New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting

Medicaid Program
Department of Health

Report 2014-S-55 October 2016

Executive Summary

Purpose

To determine whether mainstream managed care organizations (MCOs) are submitting accurate administrative costs to the Department of Health (Department) and whether the Department is appropriately applying the administrative costs in determining mainstream managed care premium rates. Our audit covered the period January 1, 2011 through December 31, 2015.

Background

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2015, New York's Medicaid program had approximately 7.1 million enrollees and Medicaid claim costs totaled about $53 billion.

Most of the State's Medicaid recipients receive their services through Medicaid managed care. Under managed care, Medicaid pays MCOs a monthly premium payment for each enrolled Medicaid recipient and the MCOs arrange for the provision of services their members require. The State offers different types of Medicaid managed care, including mainstream managed care. Mainstream managed care provides comprehensive medical services including hospital care, physician services, dental services, pharmacy benefits, and many others. Of the $53 billion in Medicaid costs, MCOs received $17.8 billion in mainstream managed care premiums for nearly 5.2 million Medicaid enrollees.

The Department is responsible for setting the monthly managed care premium rates, which are based, in part, on allowable MCO administrative costs. For this purpose, the Department relies on financial data reported by MCOs on the Medicaid Managed Care Operating Reports (MMCORs). The Department issues MMCOR instructions to guide MCOs on how to report administrative expenses. Of the $17.8 billion in mainstream managed care premiums paid during the State fiscal year 2014-15, approximately $1.2 billion was for MCOs' administrative costs.

The Department is required by the federal Centers for Medicare & Medicaid Services to create actuarially sound rates. In October 2009, the Department contracted with Mercer Health and Benefits, LLC to provide actuarial services and premium rate-setting guidance. As of early 2015, the total value of the contract was $38.6 million. Under the New York State Social Services Law, the Department is required to assess certain costs of such actuarial services against all MCOs.

Key Findings

- The Department overpaid MCOs more than $18.9 million in mainstream managed care premiums for the State fiscal year 2014-15, and an additional $56.8 million is at risk of overpayment over the following three years. The overpayments occurred, in part, due to a flaw in the Department's rate-setting methodology. The Department incorrectly factored the cost of certain taxes levied against for-profit MCOs into the methodology, which resulted in higher premiums for all MCOs, including those MCOs that did not pay such taxes. We also determined one MCO improperly claimed certain administrative expenses on the MMCOR it submitted to the Department, which

also contributed to the overpayments.

- The Department provided insufficient and conflicting MMCOR reporting guidance that allowed MCOs to misreport non-allowable marketing expenses as allowable facilitated enrollment expenses, contrary to the intent of a policy change that was initiated from a Medicaid Redesign Team (MRT) proposal. As a result, the Department is not fully realizing the MRT's estimated $45 million in annual savings because marketing expenses are still reported by MCOs.
- The Department did not assess any of the $38.6 million in contracted actuarial costs against the MCOs, as required by law.

Key Recommendations

- Recalculate the administrative cost components of the mainstream managed care premiums based on our findings and apply them to the premiums paid for the State fiscal year 2014-15 and forward. Recover the corresponding overpayments from all mainstream MCOs based on the recalculated premiums.
- Modify the rate-setting methodology to ensure certain taxes are properly factored into the methodology.
- Determine the extent to which MCOs report non-allowable marketing expenses as facilitated enrollment, and assess whether the intended cost savings identified in the MRT proposal can be achieved given current MCO reporting practices.
- Assess the costs of the actuary contract against the MCOs, as appropriate.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Drug Rebate Program Under Managed Care (2014-S-41)
Department of Health: Improper Fee-for-Service Payments for Pharmacy Services Covered by Managed Care (2014-S-5)

State of New York
Office of the State Comptroller

Division of State Government Accountability

October 13, 2016

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

Table of Contents

State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.state.ny.us
Address:
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

Background

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Medicaid program is administered by the State Department of Health (Department). For the fiscal year ended March 31, 2015, New York's Medicaid program had approximately 7.1 million enrollees and Medicaid claim costs totaled about $53 billion. The federal government funded about 52.4 percent of New York's Medicaid claim costs; the State funded about 30.2 percent; and the localities (the City of New York and counties) funded the remaining 17.4 percent.

In January 2011, the New York State Governor's Office established the Medicaid Redesign Team to reduce Medicaid costs and improve the delivery of health services. One initiative of the Medicaid Redesign Team was to expand the enrollment of Medicaid recipients into managed care. Accordingly, most of the State's Medicaid recipients now receive their services through Medicaid managed care. Under managed care, Medicaid pays managed care organizations (MCOs) a monthly premium payment for each Medicaid recipient enrolled in the MCO. In turn, MCOs are responsible for ensuring enrollees have access to a comprehensive range of services. MCOs arrange for the provision of services their members require and reimburse providers for services provided to their enrollees.

The Department offers different types of Medicaid managed care coverage depending upon individual eligibility. Mainstream managed care provides comprehensive medical services ranging from hospital care and physician services to dental and pharmacy benefits. Other types of managed care, including managed long-term care, are specific to certain populations, such as those needing certain long-term care or those reaching specific ages.

For the fiscal year ended March 31, 2015, MCOs received $17.8 billion in monthly mainstream managed care premium payments for nearly 5.2 million Medicaid enrollees. Approximately $1.2 billion of the $17.8 billion was for the MCOs' administrative costs.

The Department sets the monthly premium rates for mainstream managed care. There are multiple components used to set the premium rates, including:

- the costs of core medical benefits;
- the costs of optional medical benefits; and
- administrative expenses.

In addition, premium rates are adjusted based on Department-identified geographic regions, medical trends, and patient acuity (the overall health of individual enrollees).

The Department is required by the federal Centers for Medicare & Medicaid Services (CMS) to create actuarially sound rates. To ensure the rates are actuarially sound, the Department has contracted with Mercer Health and Benefits, LLC (Mercer) to provide actuarial services and

premium rate-setting guidance since October 2009. Mercer develops rate ranges that it considers actuarially sound. The Department then compares its independently determined premium rates to those of Mercer's to ensure they are within Mercer's rate ranges.

Rate-Setting Methodology – Administrative Component

To calculate the administrative component of the mainstream managed care premiums, the Department relies on annual data reported by MCOs on the Medicaid Managed Care Operating Reports (MMCORs). These reports contain detailed financial information, including administrative costs. The Department issues MMCOR instructions to guide MCOs on how to report administrative expenses. MCOs report administration expenses by categories set forth by the Department, such as "rent," "salaries and fringe benefits," and "facilitated enrollment" (i.e., one-on-one enrollment assistance). MCOs also report administrative costs that are non-allowable, such as marketing and advertising. Non-allowable costs are not used to set premium rates.

In addition to administrative expenses, MMCORs contain MCO enrollment data. Enrollment data is reported as member months. The Department defines a member month as equivalent to one person for whom the MCO recognized premium revenue for one month. The MCOs' reported administrative costs and member months constitute the basis for the administrative component of the premium rate.

The Department uses two years of MMCOR data in order to establish premium rates by region. The two years of data are blended to help ensure the reasonableness of new rates. For instance, the April 1, 2014 - March 31, 2015 rates were calculated using 2011 and 2012 calendar year MMCOR data. In addition, in order to prevent excessive administrative costs from inflating the premium rate, the Department caps the MCOs' administrative costs that are used in the rate-setting process. As a result, the cap is a critical value in the rate-setting process and any changes to it will directly impact the amount paid to the MCOs. The administrative cap for the April 1, 2014 - March 31, 2015 rates was set using an average of the MCOs' 2012 allowable administrative costs.

Once the administrative cap is calculated, the Department follows a multipart methodology for calculating the base administrative component of the premium rate, as follows. Each MCO can operate mainstream managed care plans in multiple regions (see Exhibit A for the nine managed care regions). Therefore, MCOs are required to submit an MMCOR for each Department-identified region in which the MCO operates. MCOs that operate in more than one region must also submit a statewide MMCOR. Accordingly, MMCORs contain: (A) each MCO's total statewide administrative costs for their mainstream managed care plans; (B) each MCO's total number of statewide member months for their mainstream managed care plans; and (C) each MCO's number of member months per region for their mainstream managed care plans. For each region in which an MCO operates, a per-member per-month (PMPM) administrative cost is calculated, as shown in Table 1.

Table 1

Region 1	A	B	C	D = C / B	E = D * A	E / C
	Total Statewide Administrative Costs	Number of Statewide Member Months	Number of Regional Member Months	Regional Percent of Statewide Member Months	Regional Administrative Costs	Regional Per-Member Per-Month (PMPM) Cost
MCO 1	$465,000	15,000	5,000	33.3%	$155,000	$31.00
MCO 2	1,000,000	40,000	10,000	25%	250,000	25.00
MCO 3	1,200,000	50,000	15,000	30%	360,000	24.00

The Department then compares each MCO's regional PMPM administrative cost to an administrative cost cap. According to Department officials, from sometime in 2006 through March 31, 2014, the administrative cost cap was set at $25 PMPM, and administrative expenses beyond this were not included in the calculation of the mainstream managed care premium rates. Thereafter, for premium rates paid as of April 1, 2014, the Department increased the administrative cost cap to $29.80 PMPM.

As stated, administrative expenses beyond the cap are not included in the calculation of the premium rates. Therefore, if the MCO's regional PMPM administrative cost is above the cap, then that PMPM amount will be reduced to the cap, as shown in Table 2.

Table 2

Region 1	Regional PMPM	Capped (Y/N)	Adjusted PMPM
MCO 1	$31.00	Y*	$29.80
MCO 2	$25.00	N	$25.00
MCO 3	$24.00	N	$24.00

* MCO 1 is subject to an administrative cap of $29.80 PMPM

Among the last steps, the Department calculates the regional base administrative PMPM premium rate. To calculate this base premium rate, the Department applies the administrative cap in order to determine which MCO administrative costs to include in the base premium rate. If an MCO's regional PMPM administrative cost is at or below the cap, then the MCO's reported administrative costs will be used to calculate this base premium rate. If the MCO's regional PMPM administrative cost is above the cap, then the MCO's reported administrative costs will be adjusted (i.e., reduced). In the example, MCO 1's regional administrative costs (see Table 1, column E) are adjusted for the calculation of the base premium rate. Specifically, MCO 1's administrative costs that result in the PMPM cap of $29.80 being exceeded are not used in the calculation of the base premium rate (see Table 3, MCO 1).

Once the MCOs' regional administrative costs are adjusted, the regional base administrative PMPM premium rate is calculated as follows: the adjusted regional administrative costs for all

MCOs within a region are totaled and divided by the total member-months for all MCOs within the region, as shown in Table 3.

Table 3

Region 1	E	C	E / C	(a) / (b)
	Adjusted Regional Administrative Costs	Number of Regional Member Months	Adjusted Regional PMPM	Regional Base Administrative PMPM Premium Rate
MCO 1	$149,000 *	5,000	$29.80 *	
MCO 2	250,000	10,000	25.00	
MCO 3	360,000	15,000	24.00	
Regional Totals	**$759,000 (a)**	**30,000 (b)**		**$25.30**

* Adjusted Regional Administrative Costs

The flowchart in Exhibit B illustrates, overall, how costs and member-months are factored into the premium rate calculation.

Lastly, as part of the overall rate development process, the regional base administrative PMPM premium rate is combined with the regional medical component. The combined rate is then adjusted by MCO-specific factors, such as patient acuity (the overall health of individual enrollees), optional medical benefits, and other factors.

This report includes our examination of the 2012 administrative expenses submitted by the New York State Catholic Health Plan, Inc. (d/b/a Fidelis Care New York [Fidelis]). These expenses were used to calculate the 2014-15 base administrative premium rate. We selected Fidelis for review because it was one of the larger MCOs (based on enrollment), it operated in every managed care region, and its administrative costs were under the administrative cap.

Audit Findings and Recommendations

We determined the Department overpaid more than $18.9 million in premiums to mainstream MCOs in the State fiscal year 2014-15. Moreover, the Department could realize an additional $56.8 million in savings over the following three State fiscal years by using a lower administrative cost cap based on our audit findings. The improper payments were the result of two deficiencies. First, we determined the Department improperly included the cost of certain taxes levied against for-profit MCOs when calculating the administrative cost cap, thereby increasing the administrative cap, resulting in higher premiums for all MCOs. This included not-for-profit MCOs, which are not assessed these taxes. Second, we determined Fidelis reported over $260,000 in inappropriate administrative costs, which also impacted the administrative cost cap and increased the premiums paid to other MCOs.

We determined the Department provided insufficient and conflicting cost reporting guidance that allowed MCOs to misreport non-allowable marketing expenses as allowable facilitated enrollment expenses, contrary to the intent of a Medicaid Redesign Team (MRT) proposal and corresponding policy change to eliminate the reimbursement of marketing expenses to MCOs. As a result, the Department is not fully realizing the MRT's estimated $45 million in annual savings, because we found that marketing expenses are still being included in the premium rate calculations. We also determined the Department's MMCOR cost reporting instructions failed to provide clear and specific instructions for reporting certain other expenses, such as fines and penalties and certain legal expenses. As a result, expenses that would otherwise be unallowable could be reported and improperly factored into the Department's administrative cost cap calculations, inappropriately increasing the premium rates paid to MCOs.

In addition, the Department did not assess MCOs for any of the $38.6 million in Mercer actuarial services related to rate setting, as required by law.

In the Department's State fiscal year 2016-17 Executive Budget that outlined various managed care proposals, the Department estimated that by addressing the audit findings related to recalculating the mainstream managed care premiums and assessing the costs of the actuary contract to all MCOs, savings of up to $40 million in 2016-17 could be achieved.

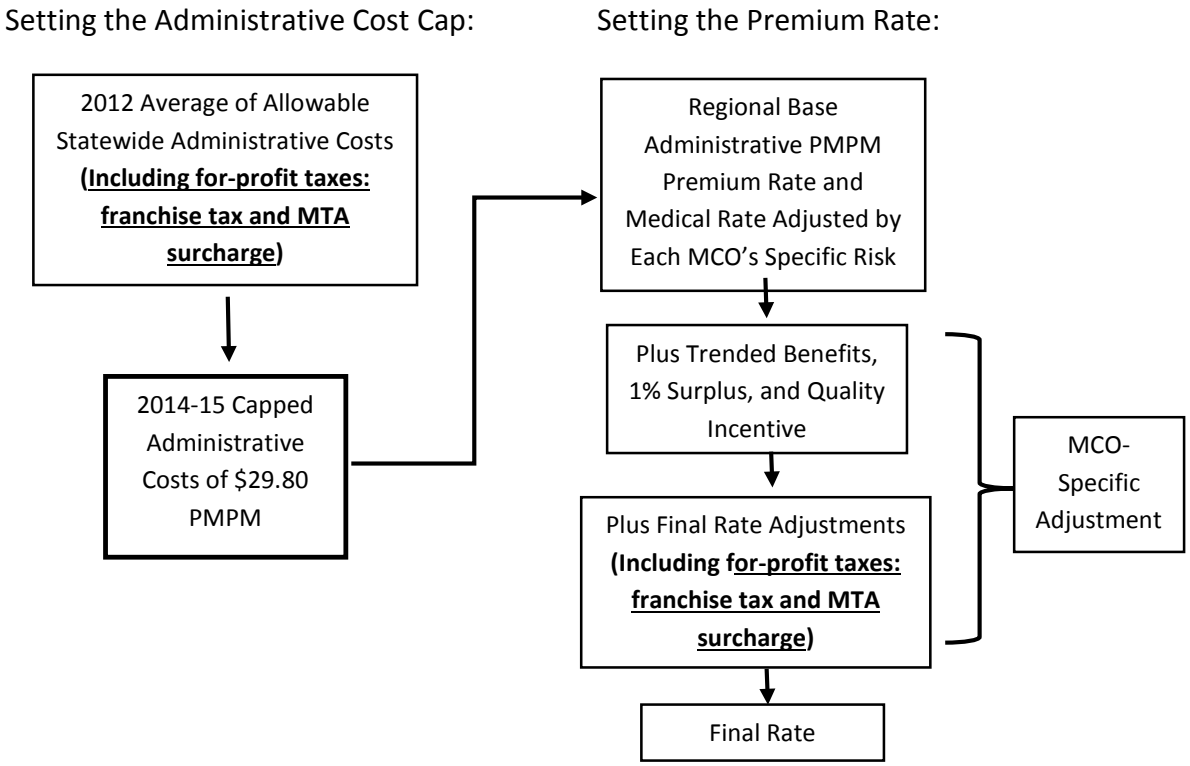
Inclusion of For-Profit Taxes in the Administrative Cost Cap Calculation

In calculating the premium rates, the Department includes certain New York State taxes that are levied on premiums paid to for-profit MCOs. The taxes include (1) a franchise tax imposed on insurance corporations and (2) the Metropolitan Transportation Business Tax (MTA surcharge), which is a tax imposed on certain employers engaging in business within the service area of the Metropolitan Transportation Authority.

However, as shown in Figure 1 (see underlined information), the Department includes these taxes twice when calculating premium rates. Specifically, the for-profit taxes are used in setting the administrative cost cap and again in determining MCO-specific adjustments, which are made after the regional base rate is established.

Figure 1

Rate-Setting Process: For-Profit Taxes



Further, because the taxes increase the administrative cost cap and the cap is used to calculate the premium rate for all MCOs, not-for-profit MCOs – which are exempt from these taxes – are reimbursed for taxes they have not paid. In 2012, three for-profit MCOs (Amerigroup, United HealthCare, and WellCare) reported these taxes, which totaled $49,767,094 for the year. We recalculated the administrative cost cap, excluding the for-profit taxes, and determined the cap would have been $28.49 PMPM ($1.31 lower than the $29.80 amount set by the Department). The lower administrative cost cap would affect premium rates established for the fiscal year 2014-15 and thereafter. (The impact of the lower cap – and the corresponding premium overpayments – is discussed in greater detail later in this report; see "Impact of Audit Determinations on Rates.")

Department officials informed us they intend to update the methodology to address the inclusion of for-profit taxes in the calculation of the administrative cost cap. However, until the Department takes steps to address this flaw in its methodology, the Department will continue to be at risk of factoring the for-profit taxes twice.

Recommendation

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

Review of Fidelis' MMCOR Administrative Costs

To determine whether Fidelis appropriately reported administrative costs, we reviewed the allowable administrative costs that Fidelis reported on its 2012 MMCOR. We selected a judgmental sample of non-compensatory (i.e., other than personal service) expenses based on dollar amount and the nature of the expense. Specifically, we selected certain higher-dollar expenses and expenses that were considered higher risk, such as marketing and entertainment. Also, expenses such as marketing were eligible for reimbursement at the outset of our audit period, but became a non-allowable expense on April 1, 2011. The sampled expenses totaled $2,609,680 (of which $2,108,118 was allocated to the Medicaid program). Also, $1.8 million of the $2.6 million accounted for one expense (loss adjustment expense).

From the sample review, we determined Fidelis inappropriately reported $71,678 in non-allowable expenses ($60,072 of this was allocated to the Medicaid program) that included:

- $55,269 in expenses ($46,528 Medicaid) that were determined to be marketing expenses (e.g., food, face painting, and other amusements at community events);
- $9,882 in expenses ($8,319 Medicaid) that were partially related to marketing; however, based on the information available to us, we could not readily determine the exact non-allowable amount and, therefore, we excluded these findings from our recalculation of the rate; and
- $6,527 in miscellaneous expenses ($5,225 Medicaid), including a retirement dinner for a Fidelis board member and a late payment fee.

Furthermore, based on the results of the sample review, we identified a total of $303,787 ($255,741 allocated to Medicaid) in non-allowable marketing expenses, as follows. We determined the vendors who were paid the $55,269 in expenses from the sample review only provided goods and services that would be considered marketing. As such, we considered all the expenses reported for these vendors, which totaled $303,787, to be marketing expenses and thus non-allowable. (note: the $55,269 is included in the $303,787). The impact of the $260,966 ($5,225 + $255,741) in non-allowable costs on the rates – and the corresponding premium overpayments – is discussed in greater detail later in this report; see "Impact of Audit Determinations on Rates."

On the 2012 MMCOR, Fidelis reported the $303,787 as allowable facilitated enrollment expenses (i.e., one-on-one enrollment assistance). In response to our findings, Fidelis officials contended they followed the MMCOR instructions and the Department's guidance, and believe they appropriately reported these expenses under facilitated enrollment because, according to officials, the expenses were incurred during the facilitated enrollment process. However, according to the MMCOR instructions, facilitated enrollment involves unbiased activities conducted solely for the purpose of assisting individuals in the enrollment process. Types of facilitated enrollment expenses include costs of enrollment personnel to assist in completing Medicaid applications, conducting interviews, and collecting appropriate documentation. As discussed below, however, expenses designed to increase the visibility of an MCO's brand do not fit this definition, and are more appropriately categorized as marketing.

Marketing Versus Facilitated Enrollment Expenses

In an effort to limit Medicaid spending while improving quality of care, the MRT, which was created in January 2011 under Executive Order 5, proposed several Medicaid reforms. One such reform, implemented by the Department in 2011, was designed to "eliminate direct marketing of Medicaid recipients by managed care plans" and thus exclude marketing expenses from the premium rate calculation process.

The proposal was projected to realize $45 million a year in Medicaid savings, based on 2010 MCO-reported marketing expenses. The proposal sought to eliminate the reimbursement of marketing expenses to MCOs on the grounds that: (1) Medicaid recipients not enrolled in MCOs were generally exempt or excluded from managed care coverage; and (2) the enrollment process had been streamlined and additional enrollment assistance was being provided by other means (e.g., enrollment centers). The MRT's proposal aligns with the MMCOR definition of marketing, which remained the same throughout our audit period, and is as follows:

> *Marketing – Refers to those personnel related functions which are designed to persuade individuals to become enrolled in the plan. This may entail selling the plan to prospective individuals using direct sales or brokers. The marketing function is responsible for designing advertising campaigns to increase a plan's visibility. It may also include communications with enrollees through newsletters or special mailings.*

As of April 2011, MCOs were no longer allowed to report marketing expenses as an allowable expense on the MMCORs. Furthermore, the Department updated the MMCOR instructions to explain that MCOs should not have engaged in any marketing activities and, therefore, would have no marketing expenses to report after March 31, 2011.

Despite the new requirements, we concluded the MCOs continued engaging in activities that were essentially identical to non-allowable marketing activities and reported them, instead, as facilitated enrollment, which is an allowable expense. This is apparent in the amount of marketing and facilitated enrollment expenses reported by Fidelis and other MCOs in 2010 versus later years. In 2010, Fidelis reported $6 million in marketing and $15.7 million in facilitated enrollment expenses, for a combined total of $21.7 million. In 2011 and 2012, Fidelis reported $0 in marketing expenses for both years, but facilitated enrollment expenses of $20.7 million and $22.2 million for 2011 and 2012, respectively.

We found that other MCOs followed this same pattern, as illustrated in Table 4.

Table 4

Selected MCOs and Reported Marketing and Facilitated Enrollment Expenses

Year	MCO	Total Facilitated Enrollment	Total Marketing	Total Facilitated Enrollment and Marketing
2010	New York State Catholic Health Plan, Inc. (Fidelis)	$15,697,658	$6,007,318	$21,704,976
2011		20,671,311		20,671,311
2012		22,181,670		22,181,670
2010	MCO 2	11,556,506	2,061,042	13,617,548
2011		11,936,023	2,227,380	14,163,403
2012		15,336,701		15,336,701
2010	MCO 3	8,084,502	1,967,703	10,052,205
2011		6,988,634	4,615,781	11,604,415
2012		10,209,248		10,209,248
2010	MCO 4	6,815,780	1,921,279	8,737,059
2011		6,642,100	1,872,320	8,514,420
2012		8,870,576		8,870,576
2010	MCO 5	2,792,866	1,658,659	4,451,525
2011		4,709,455	1,631,751	6,341,206
2012		5,601,730		5,601,730
2010	MCO 6	335,039	287,734	622,773
2011		343,808	295,709	639,517
2012		517,408		517,408

According to Fidelis officials, they contacted the Department for guidance, and were instructed to report marketing expenses associated with facilitated enrollment under facilitated enrollment, an allowable expense. However, this guidance is clearly contrary to the intent of the MRT proposal.

In response to our findings, Department officials contend that expenses such as face painting entertainers and MCO-branded materials qualify as outreach and are not marketing. However, upon our review of the Department's August 2011 amended MCO model contract along with the preceding model contract (which set forth the Department's requirements and expectations of MCOs), we found that the terms "outreach" and "marketing" were used interchangeably to describe the same type of activity. For instance, the amended contract replaced references to the term "marketing" with the term "outreach." To illustrate, the title of Appendix D changed from "Marketing Guidelines" to "MCO Outreach/Advertising Activities" and Section 11 of the contract was renamed from "Marketing" to "Outreach/Advertising."

In another example, in Appendix D, "marketing" activities that were prohibited under the March 2011 model contract (i.e., solicitations in emergency rooms, cold calling, and engaging enrollees of other MCOs) were also listed as prohibited "outreach" activities under the August 2011 amended

contract. Also, our review of the August 2011 amended contract concluded that the contract did not draw a distinction between marketing and outreach. Further, the Department's updated MMCOR instructions did not provide direction on how to report "outreach."

We, therefore, disagree with the Department's assessment that certain expenses qualify as outreach rather than marketing because: (1) these types of expenses fall within the MMCOR's definition of marketing; (2) the MCO model contract uses the terms interchangeably to describe the same type of activity; (3) neither the MCO model contract nor the MMCOR instructions offer any distinction between marketing and outreach; and (4) outreach is not defined or even mentioned in the MMCOR instructions.

Officials explained that their goal was to limit certain types of aggressive marketing activities; however, we note that those activities were already prohibited in earlier MCO contracts. Moreover, the Department cannot achieve the estimated $45 million a year in savings from the MRT proposal if it continues to allow MCOs to report marketing expenses under facilitated enrollment and if it does not differentiate between marketing and outreach and define what outreach, if any, is reimbursable.

We found that the amended contract language and lack of MMCOR instructions created an opportunity for MCOs to continue to report non-allowable marketing activities as allowable facilitated enrollment. Therefore, the Department should review current MCO reporting practices and provide appropriate guidance to the MCOs to ensure they are accurately reporting activities and that the anticipated MRT savings are achieved.

MMCOR Guidance on Other Types of Expenses

The MMCOR is similar to other types of cost reports that service providers submit to government agencies. Given the complex nature of these types of cost reporting forms, administering agencies need to provide clear, comprehensive instructions to assist providers in completing such reports completely and accurately. Notable examples include the New York State Education Department's Reimbursable Cost Manual (RCM) to help education providers identify which costs are reimbursable; the Federal Acquisition Regulations (FAR) for use by federal agencies in purchasing goods and services with appropriated funds; and CMS' Provider Reimbursement Manual (PRM), which is used by Medicare MCOs to report their expenses.

We reviewed the MMCOR instructions for reporting administrative expenses and found that they are not as specific, clear, or complete as similar cost reporting instructions regarding certain categories of expenses. For example, in addition to the ambiguities and conflicting instructions regarding marketing expenses previously discussed, the MMCOR does not provide clear guidance regarding late fee payments, whereas the RCM, FAR, and PRM specify that these are non-allowable expenses. Lacking any instruction, Fidelis reported a late payment fee of $1,102 as an allowable expense. Department officials agree that late fees are non-allowable and that the MMCOR instructions do not include clear guidance.

Similarly, the MMCOR instructions regarding the reporting of legal expenses provide a much

broader definition of allowable expenses than similar reporting instructions, potentially allowing MCOs sufficient latitude to improperly report legal expenses incurred for the defense of questionable practices. Without clear and adequate cost reporting instructions, MCOs are more likely to include unallowable expenses, which can inappropriately increase premium rates paid to the MCOs and costs to taxpayers.

Impact of Audit Determinations on Rates

The first step in estimating the impact of the audit findings is to recalculate the administrative cost cap. The Department set the administrative cap for fiscal year 2014-15 and beyond at $29.80. The calculation of the cap was based on all MCOs' calendar year 2012 allowable administrative expenses on a PMPM basis (see Table 5). However, based on the disallowed expenses we identified, we recalculated the administrative cap and determined it should be $28.48, as shown in Table 5, as follows.

Table 5

Recalculation of 2012 Total Allowable Administrative Expenses and the Administrative Cost Cap

	Statewide Allowable Administrative Expenses	Statewide Member Months	Average Statewide Allowable Administrative Expenses (PMPM)
Department of Health Calculation			
Administrative Cost Cap	$1,130,760,516	37,947,991	$29.80
Office of the State Comptroller Calculation			
Fidelis: Miscellaneous Expenses	($5,225)	N/A	N/A
Fidelis: Marketing Expenses Reported as Facilitated Enrollment	(255,741)	N/A	N/A
Fidelis Subtotal	(260,966)		
Franchise Tax/MTA Surcharge	(49,767,094)	N/A	N/A
Total Audit Adjustments	(50,028,060)	N/A	N/A
New Administrative Cost Cap Based on Audit Adjustments	**$1,080,732,456**	**37,947,991**	**$28.48**

In addition, as discussed previously and shown in Table 5, we identified $260,966 ($5,225 + $255,741) that was inappropriately reported by Fidelis. These amounts were factored into the regional administrative cost components of the State fiscal year 2014-15 premium rates. Therefore, the $260,966 in audit findings impact both the administrative cost cap and the regional base administrative rate. Since Fidelis operated in every region in New York and had administrative costs that were below the cap, the rate adjustments resulting from our review of Fidelis' expenses would impact every monthly premium payment made to each mainstream MCO.

We estimated that, in State fiscal year 2014-15, the Department overpaid more than $18.9 million based on our recalculated administrative cap of $28.48 PMPM, as summarized in Table 6.

Table 6

Change in Regional Administrative Costs on a PMPM Basis per Audit Adjustments

Region	OSC Recalculated Base PMPM	Department Calculated Base PMPM	Difference	Number of Premium Payments (SFY '14-15)	Monetary Impact
Central	$23.83	$24.11	$0.28	1,823,645	$510,621
Finger Lakes	24.23	24.53	0.30	1,848,365	554,510
Long Island	25.58	26.10	0.52	4,010,592	2,085,508
Mid-Hudson	24.22	24.50	0.28	1,620,697	453,795
Northeast	24.88	25.67	0.79	1,731,140	1,367,601
Northern Metro	23.31	23.42	0.11	2,378,680	261,655
NYC Metro	24.81	25.20	0.39	28,727,347	11,203,665
Utica-Adirondack	21.93	22.19	0.26	1,624,246	422,304
Western	24.95	25.48	0.53	3,953,105	2,095,146
Total				**47,717,817**	**$18,954,805**

In addition, since the overpayment would exist for every year the $29.80 administrative cap is used, we estimate the Department would save about $56.8 million over three State fiscal years (2015-16, 2016-17, and 2017-18) by using the lower cap. However, every year there are expected changes in: the number of enrolled individuals, the costs of administrative and medical services, and policy that could increase or decrease the estimated savings. Consequently, the Department should recalculate all Medicaid mainstream managed care premium rates for the State fiscal year 2014-15 and forward based on the findings identified in Table 5.

Factors in Recalculating the Rate

Any recalculation of the premium rate based on the findings identified in this report needs to consider the federal requirement that the State create an actuarially sound rate. While the Department and Mercer independently calculate rates and rate ranges, each determine part of the administrative component based on the costs reported by the MCOs on the MMCORs. Because some of our findings identified administrative amounts that should not have been reported as allowable, both entities would need to incorporate the disallowed amounts into their premium rate recalculation process.

Officials from the Department and Mercer disclosed factors that may impact their ability to adjust the rates based on our findings (e.g., CMS' determination of what constitutes a covered benefit or administrative expense). We acknowledge the requirement that premiums be actuarially

sound and that the implementation of our recommendations must be considered within this requirement.

Recommendations

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.

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

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.

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

Assessing Actuarial Costs Against MCOs

Since October 2009, the Department has contracted with Mercer to provide actuarial services and guidance in setting all managed care premium rates. As of January 2015, the total cost of the contract was $38.6 million. Under New York State Social Services Law, Section 364-j, the Department is required to assess the cost of such actuarial services against all MCOs. The Department must also allow the MCOs to be involved in the selection of the actuary.

We determined the Department did not assess any of the costs of Mercer's services against the MCOs. The Department also did not include any MCOs in the vendor selection process. According to Department officials, they were unaware of the law that required this. In reviewing the law, Department officials believe a majority of the costs of Mercer's services could be assessed against the MCOs. Officials also contend that the MCOs may be able to include the assessed actuarial costs as allowable administrative costs on the MMCORs. In this case, these costs would impact the premium rates, offsetting related costs assessed against the MCOs for Mercer's services. The Department should examine this issue and ensure that the costs of actuarial services are appropriately assessed against the MCOs, as warranted.

Recommendations

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

7. Include MCOs in the future selection of the actuary.

Audit Scope and Methodology

The objectives of our audit were to determine whether mainstream MCOs are submitting accurate administrative costs to the Department and whether the Department is appropriately applying the administrative costs in determining MCO premium rates. Our audit covered the period January 1, 2011 through December 31, 2015.

To accomplish our objectives and assess internal controls, we interviewed Department officials to gain an understanding of the premium rate-setting methodology; analyzed MMCORs submitted by MCOs; interviewed Mercer officials as well as Fidelis officials; and reviewed expenses reported by Fidelis on its 2012 MMCOR. We used the 2012 MMCOR as the basis for our review because the administrative costs reported in 2012 were used to establish the new administrative cap and 2012 was one of the two years of cost data used to determine the premium rates for the State fiscal year 2014-15. We reviewed applicable sections of federal and State laws and regulations, and examined the Department's Medicaid payment policies and procedures.

We conducted our 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials generally concurred with most of the audit recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the

report's State Comptroller's Comments.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Contributors to This Report

Andrea Inman, Audit Director
Dennis Buckley, Audit Manager
Salvatore D'Amato, Audit Supervisor
David Schaeffer, Examiner-in-Charge
Amy Tedesco, Senior Examiner
Roberto DiLeo, Staff Examiner
Velvet Pierre, Staff Examiner
Mary McCoy, Senior Editor

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.state.ny.us

Brian Mason, Assistant Comptroller
518-473-0334, bmason@osc.state.ny.us

Vision

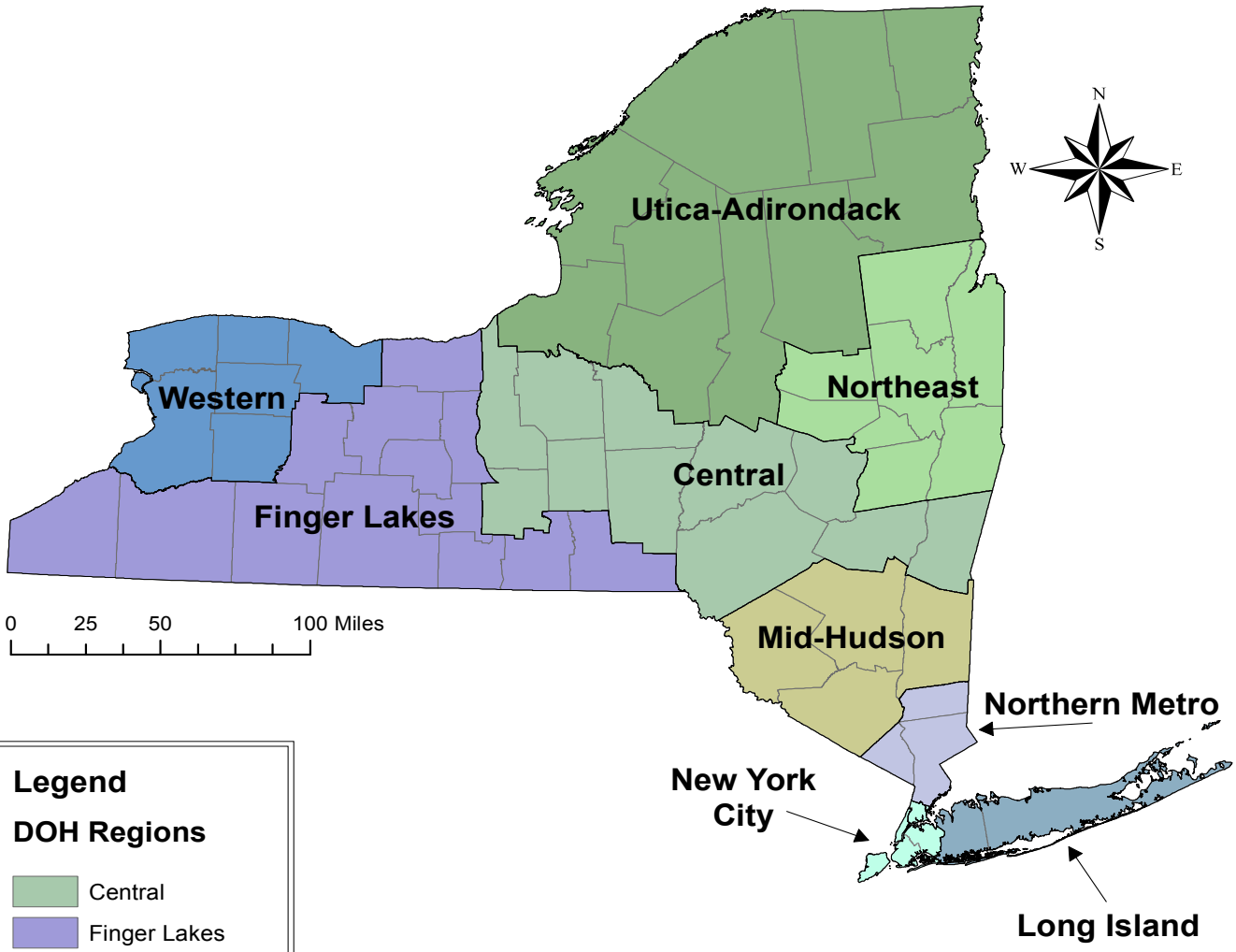
A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Exhibit A

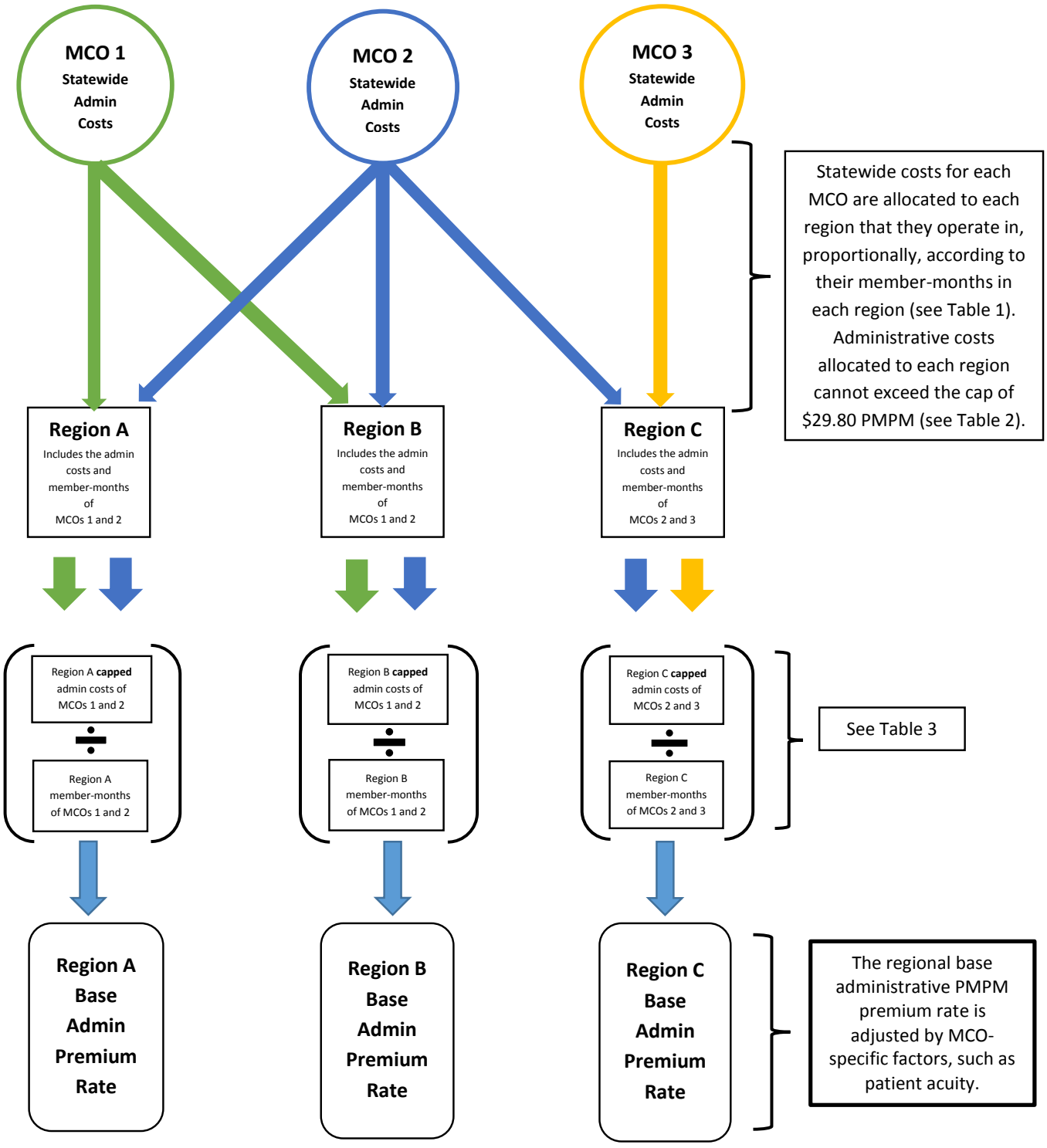
New York State Department of Health Managed Care Regions



Source: New York State Department of Health (DOH) region data provided by the New York State DOH. Spatial data obtained from the New York State Geographic Information System Clearinghouse.

Exhibit B

Illustration of the Regional Capped Administrative PMPM Cost Methodology



Agency Comments

NEW YORK STATE OF OPPORTUNITY. | Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 18, 2016

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2014-S-55 entitled, "Mainstream Managed Care Organizations Administrative Costs Used in Premium Rate Settings."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Jason A. Helgerson
Dennis Rosen
James Dematteo
James Cataldo
Ronald Farrell
Brian Kiernan
JoAnn Veith
Elizabeth Misa
Ralph Bielefeldt
Geza Hrazdina
Jeffrey Hammond
Diane Christensen
Lori Conway
OHIP Audit SM

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

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

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

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 1,405,500 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $7,868 in 2014, 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 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

* Comment 1

*See State Comptroller's Comments, Page 28.

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.

* Comment 2

MEDICAID MANAGED CARE **All Plans**

Marketing, Advertising & Facilitated Enrollment (FE)

YEAR	MEMBER MONTHS		TOTAL DOLLARS
2010	32,914,425	$	138,361,964
2011	34,959,311	$	113,995,100
2012	37,955,113	$	105,059,033

YEAR	MMs		PER MEMBER PER MONTH
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. In accordance with the Medicaid Managed Care Model Contract, MCOs are allowed to perform and be reimbursed for approved outreach activities. 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.

* Comment 3

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

The MMCOR instructions provide adequate guidance on the specific topics of marketing and facilitated enrollment administrative expenses. As the Department stated in its preliminary response, the MMCOR instructions are 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 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

* Comment 4

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 OSC 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 of the Budget.

* Comment 5

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 is less than the best estimate assumptions used for the development of the administrative component of rate ranges. This reduction is the result of the Department's incorporation of administrative caps in its administrative component build up.

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.

* Comment 6

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.

* Comment 7

[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.

State Comptroller's Comments

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).

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.

   Note: In the first table of the Department's response, the Department erroneously reported the total dollars for "Marketing, Advertising & Facilitated Enrollment (FE)" for the year 2011. Further, Department staff acknowledged the error to us, and the correct amount should be $127,269,132 (and not $113,995,100).

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.

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.

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.

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.

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.