



STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

**PERFORMANCE AUDIT
OF
MEDICAID MANAGED CARE
ORGANIZATIONS**

JANUARY 2018

FRANK J. MAUTINO

AUDITOR GENERAL

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OFFICE OF THE AUDITOR GENERAL
FRANK J. MAUTINO

*To the Legislative Audit Commission, the
Speaker and Minority Leader of the House
of Representatives, the President and
Minority Leader of the Senate, the members
of the General Assembly, and
the Governor:*

This is our report of the performance audit of Medicaid Managed Care Organizations (MCOs), which includes a comparison of State expenditures between MCOs and the Medicaid fee-for-service program for State fiscal year 2016.

The audit was conducted pursuant to House Resolution Number 100. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

Frank J. Mautino
Auditor General

Springfield, Illinois
January 2018



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

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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 (see Appendix A).

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; (page 16)
- 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; (page 18)
- 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; (page 25)
- 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; (page 26)
- 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 (page 27)
- 6) ensure that it effectively monitors the newly awarded MCO contracts to ensure compliance with all contractual provisions. (page 29)

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.

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

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.

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.
- 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

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 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

- 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**. 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.

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.

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.

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.

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

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

- 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.** 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.

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.

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 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 Department’s complete response to the audit is included as Appendix C.

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

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GLOSSARY OF TERMS

Capitation is a reimbursement arrangement 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.

Encounter is defined as an individual service or procedure provided to an enrollee that would result in a claim if the service or procedure were to be reimbursed as fee-for-service under the HFS Medical Program.

Encounter Utilization Monitoring (EUM) documents the amount each managed care organization reported it spent on claims and the amount of those claims that were accepted by HFS after the claims were run through the HFS edits in its Medicaid Management Information System (MMIS). Encounters not accepted means that the encounter was not accepted by MMIS due to a data or formatting issue, not because the actual encounter was not allowed.

Fee-for-service is the fee the medical providers charged HFS directly for each encounter or service rendered.

Gross-ups are used to reimburse the managed care organizations for the taxes paid on the HIF which are not tax deductible.

Health Insurance Fee (HIF) is an annual fee imposed on the health insurance industry, which is mandated by the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

Medical Loss Ratio (MLR) is defined in the State contracts with the managed care organizations as total plan benefit expense divided by total capitation revenue.

Waiver Services are services that allow individuals to remain in their homes or live in a community setting, instead of in an institution.

Chapter One

INTRODUCTION AND 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 (see Appendix A). 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.*
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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.

This performance audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Audit 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 found in House Resolution Number 100. Appendix B includes the audit scope and methodology used while conducting this audit.

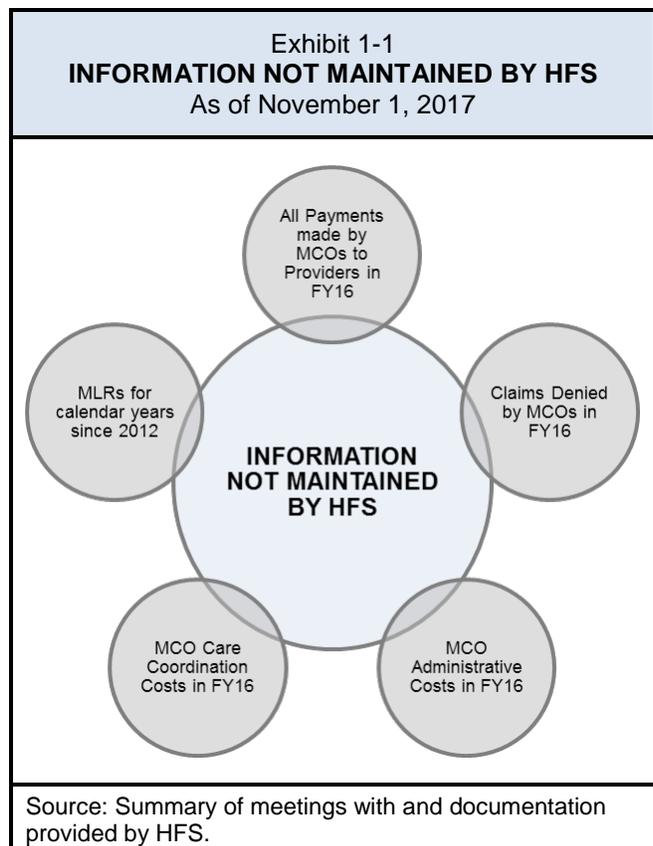
REPORT CONCLUSIONS

Based on numerous information requests and meetings with HFS officials, auditors determined that HFS did not maintain complete and accurate information needed to adequately monitor payments made to and by the 12 MCOs during FY16.

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

Medicaid reimbursements to MCOs are not paid on a fee-for-service basis; they are paid using 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.

As shown in Exhibit 1-1, auditors determined that as of November 1, 2017, HFS had not maintained complete and accurate information necessary for auditors to address several of the nine audit determinations found in House Resolution Number 100; which covered FY16.



HFS could not provide the following information:

- 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.
- 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 FY16 capitation rates.**

MCO Capitation Payments

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

Duplicate Capitation Payments for Recipients

- 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” paid by the State to MCOs for FY16 was **\$137.9 million**. HFS noted it could not break out the “gross-up” from the HIF. The HIF is an annual fee (federal tax) imposed on the health insurance industry, which is mandated by the Affordable Care Act 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.
- According to HFS and the federal Centers for Medicare & Medicaid Services (CMS) documentation, the HIF reimbursement is not specifically required by the Affordable Care Act (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.** Auditors reviewed numerous actuary 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.** 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

- 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.** 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 in a written response, "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 Medicaid providers.

MEDICAID PAYMENTS IN ILLINOIS

Traditionally, Illinois has paid Medicaid 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. In this scenario, providers submit bills directly to HFS for payment for each encounter or service provided to Medicaid clients. HFS

reviews the client's eligibility and determines whether the services are allowable and directly pays each provider for each allowable service provided.

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). At that time, the majority of Medicaid services were paid on a fee-for-services basis. The Illinois Public Aid Code (305 ILCS 5/5-30(a)) was amended to require the following:

At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015.

The Public Aid Code defines "care coordination" or "coordinated care" as a delivery system where recipients receive their medical care from providers who participate under contract. Thus, MCOs enter into contracts with HFS to provide integrated delivery systems that are responsible for providing or arranging the majority of care. Managed care includes primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. HFS is required to contract for such delivery systems to ensure enrollees have a choice of systems and primary care providers.

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 federal Centers for Medicare and Medicaid Services, and the federal regulations.

According to the Actuarial Standards of Practice No. 49, Medicaid capitation rates are **actuarially sound** if,

for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

IMPLEMENTATION OF MANAGED CARE IN ILLINOIS

According to documentation provided by the HFS, beginning in fiscal year 2008, managed care in Illinois was implemented as follows:

- In FY08, **voluntary** enrollment began for the Family Health Population (FHP). Enrollment at the end of FY08 for the FHP was 174,821, while the fee-for-service Medicaid population was almost 2.19 million recipients. The total program enrollees at the end of FY08 were 2.36 million.
- During the following two fiscal years (2009 and 2010), **voluntary** enrollment for the FHP continued. The total recipients by the end of FY10 (June 30, 2010) was 195,971. The fee-for-services Medicaid population increased to almost 2.46 million. The total program enrollees at the end of FY10 were 2.65 million.
- In FY11, **voluntary** FHP enrollment continued while in May 2011, enrollment for the Integrated Care Program (ICP) began in suburban Cook county and the collar counties. By the end of FY11, there were 199,759 enrollees in FHP, 2,017 enrolled in ICP, and there were almost 2.55 million fee-for-service Medicaid recipients. The total program enrollees at the end of FY11 were 2.75 million.
- In FY12, **voluntary** enrollment continued for FHP, while enrollment for ICP in suburban Cook and the “collar” counties only became **mandatory**. By the end of FY12, there were 214,251 enrollees in FHP, ICP increased to 34,614 enrollees, and there were almost 2.54 million fee-for-service Medicaid recipients. The total program enrollees at the end of FY12 were 2.79 million.
- In FY13, **voluntary** enrollment continued for FHP and **mandatory** enrollment continued for ICP in suburban Cook and the “collar” counties. Additionally, **mandatory** enrollment began for ICP clients in the Rockford region in April 2013. A County Care waiver to cover the Affordable Care Act (ACA) adults prior to January 1, 2014, began in November 2012. At the end of FY13, 34,838 new ACA adults were added, FHP enrollees increased to 240,189, ICP enrollees stayed about the same at 34,682, and there were 2.5 million fee-for-service Medicaid recipients. The total program enrollees at the end of FY13 were 2.81 million.
- In FY14, **voluntary** enrollment for FHP continued along with **mandatory** enrollment for ICP in suburban Cook and the collar counties and the Rockford region. **Mandatory** enrollment of ICP clients began in Central Illinois, the Quad Cities, and Metro East in October 2013. Illinois’ Medicare-Medicaid Alignment Initiative (MMAI) enrollment with opt-out provision began October 2013. **Mandatory** enrollment of ICP population in metro Chicago began in January 2014. By the end of FY14, 460,524 recipients were enrolled in managed care and 2.68 million were fee-for-service Medicaid recipients. The total program enrollees at the end of FY14 were 3.14 million.

- Enrollment in managed care increased dramatically to almost 1.62 million in FY15, up from 460,524 the year before. In July 2014, MCO enrollment of FHP and ACA populations became **mandatory**. ICP 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. According to HFS, enrollment continued as clients enrolled in Medicaid, qualified for enrollment in an MCO, or moved into a **mandatory** managed care region. The total program enrollees at the end of FY15 were 3.23 million.
- In FY16, HFS noted that enrollment continued as in FY15. By the end of FY16, 2.03 million recipients were enrolled in managed care and 1.16 million were fee-for-service Medicaid recipients. The total program enrollees at the end of FY16 were 3.19 million.

Exhibit 1-2 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.			

As shown in Exhibit 1-2, due to 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.

As enrollment in managed care increased between FY08 and FY16, the cost to the State increased at an even greater pace. In FY08, the cost for managed care was \$212.8 million. By FY16, the cost for managed care increased to \$7.11 billion. During the same period, the cost for fee-for-service decreased from \$10 billion in FY08 to \$7.6 billion in FY16. Exhibit 1-3 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.

Exhibit 1-3 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.

FISCAL YEAR 2016 MANAGED CARE PLANS IN ILLINOIS

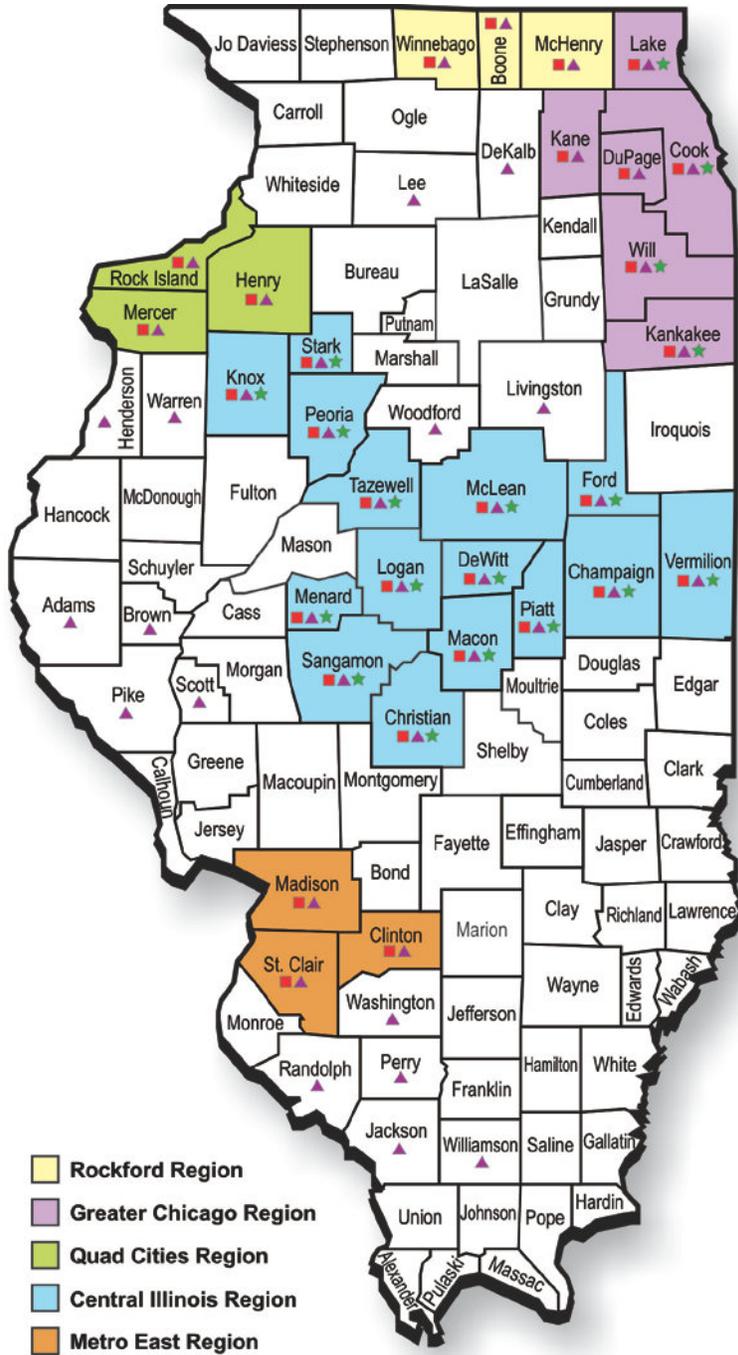
The following are the four types of MCOs which operated in Illinois during FY16: 1) Integrated Care Program (ICP) -serve individuals who are non-Medicare eligible adults with disabilities who are over the age of 18; 2) Family Health Plan (FHP) -serve children and caretaker adults; 3) Affordable Care Act (ACA) -serve the newly eligible adults who gained coverage under the Medicaid expansion provisions of the ACA; and 4) Medicare-Medicaid Alignment Initiative (MMAI) - serve individuals who are “dually” Medicare-Medicaid eligible. These plans operate in a limited number of counties.

In FY16, there were 12 MCOs that provided variations of four different plan types in Illinois (see below). Exhibit 1-4 lists the 12 MCOs in Illinois during FY16. Exhibit 1-5 lists the MCOs and plan types by area/county in which they operated in FY16.

According to HFS documentation, several populations are excluded from mandatory MCO enrollment. These populations include: clients eligible through spend down; Department of Children and Family Services wards; children with disabilities/children receiving Supplemental Security Income (SSI); clients with significant third party coverage; clients with presumptive eligibility; and refugees. Eligible clients are required to enroll in managed care in counties where two or more MCOs are operating.

Exhibit 1-4 ILLINOIS MANAGED CARE ORGANIZATIONS Fiscal Year 2016
1. Aetna Better Health
2. Blue Cross Blue Shield IL ¹
3. CountyCare ¹
4. Family Health Network/Community Care Alliance IL ¹
5. Harmony Health Plan
6. Health Alliance Connect ¹
7. HealthSpring
8. Humana Health Plan
9. IlliniCare Health Plan
10. Meridian Health Plan
11. Molina Healthcare of Illinois
12. NextLevel Health Partners
Note: ¹ Not-for-profit organization. Source: Information provided by HFS.

Exhibit 1-5 MANAGED CARE PLANS BY REGION Fiscal Year 2016



INTEGRATED CARE PROGRAM (ICP) □

Aetna Better Health	Greater Chicago, Rockford
Blue Cross Community ICP	Greater Chicago
Cigna-HealthSpring	Greater Chicago
Community Care Alliance	Greater Chicago, Rockford
CountyCare	Greater Chicago (Cook only)
Health Alliance Connect	Central Illinois, Quad Cities
Humana Health Plan	Greater Chicago
IlliniCare Health	Greater Chicago, Rockford, Quad Cities
Meridian Health Plan	Greater Chicago, Central Illinois (Stark, Knox, Peoria, and Tazewell Counties only), Metro East
Molina Healthcare of Illinois	Central Illinois, Metro East
NextLevel Health	Greater Chicago (Cook only)

FAMILY HEALTH PLANS / AFFORDABLE CARE ACT HEALTH PLANS (FHP/ACA) △

Aetna Better Health	Greater Chicago, Rockford
Blue Cross Community Family Health Plan	Greater Chicago
CountyCare	Greater Chicago (Cook only)
Family Health Network	Greater Chicago
Harmony Health Plan	Greater Chicago, Metro East, Jackson, Perry, Randolph, Washington, Williamson
Health Alliance Connect	Central Illinois, Quad Cities, Rockford
IlliniCare Health	Greater Chicago, Rockford, Quad Cities
Meridian Health Plan	Greater Chicago, Central Illinois (Stark, Knox, Peoria, Tazewell, and McLean Counties only), Brown, DeKalb, Henderson, Lee, Livingston, Pike, Scott, Warren, Woodford
Molina Healthcare	Greater Chicago (Cook only), Central Illinois, Metro East
NextLevel Health	Greater Chicago (Cook only)

MEDICARE MEDICAID ALIGNMENT INITIATIVE (MMAI) ☆

Aetna Better Health Premier Plan	Greater Chicago (excluding Lake)
Blue Cross Community	Greater Chicago
Cigna-HealthSpring	Greater Chicago (excluding Kankakee)
Humana Health Plan, Inc.	Greater Chicago
IlliniCare Health	Greater Chicago
Meridian Complete	Greater Chicago (excluding Kankakee, Lake)
Molina Healthcare of Illinois	Central Illinois

Source: HFS.

Chapter Two

MANAGED CARE COSTS

CHAPTER CONCLUSIONS

Based on information provided by the Department of Healthcare and Family Services (HFS) on June 23, 2017, the amount of managed care organization (MCO) capitation payments made by HFS for fiscal year 2016 was **\$7,110,312,919**.

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 actuary 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. 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.

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 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 federal 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.

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.

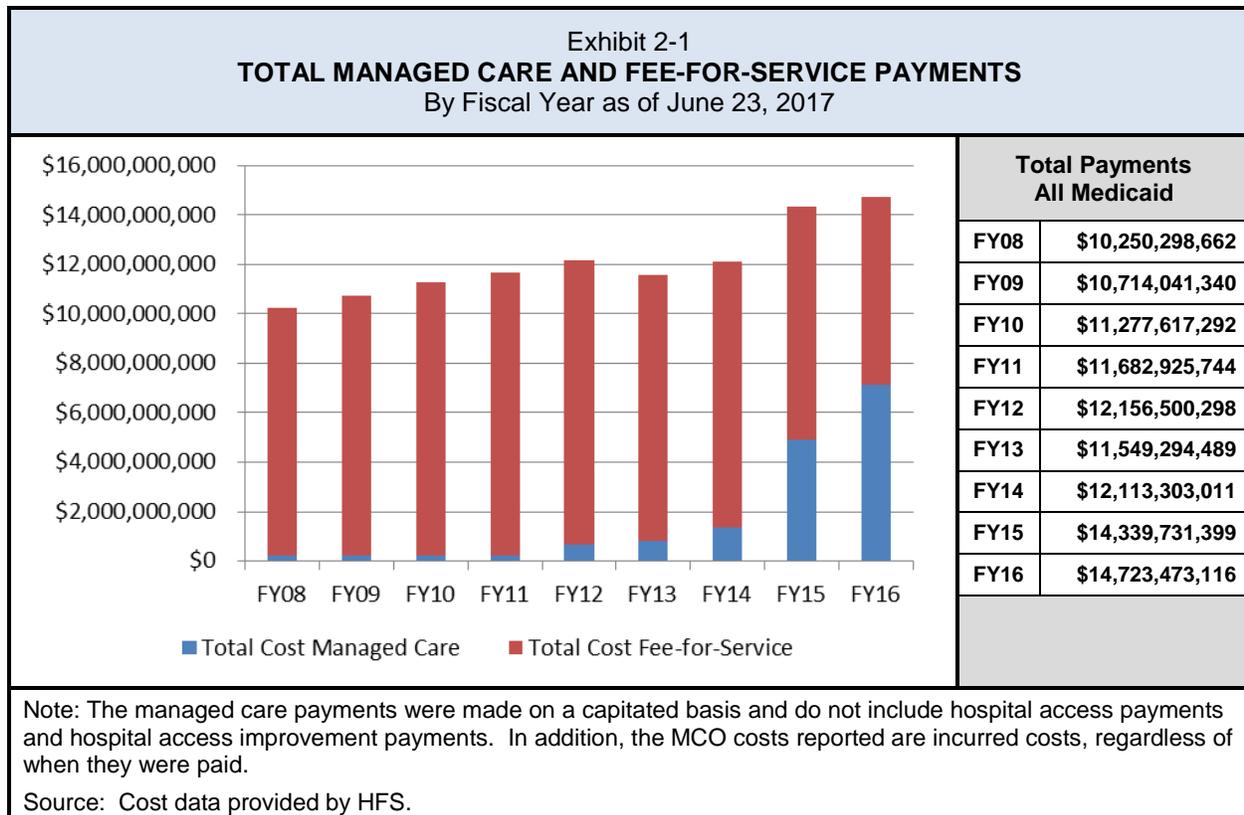
MANAGED CARE COSTS

The audit resolution requires auditors to examine specific costs related to managed care organizations in FY16. These costs include:

- The aggregate amount of MCO capitation payments made by HFS to MCOs;
- The administrative costs paid to MCOs in dollars and percentage of total medical-based payments;
- The payments made to for-profit MCOs for the Affordable Care Act Health Insurer Fee (HIF);
- The payments made to for-profit MCOs for “gross-ups” related to the HIF payments; and
- The incidence to which the MCO capitation rates contain supplemental, GRF-based payments to providers.

FY16 MCO Capitation Payments made to MCOs

As enrollment in managed care increased between FY08 and FY16, the cost to the State increased at an even greater pace. In FY08, the cost for managed care was \$212,829,112. By FY16, the cost for managed care increased to **\$7,110,312,919**. During the same period, the cost for fee-for-service decreased from \$10,037,469,550 in FY08 to \$7,613,160,197 in FY16.



As discussed in chapter one, Medicaid payments made by HFS to managed care organizations are made using capitation rates which are a reimbursement arrangement where a fixed rate of payment per enrollee (member) per month is made, regardless of whether the enrollee received covered services during that month. Exhibit 2-1 shows the total capitation payments for managed care made by HFS and the cost for fee-for-service payments made to providers from FY08 through FY16. The annual total medical costs increased by 44 percent from FY08 to FY16.

According to cost data provided by HFS on June 23, 2017, for FY16, **\$7.11 billion** was paid through capitation payments to the 12 MCOs. In FY16, the fee-for-services Medicaid reimbursements to health care providers totaled an additional \$7.61 billion.

As shown in Exhibit 2-2, MCOs that provided coverage for Family Health Plans received the most funding in FY16, totaling \$2.75 billion dollars in capitation payments. Additionally in FY16, the Integrated Care Program plan MCOs were paid \$2.02 billion, Affordable Care Act MCOs were paid \$1.90 billion, and Medicare-Medicaid Alignment Initiative MCOs were paid \$444 million.

Six of the 12 MCOs participated in all four of the plan types. Aetna Better Health and IlliniCare Health Plan each received more than \$1 billion in capitation payments in FY16. Exhibit 2-3 lists the total capitation payments made by HFS to the MCOs by MCO and by plan type for FY16.

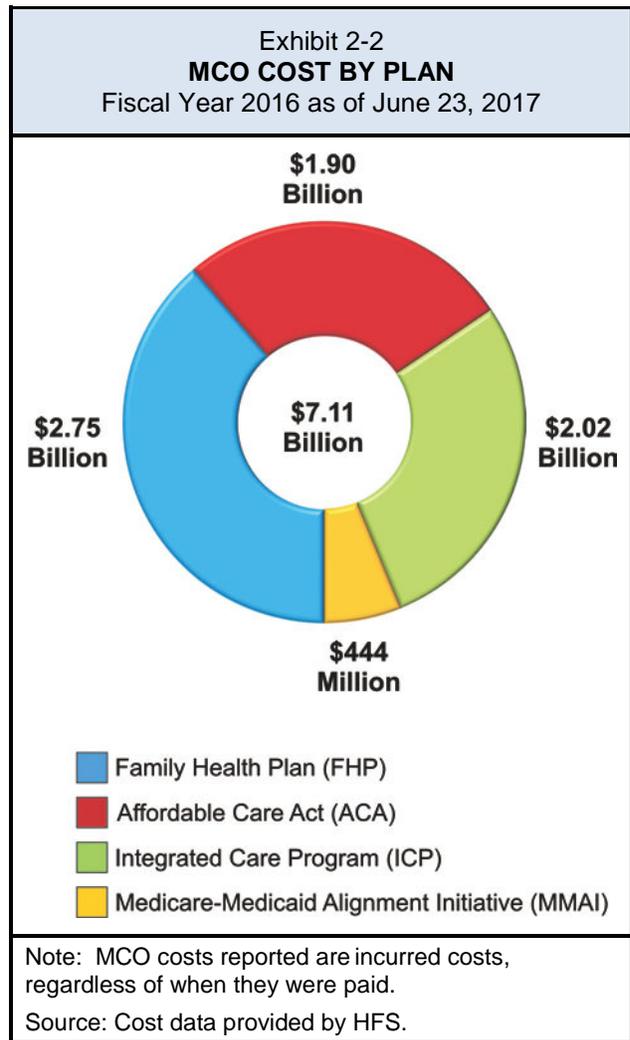


Exhibit 2-3 TOTAL CAPITATION PAYMENTS TO EACH MANAGED CARE ORGANIZATION BY PLAN For FY16 as of June 23, 2017					
MCO	ACA	FHP	ICP	MMAI	Totals
Aetna Better Health	\$192,933,543	\$266,727,452	\$575,248,592	\$67,201,688	\$1,102,111,275
IlliniCare Health Plan	191,358,171	294,305,972	553,352,432	39,432,068	1,078,448,643
County Care	568,860,777	312,315,592	64,815,335	-	945,991,704
Blue Cross Blue Shield IL	231,051,955	394,433,758	141,083,405	95,525,159	862,094,277
Meridian Health Plan	206,166,343	421,900,955	167,526,396	61,919,304	857,512,998
Family Health Network/Community Care Alliance IL	117,581,312	396,556,371	137,793,245	-	651,930,928
Molina Healthcare of Illinois	128,971,929	203,169,325	76,978,414	33,405,097	442,524,765
Health Alliance Connect	115,320,376	191,488,995	107,393,172	20,586,058	434,788,601
Harmony Health Plan	127,370,326	263,293,767	-	-	390,664,093
Cigna-HealthSpring	-	-	85,101,846	61,996,809	147,098,655
Humana Health Plan	-	-	76,127,150	63,578,741	139,705,891
NextLevel Health	24,072,869	1,653,995	31,714,225	-	57,441,089
FY16 TOTALS	\$1,903,687,602	\$2,745,846,182	\$2,017,134,212	\$443,644,923	\$7,110,312,919
Note: MCO costs reported are incurred costs, regardless of when they were paid.					
Source: Expenditure documentation provided by HFS.					

Administrative Costs Paid to MCOs in FY16

HFS did not adequately monitor the actual administrative costs, care coordination costs, or other non-benefit costs incurred by the MCOs during FY16. According to the 2016 Medicaid Managed Care Rate Setting Consultation Guides published by the federal CMS, the administrative costs for MCOs are contained within the “projected non-benefit costs.” Included in the non-benefit costs are the following cost categories:

- Administrative costs;
- Care coordination and care management;
- Provision for margin (includes profit margin, operating margin, risk margin, contingency margin, cost of capital, or underwriting gain);
- Taxes, fees, and assessments; and
- Other material non-benefit costs.

An initial audit information request was sent to HFS on June 13, 2017, which specifically requested that HFS provide the non-benefit costs paid to MCOs by category. Auditors discussed this request with HFS officials on June 20, 2017, and again on July 5, 2017. During the meeting on July 5, 2017, HFS officials indicated that HFS could not break out the non-benefit costs, which includes administrative costs.

During the next few months, auditors continued to try to obtain the administrative costs from HFS and were subsequently directed by HFS to meet with its actuary. A meeting with the actuary and HFS was held on September 5, 2017, where the actuary indicated that they did not currently have the actual administrative cost figures paid to MCOs in FY16, but were working to obtain them from the MCOs. The actuary believed they would have the information by the end of October 2017. During the meeting, the actuary indicated that administrative costs are approximately 13 percent of the total capitation rates paid; however, the actuary said that was not an actual documented percentage. If an estimate of 13 percent was used to determine the administrative costs for FY16, the administrative cost for \$7.11 billion would be approximately \$924.3 million.

Auditors also reviewed HFS monitoring documents, such as actuary reports and MCO financial audits, and found nothing that identified the actual administrative costs or the actual costs for care coordination and care management paid to the MCOs. The actuary produces bi-annual rate certification reports, which are submitted to HFS. Auditors reviewed both rate certification reports by plan for FY16 and determined that there was not a set percentage for administrative cost for all plans.

For example, the rate certification reports show that the administrative cost portion of the capitation rate for the Affordable Care Act plan in 2016 was 13 percent, while the administrative portion for the Integrated Care Program was 7.5 percent plus \$40 per member per month for nursing home enrollees and \$25 per member per month for all other enrollees. The administrative cost portion for the Family Health Plan for the second half of FY16 was 12.85 percent for non-delivery rates and 3.5 percent for the delivery case rates. Since these administrative cost rates all vary by plan and by enrollee type and HFS could not provide all encounter data for all enrollees, auditors could not estimate or determine the administrative costs for FY16.

As of November 1, 2017, neither the actuary nor HFS provided the MCO administrative cost information. 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.

ADMINISTRATIVE COSTS FOR MANAGED CARE ORGANIZATIONS	
<p>RECOMMENDATION NUMBER</p> <p>1</p>	<p><i>The Illinois Department of Healthcare and Family Services should monitor the actual administrative costs incurred by its managed care organizations to ensure that the administrative costs do not exceed what is allowed by contract.</i></p>
<p>DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE</p>	<p>The Department concurs with the recommendation and, in fact, already monitors such costs. HFS collects information from each MCO regarding spending on administrative costs as part of the overall data collection process for rate setting. If the MCO exceeds the amount allowed by contract, the costs come out of their profit. If the MCO spends less than the administrative costs included, they can keep the difference as profit, up to the limits of the Medical Loss Ratio (MLR). This additional MCO spending data was provided to the Auditor.</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><u>Auditor Comment:</u></p> <p><i>The additional administrative expense data provided by HFS was not actual administrative costs incurred by the MCOs as required by House Resolution Number 100. Additionally, the administrative expense data was not provided until January 5, 2018, after the completion of the audit. Also, the data provided was for calendar year 2016 and not fiscal year 2016, and did not contain an explanation or a methodology that described exactly how the administrative expenses were calculated and what specific source documentation was used. The email accompanying the administrative expense data noted it was "not what the language in the resolution asked for..."</i></p> </div>

Medical Loss Ratio

According to HFS officials, HFS had not calculated the required annual Medical Loss Ratio (MLR) since calendar year 2012. Had HFS calculated the MLR as required by its contracts with the MCOs, HFS would have had the administrative cost information in order to monitor the MCOs more effectively and efficiently. Without these MLR calculations, HFS did not reconcile the payments made to the MCOs for more than four years.

The MLR is defined in the contracts as total plan benefit expense divided by total capitation revenue (see MLR definition details in the adjacent text box). The Public Aid Code (305 ILCS 5/5-30(h)) requires contracts with MCOs to have a minimum MLR of 85 percent.

The MCO contracts contain a section titled Medical Loss Ratio Guarantee, which requires that HFS shall calculate the MLR within 90 days following the six month claims run-out period following the coverage year. The MCOs then have 60 days to review HFS’ calculation. If the MCO did not meet its MLR set by the contract, the MCO is required to refund the State the difference.

As of July 5, 2017, HFS officials indicated that the contractually required MLRs had **not** been calculated since calendar year 2012. As of November 1, 2017, no information was received to support the MLR calculations for any calendar year other than 2012. According to the contracts between HFS and the MCOs, the State requires health plans to maintain a minimum medical loss ratio of 85 percent for the Family Health Population/Affordable Care Act plans and the Medicare-Medicaid Alignment Initiative and 88 percent for the Integrated Care Program plans.

Fiscal year capitation payment data was provided by HFS, which shows that for FY13 through FY16, HFS paid MCOs \$14.2 billion. Without the MLR calculations, HFS cannot reconcile what was paid to the MCOs. HFS noted that in 2012, the last time it calculated the MLR rates, it recovered almost \$21.7 million from ICP plans alone. HFS has not determined whether the MCOs were overpaid by the State in calendar years 2013, 2014, 2015, and 2016.

Medical Loss Ratio (MLR) =

Benefit Expense
Revenue

Benefit Expense =

- Paid Claims (Encounters);
- Incurred But Not Paid Claims;
- Provider Incentive Payments;
- Care Coordination Expenses (personnel costs attributable to this contract); and
- Other (services not capable of being sent as encounter data).

Revenue =

Capitation Payments minus annual fee minus supplemental capitation payments to allow contractor to preserve access to hospital services

Source: HFS contracts with MCOs.

HFS officials indicated that the MLR had **not** been calculated since calendar year 2012.

Without the MLR calculations, HFS cannot reconcile what was paid to the MCOs. Thus, HFS has not determined whether the MCOs were overpaid by the State in calendar years 2013, 2014, 2015, and 2016.

MEDICAL LOSS RATIO	
RECOMMENDATION NUMBER 2	<p><i>The Illinois Department of Healthcare and Family Services should:</i></p> <ul style="list-style-type: none"> • <i>calculate the Medical Loss Ratios since calendar year 2012 as required by the MCO contracts; and</i> • <i>determine whether the State should be reimbursed by MCOs due to overpayment.</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES’ RESPONSE	<p>The Department concurs with the recommendation. MLR calculations were delayed while capitation payments were finalized. Due to system issues, some adjustments had to be made manually after the 18 month lookback period. The MLR calculations have been completed for 2013 and 2014 for the Integrated Care Program (ICP). Data to calculate the Family Health Plan (FHP) MLR for July 2014 – December 2015, and ICP for 2015, has been requested from the MCOs and was due to the Department by December 15th. Data has now been received from most plans. Additionally, a methodology has been developed in consultation with our actuaries to estimate MLR before the calculation can be made in order to track and monitor potential recoupments and report them on financial statements.</p>

Health Insurer Fee

The Health Insurer Fee (HIF) is an annual fee (federal tax) imposed on the health insurance industry, which is mandated by the Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. According to a research report done by the actuary in April 2013 titled *ACA health insurer fee*, the fee is allocated to health insurers based on the respective market share of premium revenue in the previous year. Not-for-profit insurers that receive more than 80 percent of their premium revenue from Medicare, Medicaid, and State Children’s Health Insurance Program (SCHIP) are exempt from the fee. Other not-for-profit insurers that do not reach the 80 percent threshold can exclude 50 percent of their premium revenue from the HIF calculation. The HIF is also considered an excise tax and is nondeductible for income tax purposes. This means that MCOs must pay income taxes on the health insurer fees that are imposed on them.

After the HIF is paid by the MCOs, HFS reimburses the MCOs for the HIF on a per month per member (PMPM) basis rather than a mass payment, so the PMPM is applied for a fixed period of enrollment that is relatively stable. According to the 2013 actuary report provided by HFS, the State’s reimbursement to the MCOs for the cost of the HIF is not required by the federal Centers for Medicare & Medicaid Services (CMS). However, federal CMS requires Medicaid managed care premiums to be actuarially sound. According to HFS, the Actuarial Standards Board’s Actuarial Standards of Practice recognize taxes and fees, such as the HIF, as a reasonable and unavoidable cost of doing business for MCOs. Thus, according to HFS, reimbursement for the HIF is an “actuarially sound” practice that was followed in FY16. For FY16, the amount of HIF owed to the MCOs was **\$85.8 million**.

Gross-up

When HFS was asked to define “gross-ups,” HFS noted that it is discussed in the 2013 research report completed by its actuary. The research report 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. However, since taxes and fees are recognized as a reasonable and unavoidable cost of doing business for MCOs, the MCOs are paid a “gross-up” to reimburse the MCO for the taxes paid on the HIF, which is not tax deductible.

The “gross-up” paid to the MCOs assumes a 35 percent marginal federal corporate tax rate. According to the actuary report, without the HIF and “gross-up” reimbursements, the insurer would just increase its costs to account for the cost of the HIF and lost taxes. For FY16, the amount of the “gross-up” owed to the MCOs was **\$52.2 million**. As shown in Exhibit 2-4, the combined HIF and “gross-up” owed by the State to MCOs for FY16 was **\$137.9 million**.

Exhibit 2-4 TOTAL HEALTH INSURER FEE AND GROSS-UP Fiscal Year 2016			
Managed Care Organization ¹	FY16 HIF	FY16 Gross Up	Total FY16 HIF and Gross-Up
Aetna Better Health	\$21,203,941	\$14,080,974	\$35,284,915
IlliniCare Health Plan	18,118,989	12,098,211	30,217,200
Meridian Health Plan	16,447,721	10,982,291	27,430,013
Blue Cross Blue Shield IL	11,468,028	2,867,007	14,335,036
Harmony Health Plan	8,491,011	5,669,524	14,160,536
Molina Healthcare of IL	7,312,949	4,882,922	12,195,872
Humana Health Plan	1,593,996	973,481	2,567,477
Cigna-HealthSpring	1,135,887	611,632	1,747,519
Total²	\$85,772,525	\$52,166,043	\$137,938,567

Notes:
¹ The other four MCOs were not reimbursed for the fee by HFS in FY16.
² Totals do not add due to rounding.
Source: HIF and Gross-up information provided by HFS.

Supplemental GRF-Based Payments

House Resolution Number 100 asked for 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. Based on information provided by HFS, this determination was referring to Cook County Health & Hospitals System (CCHHS) access payments.

According to the actuary's 2016 rate certification reports, the CCHHS access fee is intended for MCO members to access the CCHHS facilities. CCHHS is a key health care provider to the targeted member population in the Suburban Cook/Collar Counties region and the Chicago Metro region. The \$10 PMPM access fee is intended to provide support for contracting and access to the members to the CCHHS network and the managed care entities. According to HFS, the CCHHS payments are not directly tied to a specific service, and are the only payments of this type that were made in FY16. Based on information provided by HFS, in FY16, \$138,398,950 in CCHHS access payments were paid to MCOs.

Chapter Three

MONITORING DOCUMENTATION

CHAPTER CONCLUSIONS

HFS could not provide auditors with all paid claims to Medicaid providers by MCOs, medical loss ratio calculations, or MCO administrative denied claim data for FY16. This is information that is necessary to adequately monitor the billions of dollars paid to the MCOs and to answer the specific audit determinations.

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.

The actuary 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 FY16 capitation rates.**

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 for 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.

HFS also 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 in a written response, “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 Medicaid providers.

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.

REQUIRED MONITORING DOCUMENTATION

HFS could not provide auditors with the total amount of all paid claims to Medicaid providers by the MCOs, medical loss ratio calculations, or MCO administrative denied claim data for FY16. In order to accurately answer the determinations outlined in House Resolution Number 100, auditors determined that this information was needed. Additionally, as discussed below, this information is necessary to adequately monitor the billions of dollars paid to the MCOs.

Use of Encounter Data for Capitation Rate Setting

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.

The actuary 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 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

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.**

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 FY16 capitation rates.**

Auditors reviewed the contracts with the MCOs, the Illinois Public Aid Code, the *2016 Medicaid Managed Care Rate Development Guide* published by the federal Centers for Medicare & Medicaid Services, and the Actuarial Standards of Practice No. 49 Medicaid Managed Care Capitation Rate Development and Certification published by the Actuarial Standards Board and did not see where encounter data was specifically **required** to be used to set capitation rates. The Actuarial Standards of Practice No. 49 listed several sources of data that can be used to set capitation rates which include: financial reports; summary **encounter data** reports; **encounter data** with payment information; **encounter data** without payment information; sub-capitation payment information; and provider settlement payment reports.

The Actuarial Standards of Practice No. 49 also provided that if a managed care program is new, the actuary may need to use alternative data sources. These sources include fee-for-service experience and experience from other states. Experience data may be available in other forms such as: financial reports; summary claims data reports; raw claims data with payment information; and state-specific provider settlement payment reports.

On July 5, 2017, HFS provided a summary document that showed what information was used to set the FY16 capitation rates. The document noted for:

- **ACA and FHP plans**, fee-for-service data was used during the first half of FY16, while fee-for-service data and trend data was used during the second half to set capitation rates;
- **ICP plans**, fee-for-service data was used during the first half of the year, while MCO reported data and fee-for-service data was used to set rates for the second half of the year; and
- **MMAI plans**, fee-for-service data was used along with trend data during FY16 to set the rates.

Encounter Utilization Monitoring

When asked about the total amount of claims paid to Medicaid providers by the MCOs in FY16, HFS reported it established the Encounter Utilization Monitoring (EUM) to help improve the encounter submissions by MCOs to HFS. The EUM compares the encounters submitted by the MCOs which are accepted by the Medicaid Management Information System (MMIS) to the amount of claims paid by MCOs to Medicaid providers which are self-reported quarterly to HFS. The quarterly self-reported encounters for FY16 totaled \$5.1 billion. The encounters reported by the MCOs (minus DASA, LTC, waiver services, and MMAI) are run through a series of edit checks in HFS' MMIS. As seen in Exhibit 3-1, after the edits were run, HFS accepted \$4.67 billion. According to HFS officials, encounters rejected by the MMIS edits include either errors that are due to MCO technical or procedural issues or errors that are believed to be "due to a technical HFS MMIS issue or an absence of clear direction from HFS." Therefore, according to

the EUM, HFS’ MMIS only accepted \$4.67 billion (66%) in encounters of the \$7.11 billion paid to MCOs for FY16.

Exhibit 3-1 MCO ENCOUNTERS ACCEPTED BY HFS Fiscal Year 2016	
Health Plan	Encounters Accepted by HFS
Aetna Better Health	\$735,813,499.93
County Care	585,670,116.62
Family Health Network/Community Care Alliance IL	399,148,649.22
Harmony Health Plan	259,440,812.06
Health Alliance Connect	357,210,740.91
Blue Cross Blue Shield IL	618,619,436.00
Cigna-HealthSpring	39,725,644.22
Humana Health Plan	30,953,816.62
IlliniCare Health Plan	757,597,703.64
Meridian Health Plan	573,226,552.11
Molina Healthcare of Illinois	290,211,850.57
NextLevel Health	24,610,362.43
Total	\$4,672,229,184.33

Source: FY16 Encounter Utilization Monitoring report provided by HFS.

MCO Payout Ratio

House Resolution Number 100 directed the Office of the Auditor General to determine the average payout ratio for all MCOs in aggregate and for each MCO individually. The resolution defined payout ratio 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.” The “payout ratio” is not the same as the Medical Loss Ratio, as they are defined differently.

House Resolution Number 100 directed the Office of the Auditor General to determine the average payout ratio for all MCOs in aggregate and for each MCO individually.

HFS 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.

When information to address this audit determination was requested in June 2017, neither HFS nor its actuary could provide auditors with a total amount of all paid claims during FY16. According to contracts between HFS and the MCOs, the total amount of all claims paid to Medicaid providers by MCOs is referred to as the encounter data. The contract defines paid claims as encounters and defines an encounter as “an individual service or procedure provided to an Enrollee that would result in a claim if the service or procedure were to be reimbursed as Fee-For-Service under the HFS Medical Program.”

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.

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.

ALL CLAIMS PAID TO MEDICAID PROVIDERS BY MCOs	
<p>RECOMMENDATION NUMBER</p> <p>3</p>	<p><i>The Illinois Department of Healthcare and Family Services should:</i></p> <ul style="list-style-type: none"> • <i>require all managed care organizations to submit all Medicaid provider payment data for all services (including DASA, LTC, and waiver services); and</i> • <i>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.</i>
<p>DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE</p>	<p>The Department partially concurs with the recommendation. During the period audited, the Department was unable to accept certain claim types (LTC, Waiver and DASA) in the encounter system. The Department can now accept all encounter types in order to collect all provider payments submitted by MCOs. LTC encounters have been accepted by the MMIS for dates beginning with January 2017 and, effective January 1, 2018, the MMIS can accept Waiver and DASA encounters as well. Quarterly reporting is already in place to track encounter submissions against MCO reported financial data and sanctions are applied when the MCO does not meet the minimum submission requirements.</p> <p>The Department does not agree that on-site reviews by HFS of MCO financial data systems are necessary to test completeness and accuracy of data submitted to HFS that is used to monitor provider payments. However, in the fall of 2017, HFS procured the services of Myers and Stauffer, Certified Public Accountants, to assist in closing out contractual obligations under MCO contracts in effect during the period from July 1, 2014 through December 31, 2017 for the ICP, FHP, Affordable Care Act and Managed Long Term Services and Supports programs. This engagement, which will include on-site visits, will provide a comprehensive analysis of MCO provider payments and liabilities and inform HFS of ways to enhance its MCO monitoring process with respect to payments made to Medicaid providers.</p>

Denial Rates for MCOs

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. The contracts state that “Contractor shall submit administrative denials in the format and medium designated by the Department.” 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.

According to written documentation provided by HFS, some of the MCOs did not provide the denial data for FY16. Specifically, HFS noted in a written response “Currently, the denial data is simply not valid nor reliable.”

HFS specifically noted in a written response, “Currently, the denial data is simply not valid nor reliable.” MCOs did self-report clean claim payments and denials to HFS on a monthly basis; however, these reports are unaudited. Two different types of reports on denials were provided to auditors to address this determination; however, on August 21, 2017, HFS indicated that neither report should be used as the reports were not valid and had not been vetted or audited. HFS officials also noted that HFS had never given MCOs clear guidance on how to report denied claims. Without complete and accurate denied claim data, HFS cannot determine whether the MCOs are appropriately denying claims submitted by Medicaid providers.

According to HFS officials, HFS did not track denied and rejected fee-for-service claims in a way that could be used to determine which claims were denied. Since HFS does not have valid denial data from MCOs, it is unclear how HFS monitors the Medicaid claim payment denials by the MCOs. Specifically, it is unclear how HFS ensured that all valid claims submitted by Medicaid providers to MCOs were paid and paid timely as required by contract.

REQUIRED DENIED CLAIM DATA	
<p>RECOMMENDATION NUMBER</p> <p>4</p>	<p><i>The Illinois Department of Healthcare and Family Services should:</i></p> <ul style="list-style-type: none"> • <i>provide clear guidance to the MCOs for reporting denied claims; and</i> • <i>ensure that the MCOs provide the denied claims to HFS as required by contract.</i>
<p>DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES’ RESPONSE</p>	<p>The Department concurs with the recommendation. The Department will provide clear instructions to the MCOs regarding reporting of denied claims.</p>

DUPLICATE CAPITATION PAYMENTS FOR RECIPIENTS

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 determined that there were 302 individual social security numbers that

had more than one recipient identification number assigned for which multiple capitation payments were made.

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. An analysis of the duplicate payments identified the following:

- capitation payments made for the same recipient for the same month to the same MCO;
- capitation payments made for the same recipient for the same month to two different MCOs;
- capitation payments made for two different recipients with the same social security number to the same MCO;
- capitation payments made for two different recipients with the same social security number for the same month to two different MCOs;
- capitation payments for the same recipient for the same month to the same MCO for differing amounts; and
- capitation payments for the same recipient for the same month to two different MCOs for differing amounts.

Auditors determined that this continued to occur in FY17 as well. A review of the FY17 capitation payments showed an additional \$465,336 in duplicative payments. Therefore, for FY16 and FY17, auditors questioned a total of \$1,055,573 in duplicative capitation payments to MCOs. As a result, HFS should work to immediately remove inaccurate and duplicative eligibility data.

PAYMENTS FOR DUPLICATE RECIPIENTS	
RECOMMENDATION NUMBER 5	<p><i>The Illinois Department of Healthcare and Family Services should:</i></p> <ul style="list-style-type: none"> • <i>ensure multiple monthly capitation payments are not being made for the same Medicaid recipients;</i> • <i>immediately identify and remove all duplicative recipients from its eligibility data; and</i> • <i>recoup any overpayment of duplicate capitation payments.</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	<p>The Department concurs with the recommendation. Processes are in place to remove duplicate clients when they are identified by HFS or the MCOs. Once identified, corrections are made and overpayments are recouped. The Department will review its existing processes and provide any necessary enhancements to achieve this objective.</p>

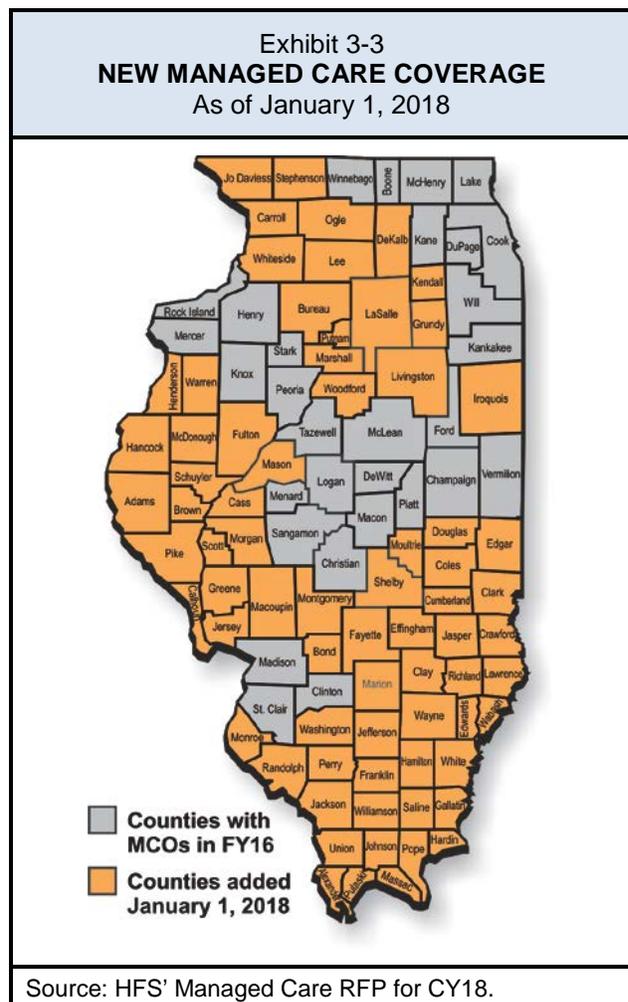
NEW MANAGED CARE CONTRACTS

On August 11, 2017, the Department of Healthcare and Family Services awarded new contracts for the delivery of health care services in Illinois. According to the new Managed Care Organization Request for Proposals (RFP), the State sought four to seven MCOs to provide managed care Statewide, thus adding 72 counties to the existing coverage area. Exhibit 3-2 lists the six MCOs selected and their coverage areas and Exhibit 3-3 shows a map of the newly added counties as of January 1, 2018.

According to the RFP, the new contracts are effective on January 1, 2018, and will assign 683,000 recipients into MCOs from the counties that currently do not have Medicaid managed care. The contracts are for an initial four year term and include an option to renew for up to an additional four years. The stated goal outlined in the RFP was to increase participation in managed care in Illinois to 80 percent.

The new contracts require extensive documentation be provided by the MCOs. Based on the lack of monitoring of payments made to and by the MCOs during FY16, as identified in this report, HFS should monitor the delivery of managed care health services provided through these new contracts as is necessary and is required. The RFP noted that Illinois is one of the largest funders of health and human services (HHS) in the country and reported that in FY15, \$32 billion (40% of the State’s total budget) was spent across all its HHS agencies. The development of a system of controls over the MCOs and the outcome of the services paid for through these MCOs is necessary due to the large dollar amount of these contracts and the significance and nature of the health services being provided to an estimated 2.7 million Medicaid recipients in Illinois.

Exhibit 3-2 NEW MANAGED CARE PROVIDERS As of January 1, 2018
STATEWIDE
Blue Cross Blue Shield of Illinois Harmony Health Plan IlliniCare Health Plan Meridian Health Molina Healthcare of IL
COOK COUNTY ONLY
CountyCare Health Plan
DCFS YOUTH
IlliniCare Health Plan
Source: HFS.



MANAGED CARE CONTRACTS	
RECOMMENDATION NUMBER 6	<i>The Illinois Department of Healthcare and Family Services should ensure that it effectively monitors the newly awarded MCO contracts to ensure compliance with all contractual provisions.</i>
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES' RESPONSE	The Department concurs with the recommendation. The Department will monitor the newly awarded MCO contracts to ensure compliance with all contractual provisions.

APPENDIX A
HOUSE RESOLUTION NUMBER 100

STATE OF ILLINOIS
HOUSE OF REPRESENTATIVES
100TH GENERAL ASSEMBLY

HOUSE RESOLUTION No. 0100

OFFERED BY REPRESENTATIVES FRED CRESPO-DAVID HARRIS-JERRY COSTELLO, II-EMANUEL CHRIS WELCH-RANDY E. FRESE, STEPHANIE A. KIFOWIT, JOHN CAVALETTO, LA SHAWN K. FORD, DANIEL J. BURKE, CYNTHIA SOTO, LINDA CHAPA LA VIA, ELIZABETH HERNANDEZ, THERESA MAH, SILVANA TABARES, JAIME M. ANDRADE, JR., MICHAEL J. ZALEWSKI, WILL GUZZARDI, ANDRÉ THAPEDI, JOHN C. D'AMICO, MICHAEL HALPIN, GREGORY HARRIS, JAY HOFFMAN, MARCUS C. EVANS, JR., CHRISTIAN L. MITCHELL, KATHLEEN WILLIS, CAMILLE Y. LILLY, SAM YINGLING, LAWRENCE WALSH, JR., JOHN M. CABELLO, BRIAN W. STEWART, CAROL AMMONS, JUSTIN SLAUGHTER, SONYA M. HARPER, RITA MAYFIELD, JOE SOSNOWSKI, LOU LANG, ELAINE NEKRITZ, SHERI JESIEL, ANNA MOELLER, ROBYN GABEL, BRANDON W. PHELPS, FRANCES ANN HURLEY, CAROL SENTE, ROBERT MARTWICK, KELLY M. BURKE, JEHAN GORDON-BOOTH, ANTHONY DELUCA, MARTIN J. MOYLAN AND LITESA E. WALLACE

WHEREAS, The Medicaid program in Illinois has an immense, and growing, impact, both in terms of taxpayer dollars and the effect it has on citizens across the State; and

WHEREAS, State resources for healthcare services are currently so scarce that many healthcare providers are discontinuing services, leading to a profoundly detrimental impact on our communities; and

WHEREAS, Enrollment under the Illinois Department of Healthcare and Family Services' Medical Assistance Programs (Medicaid) exceeds three million; and

WHEREAS, A sizable portion of the Medicaid population is currently enrolled, often mandatorily, in Managed Care Organizations (MCOs), making outlays to MCOs, measured in billions of dollars, one of the largest resource uses in the State; and

WHEREAS, There has been little information disseminated to the General Assembly in terms of how State resources are being spent on MCOs and on the overall healthcare outcomes for individuals enrolled in these MCOs; and

WHEREAS, In this quickly evolving environment, the General Assembly must stay engaged in Medicaid funding and corresponding healthcare outcome issues and must be prepared to make legislative and administrative recommendations; therefore, be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE ONE HUNDREDTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that the Auditor General is directed to conduct an audit of Medicaid MCOs, which includes a comparison of State expenditures between MCOs and the Medicaid fee-for-service program; and be it further

RESOLVED, That the audit shall examine capitation rate setting and reimbursement issues for Medicaid MCOs for fiscal year 2016 with respect to the following issues:

- (1) Compare the total dollar amount of all reported MCO encounter data submitted to the Illinois Department of Healthcare and Family Services (DHFS) during SFY 2016 to the total dollar amount of reported claims payments made on behalf of Illinois Medicaid individuals by MCOs as reported to DHFS during SFY 2016;
- (2) Whether MCO encounter data is used by the Department of Healthcare and Family Services (DHFS) to set capitation rates;
- (3) Calculate the aggregate amount of MCO capitation payments made by DHFS during SFY2016 (exclude payments authorized under 305 ILCS Sections 5/5A-12.2, 5/5A-12.4, and 5/5A-12 from this calculation);

(4) Determine the amount of payments made by DHFS to reimburse for-profit MCOs for the ACA Health Insurance Fee (HIF); determine if reimbursement by the State to for-profit MCOs for this HIF payment is mandated by federal CMS;

(5) Determine the amount of payments made by DHFS 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);

(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 DHFS for State fiscal year 2016; and

(9) What the denial rates are for MCOs and for fee-for-service providers billing the DHFS; determine whether there is a higher denial rate for services paid by MCOs; and be it further

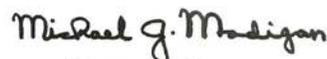
RESOLVED, That the Illinois Department of Healthcare and Family Services and any other State agency having information relevant to this audit cooperate fully and promptly with the Auditor General's Office in its conduct; and be it further

RESOLVED, That the Auditor General commence this audit as soon as possible and report his findings and recommendations upon completion in accordance with the provisions of Section 3-14 of the Illinois State Auditing Act.

Adopted by the House of Representatives on May 31, 2017.


TIMOTHY D. MAPES
CLERK OF THE HOUSE




MICHAEL J. MADIGAN
SPEAKER OF THE HOUSE

APPENDIX B
AUDIT SCOPE AND METHODOLOGY

Appendix B

AUDIT SCOPE AND METHODOLOGY

This performance audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Audit 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 found in House Resolution Number 100.

In some instances, the evidence necessary to address the audit objectives found in House Resolution Number 100 was not provided by HFS. Specifically, appropriate evidence to address the determinations related to the payout ratio, the total administrative costs paid, and the denial rates were not provided. Auditors determined that HFS did not have the necessary internal controls in place to ensure that this required information was obtained. This report contains findings and recommendations to address these issues.

The audit objectives were delineated by House Resolution Number 100, which directed 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 State fiscal year 2016. The Resolution contained nine specific determinations (listed below):

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 Insurance 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.

We reviewed policies and procedures relevant to the audit areas. We also reviewed management controls and assessed risk related to the audit's objectives. A risk assessment was conducted to identify areas that needed closer examination. Any significant weaknesses in those controls are included in this report.

In conducting this audit, we requested and reviewed the contracts with the MCOs, which contained the criteria necessary to address the audit determinations. Additionally, we requested all HFS information related to the financial monitoring of the MCO contracts for FY16. This included: all paid claims to Medicaid providers made by the MCOs; administrative costs paid to MCOs by HFS; and denial rates for MCOs and for fee-for-service billings to HFS.

Auditors reviewed numerous documents provided by HFS related to the MCOs. These documents included: actuarial reports; rate certification reports; quarterly financial reports required by the Department of Insurance; External Quality Review reports; contracts with MCOs; and Encounter Utilization Monitoring reports.

Numerous meetings and walk-throughs were conducted with HFS officials. During these meetings, auditors discussed and requested information related to the payments made by MCOs to providers, encounter data, denied claim data, MCO administrative costs, MCO care coordination costs, and HFS' monitoring activities related to MCOs. Auditors also participated in walk-through meetings with HFS officials and staff which cover encounter monitoring and analysis, the Medicaid Management Information System (MMIS), and with the bureau that directly monitors the MCOs. Additionally, auditors met with upper HFS management along with its actuary in an attempt to gather the necessary information to answer the determinations outlined by House Resolution Number 100.

Auditors sent a letter to both the Illinois Health and Hospital Association and the Illinois Association of Medicaid Health Plans offering a chance to meet to discuss the audit resolution. The Hospital Association responded and auditors met with them in October 2017. The Illinois Association of Medicaid Health Plans did not respond.

House Resolution Number 100 also directed the Auditor General to conduct an audit of Medicaid MCOs, which included a comparison of State expenditures between MCOs and the Medicaid fee-for-service program. Auditors requested information from HFS which isolated a population of Medicaid recipients who were on fee-for-service Medicaid on July 1, 2012 (the first day of FY13) and who then transitioned to on managed care by June 30, 2016 (the last day of FY16).

Auditors received data which contained more than 140 million records and attempted to compare fee-for-service costs with managed care costs. After numerous reviews and tests of the data provided, auditors could not conclude whether a valid comparison could be made.

Exit Conference Attendees

An Exit Conference was held with officials from the Department of Healthcare and Family Services on December 20, 2017. The Department was represented by: Shawn McGady, Chief of Staff; Mike Casey, Administrator of Division of Finance; Jamie Nardulli, Chief Internal Auditor; Amy Lyons, Audit Liaison; Kathleen Staley, Manager - Rate & Data Analysis Unit; Dan Jenkins, Bureau Chief - Bureau of Rate Development and Analysis; and Jamie Tripp, Manager - Medical Budget Unit.

The office of the Auditor General was represented by: Scott Wahlbrink, Senior Audit Manager; and Geoffrey Piehl and Abigail Bailey, Staff Auditors.

APPENDIX C
AGENCY RESPONSE

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

January 9, 2018

Honorable Frank J. Mautino
Auditor General
State of Illinois

Dear Auditor General Mautino:

The Department of Healthcare and Family Services (HFS) appreciates the work performed by your office in conducting the audit of the "State's Medicaid Managed Care Organizations (MCOs)".

Enclosed with this letter are detailed responses that address each of the recommendations.

If you have any questions or comments about our responses to the recommendations, please contact Amy Lyons, External Audit Liaison, at (217) 558-4347 or through email at amy.lyons@illinois.gov.

Sincerely,

SIGNED ORIGINAL ON FILE

Felicia F. Norwood
Director

001 ADMINISTRATIVE COSTS FOR MANAGED CARE ORGANIZATIONS

RECOMMENDATION

The Illinois Department of Healthcare and Family Services should monitor the actual administrative costs incurred by its managed care organizations to ensure that the administrative costs do not exceed what is allowed by contract.

DEPARTMENT'S RESPONSE

The Department concurs with the recommendation and, in fact, already monitors such costs. HFS collects information from each MCO regarding spending on administrative costs as part of the overall data collection process for rate setting. If the MCO exceeds the amount allowed by contract, the costs come out of their profit. If the MCO spends less than the administrative costs included, they can keep the difference as profit, up to the limits of the Medical Loss Ratio (MLR). This additional MCO spending data was provided to the Auditor.

002 MEDICAL LOSS RATIO

RECOMMENDATION

The Illinois Department of Healthcare and Family Services should:

- calculate the Medical Loss Ratios since calendar year 2012 as required by the MCO contracts; and,
- determine whether the State should be reimbursed by MCOs due to overpayment

DEPARTMENT'S RESPONSE

The Department concurs with the recommendation. MLR calculations were delayed while capitation payments were finalized. Due to system issues, some adjustments had to be made manually after the 18 month lookback period. The MLR calculations have been completed for 2013 and 2014 for the Integrated Care Program (ICP). Data to calculate the Family Health Plan (FHP) MLR for July 2014 – December 2015, and ICP for 2015, has been requested from the MCOs and was due to the Department by December 15th. Data has now been received from most plans. Additionally, a methodology has been developed in consultation with our actuaries to estimate MLR before the calculation can be made in order to track and monitor potential recoupments and report them on financial statements.

003 ALL PAID CLAIMS PAID TO MEDICAID PROVIDERS BY MCOs

RECOMMENDATION

The Illinois Department of Healthcare and Family Services should:

- require all managed care organizations 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.

Auditor Comment to the Department's Response to Recommendation Number 1:

The additional administrative expense data provided by HFS was not actual administrative costs incurred by the MCOs as required by House Resolution Number 100. Additionally, the administrative expense data was not provided until January 5, 2018, after the completion of the audit. Also, the data provided was for calendar year 2016 and not fiscal year 2016, and did not contain an explanation or a methodology that described exactly how the administrative expenses were calculated and what specific source documentation was used. The email accompanying the administrative expense data noted it was "not what the language in the resolution asked for..."

DEPARTMENT'S RESPONSE

The Department partially concurs with the recommendation. During the period audited, the Department was unable to accept certain claim types (LTC, Waiver and DASA) in the encounter system. The Department can now accept all encounter types in order to collect all provider payments submitted by MCOs. LTC encounters have been accepted by the MMIS for dates beginning with January 2017 and, effective January 1, 2018, the MMIS can accept Waiver and DASA encounters as well. Quarterly reporting is already in place to track encounter submissions against MCO reported financial data and sanctions are applied when the MCO does not meet the minimum submission requirements.

The Department does not agree that on-site reviews by HFS of MCO financial data systems are necessary to test completeness and accuracy of data submitted to HFS that is used to monitor provider payments. However, in the fall of 2017, HFS procured the services of Myers and Stauffer, Certified Public Accountants, to assist in closing out contractual obligations under MCO contracts in effect during the period from July 1, 2014 through December 31, 2017 for the ICP, FHP, Affordable Care Act and Managed Long Term Services and Supports programs. This engagement, which will include on-site visits, will provide a comprehensive analysis of MCO provider payments and liabilities and inform HFS of ways to enhance its MCO monitoring process with respect to payments made to Medicaid providers.

004 REQUIRED DENIED CLAIM DATA

RECOMMENDATION

The Illinois Department of Healthcare and Family Services should:

- 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.

DEPARTMENT'S RESPONSE

The Department concurs with the recommendation. The Department will provide clear instructions to the MCOs regarding reporting of denied claims.

005 PAYMENTS FOR DUPLICATE RECIPIENTS

RECOMMENDATION

The Illinois Department of Healthcare and Family Services should:

- 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.

DEPARTMENT'S RESPONSE

The Department concurs with the recommendation. Processes are in place to remove duplicate clients when they are identified by HFS or the MCOs. Once identified, corrections are made and

overpayments are recouped. The Department will review its existing processes and provide any necessary enhancements to achieve this objective.

006 NEW MANAGED CARE CONTRACTS

RECOMMENDATION

The Illinois Department of Healthcare and Family Services should ensure that it effectively monitors the newly awarded MCO contracts to ensure compliance with all contractual provisions.

DEPARTMENT'S RESPONSE

The Department concurs with the recommendation. The Department will monitor the newly awarded MCO contracts to ensure compliance with all contractual provisions.

