New Jersey Legislature

Office of LEGISLATIVE SERVICES

OFFICE OF THE STATE AUDITOR

Department of Human Services
Division of Medical Assistance and Health Services
New Jersey FamilyCare
Medicaid Managed Care Rate Setting and
Managed Care Organization Administrative Costs

July 1, 2015 through August 31, 2020

NEW JERSEY STATE LEGISLATURE
Office of LEGISLATIVE SERVICES

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Governor of New Jersey

The Honorable Stephen M. Sweeney
President of the Senate

The Honorable Craig J. Coughlin
Speaker of the General Assembly

Ms. Peri A. Horowitz
Executive Director
Office of Legislative Services

Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, New Jersey FamilyCare, Medicaid Managed Care Rate Setting and Managed Care Organization Administrative Costs, for the period of July 1, 2015 to August 31, 2020. If you would like a personal briefing, please call (609) 847-3470.

David J. Kaschak
Assistant State Auditor
January 6, 2021

Thomas Troutman
Assistant State Auditor
January 6, 2021

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (division), New Jersey FamilyCare, Medicaid Managed Care Rate Setting and Managed Care Organization (MCO) Administrative Costs for the period July 1, 2015 through August 31, 2020. The division administers Medicaid's state-and federally-funded New Jersey FamilyCare programs by contracting with five MCOs to provide services for certain groups of low-to moderate-income adults and children. New Jersey FamilyCare's comprehensive health coverage provides a wide-range of acute and long-term services and supports (LTSS) including: doctor visits, hospital services, prescription drugs, medical tests, vision care, mental health care, dental, nursing home care, and other healthcare services, depending on the person's eligibility category.

Our audit included a review of managed care acute and LTSS capitation rates for fiscal year 2016 through fiscal year 2020. Capitation rates are developed using encounter claim data (paid claims), financial statements and reports, and monthly beneficiary data from the fiscal year that is two years prior to the rate setting period. For the fiscal year ended June 30, 2018, the state paid the MCOs $9.49 billion ($7.43 billion for acute care and $2.06 billion for LTSS) to manage, coordinate, administer, and monitor the contracted services to approximately 1.7 million New Jersey FamilyCare beneficiaries. The division pays the MCOs based on a per-beneficiary per-month rate (capitation rate) that must be actuarially sound and approved by the Centers of Medicare and Medicaid Services (CMS).

Objectives

The objectives of our audit were to determine if the methodology used by the division to set actuarially sound Medicaid managed care capitation rates was reasonable and appropriate, to ensure complete and accurate data was used to set the capitation rates, and to determine the percentage of capitation payments allocated to medical care as opposed to MCO administrative costs and underwriting margins.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In preparation for our testing, we studied legislation, the administrative code, federal regulations, the managed care contract, the actuarial firm's contract, and procedures of the division. Provisions we considered significant were documented and compliance with those requirements was verified by interviews with division personnel, observation, our review of managed care financial statements and reports, and encounter claims data. We reviewed managed care financial trends and interviewed the contracted actuary's personnel to obtain an understanding of the capitation rate setting process and the internal controls. We also interviewed personnel from other states with similar Medicaid programs to compare managed care contract terms related to administrative costs and profits.

In addition, we assessed the reliability of encounter claims data in the Medicaid Shared Data Warehouse by reviewing existing reconciliations prepared by the division and interviewing division personnel knowledgeable about the data. We determined that the encounter claims data in the Shared Data Warehouse is sufficiently reliable for the purpose of our audit findings and conclusions in this report.

Conclusions

We found the division used a reasonable and appropriate methodology and data to set actuarially sound capitation rates. In making these determinations, we noted weaknesses and opportunities for cost savings meriting management's attention. We found the division's MCO contract lacks terms limiting MCO underwriting margins. We also found the division did not retrospectively analyze and calculate specific instances related to the pharmacy benefit manager (PBM) financial expense. Furthermore, the division is not in compliance with federal regulations or the MCO contract requiring MCOs to submit audited annual financial statements and reports specific to the managed care contract. Lastly, we presented an observation regarding the division's vacant actuary position.

Background

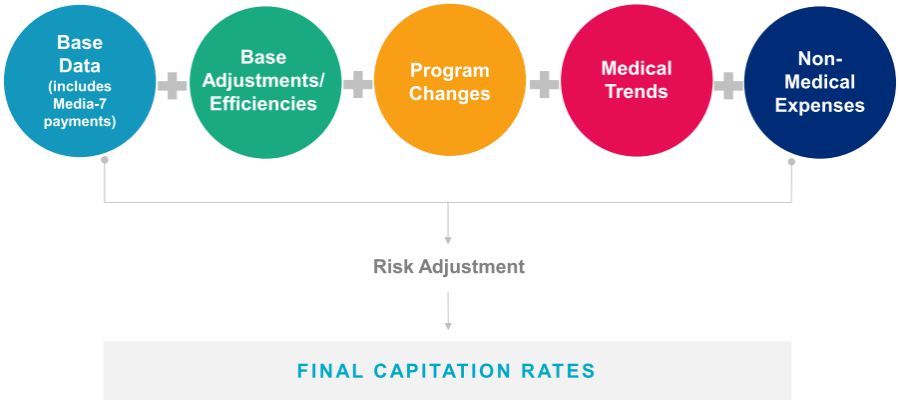
New Jersey FamilyCare (Medicaid) is a program that provides health coverage for individuals and families with low incomes and limited resources. The federal government established Medicaid under Title XIX of the Social Security Act on July 30, 1965. States operate Medicaid programs in accordance with state rules and criteria that vary within the broad framework established by the federal government. The framework requires states to provide a basic set of medical services to individuals eligible for Medicaid. Funds expended under the Medicaid program should be used appropriately and efficiently to promote the public health.

In 1995, New Jersey began transitioning Medicaid beneficiaries from a traditional fee-for-service health insurance program, in which healthcare providers bill Medicaid directly, into a managed care program. Managed care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid

agencies and MCOs that accept a capitated monthly payment (premium) for these services. Medicaid managed care capitation rates must be actuarially sound in order to qualify for federal financial participation.

Federal regulations require that capitation rates be actuarially sound, meaning the rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. Rates should include a provision for administrative expenses and an allowable margin for risk. Actuarially sound capitation rates must be: developed in accordance with federal rate development standards and generally accepted actuarial principles and practices; appropriate for the populations to be covered, and the services to be furnished under the MCO contract; certified, as meeting the requirements of payments under risk contracts, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

Federal regulations further require that, in setting actuarially sound rates, states must demonstrate compliance with the actuarial soundness requirements by documenting the rate setting methodology and the base utilization data used to set capitation rates. When developing capitation rates, the contracted actuary utilizes encounter claim data from the fiscal year that is two years prior to the rate setting period, MCO financial reports, and monthly beneficiary data collected by the MCOs and the division. The following framework provided by the contracted actuary is an overview of the New Jersey Medicaid capitation rate setting process:



Media-7 payments are made to MCOs outside of the standard monthly premium

Capitation rates must also be developed in such a way that MCOs would reasonably achieve a medical loss ratio (MLR) of at least 85 percent for the rate year, as calculated under 42 CFR 438.8 and the MCO contract. The MLR is the proportion of premium revenues spent on clinical services and quality improvement, as opposed to administration and profits. Under 42 CFR 438.8(e), the MLR's numerator is the sum of the MCO's incurred claims, expenditures for activities that

improve health care quality, and fraud prevention activities. The denominator must equal the MCO's adjusted premium revenue minus federal, state, and local taxes and licensing and regulatory fees.

The New Jersey Medicaid minimum MLR is 85 percent of premiums paid in all forms for non-MLTSS (managed long-term services and supports) premium groups (acute care), and 90 percent of premiums paid in all forms for MLTSS premium groups. The division and the contracted actuary are responsible for ensuring MCOs are compliant with MLR requirements and routinely auditing reported data and MLR calculations to ensure that revenues, expenditures, and other amounts are appropriately identified and classified within each MCO's MLR. Although it is not federally required, New Jersey Medicaid requires remittance when an MCO fails to meet the minimum MLR standard in any given year and shall recover 100 percent of the under expenditures.

MCO Underwriting Margins

Medicaid capitation rates were actuarially sound, but resulted in $516.1 million in MCO underwriting gains.

The division and the contracted actuary established capitation rates that although actuarially sound, led to $516.1 million ($403 million for acute care and $113.1 million for MLTSS) in Medicaid funds that have been retained by the MCOs as underwriting gains for fiscal years 2015 through 2018. The underwriting gains were retained by the MCOs because the MCO contract lacks terms which would limit the excess percentage of underwriting gains an MCO can retain. The state has a continuing responsibility to ensure that all federal and state funds expended under the Medicaid program are used appropriately and efficiently to promote the public health.

The Actuarial Standard of Practice No. 49, Medicaid Managed Care Capitation Rate Development and Certification, states "the actuary should include a provision for underwriting gain, which is typically expressed as a percentage of the premium rate, to provide for the cost of capital and a margin for risk or contingency." Research by the Society of Actuaries, *Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting*, found:

> *"Most states' capitation rates (payments to MCOs) include an explicit provision for margin, and in recent periods these range from 0.5% to 2.5%. Most for-profit MCOs target margin higher than 2.0%; most nonprofit MCOs target margin of around 2.0%. Actual performance over the past few years has varied widely among MCOs and states, but the average margin in 2015 was 1.8% for for-profits and 1.5% for nonprofits, according to financial database results…"*

In 2018, the division's actuary completed a report measuring MCO profitability since 2009 and found the total annual profits of the MCOs had been in the $100s of millions, with historical underwriting margins ranging from negative to over 5 percent. If an MCO makes an underwriting margin in excess of the explicit provision included in the capitation rates for any given fiscal year, the capitation rates for that year cannot be recalculated to recoup any of the excess underwriting margin. Similarly, if an MCO experiences an underwriting loss, the capitation rates cannot be increased. The table on the following page displays the underwriting gain of all five MCOs, collectively, in excess of a 2 percent underwriting margin:

ALL MCOS	FY 2017		FY 2018		FY 2019		FY 2020		Total
	FY 2015 base data		FY 2016 base data		FY 2017 base data		FY 2018 base data		
	Acute	MLTSS	Acute	MLTSS	Acute	MLTSS	Acute	MLTSS	
Premium Revenue	$6,766,587,441	$507,860,365	$7,173,398,544	$1,114,172,160	$7,495,120,545	$1,621,632,762	$7,435,341,173	$2,056,693,717	
Claims Incurred	$5,859,244,519	$410,472,848	$6,396,380,154	$936,961,410	$6,706,746,579	$1,450,589,108	$6,625,649,326	$1,807,489,729	
Care Management	n/a	n/a	n/a	$47,901,485	n/a	$62,995,062	n/a	$67,234,614	
Administrative Expenses	$572,090,324	$67,943,808	$508,581,838	$40,224,617	$560,340,829	$66,412,413	$692,024,814	$123,032,247	
Underwriting Gain (UG)	$335,252,598	$29,443,709	$268,436,552	$89,084,648	$228,033,137	$41,636,179	$117,667,033	$58,937,127	
Underwriting Margin (UM)	4.95%	5.80%	3.74%	8.00%	3.04%	2.57%	1.58%	2.87%	
UG >2% UM	$ 199,920,849	$ 19,286,502	$ 124,968,581	$ 66,801,205	$ 78,130,726	$ 9,203,524	$ -	$ 17,803,253	$ 516,114,639

A negotiated limitation on MCO underwriting margins would offer the state some financial protection while not deterring the efficient management of costs by the MCOs.

In an effort to identify best practices, we contacted other states and noted the State of Texas legislatively enacted Texas Government Code 533.014, which requires the Texas Health and Human Services Commission (HHSC) to adopt rules to ensure MCOs share profits earned through the Medicaid managed care program. The Texas Government Code 353.3 states that each MCO must pay an experience rebate according to a tiered rebate method described in the MCOs contract with HHSC. The HHSC MCO contract states MCOs must pay an experience rebate to the state if the percentage of the MCO's net income before taxes is more than three percent of the total revenue for a specified 12-month period. Revenue from the experience rebates is appropriated to HHSC to fund Medicaid client services. The HHSC experience rebate is based on the tiered percentages in the table below:

Pre-tax Income as a Percent of Revenues	MCO Share	State Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

Recommendation

We recommend the division include language in the MCO contract that limits MCO profits by requiring underwriting margins that exceed a defined percentage to be shared with the state.

Pharmacy Benefit Manager

The division did not retrospectively examine the complete financial effect of the pharmacy benefit manager expense misclassification and administrative costs.

The Medicaid prescription drug programs are an optional benefit under federal Medicaid regulation, but all states currently provide coverage for outpatient prescription drugs to all categorically eligible beneficiaries and most other beneficiaries within state Medicaid programs. The Medicaid prescription drug programs include the management, development, and administration of systems and data collection necessary to operate the Medicaid Drug Rebate program, the Federal Upper Limit calculation for generic drugs, and the Drug Utilization Review program. The New Jersey Medicaid prescription drug benefit is delivered through either the fee-for-service (FFS) program or through managed care. The MCOs often contract with a third-party administrator known as a pharmacy benefit manager (PBM) to provide the prescription drug benefit.

During fiscal year 2018, the division identified that three of the five MCOs were incorrectly reporting PBM administrative costs as a pharmacy medical expense and not as an administrative expense in their acute care annual financial reports for fiscal years 2015, 2016 and 2017. The division subsequently clarified the financial reporting instructions in the MCO contract and requested the MCOs resubmit their annual financial reports for the prior three fiscal years to reflect the appropriate administrative expense classification. Since the base financial data used for setting capitation rates is from the fiscal year two years prior to the rate setting period, the financial expense misclassification would have only impacted fiscal year 2018 and prior acute care capitation rates. The fiscal year 2018 capitation rates were set without knowledge of the financial expense misclassification due to the timing of the capitation rate setting process (i.e., fiscal year 2016 base financial data was used for fiscal year 2018 capitation rates).

Although it was determined that the financial expense misclassification did not have a measurable impact on the overall capitation rates, the division and it's contracted actuary identified that one of the MCO's MLR would have been impacted. The minimum MLR for acute care is 85 percent of premiums paid**,** and the division and the contracted actuary are responsible for ensuring MCOs are compliant with MLR requirements. New Jersey Medicaid requires remittance when an MCO fails to meet the minimum MLR standard in any given year and shall recover 100 percent of the under expenditures. Neither the division nor the contracted actuary retrospectively analyzed or calculated the actual impact of the MCO's MLR. Therefore, the division did not ensure the MCO was in compliance with the MLR regulations or determine if the MCO would be required to submit an MLR remittance.

The division and the contracted actuary also identified that the same MCO's reported PBM administrative costs decreased from fiscal year 2017 to fiscal year 2018. With fiscal year 2017 annual financial statements and reports serving as the base data for the fiscal year 2019 capitation rates, the contracted actuary made a downward adjustment to the PBM administrative costs built

into the capitation rates. Neither the division nor the contracted actuary has retrospectively reviewed the MCO's reported PBM administrative costs for fiscal years 2015 and 2016 to determine if the MCO reported PBM administrative costs were considered reasonable and appropriate, and if the MCOs MLR would have been impacted.

Recommendation

We recommend the division and the contracted actuary retrospectively analyze and calculate the actual financial impact of the MCO's PBM financial expense related to the MLR. We also recommend the division and the contracted actuary retrospectively analyze and determine if the MCO's PBM administrative costs for fiscal years 2015 and 2016 were reasonable and appropriate, and if the MCO's MLR would have been impacted.

MCO Financial Reporting

The division is not in compliance with federal regulations or the MCO contract requiring audited financial statements and reports of the MCOs when setting capitation rates.

The division's practice of using unaudited annual MCO financial statements and reports when setting capitation rates is not in compliance with federal regulations or the MCO contract. Federal regulation 42 CFR 438.3(m) requires MCOs to submit audited annual financial reports specific to the Medicaid contract, while the MCO contract requires MCOs to submit both audited annual financial reports and statements specific to the Medicaid contract. The MCOs submit audited annual financial statements to the New Jersey Department of Banking and Insurance; however these audited financials are of the MCOs' comprehensive business entity and not explicitly on the financial reporting of Medicaid revenues and expenses.

The MCO contract also states MCOs must submit quarterly financial reports for Medicaid rate cell grouping costs. A rate cell is a set of mutually exclusive categories of beneficiaries that is defined by one or more characteristics for the purpose of determining the capitation rate which must be reviewed annually by an independent public accountant in accordance with agreed upon procedures (AUPs). The division and the contracted actuary jointly develop the AUPs which establish a means for assuring valid health care data for use in actuarial valuations. In general, AUPs are more focused than financial audits; however AUPs do not provide the comprehensive assurance of audit opinions. Per the American Institute of Certified Public Accountants, Statements on Standards for Attestation Engagements 201.31k, a required element in the independent public accountant AUP review is:

> *"A statement that the practitioner was not engaged to and did not conduct an examination of the subject matter, the objective of which would be the expression of an opinion, a disclaimer of opinion on the subject matter, and a statement that*

if the practitioner had performed additional procedures, other matters might have come to his or her attention that would have been reported."

While the division asserts that the reporting of the quarterly MCO financial reports are accurate based upon the independent public accountant review, audited annual financial statements and reports specific to Medicaid revenue and expenses would ensure all potential financial matters are identified and addressed accordingly.

Recommendation

We recommend the division comply with federal regulations and the MCO contract requiring audited annual MCO financial statements and reports specific to Medicaid revenues and expenses when setting capitation rates.

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Observation

Managed Care Actuary

The division's managed care actuary position has been vacant since November 2018.

The division's Managed Care Finance unit is responsible for the financial oversight of the five MCOs. Annual expenditures for managed care exceeded $9.49 billion in fiscal year 2018. Specific responsibilities of the unit include, but are not limited to: managing and analyzing the MCO financial statements and reports; monitoring the contracted actuary's rate setting operations; performing cost-benefit analyses for new managed care programs and policy decisions; auditing MCO encounter claim data completeness on a monthly basis to ensure encounter claim data reliability for capitation rate setting; and providing CMS the capitation rate setting documentation.

The managed care actuary position within the division's Managed Care Finance unit has been vacant since November 2018, after the retirement of the prior actuary. According to the division, the managed care certified and dedicated actuary position plays a role in providing the division actuarial knowledge and experience as additional financial oversight of the MCOs and the contracted actuary during the capitation rate setting process. The actuary's responsibilities include, but are not limited to: analyzing technical actuarial and related problems; formulating appropriate policies, procedures, and standards; directing the review and critical analysis of actuarial information to assure the analysis meets legal requirements and are otherwise reasonable, equitable and understandable; and completing special projects on an as-needed basis.

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State of New Jersey
Department of Human Services

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December 30, 2020

David J. Kaschak
Assistant State Auditor
Office of the State Auditor
125 South Warren Street
P.O. Box 067
Trenton, NJ 08625-067

Dear Mr. Kaschak:

The Department of Human Services (the Department) is in receipt of the Office of the State Auditor's (OSA) draft audit report titled "Department of Human Services Division of Medical Assistance and Health Services New Jersey Family Care, Medicaid Managed Care Rate Setting and Managed Care Organization Administrative Costs." The Department agrees with OSA's finding that it used a reasonable and appropriate methodology to set actuarially sound capitation rates. We appreciate OSA's review and thank you for the opportunity to comment on the draft report.

Please accept the following responses to the draft audit recommendations:

OSA Recommendation

"We recommend the division include language in the MCO contract that limits MCO profits by requiring underwriting margins that exceed a defined percentage to be shared with the State."

Response

The Department concurs with the objective of limiting excessive profits. It also notes that the underwriting gains reported in the audit for fiscal years 2015 through 2018 pre-date the current Administration.

This Administration's concern about excessive profitability is why the Department sought and received approval for a program-wide risk corridor early in the COVID-19 pandemic. Managed care capitation rates had been developed prior to the known impact of the public health emergency. The retroactive risk corridor enabled the State to recoup payments from managed care entities based on pandemic-driven underutilization of discretionary health services in the

second half of SFY 20. This resulted in an estimated $400 million in total Medicaid savings ($140 million state share). Without this action, those resources would have flowed to the bottom line of managed care organizations (MCOs). Instead, use of a risk corridor allowed NJ Medicaid to recoup substantial funding as a good steward of state and federal resources.

While this audit applies to base data from years that pre-date this Administration, in Fiscal Year 2019 and subsequent years, margins have remained lower. Further, the Division will take the recommendation under advisement, and notes that the Division uses the Medical Loss Ratio (MLR) requirement to protect against excessive profits. The New Jersey Medicaid minimum MLR is 85 percent of premiums paid in acute care groups, and 90 percent of premiums paid for managed long-term services and supports premium groups. As the audit notes, "The MLR is the proportion of premium revenues spent on clinical services and quality improvement, as opposed to administration and profits," and "Although it is not federally required, New Jersey Medicaid requires remittance when an MCO fails to meet the minimum MLR standard in any given year and shall recover 100 percent of the under expenditures."

OSA Recommendation

"We recommend the division and the contracted actuary retrospectively analyze and calculate the actual financial impact of the MCO's PBM financial expense related to the MLR. We also recommend the division and the contracted actuary retrospectively analyze and determine if the MCO's PBM administrative costs for fiscal years 2015 and 2016 were reasonable and appropriate, and if the MCO's MLR would have been impacted."

Response

DMAHS has updated the MCO contract language to more clearly provide direction on reporting expenses paid to the pharmacy by the PBMs. Additionally, all affected MCO's have re-submitted financials and, in the normal course of the MLR process, continue to submit a three-year lookback of financials to true-up with additional runout as per their contract. This lookback true-up was put in place to capture any prior year re-classifications that may impact the MCO's MLR.

OSA Recommendation

"We recommend the division comply with federal regulations and the MCO contract requiring audited annual MCO financial statements and reports specific to Medicaid revenues and expenses when setting capitation rates."

Response

The Department believes that the Consolidated Level "Audited" Financials that are submitted by the MCOs to the Department of Banking and Insurance (DOBI), in conjunction with the MCO's Agreed Upon Procedure (AUP) submissions, satisfy the requirements of both the federal regulations and the MCO contract. The MCO contract, inclusive of the AUP requirements, is approved by the federal Centers for Medicare and Medicaid Service every year.

The Department believes that the AUP, a third party independent review of the MCO's individual rate cells, is an extremely reliable approach. The Department and its actuary update this process annually to maintain the integrity and strict standards of the AUP process. Lastly, the AUP requires MCOs to submit a valid corrective action plan addressing any anomalies.

OSA Observation

"The divisions managed care actuary position has been vacant since November 2018"

Response

The Department agrees that filling this position would add value to actuarial review and fiduciary oversight of the managed care capitation rate setting process. The Department has made filling this position a priority and is currently going through the state hiring approval process.

Thank you again for the opportunity to review and respond to OSA's draft audit report. We welcome any opportunity to improve the rate setting process.

Sincerely,

Jennifer Langer Jacobs
Assistant Commissioner

c: Sarah Adelman, Deputy Commissioner
Allan Brophy, Director, Office of Auditing