STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

REPORT DIGEST

PERFORMANCE AUDIT

For Fiscal Year 2016

Release Date: January 2018

Audit performed in accordance with House Resolution No. 100

Office of the Auditor General
Iles Park Plaza
740 E. Ash Street
Springfield, IL 62703

Phone: (217) 782-6046
TTY: (888) 261-2887

The full audit report is available on our website: www.auditor.illinois.gov

EXECUTIVE SUMMARY

Medicaid Managed Care Organizations

On May 31, 2017, House Resolution Number 100 was adopted and directed the Office of the Auditor General to conduct an audit of Medicaid Managed Care Organizations (MCOs), which included a comparison of State expenditures between MCOs and the Medicaid fee-for-service program for fiscal year 2016.

The audit found:

- Auditors determined that the Department of Healthcare and Family Services (HFS) did not maintain the complete and accurate information needed to adequately monitor $7.11 billion in payments made to and by the 12 MCOs during FY16.
- Specifically, HFS could not provide auditors with the following information:
  - ✓ all paid claims to Medicaid providers by the MCOs in FY16;
  - ✓ Medicaid provider claims denied by MCOs in FY16;
  - ✓ the administrative costs incurred by MCOs in FY16;
  - ✓ the coordinated care costs incurred by MCOs in FY16; and
  - ✓ Medical Loss Ratio (MLR) calculations since calendar year 2012.
- In FY16, HFS made multiple monthly capitation payments to MCOs for the same months for the same individuals totaling $590,237.

The audit recommends HFS should:

1) monitor the actual administrative costs incurred by its MCOs to ensure that the administrative costs do not exceed what is allowed by contract;
2) calculate the Medical Loss Ratios for the previous four calendar years (2013 through 2016), and determine whether the State should be reimbursed by MCOs due to overpayment;
3) require all MCOs to submit all Medicaid provider payment data for all services (including DASA, LTC, and waiver services), and perform on-site reviews of the MCOs' financial data systems and test the completeness and accuracy of the data reported to HFS that is used to monitor the payments made to Medicaid providers;
4) provide clear guidance to the MCOs for reporting denied claims, and ensure that MCOs provide the denied claims to HFS as required by contract;
5) ensure multiple monthly capitation payments are not being made for the same Medicaid recipients, immediately identify and remove all duplicative recipients from its eligibility data, and recoup any overpayment of duplicate capitation payments; and
6) ensure that it effectively monitors the newly awarded MCO contracts to ensure compliance with all contractual provisions.

AUDIT RESULTS AND CONCLUSIONS

HFS did not maintain the complete and accurate information needed to adequately monitor payments made to and by the 12 MCOs during FY16.

Based on numerous information requests and meetings with HFS officials, auditors determined that HFS did not maintain the complete and accurate information needed to adequately monitor payments made to and by the 12 MCOs during FY16. Additionally, HFS made multiple monthly capitation payments to MCOs for the same months for the same individuals totaling $590,237.

HFS made multiple monthly capitation payments to MCOs for the same months for the same individuals totaling $590,237.

According to payment information provided by HFS on June 23, 2017, the amount of Medicaid MCO capitation payments made by HFS during FY16 was **$7.11 billion**. An additional $7.61 billion was paid through fee-for-services in FY16.

Auditors determined that as of November 1, 2017, HFS could not provide information to address several of the nine audit determinations found in House Resolution Number 100. The information that was not provided includes:

- all paid claims to Medicaid providers by the MCOs in FY16;
- Medicaid provider claims denied by MCOs in FY16;
- administrative costs incurred by MCOs in FY16;
- coordinated care costs incurred by MCOs in FY16; and
- Medical Loss Ratio (MLR) calculations since calendar year 2012.

The following bullets summarize the audit conclusions related to the specific audit determinations:

Encounter Data

- House Resolution Number 100 asked whether MCO encounter data was used to set capitation rates. On September 5, 2017, when asked if encounter data was used to set the FY16 capitation rates, HFS and its actuary noted that, although using encounter data was the preferred way to set capitation rates, it was not required. The actuary further noted there are several factors that can be used and noted there would not be encounter data for newly created MCOs; therefore, other methods are used and are acceptable.

HFS did not have complete encounter data in its data warehouse, and as such, a combination of plan-reported claims information and fee-for-service claims information was used to develop the base data actuarial models. Thus, encounter data was not used to set 2016 capitation rates.

- The actuary also noted that they were in the process of requesting complete encounter data from each of the 12 MCOs. It was discussed that encounters related to the Division of Alcoholism and Substance Abuse (DASA), long term care (LTC), waiver services (services that allow individuals to remain in their own homes or live in a community setting, instead of in an institution), and the Medicare-Medicaid Alignment Initiative (MMAI) were not received by HFS from the MCOs.
- According to the various rate certification reports completed by the actuary for 2016, HFS did not have complete encounter data in its data warehouse, and as such, a combination of plan-reported claims information and fee-for-service claims information was used to develop

the base data actuarial models. Thus, **encounter data was not used to set 2016 capitation rates**.

MCO Capitation Payments

- Based on information provided by HFS, the amount of MCO capitation payments made by HFS during fiscal year 2016 as of June 23, 2017, was $7,110,312,919.

Duplicate Capitation Payments for Recipients

Auditors questioned a total of $590,237 in duplicative capitation payments for 302 individual social security numbers. In each instance, two payments were made for the same social security number for the same eligibility period.

- During our review of FY16 capitation payments made to MCOs by HFS, auditors determined that **HFS made multiple monthly capitation payments for the same month for the same recipient.** Auditors questioned a total of $590,237 in duplicative capitation payments for 302 individual social security numbers in FY16. In each instance, two payments were made for the same social security number for the same eligibility period. Auditors could not determine which payment was the correct payment and which payment was the duplicate; therefore, all $590,237 was questioned.

Health Insurer Fee/Gross-Up Payments

According to documentation provided by HFS, the combined Health Insurer Fees (HIF) and "gross-up" owed by the State to MCOs for FY16 was $137,938,567.

- According to documentation provided by HFS, the combined Health Insurer Fees (HIF) and "gross-up" owed by the State to MCOs for FY16 was **$137,938,567**. The HIF is an annual fee (federal tax) imposed on the health insurance industry, which is mandated by the Affordable Care Act (ACA) and the Health Care and Education Reconciliation Act of 2010. The 2013 research report completed by its actuary defined "gross-up" as a fee to reimburse the MCOs for the income taxes paid on the revenue that was used to pay the HIF, since the HIF is considered an excise tax and is nondeductible for income tax purposes. As a result, the MCOs pay federal corporate income taxes on the revenue used to pay the HIF. For FY16, the amount of HIF owed to the MCOs was $85.8 million and the gross-up owed was $52.2 million.
- According to HFS and the Centers for Medicare & Medicaid Services (CMS) documentation, the HIF reimbursement is not specifically required by the ACA; however, it is defined as an actuarially sound cost of doing business recognized by the Actuarial Standards Board's Actuarial Standards of Practice and is therefore an allowable cost.

Incidence to Which MCO Capitation Payments Contain Supplemental GRF-Payments

- To address the determination related to the incidence to which the MCO capitation rates include supplemental, GRF (general revenue fund) based payments to providers, auditors were told this would be the Cook County Health & Hospitals System (CCHHS) access payments. Based on information provided by HFS, in FY16, $138,398,950 in CCHHS access payments were paid to MCOs. According to HFS, the CCHHS payments are not directly tied to a specific service, but are intended for MCO members to access the CCHHS facilities.

Administrative Costs Paid to MCOs

After numerous meetings and requests for information, HFS could not provide auditors with the actual administrative costs or other non-benefit costs, such as care coordination costs, incurred by the MCOs during FY16.

- **After numerous meetings and requests for information, HFS could not provide auditors with the actual administrative costs or other non-benefit costs, such as care coordination costs, incurred by the MCOs during FY16.** Auditors reviewed numerous actuarial and financial reports and could not determine the administrative costs or other non-benefit costs for FY16. Without an accounting of actual administrative costs incurred by the MCOs, it is unclear how HFS monitored the costs incurred by the MCOs and how future rates were set to ensure that the MCOs were compensated correctly for administering $7.11 billion in capitation payments received during FY16.

HFS had not calculated the required annual Medical Loss Ratio (MLR) since calendar year 2012.

- **HFS had not calculated the required annual Medical Loss Ratio (MLR) since calendar year 2012.** The MLR is defined in the MCO contracts as total plan benefit expense divided by total capitation revenue. Without these MLR calculations, as of November 1, 2017, HFS had not reconciled the $14.2 billion in payments made to the MCOs since calendar year 2012. Thus, HFS has not determined whether the MCOs were overpaid by the State.

Payout Ratio

Since HFS did not monitor or track all encounter information for the 12 MCOs or monitor the expenditures for DASA, LTC, waiver services, and MMAI costs during FY16, there was not complete and accurate information for auditors to calculate the average payout ratio.

- HFS also indicated that no on-site fiscal monitoring was done to ensure that complete and accurate data was available to determine the total paid claims to Medicaid providers by MCOs for the $7.11 billion paid to the MCOs in FY16. Medicaid spend data was provided to HFS by the MCOs, but was self-reported and auditors found no actual reviews or testing of the MCOs' payment systems by HFS. Thus, auditors had no assurance that the encounter data submitted to HFS included actual paid encounters.
- Since HFS did not monitor or track all encounter information for the 12 MCOs or monitor the expenditures for DASA, LTC, waiver services, and MMAI costs during FY16, **there was not complete and accurate information for auditors to calculate the average payout ratio.** Additionally, since HFS did not have the total for all paid claims to Medicaid providers by the 12 MCOs more than 16 months after the end of FY16, auditors determined that HFS lacked sufficient monitoring of payments made to and by the 12 MCOs during FY16.

Denial Rates

HFS could not provide auditors with any valid data to document encounters denied by the MCOs for FY16.

- **HFS could not provide auditors with any valid data to document encounters denied by the MCOs for FY16.** Like the encounter data, MCOs are required to provide denial data to HFS at least monthly. Auditors requested denial data from HFS, and according to its July 13, 2017, written response, HFS indicated that some of the MCOs did not provide the denial data for FY16. Additionally, responding to further questions, HFS specifically noted, "Currently, the denial data is simply not valid nor reliable." HFS officials also noted that HFS had never given MCOs clear guidance on how to report denied claims. Without complete and accurate denial data, HFS cannot determine whether the MCOs are appropriately denying claims submitted by providers.

BACKGROUND

On May 31, 2017, House Resolution Number 100 was adopted and directed the Office of the Auditor General to conduct an audit of Medicaid Managed Care Organizations (MCOs), which included a comparison of State expenditures between MCOs and the Medicaid fee-for-service program for fiscal year 2016. The Resolution contained nine specific determinations:

1. Compare the total dollar amount of all reported MCO encounter data submitted to the Illinois Department of Healthcare and Family Services (HFS) during State fiscal year 2016 to the total dollar amount of reported claims payments made on behalf of Illinois Medicaid individuals by MCOs as reported to HFS during State fiscal year 2016.
2. Whether MCO encounter data is used by the Department of Healthcare and Family Services to set capitation rates.
3. Calculate the aggregate amount of MCO capitation payments made by HFS during SFY 2016 (exclude payments authorized under 305 ILCS Sections 5/5A-12.2, 5/5A-12.4, and 5/5A-12 from this calculation). *Note: the excluded payments include Hospital Access Payments and Hospital Access Improvement Payments.*
4. Determine the amount of payments made by HFS to reimburse for-profit MCOs for the Affordable Care Act (ACA) Health Insurer Fee (HIF); determine if reimbursement by the State to for-profit MCOs for this HIF payment is mandated by federal Centers for Medicare & Medicaid Services (CMS).
5. Determine the amount of payments made by HFS to reimburse for-profit MCOs for "gross-ups" related to the HIF payment; determine the purpose of the "gross-up" payments.
6. The incidence to which the MCO capitation rates contain supplemental, GRF-based payments to providers; for these payments, determine the amount of the supplemental, which providers received these payments, and whether these monies were directly tied to services actually provided (do not include payments authorized under 305 ILCS Sections 5/5A-12.2, 5/5A-12.4, and 5/5A-12). *Note: the excluded payments include Hospital Access Payments and Hospital Access Improvement Payments.*
7. What administrative costs are paid to MCOs in terms of total dollars and percent of overall MCO medical-based payments.
8. What is the average payout ratio for all MCOs in aggregate and for each MCO individually; for the purposes of this audit, payout ratio is defined as all paid claims to Medicaid providers made by MCOs as reported to HFS for State fiscal year 2016 divided by aggregate MCO capitation payments made by HFS for State fiscal year 2016.
9. What the denial rates are for MCOs and for fee-for-service providers billing the HFS; determine whether there is a higher denial rate for services paid by MCOs.

Medicaid Payments

Traditionally, Illinois has paid medical providers (physicians, hospitals, dentists, etc.) directly on a fee-for-services basis. Fee-for-service is a payment method where providers are paid an agreed upon rate for each encounter or service provided. An encounter is defined as an individual service or procedure provided to an enrollee.

On January 25, 2011, Public Act 96-1501, amended the Illinois Public Aid Code and mandated that HFS increase the percentage of Medicaid clients whose Medicaid services are paid through managed care organizations (MCOs). MCOs are not paid on a fee-for-service basis; they are paid using monthly capitation rates. Capitation rates are reimbursement arrangements in which a fixed rate of payment per enrollee (member) per month is made, regardless of whether the enrollee received covered services during that month.

HFS contracts with an actuary to provide actuarial and consulting services related to the development of capitation rates for the managed care program in Illinois. According to the contract, FY16 capitation rates were required to be **actuarially sound** and were developed using published guidance from the American Academy of Actuaries, the Actuarial Standards Board, the Centers for Medicare and Medicaid Services, and the federal regulations.

In FY08, the cost for managed care was $212.8 million. By FY16, the cost for managed care increased to $7.11 billion.

The cost of managed care increased between FY08 and FY16. In FY08, the cost for managed care was $212.8 million. By FY16, the cost for managed care increased to $7.11 billion. Digest Exhibit 1 shows the total cost by fiscal year for both fee-for-service and for managed care from FY08 through FY16. The annual total medical costs increased by 44 percent from FY08 to FY16.

Digest Exhibit 1
TOTAL MEDICAID COSTS FOR FEE-FOR-SERVICE AND MANAGED CARE
By Fiscal Year as of June 23, 2017

State Fiscal Year	Total Cost Managed Care	Total Cost Fee-for-Service	Total Cost All Medicaid
FY08	$212,829,112	$10,037,469,550	$10,250,298,662
FY09	$233,606,434	$10,480,434,906	$10,714,041,340
FY10	$248,990,625	$11,028,626,667	$11,277,617,292
FY11	$246,753,932	$11,436,171,812	$11,682,925,744
FY12	$662,241,526	$11,494,258,772	$12,156,500,298
FY13	$840,602,476	$10,708,692,013	$11,549,294,489
FY14	$1,351,423,766	$10,761,879,245	$12,113,303,011
FY15	$4,890,727,525	$9,449,003,874	$14,339,731,399
FY16	$7,110,312,919	$7,613,160,197	$14,723,473,116

Note: MCO costs reported are incurred costs, regardless of when they were paid.
Source: Medicaid cost data provided by HFS on June 23, 2017.

Managed Care Enrollees

In July 2014, MCO enrollment of Family Health Plan and Affordable Care Act populations became mandatory. Integrated Care Plan enrollment became mandatory in all regions with two or more MCOs offering plans. Roll out of all managed care programs was completed by late spring 2015. As managed care enrollment became mandatory, the number of enrollees in managed care increased dramatically to almost 1.62 million in FY15, up from 460,524 in FY14.

As shown in Digest Exhibit 2, due to the increased efforts to increase managed care, Medicaid enrollees in fee-for-service began to sharply decrease in FY15, while enrollees in MCOs increased dramatically. Auditors determined:

- that from FY08 to FY16, fee-for-service enrollees decreased 47 percent, while MCO capitation enrollees increased by 1,061 percent; and
- fee-for-service enrollees decreased from 2.19 million in FY08 to 1.16 million in FY16. During the same period, MCO enrollees increased from 174,821 in FY08, to almost 2.03 million in FY16. The total enrollees at the end of FY16 increased by 35 percent from the end of FY08.

MCO enrollees increased from 174,821 in FY08, to almost 2.03 million in FY16.

Digest Exhibit 2
TOTAL MEDICAL ASSISTANCE ENROLLEES
Enrollees as of the last day of the fiscal year

State Fiscal Year	Total Managed Care	Total Fee-for-Service	Total All Medicaid
FY08	174,821	2,185,932	**2,360,753**
FY09	190,653	2,322,021	**2,512,674**
FY10	195,971	2,457,191	**2,653,162**
FY11	201,776	2,547,377	**2,749,153**
FY12	248,865	2,539,260	**2,788,125**
FY13	309,709	2,501,202	**2,810,911**
FY14	460,524	2,682,660	**3,143,184**
FY15	1,619,874	1,612,799	**3,232,673**
FY16	2,029,064	1,164,386	**3,193,450**

Source: Enrollment data provided by HFS.

AUDIT RECOMMENDATIONS

The audit report contains six recommendations directed to the Department of Healthcare and Family Services. The Department generally agreed with all of the recommendations except for the second part of recommendation number 3 related to the on-site monitoring of the MCOs.

The audit recommends HFS should:

1. Monitor the actual administrative costs incurred by its MCOs to ensure that the administrative costs do not exceed what is allowed by contract;
2. Calculate the Medical Loss Ratios for the previous four calendar years (2013 through 2016), and determine whether the State should be reimbursed by MCOs due to overpayment;
3. Require all MCOs to submit all Medicaid provider payment data for all services (including DASA, LTC, and waiver services), and perform on-site reviews of the MCOs' financial data systems and test the completeness and accuracy of the data reported to HFS that is used to monitor the payments made to Medicaid providers;
4. Provide clear guidance to the MCOs for reporting denied claims, and ensure that the MCOs provide the denied claims to HFS as required by contract;
5. Ensure multiple monthly capitation payments are not being made for the same Medicaid recipients, immediately identify and remove all duplicative recipients from its eligibility data, and recoup any overpayment of duplicate capitation payments; and
6. Ensure that it effectively monitors the newly awarded MCO contracts to ensure compliance with all contractual provisions.

This performance audit was conducted by the staff of the Office of the Auditor General.

SIGNED ORIGINAL ON FILE

Ameen Dada
Division Director

This report is transmitted in accordance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

FJM:SAW