



Department of Health

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December 7, 2017

Ms. Andrea Inman
Audit Director
New York State Office of the State Comptroller
110 State Street, 11th Floor
Albany, New York 12236

Dear Ms. Inman:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2015-S-76 entitled, "Administrative Costs Used in Premium Rate Setting of Mainstream Managed Care Organizations."

Please feel free to contact Estibaliz Alonso, Acting Assistant Commissioner, Office of Governmental and External Affairs at (518) 473-1124 with any questions.

Sincerely,

Howard A. Zucker, M.D., J.D.
Commissioner of Health

Enclosure

cc: Estibaliz Alonso

**Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2015-S-76 entitled,
Administrative Costs Used in Premium Rate Setting of Mainstream
Managed Care Organizations**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2015-S-76 entitled, "Administrative Costs Used in Premium Rate Setting of Mainstream Managed Care Organizations."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 1,276,304 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to \$8,609 in 2016, consistent with levels from a decade ago.

Recommendation #1:

Review the \$1,935,602 in non-allowable administrative expenses reported by WellCare that we identified, and recalculate the administrative cost cap and the base administrative premium rate based on our findings, as appropriate. Apply the recalculations to the premiums paid for fiscal year 2014-15 and thereafter.

Response #1:

The Department will assess whether the Medicaid Managed Care Operating Reports (MMCORs) findings associated with the reporting of non-allowable administrative expense will impact the rates in a substantive manner. It should be noted that for the period in question, the Department has the flexibility based on Centers for Medicare and Medicaid Services (CMS) policy, to pay within the actuarially certified premium rate ranges produced by the State's actuary. It is unlikely that correcting for this finding would move rate ranges or premium rates significantly towards either the lower or upper bounds of the actuarially certified rate range. Additionally, the cost of engaging the actuary in a complete recertification of the rates should be considered in relation to this recommendation. It is estimated the recertification cost would range between \$28,000 and \$35,000. Finally, any recalculation of these premiums would need the approval of CMS, and the New York State Division of the Budget.

It should also be noted that the Department's reimbursement for administrative expense as a percentage of premium for Mainstream Managed Care Organizations (MCOs) is at 7%, much less than actual MCO reported administrative costs of 8.3%. Furthermore, although the Mainstream Managed Care premium is actuarially sound, and falls within the certified rate ranges, the Department's administrative component of premium as a percentage of total premium is less than the actuarially developed "best estimate" of 8.5%.

Finally, an analysis of recent Managed Care plan financial reports has shown that plans, on average, are experiencing an overall premium loss on the rates currently being paid. The MMCOR data in question is used, along with many other assumptions, to develop at risk capitation rates which is why the State's actuary develops a "range" for rates to be set, knowing full well that data and or assumptions used is the best information available at a point in time. Any negative restatement of rates could potentially impact the State's ability to retain its high-quality health plans.

Recommendation #2:

Recover overpayments from all mainstream MCOs based on the recalculated premiums.

Response #2:

Please refer to the Department's response to recommendation #1. If the rates are recalculated, OMIG will review and take appropriate action.

Recommendation #3:

When reviewing MMCORs for the determination of premium rates, determine the extent to which MCOs reported marketing and outreach expenses as facilitated enrollment and require non-compliant MCOs to remove these expenses from their MMCORs.

Response #3:

Both the Department and the State's actuary review MMCORs for accuracy as a component of the premium rate setting process. MCOs are contacted during the review process if any discrepancies are noted and are often required to re-file the MMCORs for various issues including reporting expenses on incorrect lines.

The MMCOR instructions clearly state that effective April 1, 2011 any Medicaid marketing activities are ceased and therefore should not be reported. It should be noted however, that commercial lines of business are not subject to this limitation. Since the implementation of the MRT#10 the review of plan's marketing expenses, as reported in the MMCOR, has been added to the list of oversight activities performed by the Department. Also, instructions pertaining to the administrative expense tables were revised, as recommended by OSC to include specific guidance for the plans relating to "Non-Allowable Advertising", "Non-Allowable Marketing" and "Non-Allowable Legal Fees and Expenses." Lastly, as part of audits of MMCORs, OMIG reviews reported expenses to determine if they are allowable according to contract provisions and MMCOR guidance.

Recommendation #4:

Review the \$100,172 in legal expenses reported by WellCare that we identified, and recalculate the administrative cost cap and the base administrative premium rate based on our findings, as appropriate. Apply the recalculations to the premiums paid for fiscal year 2014-15 and thereafter.

Response #4:

Please refer to the Department's response to recommendation #1.

Recommendation #5:

Revise the MMCOR instructions to ensure adequate guidance is given, including guidance on reporting facilitated enrollment and outreach expenses, legal costs, and fines and monetary penalties.

Response #5:

The Department disagrees with the OSC recommendation because this recommendation has been addressed already in our responses to the 2014-S-55 audit. The MMCOR instructions are a living document that is updated, and amended, each time new populations and/or benefits are carved into Managed Care. Additionally, the instructions are revised on a quarterly basis to reflect changes in reporting tables as necessitated by the programmatic and policy changes impacting MCOs service provision and financial reporting. Specifically, in a response to the OSC's preliminary audit report 2014-S-55, MMCOR instructions were revised to add explicit and more specific guidance to various reporting categories as necessary.

The Department continues to update MMCOR instructions with inclusion of new benefits and populations, as well as to reflect any changes to State laws or regulations as necessary each quarter. We respectfully request OSC to provide us, in writing, with specific changes to the MMCOR instructions they believe are necessary so these can be taken into consideration for future amendments to the MMCOR instructions and corresponding tables.

Recommendation #6:

Monitor MCO management contracts to ensure they are reviewed and approved in a timely manner. Such actions could include periodically communicating with MCOs to identify expiring and upcoming contracts that MCOs plan to enter into.

Response #6:

The Department disagrees with the assertions made by OSC in this report that the Department does not monitor MCOs for contractual compliance. The Department currently monitors MCO management agreements annually during either an operational or targeted survey of the MCO. On these surveys, staff verify that all management contracts have been approved by the Department. If it is found that the MCO has any unapproved contracts, the Department issues a Statement of Deficiency (SOD) for contracts identified as being out of compliance. The MCO is required to submit an acceptable Plan of Correction (POC). Generally, an acceptable POC requires the MCO to identify all its management contracts and state whether each contract has been approved. If any other contracts are identified as not being submitted to and approved by the Department, the MCO must submit all unapproved contracts for review and approval. In addition to established monitoring activities, the Department is in the process of implementing a procedure to notify MCOs of management contracts that will soon be expiring.

During the course of contract monitoring, it was discovered that Wellcare and another manager were operating with an expired Management Services Agreement (MSA). Wellcare was issued

a SOD on December 16, 2009 for a violation of 10 NYCRR Part 981.11(k). In response to the SOD, Wellcare provided a POC to the Department on January 8, 2010. The POC identified steps the company would take to ensure MSAs would be identified and submitted for approval by the Department at least 90 days prior to expiration. In their POC, Wellcare acknowledged it should have submitted an application for renewal of this agreement at least ninety (90) days prior to its expiration. Subsequently, on January 20, 2010, Wellcare submitted to the Department, for review and approval, a new contract between Wellcare and CHMI.

Additionally, OSC's assertion that it took 16 months for the parties to receive approval of the contract is inaccurate. Although MCOs are required by regulation to submit MSAs or amendments to MSAs 90 days prior to the expected date of implementation, 10 NYCRR Part 98 does not require the Department to complete its review and approval of the MSA or amendment within 90 days of receipt. Additionally, it is not uncommon for review and approval of MSAs to exceed 90 days due to multiple correspondences that are necessary between various Department programmatic, fiscal and legal experts and the MCO. These exchanges of questions, concerns, and additional documentation are often necessary to provide a thorough review and approval of an MSA and may lengthen the review process. In the case of the Wellcare-CHMI MSA, review and approval of the new contract submitted took a little over eight months due to several concerns and comments exchanged between the Department and the MCO.

Moreover, the Department does not agree with the reference the report makes to the "effective date" in the timeline. "Effective date" is misleading because an MSA cannot be considered effective until it receives approval from the Department. The Department suggests changing the terminology to "Expiration date." Furthermore, the Department respectfully requests an additional event be added whereby OSC acknowledges the issuance of an SOD to Wellcare on December 16, 2009 for failing to comply with 10 NYCRR Part 98-1.11(k).

Recommendation #7:

Amend the Department's guidelines to ensure the Department independently and sufficiently assesses the reasonableness of the terms of management contracts. Such an assessment should include a determination as to whether amounts paid to related parties are excessive.

Response #7:

The Department disagrees with this recommendation as existing Department of Health and Department of Financial Services (DFS) regulations provide sufficient authority and guidance for both departments to determine the appropriateness and reasonability of management contracts. Specifically, the Department has been utilizing established guidelines titled, "Management Contract Guidelines for MCOs and Individual Practice Associations," to approve all management contracts.

These guidelines include the requirement that the management contract payment terms are reasonable, and do not jeopardize the financial security of the MCO in accordance with the Department's Regulations Part 98-1.11 (k)(7) and Part 98-1.11 (l)(5).

When applicable, the Department applies additional review requirements noted in Part 98-1.10 relating to "Transactions within a holding company system affecting controlled MCOs." Additionally, DFS reviews management contracts, as applicable, under Insurance Law Section 1505(a).

Recommendation #8:

Assess the appropriateness of the questionable Contract expenses we identified and recalculate the administrative cost cap and the base administrative premium rate based on our findings, as warranted. Apply the recalculations to the premiums paid for fiscal year 2014- 15 and thereafter.

Response #8:

Please refer to the Department's response to recommendation #1.

Recommendation #9:

Recover overpayments from all mainstream MCOs based on the recalculated premiums.

Response #9:

Please refer to the Department's response to recommendation #1. If the rates are recalculated, OMIG will review and take appropriate action.

Recommendation #10:

Review MCO facilitated enrollment activities and, if necessary, adjust the methodology used to calculate the facilitated enrollment portion of the managed care premium rates to ensure each MCO's compensation for facilitated enrollment is appropriate and commensurate with facilitated enrollment activities actually performed.

Response #10:

Successful enrollment in NY State of Health is largely attributed to the work of the Marketplace Facilitated Enrollers, and they are critical to its continued success. As of January 31, 2016, approximately 74% of enrollment through NY State of Health was done through an assistor, with most of this enrollment being attributed to Marketplace Facilitated Enrollers. Medicaid applicants are assisted at a higher level than other populations, with approximately 77% applying with the help of an assistor. Currently, a large group of new enrollees are immigrants entering the country who require additional assistance. Many applicants are also non-English speaking, so may need additional assistance. Marketplace Facilitated Enrollers speak 26 different languages, and dialects, to further assist this population. The Department feels strongly that Marketplace Facilitated Enrollment efforts must be maintained to assist in the enrollment process. This will become even more important when Medicaid enrollment, that was initially performed by the local Departments of Social Services, is transitioned to NY State of Health. The Department anticipates that Marketplace Facilitated Enrollers will play a critical role in the smooth transition of this population.

In addition to new enrollment, the Department is undertaking various strategies to improve timely renewal rates in NY State of Health. One such strategy is the use of Marketplace Facilitated Enrollers to provide application assistance to Medicaid enrollees in the renewal process. Marketplace Facilitated Enrollers are performing outreach calls to individuals that are due to renew their Medicaid coverage on NY State of Health, and are assisting such individuals in

competing the renewal application. The Department is confident that will improve retention rates in the Medicaid program.

Finally, as part of the State Fiscal Year 2017-18 enacted budget, a \$20 million gross reduction in the facilitated enrollment portion of the Managed Care premium was realized to reflect the decline in the number of uninsured individuals.

The Department will continue to evaluate the enrollment assistance portion of the managed care premium rates based on the continued role of MCO Marketplace Facilitated Enrollers.

Recommendation #11:

Formally assess the Department's funding of MCO facilitated enrollment based on current and future need.

Response #11:

The Department will continue to evaluate the enrollment assistance portion of the managed care premium rates based on the continued role of MCO Marketplace Facilitated Enrollers.

State Comptroller's Comments:

OSC Comment #1:

As summarized in the report's Executive Summary, our audit identified approximately \$4 million in estimated annual savings. These savings exceed the cost of Mercer's rate recertification.

Response to Comment #1:

The MMCORs are an important source of cost information that the Department utilizes for MMC regional rate setting. Accordingly, the Department issues instructions for MCOs to accurately record both medical and administrative costs. The Department agrees with OSC's findings that \$9.8M in Wellcare's reported administrative cost is non-allowable.

As noted in previous responses, the Department goes through an extensive process of setting MMC rates which results in regional MCO rates adjusted for MCO-specific acuity. Moreover, to ensure MCO efficiency, the Department sets an administrative cost cap which is less than regional administrative costs as reported by the MCOs. OSC is recommending that regional rates be revised back to State Fiscal Years (SFYs) 2014-15 and 2015-16. The Department does not advise taking this approach because it would be a modest adjustment (estimated \$4M compared to \$20B in total premium expenditures) and would have the effect of penalizing all MCOs under the regional rate setting methodology. Additionally, we have confirmed with the Department's actuary that this finding is not material, and the actuary would not recommend an adjustment to rates.

However, maintaining the accuracy of cost reporting by all MCOs is critical for developing accurate MMC rates. The Department believes that it is appropriate to convene a meeting with Wellcare and OSC to discuss how the error was made and appropriate steps for financial remediation that will not impact other MCOs.

OSC Comment #2:

As stated on page 13 of our report, we reviewed the Department's updated amendments to the MMCOR instructions and determined they still failed to provide clear and consistent guidance. During the audit, we verbally provided the Department with information specifying improvement opportunities in the MMCOR instructions that could help to ensure adequate guidance is given to MCOs. Upon request by the Department in their response, we subsequently provided, in writing, examples of changes to the MMCOR instructions that the Department can take into consideration for future amendments to the MMCOR instructions.

Response to Comment #2:

The MMCORs require plans to report their quarterly financial information in accordance with Statutory Accounting Practices (SAP). In some instances, such plans are also required to prepare financial statements according to Generally Accepted Accounting Principles (GAAP) as well. The MMCOR instructions are meant to provide general guidance to plans as to how to report their financial conditions to the state on a quarterly basis.

MCOs comply with Public Health Law requiring reporting under Subpart 98-3 audit and reporting standards modeled on the standards imposed by the Sarbanes-Oxley Act of 2002.

OSC Comment #3:

We did not assert that the Department does no monitoring of MCOs for contractual compliance. On pages 10 and 15 of our report, we stated the Department did not monitor compliance with NYCRR to ensure that the management contract (Contract) WellCare entered into with CHMI (a related party) was approved timely by the Department. As a result, the Department did not approve the Contract until 16 months after the Contract's proposed and actual effective start date. Further, on page 15, we stated that had the Department communicated with WellCare to identify expiring and/or upcoming contracts that WellCare planned to enter into, the Department could have better monitored compliance with NYCRR.

The oversight process described in the Department's response [the Statement of Deficiency (SOD) and Plan of Correction (POC)] is, in essence, post monitoring and does not allow for timely identification of expiring or new contracts since the process only occurs annually. Despite the Department's response that an SOD was issued on December 16, 2009, this was nine months after the Contract's effective start date of June 1, 2009. Accordingly, we recommended that the Department monitor MCO management contracts to ensure they are reviewed and approved in a timely manner (i.e., take steps in addition to the SOD/POC post monitoring). We are pleased the Department's response indicates the Department is in the process of implementing a procedure to notify MCOs of management contracts that will soon be expiring. We further encourage Department officials to communicate with MCOs to identify new, upcoming contracts that MCOs plan to enter into.

Lastly, in the Department's response, officials state, "OSC's assertion that it took 16 months for the parties to receive approval of the contract is inaccurate." However, it, in fact, did take the Department over 16 months to approve the Contract: CHMI started performing services under the Contract as of the Contract's proposed effective date of June 1, 2009, and the Department

approved the Contract over 16 months later, on October 7, 2010. The Department also states that NYCRR Part 98 does not require the Department to complete its review and approval of the Management Services Agreement (MSA, or management contract) or amendment within 90 days of receipt, and that it is not uncommon for review and approval of MSAs to exceed 90 days due to multiple correspondences that are necessary. This further stresses the importance of adequate monitoring to ensure such contracts and corresponding documentation are submitted in a timely manner and in accordance with NYCRR.

Response to Comment #3:

The Department agrees that the CHMI and WellCare were operating without an approved contract. However, OSC fails to recognize that the Department had discovered during an operational survey of WellCare that a management contract with another vendor was out of compliance. Subsequently, WellCare was issued a SOD for failing to submit the contract prospectively in accordance with Department regulations. As part of WellCare's POC, WellCare identified that their contract with CHMI had also expired. WellCare submitted the required contract documents which were subsequently approved retroactively to June 2009.

OSC Comment #4:

CHMI was providing management services – as if the new Contract was approved – since June 1, 2009; thus, the Contract had an operative, effective date of June 1, 2009. While the Department formally approved the Contract on October 7, 2010, the old contract expired May 31, 2009 and CHMI began providing services under the new Contract as of June 1, 2009, regardless of the Department's subsequent formal approval of the Contract. Lastly, we note that the approved Contract documented June 1, 2009 as the effective date.

Response to Comment #4:

Please refer to the Department's response to comment #3.

OSC Comment #5:

As stated on pages 16-17 of our report, the Department's assessment of reasonableness addressed whether the Contract was financially feasible – not whether the payment terms were excessive. While the Department's guidelines require an assessment of reasonableness, the word "reasonableness" is not defined to include language that payment terms should be appropriate and not excessive.

Response to Comment #5:

The terms of the WellCare CHMI agreement were deemed reasonable as per the existing regulation.

OSC Comment #6:

We acknowledge the importance of facilitated enrollment, and our report does not state that facilitated enrollment efforts should be discontinued. We are pleased the Department states it will evaluate the facilitated enrollment portion of the premium rate, as we recommended.

Response to Comment #6:

The Department agrees with OSC's comment.