

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL**

**AUDIT OF THE DEPARTMENT OF
HEALTH'S OVERSIGHT OF THE
DISTRICT OF COLUMBIA MEDICAID
MANAGED CARE PROGRAM**



**CHARLES J. WILLOUGHBY
INSPECTOR GENERAL**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General



July 18, 2007

Gregg A. Pane, MD
Director
Department of Health
825 North Capitol Street, N.E., Suite 4400
Washington, D.C. 20002

Dear Dr. Pane:

Enclosed is our final report summarizing the results of the Office of the Inspector General's audit of the *Department of Health's Oversight of the District of Columbia Medicaid Managed Care Program* (OIG No. 05-2-20HC). We conducted this audit as a part of our continuous review of the Medicaid Program in the District of Columbia.

Our draft report contained six recommendations for necessary action to correct described deficiencies. We received a response to a draft of this report from the Department of Health (DOH) on June 13, 2007, and consider the actions currently ongoing and/or planned to be responsive for Recommendation 6. We do not consider the DOH to be responsive to Recommendations 1-5, and officials did not propose alternative actions to address the deficiencies identified in the draft report.

In addition, DOH officials did not provide target completion dates for any of the recommendations. We ask that the DOH reconsider its position on Recommendations 1-5, as well as provide target completion dates for Recommendations 1-6 within 60 days from the date of this report.

The DOH response indicated that the Medical Assistance Administration made aggressive management changes in its oversight of the managed care program beginning in late 2004 and noted that the OIG report fails to recognize a number of the reforms instituted by MAA. DOH officials also disagreed with many of the draft report conclusions. Specifically, DOH disagreed that the:

- rate-setting methodology was flawed and resulted in excess payments;
- OIG properly calculated future excess payments;
- District lags behind other local states in the collection and use of encounter data; and
- District is in danger of losing federal funds.

We cannot comment on the Managed Care Organization Program improvements noted by DOH officials because they were related to quality of service, which we excluded from the

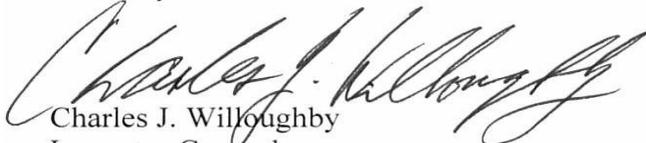
scope of the audit. While quality of service is of paramount importance, the amount paid for quality services should not be excessive. We plan to conduct quality of service audits in the future.

We re-examined our facts and determined that our conclusions and calculations are valid. We clarified our position and included additional information after the *Conclusion* and before the *Recommendations* section in the body of the final report. The full text of DOH's response is included at Exhibit C.

While we did not direct recommendations to Mercer Government Human Services Consulting (Mercer), we provided a courtesy copy of our draft report to the company. We received a response, dated June 13, 2007, from Mercer. The full text of the response is included at Exhibit D.

We appreciate the cooperation and courtesies extended to our staff during the audit. If you have questions, please contact William J. DiVello, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,



Charles J. Willoughby
Inspector General

CJW/wg

Enclosure

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**AUDIT OF THE DEPARTMENT OF HEALTH’S OVERSIGHT OF THE
DISTRICT OF COLUMBIA MEDICAID MANAGED CARE PROGRAM**

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EXECUTIVE DIGEST

OVERVIEW

The District of Columbia Office of the Inspector General (OIG) has completed an audit of the Department of Health's Oversight of the District of Columbia (District) Medicaid Managed Care Program (managed care program). This report is part of our continuous review of the District Medicaid program. Our audit focused on the Department of Health's method of setting capitation rates to compensate three contractors for coordinating health care to District managed care members.

District Managed Care Program. The District managed care program was established by the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1993, (D.C. Law 9-247). As of January 1, 2007, the District's managed care program covered approximately 90,000 of 141,000 District residents eligible for Medicaid.

Medical Assistance Administration. The Department of Health's Medical Assistance Administration (MAA) is the District's state agency responsible for administering all Medicaid services authorized by Title XIX of the Social Security Act, including the managed care program. The MAA Office of Managed Care is responsible for "planning, setting policies and requirements, pursuing resources, developing programs, providing program oversight, and ensuring fiscal accountability to promote an accessible system of quality care for the District's Medicaid managed care population."¹

Under the managed care program, MAA uses an actuary to develop capitation rates (also called capitation payments) that will be paid to Managed Care Organizations (MCOs) for coordinating medical services for members. Capitation, a per member monthly amount paid to a health care plan (in this case, MCOs) that covers contracted services, is the most frequently used methodology to purchase managed care services. A fixed monthly capitation payment is made regardless of the type or level of service used. In turn, the MCOs authorize, monitor, and pay for services provided through a network of physicians and other health care providers.

The overall audit objectives were to determine whether the Department of Health: (1) administered MCO contracts in compliance with applicable laws, rules and regulations, policies, and procedures; (2) ensured that the managed care program operated in an efficient, effective, and economical manner; and (3) established internal controls to safeguard against fraud and abuse. In this report, we discuss whether MAA established capitation rates for the managed care program in accordance with applicable requirements.

¹ D.C. DEPARTMENT OF HEALTH, MEDICAL ASSISTANCE ADMINISTRATION, OFFICE OF MANAGED CARE, CONTINUOUS QUALITY IMPROVEMENT PLAN FOR OVERSIGHT AND ASSESSMENT OF MEDICAID MANAGED CARE ORGANIZATIONS 4 (Mar. 18, 2004).

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CONCLUSION

The audit disclosed that MAA fiscally mismanaged the MCO program. The strategy for setting annually renewable capitation rates was flawed when MAA officials did not adjust the capitation rates to levels which would have avoided excessive MCO profits and maximized dollar expenditures for patient care. Further, MAA did not have a system to collect and use valid encounter data to best identify and evaluate the extent that MCO members used medical services.

MAA accepted an actuarial methodology that used the total medical costs of three MCOs to develop a single base as the starting point for capitation rate development. This “one size fits all” method of setting capitation rates and the lack of encounter data resulted in Amerigroup² receiving \$74 million (or 20.9 percent) more than necessary for patient care over the past 5 years. In addition, DC Chartered and Health Right received \$17.5 and \$5.1 million (or 4.2 and 3.8, percent respectively) more than necessary for patient care over the past 5 years. More importantly, Amerigroup spent as little as 64 percent of its capitation payment on patient care, as compared to 77 percent or more spent by the same MCO in Maryland and New Jersey and the 76 to 86 percent spent in the District by DC Chartered Health Plan, Inc. and Health Right, Inc. Although Amerigroup’s capitation rates have been reduced by MAA over the past two years, we still feel that Amerigroup has made excess profits.

Based on the most current premium payment information available, we calculated that over the next 5 years the District could pay DC Chartered and Amerigroup \$51.6 million (or 3.9 percent) more than necessary for patient care if quality encounter data are not used and this “one size fits all” practice continues. Further, because the District has not complied with the federal requirement to use valid encounter data in the development of capitation rates, it is in danger of losing its federal approval and funding.

SUMMARY OF RECOMMENDATIONS

We directed six recommendations to the Director, Department of Health, that we believe are necessary to correct the deficiencies noted in this report. The recommendations centered on calculating individual base starting points using each MCO’s medical costs to eliminate the “one size fits all” methodology until quality encounter data are available; collecting, validating, and using encounter data to supplement cost data for rate-setting purposes; coordinating efforts with the actuary to require the use of risk adjustment factors; benchmarking the Maryland MCO program to identify and implement better methods for setting capitation rates; establishing internal controls designed to measure performance of the Office of Managed Care in relation to the rate-setting process and pursuing with the MCO

² Amerigroup Maryland, Inc. coordinates health care for the District Medicaid Program as well as for other state Medicaid programs. The excess payments are based only on the revenues and costs of the District Medicaid Program. We refer to this MCO as Amerigroup in the report.

EXECUTIVE DIGEST

contractors and the actuary, monetary remuneration, due to the excess profits made over the target rate.

A summary of the potential benefits resulting from the audit is shown in Exhibit A.

MANAGEMENT'S RESPONSE AND OIG COMMENTS

We received a response to a draft of this report from the Department of Health (DOH) on June 13, 2007 and consider the actions currently ongoing and/or planned to be responsive for Recommendation 6. We do not consider the DOH to be responsive to Recommendations 1-5, and officials did not propose alternative actions to address the deficiencies identified in the draft report. In addition, DOH officials did not provide target completion dates for any of the recommendations. We ask that the DOH reconsider its position on Recommendations 1-5, as well as provide target completion dates for Recommendations 1-6 within 60 days from the date of this report.

The DOH response indicated that the Medical Assistance Administration made aggressive management changes in its oversight of the managed care program beginning in late 2004 and noted that the OIG report fails to recognize a number of the reforms instituted by MAA. DOH officials also disagreed with many of the draft report conclusions. Specifically, DOH disagreed that the:

- rate-setting methodology was flawed and resulted in excess payments;
- OIG properly calculated future excess payments;
- District lags behind other local states in the collection and use of encounter data; and
- District is in danger of losing federal funds.

We cannot comment on the MCO program improvements noted by DOH officials because they were related to quality of service, which we excluded from the scope of the audit. While quality of service is of paramount importance, the amount paid to receive quality services should not be excessive. We plan to conduct quality of service audits in the future.

We re-examined our facts and determined that our conclusions and calculations are valid. We clarified our position and included additional information after the *Conclusion* and before the *Recommendations* section in the body of the final report. The full text of DOH's response is included at Exhibit C. While we did not direct recommendations to Mercer Government Human Services Consulting (Mercer), we provided a courtesy copy of our draft report to the company. We received a response, dated June 13, 2007, from Mercer. The full text of the response is included at Exhibit D.

INTRODUCTION

BACKGROUND

The District of Columbia Office of the Inspector General (OIG) has completed an audit of the Department of Health's Oversight of the District of Columbia (District) Medicaid Managed Care Program (managed care program). This report is part of our continuous review of the District Medicaid program. Our audit focused on the Department of Health's method of setting capitation rates (a per member monthly amount) to compensate three contractors for coordinating health care to District managed care members.

District Managed Care Program. The District managed care program was established by the Medicaid Managed Care Amendment Act of 1992, effective March 17, 1993, (D.C. Law 9-247). The Department of Health's Medical Assistance Administration (MAA) began operating a managed care program for its Temporary Assistance to Needy Families population in April 1994. By 1998, about 65 percent of District Medicaid enrollees participated in the managed care program through 1 of 7 Managed Care Organizations (MCOs). In October 2002, the number of MCOs decreased from seven to four with an average monthly census of about 85,000 members. As of January 1, 2007, the District's managed care program covered approximately 90,000 of the 141,000 District residents eligible for Medicaid.

Medical Assistance Administration. The Medical Assistance Administration (MAA) is the District's state agency responsible for administering all Medicaid services authorized by Title XIX of the Social Security Act, including the managed care program. The MAA Office of Managed Care is responsible for "planning, setting policies and requirements, pursuing resources, developing programs, providing program oversight, and ensuring fiscal accountability to promote an accessible system of quality care for the District's Medicaid managed care population."³

Under the managed care program, MAA uses an actuary to develop capitation rates. MAA pays MCOs a fixed monthly amount to coordinate medical services for members. The monthly payment (also called a capitation payment) is made regardless of the type or level of service used. In turn, the MCOs authorize, monitor, and pay for services provided through a network of physicians and other health care providers.

Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services (CMS), an agency within the United States Department of Health and Human Services, administers the federal Medicaid program. In FY 2003, the CMS established a requirement for states to develop capitation rates that are actuarially sound. As part of that

³ D.C. DEPARTMENT OF HEALTH, MEDICAL ASSISTANCE ADMINISTRATION, OFFICE OF MANAGED CARE, CONTINUOUS QUALITY IMPROVEMENT PLAN FOR OVERSIGHT AND ASSESSMENT OF MEDICAID MANAGED CARE ORGANIZATIONS 4 (Mar. 18, 2004).

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requirement, CMS mandated the use of base encounter data⁴ and cost data in the development of capitation rates. This requirement was codified under 42 CFR Part 438 and must be met before CMS will approve Federal Financial Participation (FFP)⁵ funding for managed care services.

OBJECTIVES, SCOPE, AND METHODOLOGY

The overall audit objectives were to determine whether the Department of Health: (1) administered MCO contracts in compliance with applicable laws, rules and regulations, policies, and procedures; (2) ensured that the managed care program operated in an efficient, effective, and economical manner; and (3) established internal controls to safeguard against fraud and abuse. In this report, we discuss whether MAA established capitation rates for the managed care program in accordance with applicable requirements.

To accomplish our objectives we:

- met with CMS and MAA officials responsible for the District managed care program;
- met with the actuary, Mercer Human Resource Consulting, as well as three of the four District MCOs including Amerigroup Maryland, Inc.⁶ (Amerigroup); DC Chartered Health Plan, Inc. (DC Chartered); and Health Right, Inc. (Health Right) officials regarding the rate-setting process;
- reviewed applicable federal, state, and municipal laws and regulations related to Medicaid managed care program implementation and oversight;
- reviewed MCO procurement and contract files, and obtained an understanding of the methodology MAA used to set capitation rates for compensating MCOs;
- made comparisons to other states' policies for managed care contracts; and
- analyzed MCO financial statements and compared the performance of MCOs in and around the District.

⁴ Encounters are contacts between a member and a plan or provider in which a covered service is delivered. Encounter data elements include, in part, the name of the person receiving services, the provider name, and the type of services provided.

⁵ The FFP rate for District Medicaid health care expenditures is 70 percent.

⁶ Amerigroup Maryland, Inc. coordinates health care for the District and Maryland Medicaid programs. Amerigroup Maryland, Inc. revenue, costs, and other data used to calculate past and future excess payments are related to the District Medicaid Program.

INTRODUCTION

The scope of the audit included contract years 2002 through 2005⁷ for three of the four District MCOs.⁸ We relied on the MCOs' audited financial statements for calendar years 2002 through 2006 medical cost data. We also relied on computer-processed data from CMS regarding the number of MCO enrollees but did not perform a formal reliability assessment of the data because we used it for background and informational purposes only.

The audit was conducted in accordance with generally accepted government auditing standards, and included such tests as we considered necessary under the circumstances.

⁷ Contract years cover August 1 through July 31.

⁸ The excluded MCO was established specifically for Social Security Insurance-eligible children.

FINDING AND RECOMMENDATIONS

FINDING: CAPITATION RATE SETTING

SYNOPSIS

MAA fiscally mismanaged the MCO program. The strategy for setting annually renewable capitation rates was flawed when MAA officials did not adjust the capitation rates to levels which would have avoided excessive MCO profits and maximized dollar expenditures for patient care. This condition occurred because MAA accepted an actuarial methodology that used the total medical costs of three MCOs to develop a single base as the starting point for capitation rate development. In addition, MAA accepted the CMS approval of the capitation rates as evidence of rate reasonableness. Further, MAA did not have a system to collect and use valid encounter data to best identify and evaluate the extent that MCO members used medical services.

The “one size fits all” method of setting capitation rates and the lack of encounter data resulted in Amerigroup⁹ receiving \$74 million (or 20.9 percent) more than necessary for patient care over the past 5 years. In addition, DC Chartered and Health Right received \$17.5 and \$5.1 million (or 4.2 and 3.8, percent respectively) more than necessary for patient care over the past 5 years. More importantly, Amerigroup spent as little as 64 percent of its capitation payment on patient care, as compared to 77 percent or more spent by the same MCO in Maryland and New Jersey and the 76 to 86 percent spent in the District by DC Chartered Health Plan, Inc. and Health Right, Inc. Although Amerigroup’s capitation rates have been reduced by MAA over the past 2 years, we still feel that Amerigroup has made excess profits.

Based on the most current premium payment information available, we calculated that over the next 5 years the District could pay DC Chartered and Amerigroup \$51.6 million (or 3.9 percent) more than necessary for patient care if quality encounter data are not used and this “one size fits all” practice continues. About \$15.5 million (30 percent) of this amount represents local District funds and the balance, \$36.1 million, are federal Medicaid dollars. The loss to the District will likely exceed the \$15.5 million local spending level because of historical problems in recovering all of the dollars covered by the federal Medicaid program. Further, because the District has not complied with the federal requirement to use valid encounter data in the development of capitation rates, it is in danger of losing its federal approval and funding.

⁹ Amerigroup Maryland, Inc. coordinates health care for the District Medicaid Program as well as for other state Medicaid programs. The excess payments are based only on the revenues and costs of the District Medicaid Program. We refer to this MCO as Amerigroup in the report.

FINDING AND RECOMMENDATIONS

DISCUSSION

Capitation, a per member monthly amount paid to a health care plan (in this case, MCOs) that covers contracted services, is the most frequently used methodology to purchase managed care services. The MCO is paid the same amount every month for an enrolled member regardless of whether that member receives services and regardless of the costs associated with providing those services. The amount may be fixed for all members or adjusted for the age and gender of groups of members based on actuarial projections of medical utilization.

Medical utilization, which has a direct impact on medical costs, is reflected in encounter data that can be used to assess and improve quality, as well as monitor program integrity and determine capitation rates. To effectively serve these purposes, the data must be valid, i.e., accurate, complete, and consistent. According to a study by The Lewin Group,¹⁰ the most frequently used sources of base year medical cost data by state Medicaid programs are MCO financial statements followed by encounter data and fee-for-service claims data.

MAA contracted with Mercer Human Resource Consulting (Mercer) from February 2001 through February 2009 to develop actuarially sound capitation rates for the three MCOs.¹¹ Prior to August 1, 2003, the actuary used 1998 District fee-for-service medical claims history as the starting point for setting capitation rates and certified the rates as actuarially sound. However, the requirement for actuarially sound¹² capitation rates based on the use of encounter and cost data became effective in FY 2003. When validated encounter data do not exist, CMS requires states and their actuaries to identify other sources of data and to use the data with the highest degree of reliability. Other sources of data include databases from state employee health insurance, low-income health insurance, and fee-for-service programs.

The actuary develops capitation rate ranges annually. Capitation rate ranges include minimum and maximum capitation rates that are used as a frame of reference for negotiating contract rates. These rate ranges are not disclosed to bidders and bids received in excess of the maximum capitation rate are negotiated downward to within the rate range.

Encounter Data. MAA did not use encounter data in developing the capitation rates. The failure to use encounter data distorts the capitation rate calculation because it excludes the extent to which MCO members used medical services. An encounter is a contact between a

¹⁰ THE LEWIN GROUP, RATE SETTING AND ACTUARIAL SOUNDNESS IN MEDICAID MANAGED CARE 6 (Jan. 23, 2006).

¹¹ An actuary is a statistician who calculates insurance payments.

¹² Title 42 CFR § 438.6(c)(1)(i) defines actuarially sound capitation rates as those: “(A) [] developed in accordance with generally accepted actuarial principles and practices; (B) appropriate for the populations to be covered; and (C) certified . . . by actuaries who meet the qualification standards established by the American Academy of Actuaries and [who] follow the practice standards established by the Actuarial Standards Board.”

FINDING AND RECOMMENDATIONS

member and a plan or provider in which a covered service is delivered (e.g., billable event or claim). Thus, managed care encounter data is generated at the provider level when MCO members use medical services. Encounter data elements include, in part, the name of the person receiving services, the provider name, and the type of services provided. Planners can use encounter data as a starting point to reasonably assess future levels of service related to doctors' visits, inpatient hospital stays, outpatient visits, primary care, specialty care, pharmacy, and dental care.

Title 42 CFR § 438.242(a) requires states to include the requirement to maintain “a health information system that collects, analyzes, integrates, and reports data . . . on areas including, but not limited to, utilization . . .” in MCO contracts. At a minimum, the state must require MCOs to “[c]ollect data . . . on services furnished to enrollees through an encounter data system or other methods as may be specified by the State.” *Id.* § 438.242(b)(1). The Office of Contracting and Procurement (OCP) included these requirements in the MCO contract, which specifies that the data requirements include, in part, current and historical encounter and claim payment records as well as utilization management. The contract also requires the MCOs to screen the data for completeness, logic, and consistency to ensure that accurate data are reported to the District.

In the absence of encounter data, Mercer needed another historical basis upon which to forecast future MCO medical costs and develop rates. With the approval of CMS, Mercer used financial reporting data and requested that each MCO provide actual per member per month medical costs by major service category for each of the District's 10 rate cells. Each rate cell denotes a different gender and age band, which represents different levels of risk.¹³ However, the financial reporting data are not sufficient for determining the extent that MCO members used medical services. The CMS checklist for rate setting indicates that financial reporting data can be used to supplement encounter data and to balance limitations of other data sources related to service utilization.

Methodology of Setting Capitation Rates. MAA accepted a flawed actuarial methodology that used the total medical costs of the three MCOs to develop a single base as the starting point for rate development. The methodology is flawed because Mercer assumed that all the patients of each of the MCOs use the same level of service and care. This methodology resulted in Amerigroup receiving \$74 million (or 20.9 percent) more than needed for patient care over the past 5 years. In addition, DC Chartered and Health Right received \$17.5 and \$5.1 million (or 4.2 and 3.8 percent) more than needed for patient care over the past 5 years.

¹³ The 10 rate cells include children less than 1, children 1 to 12, males 13 to 18, females 13 to 18, males 19 to 36, females 19 to 36, males 37 and older, females 37 and older, infant birth month, and mother's delivery month. In FY 2005, the District added a rate cell for males and females 50 to 64 years of age.

FINDING AND RECOMMENDATIONS

We calculated payments in excess of the amounts needed for patient care over the past 5 years by subtracting the expected premium revenue from the premium revenue per the financial statements. To determine the expected premium revenue, we calculated the expected administrative cost and the expected profit (before taxes). We calculated the expected administrative cost by multiplying the actual medical costs per the financial statements by the 15 percent administrative load.

We calculated the expected profit (before taxes) by adding the actual medical costs and the expected administrative costs and multiplying the total by the 3 percent profit rate during the rate-setting process.¹⁴ See Exhibit B for the OIG calculation of payments in excess of the amount needed for patient care over the past 5 years.

Rather than calculating individual base starting points using each MCO's medical costs, Mercer totaled the medical costs of the three MCOs to arrive at a single base starting point for rate development. The single starting point was then adjusted for:

- completion factors to account for unpaid claims at the time of submission;
- trend factors to forecast the expenditures and utilization to the appropriate contract period;
- prospective and historic program changes not reflected in the base data,
- data smoothing; and
- administrative loading.

The administrative load included 15 percent for administration costs as well as 2-3 percent for profit. The actuary determined the administrative load necessary for an average managed care plan by dividing the District's managed care population of 90,000 among the three MCOs. The average plan size is another example of a "one size fits all" methodology and could have affected the reasonableness of the capitation rates, given that the number of members enrolled in Health Right prior to 2006 was consistently lower than DC Chartered and Amerigroup. See Exhibit B for 5-year enrollment data.

More importantly, MAA and the actuary assumed that all the patients of each of the MCOs used the same level of service and care. Utilization of service has a direct impact on costs. For example, if the rates are based on each MCO having 100 patients and 50 of the patients in one MCO never seek care, that MCO's costs will be lower. Therefore, quality encounter data are needed for rate-setting purposes.

The OCP used the rate ranges certified as actuarially sound by Mercer to negotiate fixed monthly capitation rates and award 5-year contracts to the three MCOs. According to the

¹⁴ Although Mercer used a 2-3 percent rate of profit during the rate-setting process, we used 3 percent to be conservative in our calculations.

FINDING AND RECOMMENDATIONS

Capitation Rate Development Guide for States Implementing Medicaid Managed Care Programs published by the National Association of State Medicaid Directors:

The advantage of [using] a rate range is it allows the State to compare its capitation rates and assumptions to those of the health plans. This comparison identifies discrepancies in assumptions. Additionally, this methodology will most likely result in a more realistic capitation rate since it is bid by the health plans that will be providing the services.¹⁵

However, we noted that when bidding for contract years 2005 and 2006, two MCOs proposed capitation rates (including an allowance for profit and administrative costs) that were below the actuarially-sound minimum rate range for several rate cells. The lower bids were indicators that a problem might exist with a “one size fits all” method of setting capitation rates. OCP did not accept the proposed capitation rates because they were below the minimum rate range established as actuarially sound.

In addition, using the combined medical costs of the three MCOs to develop a single base as the starting point for rate development without encounter data negated the benefits of using a rate range. The existence of excess payments to the MCOs, as well as the disparity between the amounts received by Amerigroup and the other MCOs, suggest that an actuarially sound capitation rate in the aggregate, without encounter data, is not working. We noted that DC Chartered issued a letter to OCP and MAA on April 18, 2004, expressing disagreement with the actuary using the same base starting point to develop capitation rates.

Mercer formulates rate ranges in the first year of the 5-year contract and makes adjustments annually based on revised financial reporting data provided by the MCOs. In addition, Mercer adjusts the capitation rates annually for inflation, as well as programmatic and legislative changes. Accordingly, Mercer had ample opportunity to adjust the rates to address apparent inequities within the managed care program.

Although the amount of administrative cost and profit received by the MCOs has decreased since 2002, more improvement is needed. Until encounter data, or some other data source sufficient for measuring service utilization, can be validated and used for rate-setting purposes and as long as the actuary uses a “one size fits all” approach to rate setting, we believe the excess payments and disparity among MCOs will continue.

We applied the same formulas previously discussed on page 6 to the MCOs’ calendar year 2006 medical costs reported per the financial statements to calculate the excess payments. We calculated that, all else being equal, DC Chartered and Amerigroup could

¹⁵ NATIONAL ASSOCIATION OF STATE MEDICAID DIRECTORS, CAPITATION RATE DEVELOPMENT GUIDE FOR STATES IMPLEMENTING MEDICAID MANAGED CARE PROGRAMS 9-10 (1999).

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receive \$51.6 million (or 1.5 and 4 percent, respectively) more than needed for patient care over the next 5 years.¹⁶ See Table 1 below for the results of our calculation.

Table 1 – Calculation of the Payments in Excess of Amount Needed for Patient Care Over the Next 5 Years (in millions)¹⁷

MCO	Expected Annual Payment ¹⁸	Anticipated Actual Annual Payment ¹⁹	Actual Medical Costs	Expected Admin Costs	Expected Profit (Before Taxes)	Annual Excess Payment	Potential Excess Payment Over 5 Years ²⁰	District Share at 30 Percent FFP
DC Chartered	\$99.8	\$102.7	\$84.2	\$12.6	\$2.9	\$2.9	\$14.6	\$4.4
Health Right	35.4	35.1	29.9	4.5	1.0	(3) ²¹	²¹	
Amerigroup	93.3	100.7	78.8	11.8	2.7	7.4	37.0	11.1
Total	\$228.5	\$238.5	\$192.9	\$28.9	\$6.6	\$10.3	\$51.6	\$15.5

System to Collect Valid Encounter Data. MAA did not have a system to collect, validate, and use quality encounter data. MAA created new methods for the submission of encounter data in July 2002. By July 2003, the MCOs still had not begun to submit encounter data. MAA developed a corrective action plan in 2003 and, as of December 2005, the encounter data collection had entered the submission phase.

However, the actuary reviewed the encounter data submissions and determined they were not a complete and accurate source of cost data for setting contract year 2006 capitation rates. MAA's goal is to have the encounter data ready for the contract year 2008 rate setting. According to MAA officials and the actuary, converting provider claims history into the CMS-mandated encounter data format was a significant technical challenge for MCOs.

According to the MAA Encounter Data Corrective Action Plan, the most difficult issues were related to the required submission format of the contractor responsible for the Medicaid Management Information System and the MCO conversion from paper processing to

¹⁶ Calendar year 2006 administrative costs per Health Right, Inc. financial statements were less than the expected 15 percent, which resulted in a negative excess payment calculation. Because we used calendar year 2006 as the base for calculating future cost avoidance, our calculations resulted in no future excess payments for Health Right.

¹⁷ Minor differences are due to rounding.

¹⁸ The Expected Annual Payment is based on the actual medical costs of 2006, plus a 15 percent administrative allowance and a 3 percent profit allowance.

¹⁹ The Anticipated Actual Annual Payment represents the capitation payments made in fiscal year 2006.

²⁰ The Potential Excess Payment Over 5 Years was calculated by subtracting the Expected Annual Payment from the Anticipated Actual Annual Payment and multiplying the result by 5.

²¹ See footnote 4 on Exhibit B for the explanation of this negative amount not included in the excess payment calculation.

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electronic processing. In addition, the MCOs had not developed or collected provider identification numbers for non-Medicaid providers.

Because other states are subject to the CMS-mandated format, we queried nearby states for comparison purposes. We found that the District lags far behind Maryland, Virginia, and New Jersey, all of which have been collecting encounter data since calendar year 2000, even though the District's managed care program is six times smaller than the one's operating in these other states. As of June 30, 2004, managed care enrollment for these states was between 398,000 and 542,000 as compared to a District enrollment of less than 90,000 members. In addition, CMS reported that 25 states were reporting encounter data back in FY 2003. As of the date of this report, MAA still did not have a system for gathering accurate, complete, and consistent encounter data for MCO members.

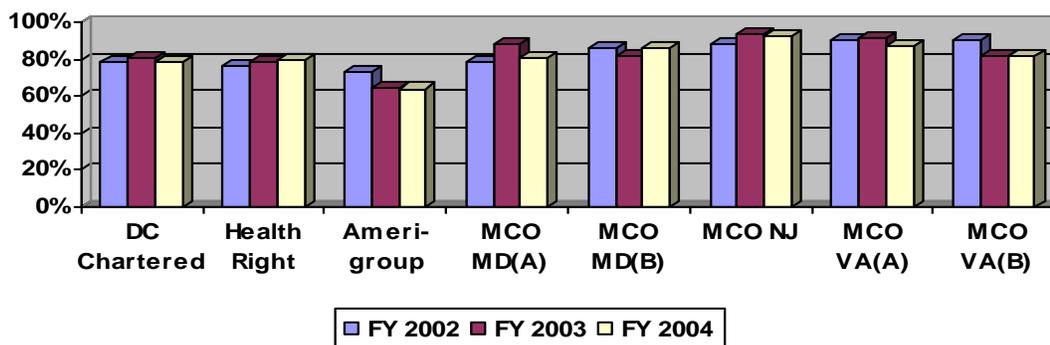
Spending for Patient Care. Another way of measuring the success of the methodology for setting capitation rates is to evaluate the percentage of payments spent for patient care. Amerigroup spent as little as 64 percent on patient care as compared to 77 percent or more spent by the same MCO in Maryland and New Jersey. In addition, the other District MCOs and MCOs in nearby states spent 76 percent or more on patient care.

The insurance industry and a number of state Medicaid agencies use the Medical Loss Ratio (MLR) to determine how much is being spent on patient care. The MLR is the ratio between the cost to provide medical care and the total amount of payments received (premium revenue) by the MCO.

Some states (such as Maryland) have incorporated a minimum MLR in contracts to ensure MCOs spend an acceptable percentage of payments on member health care. Because the District had no such requirement, we compared the MLR for District MCOs to a sample of MCOs under contract with nearby states. We found that other than Amerigroup, the District MCOs generally spent about 80% of payments on patient health care. MCOs in Maryland, Virginia, and New Jersey typically spent more than 80% on patient care. Our comparison is shown in Chart 1 below.

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Chart 1 - Comparison of District Medical Loss Ratios with Nearby States



Conclusion. MAA is in the process of gathering and evaluating encounter data, which is needed for capitation rate-setting purposes. The use of quality encounter data is critical when using a “one size fits all” method of setting capitation rates because utilization of medical services has a direct impact on medical costs. We question the reasonableness of the capitation rates because of the lack of encounter data and the different variables affecting such a determination. For example, some MCOs may categorize costs differently and some may coordinate services more efficiently and effectively than others. In addition, capitation rates may be affected by the health needs of members. Risk adjustment is a way to account for a member’s health status and is intended to minimize any financial incentives health plans may have to select healthier than average enrollees.

For example, Maryland and New Jersey established monthly capitation rates for 2006 that ranged from \$71 to \$294 for healthy clients less than 44 years old, while the rates for similarly aged HIV/AIDS clients ranged from \$811 to \$3,429. The use of risk adjustment would help ensure that health plans that attract higher risk providers and members would be compensated for any differences in the proportion of their members that require high levels of care compared to other plans. However, quality encounter data are critical for using a risk adjusted capitated rate methodology.

Further, a study by The Lewin Group²² indicates that actuarial soundness seems to have little bearing on the rates ultimately paid to MCOs partly because of the wide latitude actuaries have in setting assumptions and choosing and applying methods for obtaining results. If this is the case, it is even more important for MAA to work with the actuary to develop capitation rates that are actuarially sound for each MCO until encounter data can be collected, validated, and used for rate-setting purposes.

²² THE LEWIN GROUP, RATE SETTING AND ACTUARIAL SOUNDNESS IN MEDICAID MANAGED CARE 17 (Jan. 23, 2006).

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Although we could not determine whether the capitation rates were reasonable, we note that Amerigroup received \$74 million (or 20.9 percent) more than necessary for patient care over the past 5 years, which seems excessive; especially when compared to the other MCOs, which received \$22.6 million (or 3.9 percent) more. Further, DC Chartered and Amerigroup could receive \$51.6 million more than necessary for patient care over the next 5 years compared to no excess payments for Health Right.

Under these circumstances, the cost to the District would be \$15.5 million which represents the 30 percent share of Medicaid medical costs. However, losses could be much greater since the District historically does not recover the entire federally funded portion of the Medicaid program which in this scenario could be as much as \$36.1 million.

The timeliness of encounter data submission given the small size of the District managed care program is troubling as is the apparent disparities in the amounts paid to Amerigroup, DC Chartered, and Health Right. We are concerned that the Director, DOH, does not have the tools needed to identify and resolve issues such as the ones reported herein during normal, day-to-day operations. As a result, we believe that the Director should benchmark the Maryland managed care program and establish internal controls designed to measure the performance of the Office of Managed Care in relation to the rate-setting process.

MANAGEMENT'S RESPONSE AND OIG COMMENTS

In this section we summarize and respond to DOH's disagreement with the content of the finding and certain report conclusions.

The DOH response indicated that the Medical Assistance Administration made aggressive management changes in its oversight of the managed care program beginning in late 2004 and noted that the OIG report fails to recognize a number of the reforms instituted by MAA. DOH officials also disagreed with many of the draft report conclusions. Specifically, DOH disagreed that the:

- rate-setting methodology was flawed and resulted in excess payments;
- OIG properly calculated future excess payments;
- District lags behind Maryland, Virginia, and New Jersey in the collection and use of encounter data; and
- District is in danger of losing its federal funds.

Improvements in the MCO Program. DOH officials stated that the agency made aggressive management changes, which “set the stage for major reforms in how care in a managed care environment will be purchased in the District in the future.” According to DOH, the following actions occurred:

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- Increased emphasis was placed on encounter data reporting.
- Encounter data were received from MCOs for the first time ever.
- DOH slowed rate of growth and decreased premium payments for MCOs.
- DOH instituted nationally accepted Health Plan Employer Data and Information Set (HEDIS[®])²³ measures.
- DOH had the HEDIS[®] measures audited by an external quality review organization.
- Quality of care provided by District MCOs was at or above the national mean in most categories.
- MCOs became certified by the National Commission for Quality Assurance.

OIG Comments. It is the OIG’s policy to give agencies credit for program improvements and actions taken as a result of our audit when the action is related to our audit objectives and can be validated. However, we did not evaluate the adequacy of the MCO program management or the quality of services because this portion of the audit focused on the capitation rate-setting process. Accordingly, we cannot comment on the “aggressive management changes” other than to say we are pleased that MAA received encounter data to be used for the CY 2008 rate-setting process. Other comments made by DOH officials regarding the validity of the encounter data (see pages 16 and 17) are cause for concern. We did not give MAA credit in the draft report for the receipt of encounter data because MAA had not received valid encounter data that could be used for CY 2007 rate setting.

Flawed Methodology. DOH officials disagree that Mercer’s methodology was flawed and caused excess payments. The response indicates that the primary reason for the profits appears to be related to a program change in mental health services. Officials state that this issue was not addressed in the OIG draft report.

According to the DOH response, Mercer included the cost of mental health benefits in the District’s contract in 2002-2003. Initially, the per-member-per-month (PMPM) cost for mental health services was based on the costs of these services in the fee-for-service program. DOH alleged that the actual managed care experience was lower because mental health services and members did not transition from the fee for service program in the manner anticipated by the District. As a result, the mental health rates in the managed care program decreased from \$29.86 PMPM to \$8.02 PMPM over a 5-year period.

DOH officials also stated that because the rates were set using historical experience, the impact of the change (more than 10 percent) was not immediate. Officials also believe that

²³ According to the National Commission of Quality Assurance, HEDIS[®] is a tool used by more than 90 percent of America’s health plans to measure care and service performance. The eight categories of measures include (1) effectiveness of care, (2) access/availability of care, (3) use of services, (4) satisfaction with care, (5) health plan stability, (6) cost of care, (7) informed health care choices, and (8) health plan descriptive information.

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the decrease in mental health cost was a unique phenomenon to the District, which added complexity to the rate-setting process in the District.

The DOH stated that it will seek guidance from legal staff to determine if a basis exists for recouping funds paid to the MCOs for mental health services that did not transition to the managed care program as expected.

OIG Comments. During the course of the audit, we were unable to acquire an explanation as to the cause of the excess payments from DOH, Mercer, and Amerigroup officials. Similarly, during this period, MAA officials did not submit or proffer the transition of mental health services and members as a possible cause of the excess payments. The DOH assertion of a program change in mental health services as the apparent source or cause of the excess payments was first suggested in its response to the draft report.

If this programmatic change occurred during 2002-2003, it would seem that Mercer should have made some form of corresponding adjustment to the capitation rates as allowed by Contract P0HC-2002-D-0003, Section B.5.1. Contract P0HC-2002-D-0003, Section B.5.1., requires Mercer to conduct an actuarial review of the capitation rates on an annual basis to “determine the actuarial soundness of the rates paid to [c]ontractors.” *Id.* Section B.5.1. also requires the review to take into account factors such as “significant changes in the demographic characteristics of the member population.” *Id.* In addition, one of the elements of being actuarially sound is that the rates are appropriate for the population to be covered.

Further, the Rate Development and Actuarial Certification Reports generated by Mercer, indicate that the rate-setting process includes applying programmatic change adjustments to incorporate factors not fully reflected in the base data. Likewise, best practice indicates that adjustments should also be made when factors reflected in the base data (mental health services) do not transition as planned.

According to a rate issues chart that was included with the Rate Development and Actuarial Certification, MAA and Mercer officials knew as early as June 4, 2004, that mental health services and members were not transitioning to the MCOs as expected. Mercer’s response to the draft report indicated that “Annual adjustments to the rates paid for these services have been made based upon actual program experience to align the costs for this component of the program.” However, we found no evidence that Mercer made these annual adjustments. For example, as of December 29, 2005, Mercer and MAA were aware that mental health services and members still were not transitioning to the MCOs as expected but decided to continue monitoring the issue and that no adjustment would be incorporated into the rate setting. In addition, the June 7, 2006, Rate Development and Actuarial Certification for the contract

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period August 1, 2006, through July 31, 2007, contains no reference to the transition of mental health services and members.

We commend DOH's plans to explore the potential to recoup funds paid to the MCOs for mental health services that did not transition to the managed care program as expected. However, the fact that programmatic changes that caused excess payments were not addressed during the annual capitation rate adjustment could negatively impact recoupment efforts. This negative impact is another example of why programs must be properly managed on a day-to-day basis.

Calculation of Future Excess Payments. DOH officials stated that the method used by the OIG to forecast profit levels for the three MCOs over the next 5 years is not an appropriate methodology. DOH also disagreed with the assumption that excess payments and disparity between the MCOs will continue.

The DOH response indicates that the OIG statement that DC Chartered and Amerigroup could receive an additional \$51.6 million more than necessary appears to be based on 2006 data, multiplied by 5 to arrive at a 5-year projection. DOH believes this type of straight line projection is an over-simplified approach and is not supported with an appropriate discussion on key assumptions, such as prospective trend, managed care efficiencies, or membership projections. Further, the results of this forecast are neither credible nor likely to occur, given the requirements placed in the new MCO procurement.

DOH also states that the payment levels declined in 2005 and 2006 as a result of aggressive rate negotiations, which increased the percentage of capitation spent on patient care. The DOH believes this trend will continue into 2007 and 2008. In addition, there is no guarantee DC Chartered or Amerigroup will have a contract in 2008, and requirements in the new MCO procurement establish a minimum Medical Loss Ratio of 75 percent.

Further, DOH states that the District's rates are renegotiated annually, which means the expectation that medical costs will remain at a fixed percentage of premium is inaccurate. For example, the MCOs received an overall rate decrease in 2007, even though health care trends averaged 7 percent nationally. Therefore, the percentage spent on medical care is expected to rise in 2007 and overall profit levels are expected to decline.

Finally, DOH officials state that MAA requested independent financial audits of the three MCOs. These audits will be reviewed when complete and appropriate action recommended based on the findings, to include legal action if wrongdoing is suspected.

OIG Comments. We disagree that our straight line calculation of excess payments over the next 5 years is inappropriate. We find the DOH argument lacking in merit in light of the fact

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that MAA did not rebut our calculation with calculations of their own using the criteria (e.g., assumptions, trends, etc.) mentioned above.

We disagree that the payment levels declined in 2005-2006. According to the MCO financial statements, premium revenue has steadily increased each year since 2002. Although the Medical Loss Ratio did increase from CY 2005 to CY 2006, so did the profit levels for DC Chartered and Health Right.

Whether Amerigroup receives a contract in 2008 is not relevant. The potential exists for any MCO that contracts with the District to benefit from excess payments. We are pleased that MAA plans to establish a Medical Loss Ratio in future contracts. However, that factor alone will not preclude excess payments. For example, the Health Right Medical Loss Ratio was 85.6 percent in CY 2006 but the profit level was 7.4 percent, which is 4.4 percent above the amount Mercer used as reasonable as part of the rate-setting process. It is not our position that MCOs should always be limited to a 3 percent profit. Our point is that MAA and Mercer should have determined the extent to which profit levels exceeded the amount deemed reasonable during the rate-setting process and made appropriate adjustments in future years.

Further, we place little reliance on the annual renegotiation of rates since MAA and Mercer did not adjust the rates for the mental health services and members that did not transition to the MCOs as expected. However, we commend MAA for having independent financial audits performed on the MCOs. We believe these audits could find that the amount of excess payments might be even higher due to internal control and accounting deficiencies.

Collection and Use of Encounter Data. DOH agrees that encounter data collection in the District began after Maryland and New Jersey but argues that they did not lag far behind these states. DOH also disagrees with our conclusion that MAA did not have a system to collect and use valid encounter data to best identify and evaluate the extent to which MCO members used medical services. In addition, DOH officials do not agree that the availability of encounter data has a direct impact on the medical costs.

DOH officials indicate that encounter data collection did not begin until 2003 because the MCO contracts were not implemented until August 2002, and the MCOs had to be operational before the encounter data process could begin. In addition, the DOH emphasized that the encounter data system and collection of data moved forward aggressively and now produce usable encounter data. DOH also emphasized that CMS approved the District's encounter data plans and supports the timeframes MAA proposed. Further, DOH officials argued that the District is the only local jurisdiction to incorporate encounter data as a direct data source in rate setting whereas the other two states rely solely on MCO financial data and use encounter data merely to support risk adjustment calculations.

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According to DOH officials, MAA now has a system for gathering accurate, complete, and consistent encounter data. Officials stated:

The District's encounter data collection system is fully operational; the remaining encounter data challenges are primarily centered on the collection of data from service providers, by the MCOs. This is particularly true where the plans have sub-capitated the providers and may need to consider changing their reporting incentive/disincentive policies and procedures.

DOH also stated that MAA's experience and progress with its encounter data system was fairly typical of numerous other states.

Further, DOH agrees that encounter data will allow MAA to better explain cost differences among the MCOs and enhance the overall rate-setting process but will not change the actual costs to deliver services to the Medicaid population. DOH continues that the financial data submitted by the MCOs outlines the amount of money spent on doctors' visits, inpatient hospital stays, outpatient visits, primary care, specialty care, pharmacy, and dental care. This is a reasonable starting point to adequately assess future levels of service costs. MAA asserts that the capitation rates are not distorted due to the lack of encounter data. While CMS prefers encounter data as the primary data source, the financial data is sufficient to determine the cost of the medical services utilized by MCO members. According to DOH officials, CMS has approved the use of financial data as a source for rate setting in the District as well as in Maryland, New Jersey, and numerous other states.

DOH states that when the requirement became apparent, the District proactively made it a priority to develop an encounter data collection system. The experience throughout the country has been that it takes 3 to 5 years before encounter data reported by MCOs is complete and accurate enough to incorporate into rate setting. The DOH believes the District's experience in developing their system is consistent with the experience of other states.

DOH officials conclude that the District has worked diligently to collect encounter data and Mercer incorporated encounter data into the CY 2008 rate setting.

OIG Comments. We believe the DOH response is misleading and are concerned about the validity of the encounter data provided to Mercer for the CY 2008 rate development. Encounter data is the record of medical services received by MCO members from, in part, doctors' visits, outpatient visits, pharmacy, and dental care. Thus, the encounter data exists at the provider level, which is where data challenges remain.

Further, the District should have known as early as other states that the federal government planned to require the use of encounter data in the rate-setting process. Maryland and New

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Jersey began collecting encounter data in 1997. Although they do not use encounter data as the baseline data for rate-setting purposes, Maryland and New Jersey use the encounter data for risk adjustment purposes. Maryland and New Jersey appear to have done significantly better at planning and were able to incorporate encounter data into their rate-setting processes at a much earlier date than the District, even though their MCO programs were much larger.

Our draft report does not state that the lack of encounter data changes the cost of services provided. Our point was (and is) that encounter data, which shows medical utilization, is needed because utilization has a direct impact on costs. As explained in the draft report, if an MCO has 100 enrollees and only 50 use services, the cost of providing services will be higher than an MCO with 90 of 100 enrollees using services. We would like to add that the difference in cost could decrease if the 50 enrollees use more costly services than the 90 enrollees in the other MCO.

We disagree with the DOH assertion that financial data is sufficient to determine the cost of the medical services utilized by MCO members for purposes of setting capitation rates. It is clear that CMS considers financial data to be the least reliable for rate-setting purposes and requires that financial data be supplemented by other data. We would hope that CMS only approves the use of financial data as a last resort when other valid service utilization data does not exist.

Potential Loss of Federal Funds. DOH officials stated that there is no basis to the statement that the District is at risk of losing federal funding because of its encounter data collection efforts. CMS has approved the District's use of financial data in determining capitation rates. Throughout this process, MAA periodically discussed and reported to CMS its plans and progress made on encounter data collection.

OIG Comments. We continue to believe that the District is at risk of losing federal funding. Any state is at risk of losing federal funding when significant deficiencies are identified as a result of an audit. The CMS approval relates to the plans and progress, not to the effect the lack of encounter data could have on program costs. Managing MCO costs is the responsibility of MAA. The law requires the District to apply base utilization and cost data to rate setting or explain why it is not applicable. We believe it is clear from the checklist used by CMS to approve capitation rates that financial reporting data should be used in conjunction with encounter data.

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RECOMMENDATIONS

We recommended that the Director, Department of Health:

1. Calculate a base starting point for each MCO using individual medical costs to eliminate the “one size fits all” methodology until encounter data can be collected, validated, and used to supplement cost data for rate-setting purposes.
2. Enforce 42 CFR § 438.242 and contract provisions that require MCOs to collect and submit valid encounter data to MAA and have MAA make valid encounter data available to the actuary responsible for calculating capitation rates for each MCO.
3. Coordinate efforts with the actuary to require the use of risk adjustment factors when developing capitation rates based on valid encounter data.
4. Benchmark the Maryland managed care program to identify and implement better methods for setting capitation rates.
5. Establish internal controls designed to measure the performance of the Office of Managed Care in relation to the rate-setting process.
6. Pursue with the MCO contractors and the actuary, monetary remuneration, due to the excess profits made over the target rate.

DOH RESPONSE (Recommendation 1)

DOH did not concur with the recommendation. In its response, DOH officials stated that our approach for rate setting is a limited viewpoint that is not useful for enhancing the District’s MCO program and, may have an opposite, harmful effect if implemented. For example, DOH officials stated that the recommended method would not have solved the problem of excess payments; the report lacks evidence that the recommended method is better or even feasible; and the recommended approach is nonstandard and would lead to different, potentially disparate rate ranges for each MCO.

DOH also believes that we focused on the rate-setting methodology as the only driver of profits, which caused us to draw incorrect conclusions. DOH officials stated that using the existing approach results in higher starting points for some MCOs and lower starting points for others, which provides an incentive for “high cost” MCOs to increase operating efficiency. According to DOH officials, the use of MCO-specific data for rate setting had been used previously and CMS requested the practice be discontinued because it resulted in large unexplainable rate variations between MCOs. The rates being developed and implemented at that time appeared to be based upon an MCO’s ability to negotiate as

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opposed to a reflection of the risk or cost of the population. The DOH believes the previous use of MCO-specific data for rate setting risked the loss of the federal share of Medicaid dollars.

In addition, DOH officials believe that a competitive procurement would not be feasible if the District discontinues the practice of using a single base starting point for rate development. Further, DOH believes that the OIG method is similar to cost plus reimbursement, which CMS and Medicaid programs throughout the country generally oppose.

For example, the current methodology allows the District to develop a rate range and negotiate within that range. If the individual MCO data were used for each plan, it would be difficult to develop an appropriate rate for potential new vendors because new MCOs would receive their membership from the existing MCOs. Further, the DOH indicates that the rate-setting methodology in question was generally accepted by CMS and the American Academy of Actuaries, and is used in nearly every other state, including Maryland and New Jersey.

The DOH's full response is included at Exhibit C.

OIG COMMENT

We consider DOH to be nonresponsive to the recommendation. The DOH response does not acknowledge the basic principles of competition. Competitive procedures are supposed to reduce the cost of obtaining goods and services. Our method would solve the problem of excess payments. For example, the MCOs would submit bids based on their own cost of doing business. The bids should include a separate line item identifying administrative costs and profit. OCP and MAA would then evaluate the proposed rates for technical sufficiency and rate reasonableness. Upon completion of the evaluation, OCP would begin negotiations to obtain a fair and reasonable price in accordance with 45 CFR § 74.45.

We question whether the rates paid to the MCOs were fair and reasonable and do not believe the rates met the traditional definition of actuarially sound ("neither excessive nor inadequate").²⁴ For example, when MCOs proposed rates (including profit and administrative costs) that were lower than the actuarially sound rate, OCP could not accept the rates. In these cases, we expected that OCP would use the lowest of the actuarially sound rate range. Instead, OCP sometimes negotiated a higher rate.

For example, in 2005-2006, the actuarially sound rate range for one rate cell was \$154 to \$173. However, Amerigroup proposed a rate of \$142, which was \$12 below the lower end of

²⁴ THE LEWIN GROUP, RATE SETTING AND ACTUARIAL SOUNDNESS IN MEDICAID MANAGED CARE i (Jan. 23, 2006).

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the rate range and OCP negotiated a rate of \$158, which was \$4 over the lowest rate. In addition, the actuarially sound rate range for a second rate cell was \$141 to \$159, yet Amerigroup proposed \$116, which was \$25 below the lower end of the rate range, and OCP negotiated a rate of \$145, which was \$4 over the lowest rate. Although CMS approved the MCO contracts and the capitation rates, we consider the negotiation of rates higher than the lowest rate (when MCOs bid less) to be a waste of District taxpayer dollars.

We also note that the DOH response does not acknowledge that the OIG recommendation was to develop a base starting point for each MCO using individual medical costs as a short-term measure *until* encounter data can be collected, validated, and used to supplement cost data for rate-setting purposes. Once the encounter data is used for rate setting, MAA may find that a totally different rate-setting methodology is needed.

Further, the DOH response appears to disregard District managers' inherent responsibility to ensure that local funds are spent responsibly. The response places the emphasis on developing capitation rates that reduce the variation of rates between MCOs instead of developing rates based on demonstrated costs (including a reasonable profit). During the period covered by our audit, the methodology used by DOH to develop capitation rates yielded results (more than \$95 million in excess payments) that were detrimental to the District government, as well as the citizens of District of Columbia.

We also disagree that we focused on the rate-setting methodology as the only driver of profits. The OIG draft report clearly states that different variables (such as how costs are categorized, how efficiently and effectively services are coordinated, and the health needs of members) affect the rates (including profit levels).

Although DOH disagreed with the recommendation, officials did not propose alternative solutions. DOH officials also did not explain the harm that would have occurred to the District by the "very large unexplainable rate variations from one MCO to another" caused by using MCO-specific data for rate setting. Further, the DOH response implies that CMS officials were only concerned about rate variations rather than its responsibility to ensure that federal Medicaid funds are spent in a reasonable manner and as intended by Congress.

We cannot comment on the methodology used to establish capitation rates prior to the Mercer contract because those efforts were outside the scope of this audit. We request that the DOH reconsider its position, or propose alternative solutions to correct the cited deficiency, and provide a target completion date for planned actions.

DOH RESPONSE (Recommendation 2)

DOH did not concur with the recommendation and stated that the District is in compliance with the federal requirement to collect and use encounter data in the rate-setting process.

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Although the DOH response gives the OIG credit for stressing the importance of encounter data and indicates agreement with the importance of encounter data, officials did not propose alternative solutions to meet the intent of the recommendation. According to DOH officials, the new MCO contracts will have enhanced contract provisions related to encounter data collection. DOH also stated that MAA provided Mercer with encounter data for the CY 2008 rate development.

OIG COMMENT

We disagree with the DOH response. The CMS approval of the District's rate-setting methodology was, in effect, a waiver allowing the District to not comply with the law. Therefore, it is a true statement that during the period covered by the audit (2002 through 2005) the District was not in compliance with 42 CFR § 438.242. As of the end of the audit field work, the District still was not in compliance, though MAA and Mercer were working with the MCOs to gather and validate encounter data. The DOH statement that it now has a system for gathering accurate, complete, and consistent encounter data is misleading.

For example, the DOH response states that “[t]he District’s encounter data collection system is fully operational; the remaining encounter data challenges are primarily centered on the collection of data from service providers, by the MCOs.” *Id* at 3. Encounter data that shows service utilization is a key component of developing reasonable capitation rates based on the population served. Thus, we are concerned about these “data challenges” at the service provider level, which could affect the validity of the encounter data provided to Mercer for the CY 2008 rate development.

We request that DOH clarify its position and provide target completion dates for planned actions.

DOH RESPONSE (Recommendation 3)

DOH concurred with Recommendation 3. In its response, DOH stated that MAA and Mercer have discussed the potential for risk adjustment and that MAA is interested in pursuing this option. However, DOH indicates that MAA must first determine the MCOs that will serve the Medicaid members (under the upcoming procurement) before doing so. As a result, DOH officials believe that risk adjustment is a goal for the coming years. DOH officials also noted that the risk adjustment process reallocates the capitation dollars among the winning MCOs and does not reduce the amount of capitation outlay for the Medicaid program.

OIG COMMENT

The DOH response was partially responsive. We disagree that the DOH must first identify participating MCOs before requiring the use of risk adjustment factors when

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developing capitation rates. However, we do agree that it is too late to use risk adjustment factors during the CY 2008 rate-setting process. The concept of using risk adjusted rate cells is that risk is adjusted to incorporate the special needs of certain populations. For example, the benefits of the concept would become evident when you could determine the number of MCO enrollees with HIV/AIDS or permanent disabilities such as blindness, a more important factor than identifying which MCOs will participate.

Failure to adequately plan when implementing new methods or programs often results in lengthy delays. We believe that MAA needs to begin planning now to incorporate the use of risk adjustment factors into future rate-setting processes. Further, once the use of risk adjustment factors is developed and approved, MAA could decide that its actuary should incorporate the factors into the annual capitation rate adjustment. Because the OIG draft report never concluded or implied that risk adjustment would reduce capitation outlays, we do not understand the DOH comment that the risk adjustment process reallocates capitation dollars among participating MCOs rather than reduces capitation outlay.

We request that DOH clarify its position regarding the use of risk adjustment factors and provide a target completion date for planned actions.

DOH RESPONSE (Recommendation 4)

DOH did not concur with the recommendation to benchmark the Maryland managed care program, stating that doing so would appear to be inconsistent with the OIG's expressed concerns about how the District calculates rate ranges. According to DOH officials, Maryland and the District use similar rate-setting methodologies based on program-wide financial data. Although the DOH acknowledges that Maryland used encounter data to adjust rate cells based on risk and developed plan-specific rates, officials state that the base rates are established in a manner similar to how the District calculates their rates. Finally, DOH officials pointed out that the District's capitation rates are 5-10 percent lower than Baltimore rates, and the annual rate increases have been lower in the District than in Maryland.

OIG COMMENT

We disagree with the DOH response and the assertion that the recommendation to benchmark against the Maryland managed care program is inconsistent with our concerns about how the District calculates rate ranges. According to Maryland officials, the base rate that is set using program-wide financial data applies to only about 25 percent of the MCO population. We also noted that Maryland sets the managed care capitation rates and MCOs either accept the rates or decline to participate in the program. When a state sets a rate it means that the state has determined what it believes is a reasonable reimbursement rate for

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providing medical services. Further, Maryland (unlike the District) controls MCO payments using other tools and processes (e.g., internal controls) such as cost audits of MCO-provided data,²⁵ Medical Loss Ratio requirements, adjustable administrative costs, and risk adjusted rate cells.

Benchmarking is the process of identifying organizations with best practices and comparing that data to MAA data. The goal is to identify and implement new and improved business practices that will help MAA meet or exceed the benchmarks. Part of the benchmarking process is to determine the reasons for the differences in rates between Baltimore, Maryland, and the District.

For example, Baltimore may have MCO members who use services more often or who use more costly services, both of which would increase costs. Maryland MCO enrollee data as of June 29, 2001, shows that Baltimore accounted for more than 189,000 MCO members as compared to less than 90,000 in the District. Preliminary research also indicates that more than half the capitation rate is used for the cost of injuries to children under six living in Baltimore and that Baltimore children have almost twice the rate of injury as the national average. These are just a few of the factors that could cause the capitation rate in Baltimore to be higher than the District.

We request that DOH reconsider its position or suggest alternate actions to resolve the deficiencies identified in this report and provide target completion dates for planned actions.

DOH RESPONSE (Recommendation 5)

DOH did not concur with the recommendation. The DOH did not agree that MAA fiscally mismanaged the MCO program and did not adequately respond to our recommendation to establish internal controls designed to measure the performance of the Office of Managed Care in relation to the rate-setting process. According to the DOH, MAA has worked proactively to manage the MCO program, ensure compliance with federal law, and keep the program within budget. In the response, officials indicate that MAA will continue to look for ways to improve program performance but emphasize that the Office of Managed Care operated in compliance with all District and federal laws while managing the program.

DOH stated that MAA worked with its actuary and CMS to develop a rate-setting methodology that is in compliance with all applicable laws and regulations, and that CMS reviewed and approved MCO rates in each of the last 5 years. Officials also emphasized that MAA managed the MCO program to much lower annual increases than the national average, which attested to the aggressive management reforms instituted in the program.

²⁵ MAA merely requires MCOs to certify the accuracy of cost data submitted to Mercer for the rate-setting process.

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DOH explained, for example, that MAA negotiated rate increases over the past 5 years that average 2.2 percent overall even though medical costs increased nearly 7 percent per year at the national level. Further, MAA instituted an aggressive system of purchasing reform that slowed the rate of growth of capitation rates and reduced the rates for some MCOs. According to DOH officials, payments to DC Charter were reduced by 0.2 percent and payments to Amerigroup were reduced by 1.9 percent. The DOH response indicates that the decreases would have been even greater but the reform occurred in the midst of a required increase in childrens' dental rates. As a result, DOH believes these reductions have resulted in paying the MCOs close to the minimum they can legally be paid.

DOH officials also indicated that the MCO program was not mismanaged because in FY 2006 MAA established a quality-based reporting system that utilized the nationally accepted HEDIS[®] quality measures to assess the quality of the services being provided by the MCOs. According to DOH officials, the first year results show that the District was equal to or substantially above nationally accepted measures in most quality measures reported by Medicaid programs nationally.

Further, DOH asserts that the contracts resulting from the CY 2008 procurement will provide the Office of Managed Care with additional authority to manage medical loss performance, reporting requirements, and quality of service.

OIG COMMENT

We consider DOH to be non-responsive to Recommendation 5. We continue to believe that MAA fiscally mismanaged the MCO program and that internal controls designed to measure the performance of the Office of Managed Care in relation to the rate-setting process are needed. The DOH focus on compliance with federal and District laws and regulations indicates that officials may not understand the concept of internal controls. Compliance with laws and regulations does not necessarily equate to efficient and effective operations, nor does compliance negate the need for adequate internal controls.

For example, we believe that a review by DOH or MAA officials of the MCO financial statements posted on the Department of Insurance, Securities and Banking website would have resulted in them noting that profit and administrative cost for each MCO significantly exceeded the amount used as reasonable during the rate-setting process. A review of the financial statements by a level higher than that of the Office of Managed Care is an internal control. In our estimation, this should have been followed by the Office of Managed Care, in conjunction with Mercer, evaluating the situation, identifying reasons for the differences, and determining whether an adjustment to the capitation rates was warranted.

FINDING AND RECOMMENDATIONS

Given the amount of excess payments made to the MCOs, we would hope that the District MCO program incurred lower annual increases than the national average. A comparison to the national average is a form of benchmarking but does not address the need to develop and implement strong internal controls. We cannot address the use of HEDIS[®] quality measures because we excluded quality of services from the scope of this audit. Even if the District is receiving quality services, we question the need to spend \$90 million in excess payments to achieve that quality when the same quality could be purchased elsewhere for less.

Whether the Office of Managed Care obtains additional authority through the CY 2008 MCO contracts is not the point. DOH and MAA must establish internal controls to obtain reasonable assurance that the Office of Managed Care adequately monitors the MCO contracts. We request that DOH reconsider its position or develop alternate solutions and provide a target completion date for planned actions.

DOH RESPONSE (Recommendation 6)

DOH concurred with the recommendation but stated that the actuary has satisfied the requirements of its contract with MAA, and that MAA does not appear to have recourse to pursue monetary remuneration from them (or the MCOs) based upon the analysis provided in the OIG draft report. However, DOH also stated that because MAA has been concerned about MCO profit levels, independent audits are being completed on the finances of each of the MCOs and that District legal staff will determine the action to take once the audits are complete.

OIG COMMENT

Actions completed and planned by DOH are responsive and meet the intent of the recommendation. However, we request that DOH officials provide target completion dates for planned actions.

**EXHIBIT A: SUMMARY OF POTENTIAL BENEFITS
RESULTING FROM AUDIT**

Recommendation	Description of Benefit	Amount and Type of Monetary Benefit	Agency Reported Estimated Completion Date²³	Status
1	Economy and Efficiency. Ensures that future capitation rates will not result in excess payments.	Monetary \$29 million wasted and \$15.5 million cost avoidance (District share) over the next 5 years.	TBD	Unresolved
2	Compliance. Ensures compliance with CMS and contract requirement to use encounter data in the rate-setting process.	Non-monetary	TBD	Unresolved
3	Economy and Efficiency. Ensures that health plans that attract higher risk members will be compensated for any differences caused by providing services to members requiring the higher levels of care.	Non-monetary	TBD	Unresolved
4	Economy and Efficiency. Identifies lessons learned and better methods for setting capitation rates.	Non-monetary	TBD	Unresolved
5	Internal Control. Ensures that the MAA Office of Managed Care properly manages the rate-setting process.	Non-monetary	TBD	Unresolved
6	Economy and Efficiency. Recovers excess payments.	Monetary Undetermined	6/12/2007	Closed

²³ This column provides the status of a recommendation as of the report date. For final reports, “Open” means management and the OIG are in agreement on the action to be taken, but action is not complete. “Closed” means management has advised that the action necessary to correct the condition is complete. If a completion

EXHIBIT D: MERCER RESPONSE

date was not provided, the date of management's response is used. "**Unresolved**" means that management has neither agreed to take the recommended action nor proposed satisfactory alternative actions to correct the condition.

EXHIBIT B: PAYMENTS MADE TO MANAGED CARE ORGANIZATIONS IN EXCESS OF AMOUNTS NEEDED FOR PATIENT CARE

Calendar Year ¹	Enrolled Members as of End of Year	DC Chartered Health Plan, Inc.				Percent of Capitation Spent on Patient Care	Expected Admin Costs	Expected Before Tax Profit	Excess Payment ²	District Share of Excess Payment
		Expected Premium Revenue	Premium Revenue Per FS	Medical Costs Per FS	Spent on Patient Care					
2002	34,383	\$ 57.5	\$ 61.5	\$ 48.6	79.0	\$ 7.3	\$ 1.7	\$ 3.9	\$ 1.2	
2003	36,203	77.4	80.8	65.4	80.9	9.8	2.3	3.4	1.0	
2004	38,412	86.1	89.3	72.7	91.4	10.9	2.5	3.2	1.0	
2005	38,575	94.6	98.7	79.9	81.09	12.0	2.8	4.1	1.2	
2006	37,460 ³	99.8	102.7	84.3	82.1	12.6	2.9	2.9	.87	
Subtotal		415.4	\$ 433	350.9	81.1	\$ 52.6	\$ 12.2	\$ 17.5	\$ 5.1	
Health Right, Inc.										
2002	10,472	\$ 17.1	\$ 18.9	\$ 14.4	76.2	\$ 2.2	\$.5	\$ 1.8	\$.5	
2003	11,224	23.0	24.9	19.4	77.9	2.9	.7	1.9	.6	
2004	12,367	25.7	27.1	21.7	80.1	3.3	.8	1.4	.4	
2005	13,408	31.9	31.8	26.9	84.9	4.0	.9	---	---	
2006	13,127	30.8	35.1	29.9	85.2	4.5	1.8	---	---	
Subtotal		128.5	\$ 137.8	112.3	81.5	\$ 16.9	\$ 4.7	\$ 5.1	\$ 1.5	
Amerigroup Maryland, Inc.⁵										
2002	37,339	\$ 46.0	\$ 53.2	\$ 38.9	73.1	\$ 5.8	\$ 1.3	\$ 7.2	\$ 2.1	
2003	37,633	66.0	85.8	55.7	64.9	8.4	1.9	19.8	5.9	
2004	40,469	67.9	90.2	57.3	63.5	8.6	2.0	22.3	6.7	
2005	41,206	81.1	98.4	68.5	69.6	10.3	2.4	17.3	5.2	
2006	39,889	93.3	100.7	78.8	78.2	11.8	2.7	7.4	3.0	
Subtotal		354.3	\$ 428.3	\$ 299.1	69.8	\$ 44.9	\$ 10.3	\$ 74.0	\$ 22.2	
Grand Total		\$ 898.2	\$ 999.1	\$ 762.3		\$ 114.4	\$ 27.2	\$ 96.6	\$ 28.8	

¹ MCO financial statements are based on calendar year while the actuary used cost data by contract year (August 1 to July 31). Both timeframes cover 12 months of data and should be reasonably consistent. Minor differences due to rounding may exist.

² Excess payments represent the difference between the expected premium revenue from the premium revenue per the financial statements. The methodology for calculating excess payments is described on page 6 of the report.

³ DC Chartered and Health Right's enrolled members for 2006 are as of September 2006.

⁴ When administrative costs per the financial statements are less than the expected 15 percent, our excess payment calculation could show a negative amount. Negative amounts are denoted by dashes and not included in our calculation because Health Right, Inc. did not lose money during those years and actually experienced profit (before taxes) of 3-7 percent.

⁵ The Amerigroup Maryland, Inc. revenue and costs presented in this table represent only the portion applicable to the DC Medicaid Program.

EXHIBIT C: DOH RESPONSE

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH**



Office of the Director



June 12, 2007

Mr. Charles J. Willoughby
Inspector General
Office of the Inspector General
717 14th Street NW
Washington, DC 20005

Dear Mr. Willoughby:

Attached are DOH comments regarding *Department of Health's Oversight of the District of Columbia Medicaid Managed Care Program (OIG No 05-2-20HC)* report.

The Department of Health Medical Assistance Administration (DOH-MAA) has made aggressive management changes in its oversight of the Medicaid Managed Care Program since late 2004. The Department has undertaken a number of major reforms and has incorporated nationally recognized measures and standards into its oversight of the Medicaid Managed Care Program, for the first time in the history of the District's Medicaid program. Unfortunately, the OIG report fails to recognize a number of monumental reforms instituted in the District's Medicaid program.

For example, in 2005 the program instituted nationally accepted and recognized Health Plan Employer Data and Information Set (HEDIS) quality measures for the first time in the history of the District's Medicaid program. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. There is no mention of institution of HEDIS measures in the District's Medicaid Managed Care Program in the report. Further, DOH-MAA received HEDIS quality reports based on 2006 MCOs data in January 2007. The results were audited by the DelMarva Foundation, DOH-MAA's external quality review organization, and showed that quality of care in the District's Medicaid MCOs to be at or well above the national mean in most categories. The DC Medicaid health plans scored above the national mean on nearly 80 percent of the measures (44 of 56), top quartile in the nation on 27 of 56 measures (nearly 50 percent), and above the 90th percentile on 18 of 56 measures (nearly one-third). In addition, DOH-MAA has mandated that the MCOs become certified by the National Commission for Quality Assurance (NCQA), the preeminent quality assurance organization in the country, and the MCOs have complied. The omission of HEDIS quality measures from the OIG report is important because it is important to note not only what the MCOs are being paid, but also the quality of the services that are provided.

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EXHIBIT C: DOH RESPONSE

The auditors also did not recognize the increased emphasis on encounter data reporting which has led to encounter data being received by DOH-MAA from Medicaid MCOs for the first time in the history of the program.

In addition, DOH-MAA has significantly slowed the rate of growth and reduced premium payments for health plans that had the largest financial income prior to the new management team's arrival. DOH-MAA slowed the rate of growth in FY 05-06 and decreased premium payments in FY 06-07 -- reducing Chartered's payments by 0.2% and reducing Amerigroup's payments by 1.9%. This reduction would have been even greater had DOH-MAA not been mandated to increase dental rates for children in the MCOs. This has all resulted in our paying the MCOs close to the minimum that we can legally pay them, as required by Federal law.

Furthermore, the program follows CMS guidance in determining its actuarial sound payment ranges and uses an actuarial firm, Mercer Inc., which has been approved by CMS and is certified by the American Academy of Actuaries. The methods used in Mercer's development of rate ranges are consistent with methods used by most states that have managed care programs.

Our actions have set the stage for major reforms in how care in a managed care environment will be purchased in the District in the future. Not only will rates be competitive but we will ensure a high level of quality and a competitive bidding environment.

Our comments for each of your recommendations in the attached document expand on the above information, as well as respond to the specifics of each of the recommendations.

Thank you for the opportunity to comment on the report.

Sincerely,



Gregg Pane, MD, MPA
Director and Chief Health Officer

cc: Dan Tangherlini, City Administrator
David Catania, Councilmember At-Large
Robert Maruca, DOH-MAA
William DiVello, OIG

EXHIBIT C: DOH RESPONSE

RESPONSE TO RECOMMENDATIONS IN OIG AUDIT OF THE DOH OVERSIGHT OF THE DC MEDICAID MANAGED CARE PROGRAM (OIG NO. 05-2-20HC)

Each recommendation of the OIG report regarding oversight of the DC Medicaid managed care program is listed below. DOH has reviewed the recommendations and comments are provided below for each recommendation.

OIG RECOMMENDATION 1: Calculate a base starting point for each MCO using individual medical costs to eliminate the “one size fits all” methodology until encounter data can be collected, validated, and used to supplement cost data for rate setting purposes.

Response:

The Department believes this recommendation is not in the best interest of the District at this time. Using MCO-specific (or plan-only) data for rate setting has hurt the District in the past. Prior to its current actuary, the District's consultant did set rates in this manner. CMS requested that the District discontinue the practice of using a MCO-specific rate development approach because that type of method resulted in very large unexplainable rate variations from one MCO to another. The rates being developed and implemented at that time appeared to be more based upon an MCOs ability to negotiate as opposed to a reflection of the risk or cost of their population. Before changing methodologies to the current base data approach and hiring its current actuary, the District risked the loss of federal match due to this issue.

The OIG argues the District's rate setting methodology is flawed with a “one size fits all” method. The OIG goes further to advocate a non standard approach that would result in different, potentially disparate, rate ranges for each MCO. The OIG focuses on the methodology as the only driver of MCO profits. This is an incorrect conclusion. This limited viewpoint is not useful in enhancing the District's Medicaid MCO program and in fact may have an opposite harmful effect if implemented.

Using MCO-specific data as recommended by the OIG would actually increase the disparity in MCO rates. By using the existing approach, the starting point for rate development is higher for some MCOs and lower for others. This provides an incentive for “high cost” MCOs to increase their operating efficiency.

A competitive procurement would also not be feasible if a single base starting point was not used. Therefore, the current competitive MCO procurement process in the District would be significantly hindered. The current methodology allows the District to develop a rate range and negotiate within that range. Conversely, if the individual MCO data was used for each plan, it would be extremely difficult to develop an appropriate rate for potential new vendors. This is because new MCOs would be receiving membership from all existing MCOs; therefore a rate based on all MCO data should be used. This is especially critical given that the District is

EXHIBIT C: DOH RESPONSE

currently procuring a new competitive contract for managed care services. There is no guarantee the three current MCOs will have a contract after the procurement is complete because a truly robust competition should take place for the new managed care contracts.

Furthermore, the OIG report lacks evidence that this individual MCO approach is better or even feasible. Without supporting information – such as CMS approval, experience demonstrating this methodology is being successfully used in other states or an explanation of how this methodology can prospectively account for the dramatic decrease in the mental health benefit cost which has impacted current experience – it is difficult to determine how this would be better or result in lower cost. Also the method recommended by the OIG would not have solved the problem at hand. If anything, it moves in the direction of cost plus reimbursement which CMS and Medicaid programs throughout the country generally strongly oppose.

MAA does not support an MCO-specific rate setting methodology. For the District to follow the OIG recommendation on a rate setting methodology would put the District in the unique position of being one of the only programs in the country using this methodology. The OIG has not provided evidence that this methodology would have prevented any excess profits being earned by the MCOs or explained how it would benefit the District. Conversely, the current methodology used in the District is generally accepted by CMS and the American Academy of Actuaries, which is the governing body of actuaries. The current DC rate setting methodology is used in nearly every other state, including Maryland and New Jersey.

The OIG reports that some MCOs made excessive profits. The primary reason for those profits appears to be related to a program change in mental health services that did not materialize as the District expected. Unfortunately, this issue was not addressed in the report.

Additionally, MAA is currently having an independent auditor conduct financial audits of the three MCO's contracted with the District. These audits will be reviewed when completed and appropriate action will be recommended based on the findings, to include legal action if wrongdoing is suspected to have occurred.

OIG RECOMMENDATION 2: Enforce 42 CFR § 438.242 and contract provisions that require MCOs to collect and submit valid encounter data to MAA and have MAA make valid encounter data available to the actuary responsible for calculating capitation rates for each MCO.

Response:

The District is in compliance with 42 CFR § 438.242 in collecting encounter data from the MCOs. In the current procurement, the District has also enhanced the contract provisions related to encounter data collection. MAA has provided Mercer encounter data for use in rate setting. Mercer reviewed the data and included encounter data as a direct data source in the CY 2008 rate development.

EXHIBIT C: DOH RESPONSE

Throughout the report, the OIG stresses the importance of incorporating encounter data into rate setting. Through the various discussions with the OIG during this audit, MAA and Mercer have stressed the importance of encounter data for rate setting and evaluating risk adjustment for the MCOs. It is helpful to see that the OIG accurately reflected the importance of encounter data in this report. However, the OIG reports that the District's program is not in compliance with Federal Law regarding encounter data. This is an inaccurate statement.

OIG STATEMENT: MAA did not have a system to collect and use valid encounter data to best identify and evaluate the extent that MCO members used medical services.

MAA does now have a system for gathering accurate, complete and consistent encounter data. This system has evolved over the last few years through significant technical assistance from MAA and Mercer to the MCOs. The District's encounter data collection system is fully operational; the remaining encounter data challenges are primarily centered on the collection of data from service providers, by the MCOs. This is particularly true where the plans have sub-capitated the providers and may need to consider changing their reporting incentive/disincentive policies and procedures.

MAA agrees that encounter data collection did not begin until 2003, because the MCO contracts were not implemented until August 2002, and the MCO's had to be operational before we could begin the encounter data process. MAA emphasizes that the development of an encounter data system and collection of data has moved forward aggressively and now produces usable encounter data. CMS has approved the District's encounter data plans and supports the timeframes the District has proposed.

OIG STATEMENT: MAA did not use encounter data in developing the capitation rates. The failure to use encounter data distorts the capitation rate calculation because it excludes the extent to which MCO members used medical services.

The availability of encounter data does not have a direct impact on the medical costs. While the encounter data provides more detail for analysis, it does not change the actual costs to deliver services to the Medicaid population. With encounter data, MAA will be in a better position to explain cost differences among the MCOs and enhance the overall rate setting process; however, this does not change the actual medical costs of the program.

The financial data submitted by the MCOs outlines the amount of money spent on doctors' visits, inpatient hospital stays, outpatient visits, primary care, specialty care, pharmacy, and dental care. This is a reasonable starting point to adequately assess future levels of service costs. The capitation rates are not distorted due to the lack of encounter data. While CMS prefers encounter data as the primary data source, the financial data is sufficient to determine the cost of the medical services utilized by MCO members. CMS has approved the use of financial data as a source for rate setting in the District as well as in Maryland, New Jersey, and numerous other states.

EXHIBIT C: DOH RESPONSE

That being said, the District has worked diligently to collect encounter data and incorporate the data into detailed rate setting. Mercer has incorporated encounter data into CY 2008 rate setting as a direct data source.

OIG STATEMENT: We [The OIG] found that the District lags far behind Maryland, Virginia, and New Jersey, all of which have been collecting encounter data since calendar year 2000...

While the encounter data collection in the District did begin after Maryland and New Jersey, the District is the only one of these programs to incorporate their encounter data as a direct data source in rate setting. The other two states rely solely on MCO financial data and use encounter data to support risk adjustment calculations. Given these facts, MAA disputes the conclusion that "the District lags far behind Maryland, Virginia and New Jersey."

OIG STATEMENT: Because the District has not complied with the federal requirement to use valid encounter data in the development of the capitation rates, it is in danger of losing federal approval and funding.

This statement is simply not correct. There is no basis to the statement that the District is at risk of losing federal funding because of its encounter data collection efforts. CMS has approved the District's use of financial data in determining capitation rates. When the requirement became apparent, the District proactively made it a priority to develop an encounter data collection system. The experience throughout the country has been that it takes three to five years before encounter data reported by MCOs is complete and accurate enough to incorporate into rate setting. The District's experience in developing their system is consistent with the experience of other states. Throughout this process the Department has periodically discussed and reported to CMS its plans and progress made on encounter data collection. As mentioned above, the District now has an encounter data system and has made use of the encounter data in the most recent rate development and will continue to incorporate encounter data in future rate setting.

OIG RECOMMENDATION 3: Coordinate efforts with the actuary to require the use of risk adjustment factors when developing capitation rates based on valid encounter data.

Response:

MAA and Mercer have discussed the potential for risk adjustment during our meetings with the OIG audit team. MAA is interested in pursuing a risk adjustment program using the encounter data for this purpose. Given the upcoming procurement, MAA must first determine the MCOs that will serve the Medicaid members before introducing risk adjustment. However, risk adjustment is a goal for the program in the coming years. We would also note that the risk adjustment process reallocates the capitation dollars amongst the winning MCOs; it does not reduce the amount of capitation outlay for the Medicaid program.

EXHIBIT C: DOH RESPONSE

OIG RECOMMENDATION 4: Benchmark the Maryland managed care program to identify and implement better methods for setting capitation rates.

Response:

This recommendation appears to be inconsistent with the OIG's expressed concern about how the District calculates rate ranges. Maryland's rate setting methodology is based on utilizing total MCO costs. This is the same method used in the District. Maryland and the District have very similar rate setting methodologies. This is known because Mercer is also Maryland's actuary.

The District's contract with Mercer allows for access to a national perspective on Medicaid managed care rate development. MAA and Mercer regularly discuss rate setting or other program issues affecting Mercer's other state clients, including Maryland. Maryland and the District use similar rate setting methodologies based on program-wide financial data. Maryland has implemented risk adjustment based on encounter data to develop plan-specific rates, but base rates are established in a manner similar to how the District calculates their rates. The District's rate setting methodology, based on financial data is consistent with Maryland and the District is considering using encounter data to risk adjust plans after the vendors are selected and known as a result of the current MCO procurement. In the interim the District has already incorporated encounter data as one direct data source in its FY 2008 rate development.

In terms of "benchmarking" the Maryland program, MAA would also like to point out that the District's DCHFP capitation rates are 5-10% lower than the rates paid in Baltimore, a metropolitan jurisdiction comparable to the District; and the annual rate increases have been lower in the District than in Maryland.

OIG RECOMMENDATION 5: Establish internal controls designed to measure the performance of the Office of Managed Care in relation to the rate setting process.

Response:

The Office of Managed Care has operated in compliance with all District and federal laws while managing the program within the budget allocated by the District City Council. MAA has complied with the contracting rules put forth by the Office of Contracting and Procurement and complied with the federal regulations put forth by CMS. MAA will continue to look for ways to improve program performance. However, we want to stress that the Office of Managed Care has complied with all Department policies and applicable laws and regulations.

The OIG incorrectly concludes that the District has fiscally mismanaged the MCO program. This statement is based on the issues raised related to rate setting, what they perceive as excess profits, and encounter data. MAA disagrees with the assertion that they have mismanaged the MCO program. MAA has worked proactively to manage the Medicaid MCO program and ensure compliance with federal law and keep the program within budget.

EXHIBIT C: DOH RESPONSE

MAA has worked with its actuary and CMS to develop a rate setting methodology that is in compliance with all applicable laws and regulations. MAA has been in regular communication with CMS throughout the annual rate setting projects. MAA has received federal approval of the rates for each year to maintain compliance with federal law.

Over the last five years, MAA has negotiated rate increases with the MCOs that averaged 2.2% overall. This has allowed MAA to keep the Medicaid managed care program within budget. Nationally, medical costs have increased nearly 7.0% per year. Most recently, beginning with MCO negotiations in 2005 for FY 06 rate negotiations, an aggressive system of purchasing reforms were instituted by the MAA Management team. The rate of growth of capitation rates was slowed in FY 05-06 and capitation rates were reduced for some MCO's in the FY 06-07 rate negotiations. Chartered's payments were reduced by 0.2% and Amerigroup's payments were reduced by 1.9%. This was accomplished in the midst of a required increase in children's dental rates or the decreases would have been even greater. Additionally, MAA instituted a quality based reporting system in FY 06, utilizing the nationally accepted HEDIS quality measures to measure the quality of the services being provided by the MCO's. The first year of reports showed that the District was equal to or substantially above nationally accepted measures in most quality measures reported by Medicaid programs nationally. MAA would like to emphasize that they have managed the Medicaid MCO program to much lower annual increases than the national average, again attesting to the aggressive management reforms instituted in the program.

As mentioned above, MAA proactively addressed the issue of encounter data once the federal regulations went into effect in August 2003. MAA designed a system to collect encounter data from the MCOs and collected data beginning with October 2003 service dates. MAA recognizes the encounter data collection is a work in progress and is committed to making the resources available to collect this valuable data. There are numerous examples of other states that would show DC's experience and progress with their encounter data system is fairly typical.

Finally as vendors are selected through the current MCO procurement they will enter new contracts with the District that will provide the Office of Managed Care with additional authority to manage medical loss performance, reporting requirements and quality of service delivered by the MCOs.

OIG RECOMMENDATION 6: Pursue with the MCO contractors and the actuary, monetary remuneration, due to the excess profits made over the target rate.

Response:

The actuary has satisfied the requirements of their contracts with MAA. MAA does not appear to have recourse to pursue monetary remuneration from them based upon the analysis provided in this report. There are no legal terms and conditions in the current MCO contracts that define minimum loss ratios or excess profits. All current MCO rates have been reviewed by CMS and CMS approval was obtained for each rate cycle over the last five years. CMS review of rates and their review of the actuarial sound rate range and rate methodology is a requirement enforced by CMS on all Medicaid managed care programs.

EXHIBIT C: DOH RESPONSE

However, because MAA has been concerned about MCO profit levels, independent audits are being completed on the finances of each of the MCO's. Based on the results of these audits, and the facts that will be presented surrounding their profitability, MAA will discuss the audit results with District legal staff and make a determination on what action to take when the audits are complete.

With regard to the issues of historical and projected future excess profits, the OIG concludes that excess profits were the result of a flawed, one size fits all methodology. As discussed earlier, MAA disagrees with that conclusion. The Department's reasoning for this and concerns with certain key points from the OIG report are further provided below.

Excess Profits

The OIG performed an analysis of the financial statements of each of the District's MCOs to determine the profit levels from the Medicaid program. Recognizing the MCOs should have the opportunity to earn a profit for doing business, the OIG chose 3% profit as a reasonable return and concluded any additional profit was excess. While the profits of the MCOs exceeded expectations, the source of the profits appears to be primarily related to fee for service mental health services and members not transitioning to the managed care program as anticipated by the District rather than the rate setting methodology.

In addition the method used by the OIG to forecast profit levels for the three MCOs over the next five years is not an appropriate methodology. The results of this forecast are neither credible nor likely to occur, given the requirements placed in the new MCO procurement..

OIG STATEMENT: The methodology resulted in Amerigroup receiving \$74.9M (or 20.9 percent) more than necessary for patient care over the past 5 years. In addition, DC Chartered and Health Right received \$17.5 and \$5.1 million (or 4.2 and 3.8 percent respectively) more than necessary for patient care of the past 5 years.

All rate setting methodologies result in projections of cost in an upcoming contract period. As discussed above, the methodology used by Mercer is not flawed and did not cause excess profits. Rather, the actual experience during the contract period, which is influenced by a number of factors including the planned transition of mental health services from DMH to the MCOs that did not materialize as predicted by the District, resulted in larger than anticipated profits. The majority of the excess profits appear to be related to the inclusion of mental health benefits in the District's contract in 2002-2003. Initially, the per member per month (PMPM) cost for mental health services was based on the costs of these services in the fee-for-service (FFS) program. The actual managed care experience has been lower than the initial rates for these services because mental health services and members did not transition from the mental health fee for service program to the managed care program in the manner anticipated by the District. The profit earned from mental health services is worth approximately 10% from 2003 to 2005. This factor alone accounts for the "excessive profits" referenced in the OIG report. The District will explore the potential to recoup funds paid to the MCOs for mental health services that did not transition to the managed care program as expected, and will seek legal guidance from District legal staff to determine if there is any basis to recoup some portion of those funds.

EXHIBIT C: DOH RESPONSE

The mental health rates in the managed care program have decreased from \$29.86 PMPM to \$8.02 PMPM over a 5-year period. This represents more than a 10% impact to the rates. Because rates are set using historical experience, the capitation rate impact of this change was not immediate. The decrease in mental health costs is a unique phenomenon to the District and has not been realized in other Medicaid programs where double-digit trend increases for mental health are not uncommon. This ongoing issue has added to the complexity of rate setting in the District.

OIG STATEMENT: We [The OIG] calculated that, all else being equal, DC Chartered and Amerigroup could receive \$51.6 million (or 1.5 and 4 percent, respectively) more than needed for patient care over the next 5 years.

This statement is based on a very simplified projection method and will not occur. The statement that Chartered and Amerigroup could receive an additional \$51.6 million more than necessary appears to be based on 2006 data, multiplied by 5 to arrive at a 5-year projection. This type of straight line projection is an over simplified approach and is not supported with an appropriate discussion on key assumptions, such as prospective trend, managed care efficiencies or membership projections.

The District disagrees with the assumption that excess payments and disparity between the MCOs will continue. The payment levels have declined in 2005 and 2006 as a result of aggressive rate negotiations, which have resulted in an increasing percentage of capitation being spent on patient care. The Department believes this trend will continue into 2007 and 2008. In addition, the Department is currently procuring a new five-year contract with MCOs. There is no guarantee DC Chartered or Amerigroup will have a contract in 2008, and requirements in the new MCO procurement will require a minimum Medical Loss Ratio of 75%.

In addition, the District's rates are renegotiated annually. Therefore, the expectation that the medical costs will remain at a fixed percentage of premium is inaccurate. For example, the MCOs received an overall rate decrease in 2007 even though health care trends have averaged 7% nationally. Therefore, the percentage spent on medical care is expected to rise in 2007 and the overall profit levels will decline.

EXHIBIT D: MERCER RESPONSE

MERCER

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June 13, 2007

Charles Willoughby
DC Inspector General
717 14th St, NW
Washington, DC 20005

Dear Mr. Willoughby:

Mercer Human Resource Consulting (Mercer) has reviewed the report on the Department of Health's Oversight of the District of Columbia Medicaid Managed Care Program (OIG No 05-2-20HC).

Mercer does not believe that the report accurately reflects the Department's aggressive efforts to manage and improve the District of Columbia's Medicaid Managed Care program. Nor do we believe that the majority of the recommendations, with the exception of pursuing risk adjusted rate setting, to be useful or timely. Some recommendations, such as changing the rate setting methodology, will be detrimental to the District. The OIG criticism of the rate setting methodology employed by Mercer as being a "flawed, one size fits all" approach is neither correct nor well informed. Unfortunately, the report also contains several inaccuracies. Given these issues, we believe the report lacks credibility and utility.

Key facts we believe that the OIG should have captured in this report, but did not, include:

- The rate setting methodology used in the District of Columbia is consistent with the methodology used in nearly every other state in the country, is approved by the Centers for Medicare and Medicaid Services (CMS) and consistent with the American Academy of Actuaries guidance. It is the best choice of methods for the District to ensure competitive rates, management flexibility and program efficiency.
- The primary driver of the lower than expected medical loss ratio and what the OIG refers to as excess profits appears to be related to a program change involving the transition of the mental health fee for service program to the managed care program that did not occur as the District expected it would. Rates to accommodate this expected change were initially set using historical DMH mental health fee for service program costs based on the assumption that the services and members would become the responsibility of the managed care plans the following year. By annually reviewing actual experience it became evident that a number of

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EXHIBIT D: MERCER RESPONSE

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services and members would either transition more slowly than expected or would be retained in the fee for service program. Annual adjustments to the rates paid for these services have been made based upon actual program experience to align the costs for this component of the program.

- The Medicaid Director has aggressively managed the cost of the program; successfully keeping the rate of health care cost increases for the District's Medicaid program well below the national average of 7% and actually achieving rate reductions for the District's two largest Managed Care Plans last year while maintaining compliance with CMS requirements to offer actuarially sound capitation rates.
- The Department of Health has successfully developed an encounter data collection system and appears to be in full compliance with CMS requirements to do so. Data from this system was used by Mercer in developing the capitation rates for the District's current MCO procurement.
- The District's Medicaid Managed Care Program compares favorably to neighboring states with regard to their successful efforts to collect and use encounter data and their health care costs.
- Medicaid leadership has effectively limited the potential for future excess profits to occur by reducing the amount paid for mental health services, aggressively negotiating rates and by implementing new medical loss requirements as defined in the contract to be awarded under the current procurement for Medicaid Managed Care vendors.
- The Medical Assistance Administration and its Office of Managed Care carefully follow CMS regulations and local District policy and proactively manage the program to ensure compliance.

EXHIBIT D: MERCER RESPONSE

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Mercer appreciates the opportunity to serve as the District's Medicaid actuary. Because we have the privilege of serving in this capacity for many states throughout the country, we believe we are in a unique position to bring the District added value through the benefit of our experience, offering information on best practices and emerging health care related issues. It is Mercer's experience that the leadership and staff associated with the District's Medicaid program are deeply committed to and successful in continually improving the service delivery system and effectively managing the cost of services while maintaining a clear focus on measuring and improving the quality of care provided to Medicaid recipients.

Sincerely,



Chip Carbone

cc: Robert Maruca
Mark Hoyt, FSA
Allison Brecher