

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



**Daniel R. Levinson
Inspector General**

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EXECUTIVE SUMMARY

The Medicaid program could have saved approximately \$38.5 million during 2012 if New York had required its contracted Medicaid managed care organizations to meet medical loss ratio standards similar to those established by the Affordable Care Act.

WHY WE DID THIS REVIEW

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

Although the MLR standards do not apply to Medicaid spending, some States have applied similar standards to their contracts with Medicaid managed care organizations (MCOs) and require the MCOs to issue rebates to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards. The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program. While New York had policies in place limiting the amount plans can charge for administrative costs, New York's Medicaid managed care plan contracts do not contain such standards.

The objective of this review was to determine potential Medicaid program savings if the New York State Department of Health (State agency) required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA.

BACKGROUND

The ACA, as amended, established standards for certain commercial health insurers and Medicare Advantage plans to meet minimum MLR standards and provide rebates to enrollees or the Department if the minimum standards are not met. The MLR is the percentage of premium dollars an insurer spends to provide medical services and healthcare quality improvement activities for its members. The ACA-established minimum MLR for large group insurers and Medicare Advantage plans is 85 percent. In general, the higher an insurer's MLR, the more value an enrollee receives, that is, a larger portion of each premium dollar paid goes toward health benefits and not to administrative costs and profits. On June 1, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule in the *Federal Register* to require Medicaid managed care organizations to achieve a minimum MLR of at least 85 percent.

In calendar year (CY) 2012, almost 4.3 million Medicaid beneficiaries in New York were enrolled in Medicaid managed care plans. During this period, the State agency claimed Medicaid reimbursement from CMS, which administers the Medicaid program at the Federal level, for payments the State agency made to MCOs totaling \$19.2 billion (\$8.9 billion Federal share).

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2012 cost and premium revenue data for 20 New York Medicaid managed care plans. During this period, the total amount of Medicaid premium revenue earned by these plans was \$13.9 billion. For each plan, we determined the MLR for the same period and the amount the MCOs would have had to return to the State agency if the plans were required to meet MLR standards similar to those established by the ACA.

WHAT WE FOUND

While the State agency had policies in place limiting the amount plans could charge for administrative costs as a component of their capitated rate, the Federal Medicaid program could have achieved further savings during CY 2012 if the State agency had required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA and issue rebates to the State agency if these standards were not met. Specifically, of the 20 managed care plans that we reviewed, the MLRs for 7 plans were less than 85 percent (the ACA's minimum MLR standard for large group insurers and Medicare Advantage plans) during CY 2012. We determined that the Medicaid program could have saved \$76.9 million (approximately \$38.5 million Federal share) in CY 2012 if the State agency had required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA.

WHAT WE RECOMMEND

We recommend that the State agency incorporate MLR standards into its contracts with Medicaid MCOs. If the State agency had incorporated standards similar to those established by the ACA in its contracts for the 20 plans we reviewed, the Medicaid program could have saved \$76.9 million (approximately \$38.5 million Federal share) in CY 2012.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report dated May 5, 2015 (prior to CMS's publication of its proposed rule), the State agency did not indicate concurrence or nonconcurrence with our recommendation. The State agency stated that the average MLR for mainstream managed care plans exceeded 89 percent. Further, the State agency stated that CMS does not mandate MLR standards for MCOs and that States have the option to implement MLR standards. The State agency also stated that it plans to implement a cap on revenue profits for mainstream managed care plans that would require it to implement an MLR of approximately 88 percent. Finally, the State agency also described steps that it has taken or plans to take to limit what Medicaid MCOs can spend on allowable nonmedical expenses.

After reviewing the State agency's comments, we maintain that our finding is valid. Further, we maintain that the average MLR for managed care plans, mainstream or otherwise, does not distinguish those plans that do not meet a minimum MLR of 85 percent. In the report, we acknowledge that CMS does not currently mandate MLR standards for MCOs and that States have the option to implement MLR standards. We revised our recommendation to clarify this. Our report states that although the MLR standards do not apply to Medicaid spending, some

States have applied similar standards to their contracts with MCOs. We found that the Federal Medicaid program could have achieved further savings during CY 2012 if the State agency had required its Medicaid MCOs to meet MLR standards similar to those established by the ACA and issue rebates to the State agency if these standards were not met. We recognize the State agency's efforts to limit what plans can spend on allowable nonmedical expenses.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act¹ (ACA) established standards for the amount of premium revenue that certain commercial health insurers and Medicare Advantage plans can spend on costs other than healthcare-related expenses. These standards are known as the medical loss ratio (MLR). Insurers that do not meet these standards must pay rebates to their enrollees or the Department of Health and Human Services (the Department).

Although the MLR standards do not apply to Medicaid spending, some States have applied similar standards to their contracts with Medicaid managed care organizations (MCOs) and require the MCOs to issue rebates to the appropriate Medicaid State agency if the insurers do not meet minimum MLR standards.² The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program. While New York had policies in place limiting the amount plans can charge for administrative costs, New York's Medicaid managed care plan contracts do not contain such standards.

OBJECTIVE

The objective was to determine potential Medicaid program savings if the New York State Department of Health (State agency) required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA.

BACKGROUND

The Medicaid Program

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

New York's Medicaid Managed Care Program

Under New York's Medicaid managed care program, the State agency pays contracted MCOs fixed monthly capitated payments to provide enrollees with Medicaid-covered services. In 2012, almost 4.3 million Medicaid beneficiaries in New York were enrolled in Medicaid managed care

¹ P.L. No. 111-148 (March 23, 2010), and amending provisions of the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), are collectively known as the ACA.

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

plans.³ Of this amount, approximately 3.3 million people were enrolled in 18 mainstream Medicaid managed care plans,⁴ which offer comprehensive health services covered under the Medicaid State plan, and approximately 72,000 people were enrolled in 20 managed long-term-care plans, which offer certain services to the chronically ill or disabled.

For details on New York's Medicaid managed care plans, see Appendix A.

During calendar year (CY) 2012, the State agency claimed Medicaid reimbursement for payments made to MCOs totaling \$19.2 billion (\$8.9 billion Federal share). Of this amount, payments made to the 18 mainstream Medicaid managed care and 20 managed long-term-care plans totaled approximately \$15.8 billion (\$7.3 billion Federal share)⁵ and \$2.3 billion (\$1.1 billion Federal share), respectively.

The Medical Loss Ratio Standards Established by the Affordable Care Act

The ACA, as amended, established standards for certain commercial health insurers and Medicare Advantage plans to meet minimum MLR standards and provide rebates to enrollees or the Department if the minimum standards are not met.⁶ The MLR is the percentage of premium dollars an insurer spends to provide medical services and healthcare quality improvement activities for its members. The ACA-established minimum MLR for large group insurers and Medicare Advantage plans is 85 percent.⁷ Insurers that do not meet the MLR standards must pay rebates to their enrollees or the Department. In general, the higher an insurer's MLR, the more value an enrollee receives, that is, a larger portion of each premium dollar paid goes toward health benefits and not to administrative costs and profits. On June 1, 2015, CMS issued a

³ Medicaid MCOs included mainstream Medicaid managed care, Family Health Plus, Child Health Plus, HIV Special Needs, partial capitation managed long-term-care, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP), and Medicaid Advantage plans. We limited the scope of our review to mainstream Medicaid managed care and partial capitation managed long-term-care plans.

⁴ Mainstream Medicaid managed care plans provide to beneficiaries with full Medicaid eligibility a comprehensive benefits package that includes inpatient and outpatient hospital services, emergency care, pharmacy services, home health services, and limited behavioral health services.

⁵ This amount includes capitated payments made to MCOs for Family Health Plus and Child Health Plus enrollees. However, New York's Medicaid Management Information System does not distinguish between payments for beneficiaries enrolled in these plans and payments for those enrolled in mainstream Medicaid managed care plans. We did not review costs associated with Family Health Plus and Child Health Plus plans because they may be funded, in part, by employers or enrollees.

⁶ ACA § 1001, added section 2718 to the Public Health Service Act (PHS Act). The MLR standards do not apply to long-term-care, dental, vision, or retiree health insurance.

⁷ The ACA established a minimum MLR of 80 percent for individual and small markets (health insurance coverage offered to individuals other than in connection with a group health plan or group health plan maintained by a small employer with fewer than 100 employees) and 85 percent for large group markets (health insurance coverage through a group health plan maintained by a large employer with 101 or more employees) (PHS Act § 2718 (b)(1)(A); ACA § 1304 (a)).

proposed rule in the *Federal Register* to require Medicaid managed care organizations to achieve a minimum MLR of at least 85 percent.⁸

While the State agency had policies in place limiting the amount plans could charge for administrative costs,⁹ New York's Medicaid managed care plan contracts do not contain MLR standards.

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

HOW WE CONDUCTED THIS REVIEW

We reviewed CY 2012 cost and premium revenue data for 20 New York Medicaid managed care plans—10 mainstream plans and 10 managed long-term-care plans. During this period, the total amount of Medicaid premium revenue earned by these plans was \$13.9 billion. For each plan, we determined the MLR for the same period and the amount the MCOs would have had to return to the State agency if the plans were required to meet MLR standards similar to those established by the ACA.

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

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

FINDING

While the State agency had policies in place limiting the amount plans could charge for administrative costs as a component of their capitated rate, the Federal Medicaid program could have achieved further savings during CY 2012 if the State agency had required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA and issue rebates to the State agency if these standards were not met. Specifically, of the 20 managed care plans that we reviewed, the MLRs for 7 plans were less than 85 percent (the minimum MLR standard for large group market insurers) during CY 2012. We determined that the Medicaid program could have saved \$76.9 million (approximately¹⁰ \$38.5 million Federal share) in

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

⁹ During 2012, the State agency limited the amount plans could charge for administrative costs as a component of their capitated payment rate to \$25 and \$231 for mainstream Medicaid managed care plans and managed long-term-care plans, respectively. During this period, the capitated payment rates for mainstream Medicaid managed care plans and managed long-term-care plans were approximately \$500 and \$3,400, respectively.

¹⁰ Services provided to certain Medicaid beneficiaries enrolled in these plans do not qualify for Federal reimbursement. For these enrollees, the State agency funds 100 percent of the capitation payments; therefore, we approximated the Federal share.

CY 2012 if the State agency had required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA.

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

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

We determined that some of New York's Medicaid managed care plans did not meet a minimum MLR of 85 percent. Specifically, of the 20 plans that we reviewed, the MLRs for 7 Medicaid managed care plans were less than 85 percent during CY 2012. Of the seven plans, three were mainstream Medicaid managed care plans and four were managed long-term-care plans.

We calculated that the Medicaid program could have saved \$76,942,459 (approximately \$38,471,229 Federal share) during CY 2012 if the State agency had required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA.¹¹

Appendix D contains the results of our calculation of the MLR for the selected plans using the formula described in the ACA, the results of our calculation of "rebates" if the plans did not meet an 85-percent MLR standard, and potential Medicaid program savings if the State agency had required its Medicaid managed care plans to meet MLR standards similar to those established by the ACA.

RECOMMENDATION

We recommend that the State agency incorporate MLR standards into its contracts with Medicaid MCOs. If the State agency had incorporated standards similar to those established by the ACA in its contracts for the 20 plans we reviewed, the Medicaid program could have saved \$76.9 million (approximately \$38.5 million Federal share) in CY 2012.

STATE AGENCY COMMENTS

In written comments on our draft report dated May 5, 2015 (prior to CMS's publication of its proposed rule), the State agency did not indicate concurrence or nonconcurrence with our recommendation. The State agency stated that the average MLR for mainstream managed care plans exceeded 89 percent. The State agency stated that CMS does not mandate MLR standards for MCOs and that States have the option to implement MLR standards. The State agency also stated that it plans to implement a cap on revenue profits for mainstream managed care plans that

¹¹ Of this amount, we determined that if MCOs were required to issue a rebate to the State agency when the managed care plans did not meet an 85-percent MLR standard, the amount refunded to the State agency would have been \$53,311,728 (approximately \$26,655,864 Federal share) and \$23,630,731 (approximately \$11,815,365 Federal share) for the three mainstream Medicaid managed care plans and four managed long-term-care plans, respectively.

would require it to implement an MLR of approximately 88 percent.¹² The State agency also described steps that it has taken or plans to take to limit what Medicaid MCOs can spend on allowable nonmedical expenses.

The State agency stated that the MLR percentages that we calculated appear to be understated. Specifically, according to the State agency, performance payments to MCOs, known as Quality Incentive Program Adjustments, are not payments for direct medical services and, therefore, should not be included in our MLR calculations. Further, the State agency stated that our computation of the plans' MLRs may not account for all expenditures for the plans' activities that improve healthcare quality. Finally, the State agency stated that certain managed long-term-care management costs, such as those performed by a nurse, are treated as medical costs when it develops Medicaid payment rates. The State agency requested that we confirm whether care management expenditures were excluded from our MLR calculations for managed long-term-care plans, "which would make the MLR artificially low."

The State agency's comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our finding is valid. Further, we maintain that the average MLR for managed care plans, mainstream or otherwise, does not distinguish those plans that do not meet a minimum MLR of 85 percent.¹³ In the report, we acknowledge that CMS does not currently mandate MLR standards for MCOs and that States have the option to implement MLR standards similar to those established by the ACA. We revised our recommendation to clarify this. Although the MLR standards do not apply to Medicaid spending, some States have applied similar standards to their contracts with MCOs. We found that the Federal Medicaid program could have achieved further savings during CY 2012 if the State agency had required its Medicaid MCOs to meet MLR standards similar to those established by the ACA and issue rebates to the State agency if these standards were not met. We recognize the State agency's initiative to implement similar MLR standards in the future, limiting what the plans can spend on allowable nonmedical expenses.

We computed the MLRs using the formula described in the ACA, and maintain that our calculations are correct. Specifically, Federal regulations at 45 CFR §158.130(a), which contain the detailed methodology for calculating the MLR, define earned premium as "all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan" (emphasis added). Further, in our computation of the plans' MLRs, we used the total amounts for activities that improve healthcare quality provided by the MCOs.

¹² The State agency stated that it anticipates implementing an MLR during State fiscal year 2015-2016, which began April 1, 2015.

¹³ We did not verify the State agency's assertion that the average MLR for mainstream managed care plans exceeded 89 percent.

We revised the methodology section of our report to indicate that we used financial data obtained from the MCOs to compute the MLRs. We also revised Appendix D to indicate that the financial data used to compute the MLRs for managed long-term-care plans included costs for care management.

APPENDIX A: NEW YORK'S MEDICAID MANAGED CARE PLANS

MAINSTREAM MEDICAID MANAGED CARE

Mainstream Medicaid managed care plans provide coverage to people with full Medicaid eligibility. Beneficiaries receive a comprehensive benefits package, including inpatient and outpatient hospital services, emergency care, pharmacy services, home health services, and limited behavioral health services. In some counties, mainstream Medicaid managed care plans do not cover hospice, some behavioral health services, or transportation services, which are covered by Medicaid fee-for-service.

FAMILY HEALTH PLUS

Family Health Plus plans provide coverage to uninsured adults ages 19 to 64 who are not eligible for Medicaid.¹⁴ Beneficiaries receive a comprehensive benefits package, including inpatient and outpatient hospital services, emergency care, pharmacy services, limited home health services, and behavioral health services. Family planning services are covered by Medicaid fee-for-service if the Family Health Plus plan does not cover those services.

CHILD HEALTH PLUS

Child Health Plus plans provide coverage to uninsured children from 1 month to 19 years old who are not eligible for Medicaid.¹⁵ Beneficiaries receive a comprehensive benefits package, including inpatient and outpatient hospital services, physician services, and behavioral health services that include inpatient and outpatient mental health services and alcohol and substance abuse services.

HIV SPECIAL NEEDS

Special Needs plans (SNPs) serve Medicaid beneficiaries with HIV/AIDS who require intensive case-managed care regimens. HIV SNPs provide the same benefits as a mainstream Medicaid managed care plan, as well as special services that include additional care coordination and support for people living with HIV/AIDS, treatment adherence services to assist with medications and treatment, and HIV prevention and risk-reduction education.

¹⁴ Young adults (ages 19 to 21) residing with parents and parents with children under age 21 in their households are covered if gross family income is below 150 percent of the Federal poverty level (FPL). Young adults living alone and adults without children are covered if gross family income is below 100 percent of the FPL.

¹⁵ Premiums for Child Health Plus plans are subsidized for families with incomes between 160 and 400 percent of the FPL. Full premiums are available for uninsured children whose family incomes are above 400 percent of the FPL. No premiums are paid for families with incomes below 160 percent of the FPL.

MANAGED LONG-TERM CARE

Managed long-term care assists chronically ill or disabled individuals who require health and long-term-care services.¹⁶ The benefit package includes home care, personal care, social supports, and transportation services. The costs of skilled nursing facility services are included in the capitated payment, thereby providing a financial incentive for the plans to keep their members healthy and living in the community. Depending on the type of plan, ambulatory care, inpatient services, and mental health services may also be included in the benefit package.

Within the managed long-term-care program, there are three models of plans: partial capitation plans, PACE organizations, and MAP. All plans accept Medicaid.

Partial Capitation

Partial capitation plans receive a risk-adjusted Medicaid capitated payment to cover the costs of the long-term-care and select ancillary services, including care management, podiatry, home health care, personal care, adult day care, durable medical equipment, and transportation. The recipient's ambulatory care and inpatient services are paid by Medicare if the recipient is dually eligible for both Medicaid and Medicare or by Medicaid fee-for-service if the recipient is not Medicare eligible. Partial capitation plans are required to coordinate all services for their members, including those services that are not covered by the managed long-term-care benefit package, such as visits to physicians and hospital admissions. The minimum age requirement is 18 years.

Program of All-Inclusive Care for the Elderly

A PACE organization provides a comprehensive system of healthcare services for members age 55 and older who are otherwise eligible for nursing home admission. Beneficiaries receive a comprehensive benefits package, including care management, inpatient and outpatient hospital services, physician services, home health care, personal care, adult day care, durable medical equipment, and transportation services. PACE plans receive a capitated payment from both Medicaid and Medicare.

Medicaid Advantage Plus

MAP beneficiaries receive a comprehensive benefits package, including care management, inpatient and outpatient hospital services, physician services, home health care, personal care, adult day care, durable medical equipment, and transportation services. MAP plans receive a capitated payment from both Medicaid and Medicare. Medicare copayments and deductibles are also covered by the plan. The minimum age requirement is 18 years.

¹⁶ The beneficiary must be able to live safely in the community upon enrollment and be in need of long-term-care services for more than 120 days.

MEDICAID ADVANTAGE

Medicaid Advantage plans provide coverage to adults 18 years of age or older who have full Medicaid coverage and are enrolled in Medicare Part A and Part B. Beneficiaries receive a comprehensive benefits package, including inpatient and outpatient hospital services, physician services, home health services, some mental health services, and up to the first 100 days in a nursing home.

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

The ACA, as amended,¹⁷ requires certain health insurers to submit data on the proportion of premium revenue spent on clinical services and activities that improve healthcare quality, also known as the MLR, and to issue rebates to enrollees if the percentage of premium revenue expended on costs for clinical services and activities that improve healthcare quality does not meet minimum standards.¹⁸

The MLR is the ratio of the numerator, consisting of the insurer's incurred claims plus the expenditures for activities that improve healthcare quality for the reporting year, to the denominator, which equals the insurer's premium revenue, excluding Federal and State taxes and licensing and regulatory fees, after accounting for payments or receipts related to the Risk Adjustment, Risk Corridors, and Reinsurance programs (PHS Act § 2718(b)(1)(A)).¹⁹

The ACA-established formula for calculating the MLR is:

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

If the applicable MLR standard is not met, the insurer must issue rebates to enrollees for the total amount of premium revenue, after subtracting Federal and State taxes and licensing or regulatory fees and, after accounting for payments or receipts for Risk Adjustment, Risk Corridors, and Reinsurance,²⁰ multiplied by the difference between the applicable MLR standard and the insurer's calculated MLR (PHS Act § 2718(b)(1)(B)).

¹⁷ ACA § 1001, added section 2718 to the Public Health Service Act (PHS Act).

¹⁸ The ACA established a minimum MLR of 80 percent for individual and small markets (health insurance coverage offered to individuals other than in connection with a group health plan or group health plan maintained by a small employer with fewer than 100 employees) and 85 percent for large group markets (health insurance coverage through a group health plan maintained by a large employer with 101 or more employees) (PHS Act § 2718(b)(1)(A); ACA § 1304 (a)).

¹⁹ Federal regulations at 45 CFR § 158 contain the detailed methodology for calculating the MLR.

²⁰ The ACA's Risk Adjustment, Risk Corridors, and Reinsurance programs are designed to work together to mitigate the potential effects of higher-than-average premiums and the denial of coverage to those who are in poor health and likely to require costly medical care. Specifically, Risk Adjustment is designed to mitigate any incentives for plans to attract healthier individuals and compensate those that enroll a disproportionately sick population. Risk Corridors reduce the general uncertainty insurers face in the early years of implementation when the market is opened up to people with pre-existing conditions who were previously excluded. Reinsurance compensates plans for their high-cost enrollees and, by the nature of its financing, provides a subsidy for individual market premiums generally over a 3-year period.

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed the total amounts recorded on the MCOs' general ledgers for premium revenue, medical expenses, activities that improve healthcare quality, and Federal and State taxes and licensing and regulatory fees for 10 mainstream Medicaid managed care plans and 10 managed long-term-care plans for CY 2012.²¹ During this period, the total amount of Medicaid premium revenue earned by these plans was \$13.9 billion.

During CY 2012, the State agency claimed Medicaid reimbursement for payments made to 18 mainstream Medicaid managed care and 20 managed long-term-care plans totaling approximately \$15.8 billion (\$7.3 billion Federal share)²² and \$2.3 billion (\$1.1 billion Federal share), respectively.

Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the Medicaid Management Information System (MMIS) file for our audit period. We also established reasonable assurance of the completeness of the data by reconciling the claims data in the MMIS to the State's claim for reimbursement in the CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

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

We performed fieldwork at the State agency's office in Albany, New York, and at MCOs' offices throughout New York from June 2013 through August 2014.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal requirements;
- held discussions with CMS officials to obtain information regarding New York's Medicaid managed care program;
- held discussions with State agency officials to gain an understanding of the State agency's policies and procedures for overseeing and administering its Medicaid managed care program;

²¹ MCOs are required to file a statement of financial condition, including a balance sheet, a summary of receipts and disbursements, an income statement, and an analysis of utilization of all services covered by the MCO.

²² This amount includes capitated payments made to MCOs for Family Health Plus and Child Health Plus enrollees. We did not review costs associated with these plans.

- reconciled Medicaid managed care payments included on Form CMS-64 to the State’s MMIS for the quarter ended June 30, 2012;
- obtained from the State agency a summary of capitated payments made to MCOs contracted with the State agency during CY 2012;
- obtained from the State agency Medicaid Managed Care Operating Reports (MMCORs) for all mainstream Medicaid managed care plans and managed long-term-care plans;²³
- performed a preliminary calculation of the MLR based on cost and premium revenue elements identified in the MMCORs for all mainstream Medicaid managed care plans and managed long-term-care plans;
- judgmentally selected for review 10 mainstream Medicaid managed care plans and 10 managed long-term-care plans on the basis of our preliminary assessment of plans’ financial information obtained from the State agency and for each of these plans:
 - obtained from the MCOs total amounts recorded on their plans’ general ledgers for cost and premium revenue;²⁴
 - obtained from the MCOs supporting documentation (e.g., general ledger account summaries and actuarial estimates and opinions) for the cost and premium revenue elements, as well as an explanation of how these amounts were derived;
 - verified a judgmental sample of incurred medical expenses;²⁵
 - verified earned premium revenue;²⁶
 - used the financial data obtained from the MCOs to compute the MLR, using the formula described in the ACA;

²³ We did not review Family Health Plus, Child Health Plus, or HIV Special Needs plans. We limited our review of managed long-term-care plans to partial capitation plans.

²⁴ Specifically, we obtained the total amounts recorded on the plans’ general ledgers for premium revenue, medical expenses, activities that improve healthcare quality, and Federal and State taxes and licensing and regulatory fees.

²⁵ We selected 1 month during the audit period and verified certain medical expenses incurred during that month. For medical expenses incurred and paid, we obtained detailed underlying support, such as claims data summaries and check register details. For medical expenses incurred but not reported, we obtained a description of the actuarial methodology used to determine the estimates and obtained an actuarial opinion, when available.

²⁶ We obtained total capitated payments made to the plans by the State agency and compared those amounts to the plans’ earned premium revenue.

- calculated the rebate²⁷ that would have been issued to the State agency and determined the potential Medicaid program savings if the State agency had required the plan to meet MLR standards similar to those established by the ACA; and
- discussed our audit results with State agency officials.

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

²⁷ The ACA-established formula for calculating the rebate is (premium revenue – taxes – licensing and regulatory fees) × (the applicable MLR standard – the insurer’s calculated MLR).

**APPENDIX D: PLAN MEDICAL LOSS RATIOS
AND POTENTIAL PROGRAM SAVINGS**

Plan	MLR²⁸	Potential Medicaid Program Savings	Federal Share of Potential Medicaid Program Savings²⁹
MMMC-1	85.7%	-	-
MMMC-2	84.3%	\$7,375,943	\$3,687,971
MMMC-3	68.3%	40,964,409	20,482,204
MMMC-4	94.5%	-	-
MMMC-5	87.5%	-	-
MMMC-6	92.5%	-	-
MMMC-7	95.2%	-	-
MMMC-8	84.7%	4,971,377	2,485,688
MMMC-9	90.0%	-	-
MMMC-10	90.5%	-	-
Subtotal		53,311,728³⁰	26,655,864³⁰
MLTC-1	97.3%	-	-
MLTC-2	79.6%	5,481,452	2,740,726
MLTC-3	88.7%	-	-
MLTC-4	91.3%	-	-
MLTC-5	84.2%	3,206,223	1,603,112
MLTC-6	92.5%	-	-
MLTC-7	61.6%	1,805,179	902,590
MLTC-8	87.2%	-	-
MLTC-9	116.5%	-	-
MLTC-10	78.1%	13,137,876	6,568,938
Subtotal		23,630,731³⁰	11,815,365³⁰
Total		\$76,942,459³⁰	\$38,471,229³⁰

Notes: (1) Shaded areas indicate those plans that did not meet a minimum MLR of 85 percent.

(2) Financial data used to compute the MLRs for MLTC plans included costs for care management.

²⁸ We rounded insurers' MLRs in accordance with Federal regulations (45 CFR § 158.221).

²⁹ The Federal Government is entitled to the Federal share of the net amount recovered by a State with respect to its Medicaid program (section 1903(d)(3)(A) of the Social Security Act). To determine the approximate Federal share of potential program savings, we multiplied the Medicaid potential program savings by 50 percent (the Federal Medicaid assistance percentage applied to payments to Medicaid managed care organizations in New York for CY 2012).

³⁰ Differences in total calculations are due to rounding.

APPENDIX E: STATE AGENCY COMMENTS



Department of Health

ANDREW M. CUOMO
Governor

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

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

May 5, 2015

Mr. James P. Edert
Regional Inspector General for Audit Services
Department of Health and Human Services - Region II
Jacob Javitz Federal Building
26 Federal Plaza
New York, New York 10278

Ref. No: A-02-13-01036

Dear Mr. Edert:

Enclosed are the New York State Department of Health's comments on the United States Department of Health and Human Services, Office of Inspector General's Draft Audit Report A-02-13-01036 entitled, "The Medicaid Program Could Have Achieved Savings if New York Implemented the Affordable Care Act's Medical Loss Ratio Standards."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgerson
Dennis Rosen
Thomas Meyer
Robert Loftus
James Cataldo
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
Diane Christensen
Lori Conway
OHIP Audit SM

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

**New York State Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-13-01036 entitled
The Medicaid Program Could Have Achieved Savings if New York
Implemented the Affordable Care Act's Medical Loss Ratio Standards**

The following are the New York State Department of Health's (Department) comments in response to the Department of Health and Human Services, Office of Inspector General (OIG) Draft Audit Report A-02-13-01036 entitled, "The Medicaid Program Could Have Achieved Savings if New York Implemented the Affordable Care Act's Medical Loss Ratio Standards."

Background:

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over \$1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality 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 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to \$7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1:

We recommend that the State agency incorporate MLR standards similar to those established by the ACA into its contracts with Medicaid MCOs. If the State agency had incorporated these standards in its contracts for the 20 plans we reviewed, the Medicaid program could have saved \$76.9 million (approximately \$38.5 million Federal share) in CY 2012.

Response #1

Mainstream Managed Care:

Based on the information maintained by the Department, the overall Medical Loss Ratio (MLR) for the mainstream managed care plans continues to exceed 89 percent on average across all plans which exceeds the recommended standard. This is achieved despite the changes in the care delivery model and the inclusion of complex populations and benefits into the managed care benefit package, as well as the Medicaid program expansion consistent with the Affordable Care Act (ACA) mandates.

ACA § 1001 added section 2718 to the Public Health Service Act with intent to promulgate uniform definitions and a standardized methodology for calculating the MLR and require insurance companies to report publicly the percentage of total premium revenue that is expended on clinical services, and quality rather than administrative costs. Managed Long Term Care (MLTC) plan expenditures are directly related to long-term care services. The MLR standards do not apply to long-term care plans, dental or vision plans. Additionally, MLR requirements do not apply to "excepted benefits" as these benefits are not considered health insurance, as defined by the Department of Labor.

Furthermore, the Department finds that while the OIG encourages States to implement the MLR standards for their Medicaid managed care lines of business, similar to those established by the ACA, the Centers for Medicare and Medicaid Services does not mandate MLR requirements on the Medicaid Managed Care Organizations (MCOs). Accordingly, the implementation of the MLR threshold currently is, and should remain, an option for the States.

The MLR percentages calculated by OIG appear to be understated. The Quality Incentive Program Adjustment included in plan premiums should not be included in the MLR calculation as they are not a payment for direct medical services. Additionally, the Medical and Hospital Expenditure totals may not account for all Health Care Quality Improvement expenses incurred by the plan as occasionally such costs may be reflected in the administrative expenses outside of the direct medical costs. The MLR exhibit provided within this draft audit appears to include this component which understates the MLR percentages.

It is important to note that in the calculation of the administrative component of the Mainstream Managed Care premiums, plans are held to a cap. The administrative component of the Mainstream Managed Care premium is calculated for each of the 9 premium rating regions. In each region, individual plan Per Member Per Month (PMPM) amounts are calculated from 2 years of historical plan reported Medicaid Managed Care Operating Report (MMCOR) data. The plan PMPM amounts are calculated by dividing the total allowable administrative cost by the plan reported member months. This plan reported PMPM is then compared to a Statewide administrative PMPM cap. If the plan reported PMPM amount is at or below the cap, then the reported amount will be used to calculate the regional average. If the plan reported PMPM is above the cap, then that PMPM amount will be reduced to the cap for the regional average calculation.

The Department also incorporates an administrative component into premiums for all new populations and benefits transitioning into the benefit which are not reflected in the 2 year MMCOR base PMPM. This additional administrative component is developed by the State's actuary, Mercer. Additionally, the administrative portion of the capitation premium is adjusted by a plan specific risk score as part of the rate development process.

Finally, the State Fiscal Year (SFY) 2015-2016 Enacted Budget includes a cap on Mainstream Managed Care premium revenue profits at five (5) percent. This cap will be accomplished through the implementation of an MLR on premiums which will prescribe what plans must spend on medical benefits in SFY 2015-2016. Once implemented, this initiative will limit what the plans/State can spend on allowable non-medical expenses (e.g. administration). In order to achieve the 5 percent profit cap, the State will have to implement the MLR at approximately 88 percent. The Department has committed to working with stakeholders to determine the components of the MLR calculation and anticipates implementation in SFY 2015-2016.

Managed Long Term Care (MLTC):

Although the Department does not recognize utilizing MLR standards for MLTC services, additional clarification on the OIG methodology is desired. If the OIG includes an MLR analysis for MLTC, the Department requests OIG confirm whether Care Management expenditures were excluded in the MLTC MLR exhibit (identified as Appendix D) within the audit calculations which would make the MLR artificially low, negatively skewing MLR percentages. Generally, Care Management is performed by a nurse, a licensed medical position making professional medical judgments regarding consumer care. Such Care Management costs are treated as medical costs in rate development and the corresponding medical trend and risk scores are applied to the care management component of the rate.

For MLTC Partial plans, the average MLR (inclusive of Care Management costs) was 87 percent in Calendar Year (CY) 2012 and rose to 91 percent in CY 2013. At the same time, membership in the MLTC Partial program grew 68 percent from 2012 (67,173) to 2013 (113,159). The enrollment growth in the MLTC program is a direct result of the implementation of MRT #90 as Medicaid recipients previously receiving long term care services on a fee-for-service basis migrated into MLTC. The increase in the average MLR for plans in the program can be in part attributed to this migration and program expansion.