NEW YORK STATE OF OPPORTUNITY. Department of Health

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Executive Deputy Commissioner

January 22, 2019

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

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report 2018-F-10 entitled, "Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting" (Report 2014-S-55).

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2018-F-10 entitled, Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting (Report 2014-S-55)

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Follow-Up Audit Report 2018-F-10 entitled, "Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting (Report 2014-S-55)."

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.

Response #1:

The Department confirms agreement with this report.

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.

Response #2:

The OSC states the following: "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".

The Department disagrees with the OSC statements. The Department has determined the savings associated with the initiative MRT#10 to eliminate direct marketing of Medicaid recipients by Medicaid Managed Care Plans were achieved as shown below (see table). Furthermore, the Medicaid Managed Care Cost Reports were updated accordingly to make marketing a non-allowable expense and corresponding cells were closed in the report tables.

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.

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 nonallowable 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.

Response #3:

The Department disagrees with the OSC statements. The Department made changes to the Medicaid Managed Care Operating Report (MMCOR) specifying that fee payment and legal fees are to be reported as non-allowable expenses. The Department continues to make changes to the MMCOR instructions as necessary with inclusion of each new benefit and/or population.

During this audit, the Department reviewed the suggested cost reporting forms and found that they were not applicable and/or adaptable to reporting Medicaid Managed Care operating results. In addition, the Department does reference the Federal Acquisition Regulations in 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 nonallowable 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.

Response #4:

The Department agrees that the State Fiscal Year (SFY) 2014-15 administrative cost cap and premiums from SFY 2015-16, 2016-17, and 2017-18 were not recalculated, however, the Department achieved recoveries related to the overpayments in these years through a premium reduction targeted at fraud, waste, and abuse in the Managed Care system. From SFY 2016-17 through SFY 2018-19 across all Managed Care lines of business, the value of these recoveries totaled $130 million and is based on a one-time and an annual estimate of various internal and external audit findings including OSC 2014-S-55, on which OSC 2018-F-10 is based. Furthermore, the Department will continue to reduce Managed Care premiums by $40 million prospectively to account for internal and external audit findings such as these.

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.

Response #5:

The Department agrees that the State Fiscal Year (SFY) 2014-15 administrative cost cap and premiums from SFY 2015-16, 2016-17, and 2017-18 were not recalculated, however the Department achieved recoveries related to the overpayments in these years through a premium reduction targeted at fraud, waste, and abuse in the Managed Care system. From SFY 2016-17 through SFY 2018-19 across all Managed Care lines of business, the value of these recoveries totaled $130 million and is based on a one-time and an annual estimate of various internal and external audit findings including OSC 2014-S-55, on which OSC 2018-F-10 is based. Furthermore, the Department will continue to reduce Managed Care premiums by $40 million prospectively to account for internal and external audit findings such as these.

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.

Response #6:

The Department confirms agreement with this report.

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.

Response #7:

The Department confirms agreement with this report.