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December 27, 2018

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

Re: Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting
Report 2018-F-10

Dear Dr. Zucker:

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, we have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting* (Report 2014-S-55).

Background, Scope, and Objective

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of health care services to individuals who are economically disadvantaged and/or have special health care needs. Most of the State's Medicaid recipients receive their services through Medicaid managed care. Under managed care, the Department pays managed care organizations (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, which provides comprehensive medical services such as hospital care, physician services, dental services, and pharmacy benefits.

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 $20.9 billion in mainstream managed care premiums paid during the State fiscal

year 2017-18, approximately $1.4 billion was for MCOs' administrative costs.

We issued our initial audit report on October 13, 2016. The audit objective was to determine whether mainstream MCOs were submitting accurate administrative costs to the Department and whether the Department was appropriately applying the administrative costs in determining mainstream managed care premium rates. Our audit covered the period January 1, 2011 through December 31, 2015.

We determined the Department overpaid MCOs more than $18.9 million in mainstream managed care premiums for the State fiscal year 2014-15 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 monthly premiums for all MCOs, including those MCOs that did not pay such taxes. We also determined the Department provided insufficient and conflicting MMCOR cost 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. Lastly, the Department did not assess any contracted actuarial costs against the MCOs, as required by law.

We recommended that the Department modify the rate-setting methodology to ensure certain taxes are properly factored into the methodology; recalculate the administrative cost components of the mainstream managed care premiums based on our findings; recover the corresponding overpayments from all mainstream MCOs based on the recalculated premiums; determine the extent to which MCOs report non-allowable marketing expenses as facilitated enrollment; and assess the costs of the actuary contract against the MCOs.

The objective of our follow-up was to assess the extent of implementation, as of November 20, 2018, of the seven recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made some progress in addressing the problems we identified in the initial audit report; however, additional actions are needed. Beginning with the State fiscal year 2015-16 premium rates, the Department updated the managed care rate-setting methodology to correct flaws we identified related to certain taxes included in the calculation of the administrative component of the managed care premium. However, the Department did not recalculate premium rates for State fiscal year 2014-15 to remove such taxes; as a result, the Department has not recovered any overpayments for that year. Additionally, although the Department revised MMCOR instructions regarding marketing and facilitated enrollment expenses, we found that these changes were inadequate and, furthermore, there were no changes to instructions on reporting legal fees and fines. However, we found the Department has assessed contracted actuarial costs to MCOs as required.

Of the initial report's seven audit recommendations, three were implemented and four were partially implemented.

Follow-Up Observations

Recommendation 1

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

Status – Implemented

Agency Action – When calculating the managed care premium rates, the Department includes certain State taxes that are levied on premiums paid to for-profit MCOs. These taxes include a franchise tax imposed on insurance corporations and the Metropolitan Transportation Business Tax (MTA surcharge), which is a tax imposed on certain employers conducting business within the service area of the Metropolitan Transportation Authority. Our initial audit determined the Department incorrectly included these taxes twice when calculating premium rates. Specifically, the for-profit taxes were used in setting the administrative cost cap and again in determining MCO-specific adjustments. Further, because the taxes increased the administrative cost cap, and the cap was used to calculate the premium rate for all MCOs, not-for-profit MCOs – which are exempt from these taxes – were reimbursed for taxes they had not paid.

Department officials stated that, effective State fiscal year 2015-16, the rate methodology was updated to remove franchise taxes and MTA surcharges from the administrative component of the premium calculation. In addition, new taxes levied after the initial audit, such as the Affordable Care Act tax, were excluded.

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.

Status – Partially Implemented

Agency Action – The MRT was created in 2011 to lower health care costs and improve quality of care for Medicaid members. As a result of one MRT proposal, effective April 2011, MCOs were no longer allowed to report marketing expenses on their MMCORs. This policy change was estimated to save $45 million annually. Our initial audit concluded that 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. For example, we tested expenses reported by Fidelis Care New York (Fidelis) on its 2012 MMCOR and found $255,741 in non-allowable marketing expenses reported as facilitated enrollment.

During our follow-up, Department officials stated they believe the MRT-related policy change was successful in achieving desired cost savings. As evidence, they point to the decrease in facilitated enrollment cost on a per-member per-month (PMPM) basis. For example, they showed that Fidelis' facilitated enrollment, on a PMPM basis, decreased from $4.10 in 2010 to $2.46 in 2016. However, based on data we reviewed, we believe the PMPM decrease was due to an increase in member months, and that facilitated enrollment expenses increased at an overall lower rate. Furthermore, the Department was unable to demonstrate that it tested specific MCOs' expenses (including Fidelis') to determine if marketing was reported as facilitated enrollment. According to Office of the Medicaid Inspector General officials, MMCOR audits that are in progress include steps to identify non-allowable administrative costs reported as facilitated enrollment. However, at the time of our follow-up review, no MMCOR audits were completed.

Recommendation 3

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

Status – Partially Implemented

Agency Action – Our initial audit found that the Department's MMCOR instructions were inadequate and likely contributed to MCOs reporting non-allowable marketing activities as allowable facilitated enrollment expenses. We also found the Department needed to update MMCOR instructions regarding late fee payments and legal fees to prevent MCOs from reporting inappropriate expenses.

During our follow-up review, we compared the 2012, 2016, 2017, and 2018 MMCOR instructions to determine if the Department made revisions to address the issues we identified in the initial audit. Although we found no updates were made to sections addressing fines and legal costs, the Department did revise instructions regarding marketing and facilitated enrollment expenses. However, we believe these revisions were inadequate and, unless additional updates are made, MCOs will continue to report non-allowable expenses on their MMCORs, which can lead to higher premium rates and costs to taxpayers.

According to Department officials, they are unsure how to further revise the MMCOR instructions for clarity. However, in the initial audit, we provided examples of other cost reporting forms that could be used as guidance, such as the State Education Department's Reimbursable Cost Manual, the Federal Acquisition Regulations, and the Centers for Medicare & Medicaid Services' (CMS) Provider Reimbursement Manual. We encourage the Department to consider additional updates to the MMCOR instructions.

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.

Status – Partially Implemented

Agency Action – Our initial audit found that the Department improperly included for-profit taxes (the franchise tax imposed on insurance corporations and the MTA surcharge) twice when calculating premium rates. In addition, we found that MCOs had been reporting non-allowable marketing expenses as allowable facilitated enrollment expenses. Because the administrative cost cap is derived from reported allowable expenses, excessive expenses increase the administrative cost cap. Omitting these non-allowable expenses, we calculated the administrative cost cap to be lower than the $29.80 PMPM value determined by the Department during State fiscal year 2014-15.

Department officials stated that, starting with the State fiscal year 2015-16 premiums, the administrative cost cap has been recalculated based on the updated rate-setting methodology described in the Agency Action section of Recommendation 1. However, the Department did not recalculate the administrative cost cap or the base administrative premium rate for State fiscal year 2014-15 premiums.

Recommendation 5

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

Status – Partially Implemented

Agency Action – The Department used a $29.80 PMPM administrative cost cap when calculating managed care premium reimbursements for State fiscal year 2014-15 and beyond. However, based on the non-allowable expenses we identified in our initial audit, we calculated a revised administrative cost cap of $28.48. Using the revised cap, we estimated the Department would overpay MCOs by approximately $56.8 million over the three State fiscal years 2015-16, 2016-17, and 2017-18. We also found that Fidelis reported $261,000 in inappropriate administrative costs, which also impacted the administrative cost cap and increased the premiums paid to the other MCOs.

Although the MCO Model Contract allows the Department to recover overpayments due to MMCOR misstatements, Department officials stated they will not recalculate the rate for recovery purposes as this would interfere with rates already approved by CMS. As such, and as specified previously in the Agency Action section of Recommendation 4, the Department did not recalculate the administrative cap or premium rate for State fiscal year 2014-15 premiums. As a result, the Department has not recovered any overpayments that were due to MMCOR misstatements for State fiscal year 2014-15 rates since our initial audit.

According to Department officials, effective April 1, 2016, the Department reduces

mainstream managed care premiums by approximately $20 million annually to recover overpayments resulting from fraud, waste, and abuse identified by prior external and internal audits. However, the Department was unable to demonstrate how the $20 million was calculated or how the premium overpayments we identified from State fiscal year 2014-15 impacted this amount.

Recommendation 6

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

Status – Implemented

Agency Action – Our initial audit determined the Department contracted with Mercer Health and Benefits, LLC (Mercer) to provide actuarial services and guidance in setting all managed care premium rates. However, we determined the Department did not assess the Mercer contract cost against MCOs, as required by the Social Services Law.

After our initial audit, the Department assessed the cost of the Mercer contract against all MCOs. In addition, in March 2017, the Department contracted with Deloitte Consulting LLP (Deloitte) for actuarial services. According to Department officials, the full cost of the Deloitte contract will be assessed against MCOs over the five-year contract period.

Recommendation 7

Include MCOs in the future selection of the actuary.

Status – Implemented

Agency Action – Our initial audit found the Department did not involve MCOs in the actuary selection as required by Social Services Law Section 364-j. According to Department officials, they were unaware of this requirement.

During our follow-up review, we determined the Department engaged with the Coalition of New York State Public Health Plans and the New York Health Plan Association to discuss areas that impact managed care plan premium rates. These organizations present areas of concern regarding rate setting to the Department on behalf of MCOs. Department officials also stated they meet directly with MCOs to discuss various topics, including rate concerns, and consider these concerns when selecting the actuary.

Major contributors to this report were David Schaeffer, Jasbinder Singh, and Laura Singh.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Christopher Morris
Audit Manager

cc: Mr. Daniel Duffy, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General