicaid administration expenditures, such as the actuarial contract. Furthermore, the $38.6 million referenced is the value of the actuarial contract over a five (5) year period and not all of the $38.6 million is directly related to rate-setting as described in Section 364-j of the New York State Social Services Law.

MCO premiums with this assessment would need the approval of CMS and the New York State Division of the Budget. Once again, the Department would also need to remit any Federal funding received for the portion of costs assessed to the MCOs back to CMS to ensure no double claiming is occurring.

Recommendation #7

Include MCOs in the future selection of the actuary.

Response #7

The Department will continue to comply with all applicable laws and regulations in the selection of the independent actuary.

State Comptroller's Comments:

OSC Comment #1:

As detailed on pages 11-13 of our report, the Department did, in fact, reimburse MCOs for marketing expenses. Also, Fidelis officials told us that the Department instructed them to report marketing expenses associated with facilitated enrollment under the facilitated enrollment line item – contrary to the intent of the MRT proposal. Furthermore, our review of the expenses of five other MCOs demonstrated that the MCOs likely reported marketing expenses as facilitated enrollment costs (see Table 4 on page 13 of our report).

Response to Comment #1:

The Department does not reimburse plans for marketing expenses. Consistent with the implementation of the MRT #10, "Eliminate Direct Marketing of Medicaid Recipients by Medicaid Managed Care Plans," MMCOR instructions have been revised to explicitly state that Marketing for Medicaid lines of business is not allowable. Furthermore, the Department performs desk reviews of the submitted cost reports and if discrepancies are found, plans are notified and required to resubmit prior to finalization.

OSC Comment #2:

The Department's estimate of $47.3 million in achieved savings is flawed. The original $45 million in estimated savings from the MRT proposal was based on eliminating reimbursements of marketing expenses. However, to show that the Department achieved such savings, the Department inappropriately combined marketing, advertising, and facilitated enrollment expenses in its analysis. Through this methodology, the Department's assertion that it achieved and surpassed the $45 million in estimated annual savings from reduced marketing costs is misleading.

Furthermore, it should be noted that even if total dollars reported by the MCOs are lower, this would not result in a dollar-for-dollar savings to the State (as assumed by the Department in its analysis) because the rate-setting process involves capping expenses and aggregating regional expenses over a two-year period (see pages 6-8 of our report for the rate-setting process). While the rate would be lower due to lower reported MCO costs, again, it would be inaccurate for the Department to assert that savings met or surpassed the original MRT estimate.

Response to Comment #2:

Savings for the MRT #10 were achieved based on eliminating reimbursement for marketing expenses for Medicaid lines of business inclusive of Family Health Plus (FHP) and Human Immunodeficiency Virus Special Needs Plan (HIV SNP) programs. The MMCOR instructions were amended to explicitly to state: ***"NOTE: For Medicaid, FHP & HIV SNP all plan marketing activities ceased April 1, 2011. Plans should have no expenses reported for marketing after March 31, 2011."***

However, since the MMCOR quarterly report includes financial status of the entire MCO's book of business for a respective quarter, Table 22A was not deleted as marketing remains a reimbursable expense for Commercial and Medicare lines of business, which also are reflected in this table. During our review, the Department has confirmed that MCOs, in accordance with the above guideline, have not reported Marketing as an allowable expense for any of the Medicaid lines of business in any of the quarters subsequent to the effective date of the MRT #10 initiative and the publication of such guidelines.

OSC Comment #3:

Contrary to the Department's statement, the Medicaid MCO model contract does not state that outreach activities are reimbursable. Furthermore, the most recent MMCOR instructions (as of the 2nd quarter of 2016) explicitly state that outreach is not reimbursable.

We believe the Department can realize further savings to the Medicaid program if it comprehensively clarifies the differences between marketing, outreach, and facilitated enrollment expenses. By clarifying the differences, the Department can reduce the risk that MCOs improperly report (and receive rate reimbursements for) non-allowable expenses.

Response to Comment #3:

The Department will continue to revisit definitions within the Medicaid MCO Model Contract, as well as MMCOR instructions, and if necessary further clarify differences between marketing, outreach and facilitated enrollment. Furthermore, the Department concurs with the Office of the State Comptroller's (OSC) assertion that the Medicaid MCO model contract does not state that outreach activities are reimbursable, as evident by the explicit statement in the MMCOR instructions:

"Advertising and Outreach – *Costs associated with advertising and outreach for the Medicaid, Health and Recovery Plan & HIV SNP are* ***NOT*** *included in the capitation rate and therefore are considered non-allowable. If a plan elects to perform advertising and outreach activities, they should do so pursuant to the guidelines outlined in section 11 and Appendix D.1 of the Medicaid Managed Care and HIV SNP Model Contract. Costs associated with such advertising and marketing activities should be reported as non-allowable expenses."*

We changed this response from draft response, removing the following sentence: "In accordance with the Medicaid MCO Model Contract, MCOs are allowed to perform and be reimbursed for approved outreach activities," as it was misconstrued in our initial response. While MCOs are allowed to perform certain approved outreach activities specified in Appendix D.1, outreach and advertisement activities are considered non-allowable for the purposes of Medicaid reimbursement.

OSC Comment #4:

Department officials believe the $255,741 in audit findings related to Fidelis' inappropriate reporting of marketing expenses will not have a material impact on premium rates given the related amount of annual Medicaid expenditures. However, the Department needs to consider that other MCOs evidently reported marketing expenses as facilitated enrollment as well (as shown in Table 4), which would further impact (likely increase) premium rates.

Response to Comment #4:

The Department stands by its comments made in responses #4 and #5 of the draft report.

OSC Comment #5:

The Department's comment appears to be limited to only a small portion of our overall audit findings (i.e., the $255,741 in marketing expenses inappropriately reported as facilitated enrollment). However, as detailed in Table 5 on page 15 of our report, our audit identified more than $50 million in expenses that were inappropriately used to calculate premium rates – which, if appropriately addressed by the Department, would lead to a reduction in the administrative cap and an estimated $18.9 million in annual savings. These savings exceed the cost of Mercer's rate recertification. Furthermore, as stated on page 9 of our report, in its Executive Budget, the

Department estimated savings of up to $40 million in fiscal year 2016-17 alone based, in part, on a recalculation of the managed care premiums, as recommended by our audit.

Response to Comment #5:

The Department agreed that $49,767,094 of the $50 million in inappropriate expenses identified were related to plan franchise and MTA surcharges and as stated in the Department's comments to response #1 in the draft report that "The Department agrees that the rate setting methodology should ensure that franchise and MTA surcharges are not factored twice. The Department has subsequently updated its methodology to incorporate this change beginning in SFY 2015-16."

OSC Comment #6:

While we agree that not all of the services provided by Mercer are directly related to rate-setting according to the law, pertinent Department officials acknowledged during our audit fieldwork that a majority of the costs of Mercer's services could likely be assessed to the MCOs.

Response to Comment #6:

The Department stands by our Agency comment, in draft report response #6. Additionally, the Department has assessed the cost of the actuarial contract in plan premium development beginning in SFY 2016-17.

OSC Comment #7:

At the time of our audit fieldwork, the Department was not in compliance with the New York State Social Services Law, which required the Department to include MCOs in the selection of the actuary. The Department should either comply with this provision of the law or take actions to amend it, as appropriate.

Response to Comment #7:

The Department will comply with all applicable laws and regulations in the selection of the independent actuary. For clarification, the NYS Social Services Law states that "the Department will consult with organizations representing managed care providers." Currently, the Department meets monthly with MCOs and Association members to address concerns with premiums and premium development. These concerns are taken into consideration as part of the Department's selection of its actuary.