

New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Administrative Costs Used in Premium Rate Setting of Mainstream Managed Care Organizations

**Medicaid Program
Department of Health**



Executive Summary

Purpose

To determine whether mainstream managed care organizations (MCOs) are submitting accurate administrative costs to the Department of Health (Department) and whether the Department is appropriately applying the administrative costs in determining MCO premium rates. Our audit covered the period January 1, 2011 through October 31, 2016.

Background

The Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The New York State Medicaid program is administered by the Department. For the State fiscal year ended March 31, 2015, New York's Medicaid program had approximately 7.1 million enrollees and Medicaid claim costs totaled about \$53 billion.

Most of the State's Medicaid recipients receive their services through Medicaid managed care. Under managed care, Medicaid pays MCOs a monthly premium for each enrolled Medicaid recipient, and the MCOs arrange for the provision of services their members require. The State offers different types of Medicaid managed care, including mainstream managed care. Mainstream managed care provides a comprehensive range of medical services, including hospital care, physician services, dental services, and pharmacy benefits, among others. Of the \$53 billion in Medicaid costs, MCOs received \$17.8 billion in mainstream managed care premiums for nearly 5.2 million Medicaid enrollees.

The Department sets the monthly managed care premium rates, which are based, in part, on allowable MCO administrative costs. For this purpose, the Department relies on financial data reported by MCOs on the Medicaid Managed Care Operating Reports (MMCORs). The Department issues MMCOR instructions to guide MCOs on how to report administrative expenses. Of the \$17.8 billion in mainstream managed care premiums paid during fiscal year 2014-15, approximately \$1.2 billion was for MCOs' administrative costs.

Key Findings

- This report included our examination of the administrative expenses submitted by WellCare New York, Inc. (WellCare). We found that WellCare reported about \$9.8 million in administrative expenses that were not allowable. These expenses included, but were not limited to, legal fees, interest, marketing expenses, entertainment costs, and expenses that a related-party subcontractor was responsible for paying. We assessed the impact of these non-allowable expenses on the administrative component of the premium rate and estimated approximately \$4 million in annual overpayments for each year that the rate is not corrected.
- WellCare and several other MCOs appear to have shifted costs from the non-allowable category of marketing to the allowable category of facilitated enrollment, contrary to the intent of a policy change that was initiated from the Governor's Medicaid Redesign Team (MRT) proposal. As a result, the Department is not fully realizing the annual savings that should occur as a result of the policy change because marketing expenses are still reported by MCOs and used to calculate the administrative component of mainstream Medicaid managed care premiums.

The shifting of costs stemmed from the Department's inadequate cost reporting instructions to MCOs, which, despite being identified in a prior State Comptroller audit, remain deficient.

- The Department did not approve a management contract between WellCare and a related party, Comprehensive Health Management, Inc. (CHMI), in a timely manner, nor did it adequately assess the contract terms (and prices) for reasonableness. State regulations require such management contracts to be submitted to the Department for its prior approval at least 90 days prior to the management contract's proposed effective date. However, the Department did not approve the contract until 16 months after the contract's effective date. Also, we found that WellCare paid CHMI at least 35 percent more than the amounts that the Department typically paid MCOs for administrative expenses. Because the Department relied on these administrative expenses to calculate the premium rate, the higher amounts paid by WellCare could have increased the administrative portion of the premium rates paid to all MCOs.
- For fiscal year 2014-15, we estimate that the Department paid MCOs about \$127 million for facilitated enrollment through the premium rates. However, despite the magnitude of these payments, the Department does not adjust each MCO's premium to reflect the MCO's actual facilitated enrollment activities. (This is in contrast to non-MCO contracted organizations that provide enrollment assistance and whose contracts are, in part, based on performance.) Additionally, with the decreases in the numbers of uninsured people, the Department has not assessed whether the current level of funding for MCO facilitated enrollment reflects current and future needs.

Key Recommendations

- Review our findings and, as appropriate, recalculate the administrative cost components of the mainstream managed care premiums paid for the State fiscal year 2014-15 and forward. Recover the corresponding overpayments from all mainstream MCOs based on the recalculated premiums.
- Determine the extent to which MCOs report non-allowable marketing and outreach expenses as facilitated enrollment and require non-compliant MCOs to remove these expenses from their MMCORs.
- Revise MMCOR instructions to ensure adequate guidance is given regarding the reporting of facilitated enrollment and outreach expenses, legal costs, and fines.
- Monitor MCO management contracts to ensure they are approved in a timely manner and that the contract terms are sufficiently assessed for reasonableness. Such an assessment should include a determination as to whether amounts paid to related parties are excessive.
- 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 MCO compensation for facilitated enrollment is appropriate, and formally assess funding of MCO facilitated enrollment based on current and future need.

Other Related Audits/Reports of Interest

[Department of Health: Medicaid Managed Care Organization Fraud and Abuse Detection \(2014-S-51\)](#)

[Department of Health: Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting \(2014-S-55\)](#)

State of New York
Office of the State Comptroller

Division of State Government Accountability

September 13, 2017

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid program entitled *Administrative Costs Used in Premium Rate Setting of Mainstream Managed Care Organizations*. The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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Background

The New York State Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. New York's Medicaid program is administered by the Department of Health (Department). For the State fiscal year ended March 31, 2015, New York's Medicaid program had approximately 7.1 million enrollees and Medicaid claim costs totaled about \$53 billion. The federal government funded about 52.4 percent of New York's Medicaid claim costs; the State funded about 30.2 percent; and the localities (the City of New York and counties) funded the remaining 17.4 percent.

In January 2011, the New York State Governor's Office established the Medicaid Redesign Team to reduce Medicaid costs and improve the delivery of health services. One initiative of the Medicaid Redesign Team was to expand the enrollment of Medicaid recipients into managed care. Accordingly, most of the State's Medicaid recipients now receive their services through Medicaid managed care. Under managed care, Medicaid pays managed care organizations (MCOs) a monthly premium for each Medicaid recipient enrolled in an MCO. In turn, MCOs are responsible for ensuring enrollees have access to a comprehensive range of health care services. MCOs arrange for the provision of services their members require and reimburse health care providers for the services provided to their members.

The Department offers different types of Medicaid managed care coverage depending upon individual eligibility. Mainstream managed care provides comprehensive medical services ranging from hospital care and physician services to dental and pharmacy benefits. Other types of managed care, including managed long term care, are specific to certain populations, such as those needing certain long term care or those reaching specific ages.

For the State fiscal year ended March 31, 2015, MCOs received \$17.8 billion in mainstream managed care premium payments for nearly 5.2 million Medicaid enrollees. Approximately \$1.2 billion of the \$17.8 billion was for the MCOs' administrative costs.

The Department sets the monthly premium rates for mainstream managed care. There are multiple components used to set the premium rates, including:

- The costs of core medical benefits;
- The costs of optional medical benefits; and
- Administrative expenses.

In addition, premium rates are adjusted based on Department-identified geographic regions, medical trends, and patient acuity (the overall health of individual enrollees).

The Department is required by the federal Centers for Medicare & Medicaid Services to create actuarially sound rates. To ensure the rates are actuarially sound, the Department has contracted with Mercer Health and Benefits, LLC (Mercer) to provide actuarial services and premium rate-

setting guidance since October 2009. Mercer develops rate ranges that it considers actuarially sound. The Department then compares its independently determined premium rates to those of Mercer to ensure they are within Mercer's rate ranges.

Rate-Setting Methodology – Administrative Component

To calculate the administrative component of the mainstream managed care premiums, the Department relies on annual data reported by MCOs on the Medicaid Managed Care Operating Reports (MMCORs). These reports contain detailed financial information, including administrative costs. The Department issues MMCOR instructions to guide MCOs on how to report administrative expenses. MCOs report administrative expenses by categories set forth by the Department, such as "rent," "salaries and fringe benefits," and "facilitated enrollment" (i.e., one-on-one enrollment assistance). MCOs also report administrative costs that are non-allowable, such as marketing and advertising. Non-allowable costs are not used to set premium rates.

In addition to administrative expenses, MMCORs contain MCO enrollment data. Enrollment data is reported as member months. The Department defines a member month as equivalent to one person for whom the MCO received premium revenue for one month. The MCOs' reported administrative costs and member months constitute the basis for the administrative component of the premium rate.

The Department uses two years of MMCOR data in order to establish premium rates by region. The two years of data are blended to help ensure the reasonableness of new rates. For instance, the April 1, 2014–March 31, 2015 rates were calculated using 2011 and 2012 calendar year MMCOR data.

In addition, in order to prevent excessive administrative costs from inflating the premium rate, the Department caps the MCOs' administrative costs that are used in the rate-setting process. As a result, the cap is a critical value in the rate-setting process and any changes to it will directly impact the amount paid to the MCOs. The administrative cap for the April 1, 2014–March 31, 2015 rates was set using an average of the MCOs' 2012 allowable administrative costs.

Once the administrative cap is calculated, the Department follows a multipart methodology for calculating the base administrative component of the premium rate, as follows. Each MCO can operate mainstream managed care plans in multiple regions (see the Exhibit for the nine managed care regions). Therefore, MCOs are required to submit an MMCOR for each Department-identified region in which the MCO operates. MCOs that operate in more than one region must also submit a statewide MMCOR. Accordingly, MMCORs contain: (A) each MCO's total statewide administrative costs for their mainstream managed care plans; (B) each MCO's total number of statewide member months for their mainstream managed care plans; and (C) each MCO's number of member months per region for their mainstream managed care plans. For each region in which an MCO operates, a per-member per-month (PMPM) administrative cost is calculated, as shown in Table 1.

Table 1

Region 1	A	B	C	D = C/B	E = D*A	E/C
	Total Statewide Administrative Costs	Number of Statewide Member Months	Number of Regional Member Months	Regional Percent of Statewide Member Months	Regional Administrative Costs	Regional Per-Member Per-Month (PMPM) Cost
MCO 1	\$465,000	15,000	5,000	33.3%	\$155,000	\$31.00
MCO 2	1,000,000	40,000	10,000	25%	250,000	25.00
MCO 3	1,200,000	50,000	15,000	30%	360,000	24.00

The Department then compares each MCO's regional PMPM administrative cost to an administrative cost cap. According to Department officials, from sometime in 2006 through March 31, 2014, the administrative cost cap was set at \$25 PMPM, and administrative expenses above this were not included in the calculation of the mainstream managed care premium rates. Thereafter, for premium rates paid as of April 1, 2014, the Department increased the administrative cost cap to \$29.80 PMPM.

As stated, administrative expenses beyond the cap are not included in the calculation of the premium rates. Therefore, if the MCO's regional PMPM administrative cost is above the cap, then that PMPM amount will be reduced to the cap, as shown in Table 2.

Table 2

Region 1	Regional PMPM	Capped (Y/N)	Adjusted PMPM
MCO 1	\$31.00	Y*	\$29.80
MCO 2	25.00	N	25.00
MCO 3	24.00	N	24.00

* MCO 1 is subject to an administrative cap of \$29.80 PMPM.

Among the last steps in calculating the administrative component of the mainstream managed care premiums, the Department calculates the regional base administrative PMPM premium rate. To calculate this base premium rate, the Department applies the administrative cap in order to determine which MCO administrative costs to include in the base premium rate. That is, if an MCO's regional PMPM administrative cost is at or below the cap, then the MCO's reported administrative costs will be used to calculate this base premium rate. If the MCO's regional PMPM administrative cost is above the cap, then the MCO's reported administrative costs will be adjusted (i.e., reduced). To illustrate, MCO 1's regional administrative costs (see Table 1, column E) are adjusted for the calculation of the base premium rate. Specifically, MCO 1's administrative costs that are in excess of the PMPM cap of \$29.80 are not used in the calculation of the base premium rate. As a result, the MCO's reported regional administrative costs of \$155,000 are reduced to \$149,000 (see Table 3, MCO 1).

Once the MCOs' regional administrative costs are adjusted, the regional base administrative PMPM premium rate is calculated as follows: the adjusted regional administrative costs for all MCOs within a region are totaled and divided by the total member months for all MCOs within the region, as shown in Table 3.

Table 3

Region 1	E	C	E/C	(a)/(b)
	Adjusted Regional Administrative Costs	Number of Regional Member Months	Adjusted Regional PMPM	Regional Base Administrative PMPM Premium Rate
MCO 1	\$149,000*	5,000	\$29.80*	
MCO 2	250,000	10,000	25.00	
MCO 3	360,000	15,000	24.00	
Regional Totals	\$759,000 (a)	30,000 (b)		\$25.30

* Adjusted regional administrative costs.

Lastly, as part of the overall rate development process, the regional base administrative PMPM premium rate is combined with the regional medical component. The combined rate is then adjusted by MCO-specific factors, such as patient acuity (the overall health of individual enrollees), optional medical benefits, and other factors.

This report includes our examination of the 2012 administrative expenses submitted by WellCare New York, Inc. (WellCare). These expenses, along with the 2012 administrative expenses submitted by all the other MCOs participating in New York's mainstream Medicaid managed care program, were used to establish the new administrative cap. 2012 was also one of the two years of cost data used to determine the premium rates for fiscal year 2014-15. We selected WellCare for review because it had the highest PMPM administrative cost in relation to the administrative cap of all MCOs in 2012 and it also reported certain related-party expenses.

Audit Findings and Recommendations

We found WellCare reported \$2,035,774 in non-allowable administrative expenses on its 2012 MMCOR. The expenses included legal fees, interest, marketing expenses, and other expenses such as entertainment costs. In addition, WellCare appeared to shift costs from the non-allowable category of marketing to an allowable category of facilitated enrollment, despite the Department's April 2011 policy change to eliminate marketing expenses from the premium rate calculation. Such cost-shifting diminishes the Medicaid program's ability to fully realize the annual savings that should be occurring as a result of the policy change. Our audit found the non-allowable costs occurred because of the Department's inadequate MMCOR cost reporting instructions, which remained deficient despite a recommendation made in a previous audit by the Office of the State Comptroller (OSC) to improve these MMCOR instructions and the Department's subsequent revision of these instructions.

We also found the Department did not monitor WellCare's compliance with the New York Codes, Rules and Regulations to ensure that a contract that WellCare entered into with a related party (Comprehensive Health Management, Inc. [CHMI], owned by the same parent company) was approved by the Department before the contract's effective date. As a result, the Department did not approve the contract until 16 months after the contract's effective date. Additionally, the Department did not adequately assess the reasonableness of the terms of the contract. We found that WellCare paid its contractor at least 35 percent more than the amount that the Department typically pays MCOs for administrative expenses, which could have increased the administrative portion of the premium rates paid to all MCOs. We also found that WellCare inappropriately reported \$7,660,086 in employee salaries and \$55,777 in various administrative services on its 2012 MMCOR that CHMI was responsible for paying under the contract. WellCare should not have separately reported administrative costs to the Department for services already paid for through the contract.

We assessed the impact of our findings on the administrative component of the premium rate and estimated that approximately \$4 million in premiums was overpaid to MCOs in fiscal year 2014-15. If the Department recalculated the premium payments based on our findings, we estimated the Department could save \$12 million over three State fiscal years (2015-16, 2016-17, and 2017-18) by using a lower administrative cap and recovering overpayments.

Lastly, we found several aspects of facilitated enrollment that require attention, including: a rate-setting methodology that indiscriminately compensates MCOs for facilitated enrollment activities, and an assessment of future need and sources of facilitated enrollment in light of a steadily decreasing population of uninsured Medicaid-eligible individuals.

Review of MMCORs Submitted by WellCare

WellCare reported \$136.8 million in allowable administrative costs on its 2012 statewide MMCOR (over \$44 million of this was allocated to mainstream Medicaid managed care). To determine whether WellCare appropriately reported administrative costs, we selected a judgmental sample

of non-compensatory (i.e., other than personal service) expenses based on the dollar amount and nature of the expenses. The sampled expenses totaled \$1,862,529 (of which \$1,808,653 was allocated to mainstream Medicaid managed care). Also, approximately \$1.4 million of the \$1.8 million accounted for one expense (a class action lawsuit).

From the sample review, we found that WellCare inappropriately reported \$1,579,794 in expenses (\$1,567,316 of this was allocated to Medicaid) that, according to the MMCOR instructions, were not allowable. The expenses included:

- \$1,467,850 (all Medicaid) to settle a class action lawsuit against CHMI, in which WellCare was not a defendant;
- \$63,600 (\$51,122 Medicaid) in interest on unpaid taxes and taxes that were eligible for a refund;
- \$30,549 (all Medicaid) in marketing expenses, including exclusive marketing rights to a public event, tickets to a New York City gala, and WellCare-branded kiosks; and
- \$17,795 (all Medicaid) in miscellaneous expenses, including entertainment costs for WellCare employees such as outings to a Mets baseball game and restaurants, and other expenses that were not fully supported.

Furthermore, based on the results of the sample review, we identified additional disallowances related to marketing and mileage expenses. We determined that \$23,049 of the \$30,549 in marketing expenses were paid to a vendor that only provided goods or services that would be considered marketing. For example, WellCare provided give-away items, such as water bottles that were branded with its company logo, which raises the visibility of the WellCare brand. As such, we considered all similar expenses reported for this vendor, which totaled \$391,114 (all Medicaid), to be marketing expenses and thus non-allowable. (Note: the \$23,049 is included in the \$391,114.) In addition, we identified \$221 in mileage reimbursements (related to a sampled expense) that were inappropriately reported.

We assessed the impact of these audit findings, totaling \$1,935,602, on the administrative cost cap and corresponding premium payments. The impact of a lower cap and the corresponding premium overpayments is discussed in greater detail later in this report; see “Impact of Audit Determinations on Rates.”

Recommendations

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

MMCOR Instructions

The Department's MMCOR instructions provide guidance to MCOs on how to report administrative expenses. We identified certain deficiencies in the MMCOR instructions that, without clarification by the Department, could lead to improper reporting of MCO administrative expenses and ultimately increase premium rates.

Marketing Versus Facilitated Enrollment Expenses

In an effort to limit Medicaid spending while improving quality of care, New York's Medicaid Redesign Team (MRT), created in January 2011 under Executive Order 5, proposed several Medicaid reforms. One such reform, implemented by the Department in 2011, was designed to "eliminate direct marketing of Medicaid recipients by managed care plans" and thus exclude marketing expenses from the premium rate calculation process.

The proposal was projected to realize \$45 million a year in Medicaid savings, based on 2010 MCO-reported marketing expenses. The proposal sought to eliminate the reimbursement of marketing expenses to MCOs on the grounds that: (1) Medicaid recipients not enrolled in MCOs were generally exempt or excluded from managed care coverage; (2) marketing efforts are not focused on enrolling the uninsured; and (3) the enrollment process has been streamlined and additional enrollment assistance was being provided by other means (e.g., enrollment centers).

The MRT proposal aligns with the MMCOR definition of marketing, which remained the same throughout our audit scope, and is as follows:

Marketing – Refers to those personnel related functions which are designed to persuade individuals to become enrolled in the plan. This may entail selling the plan to prospective individuals using direct sales or brokers. The marketing function is responsible for designing advertising campaigns to increase a plan's visibility. It may also include communications with enrollees through newsletters or special mailings.

As of April 2011, MCOs were no longer allowed to report marketing expenses as an allowable expense on the MMCORs, since such activities should have ceased. Despite the new requirements, however, we concluded MCOs continued engaging in activities that were essentially identical to non-allowable marketing activities and reported them instead as "facilitated enrollment." As we reported in a prior OSC audit, *Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting* (Report 2014-S-55), this was apparent in the amount of marketing and facilitated enrollment expenses reported by MCOs in 2010 versus later years. For example, from 2010 to 2012, some MCOs' reported facilitated enrollment expenses increased by amounts that were similar to the reported decreases in marketing expenses. WellCare followed a similar pattern.

In our prior audit (Report 2014-S-55), we identified flaws in the manner in which the Department implemented the new requirements surrounding the reporting of marketing expenses. In

particular, the August 2011 MCO model contract (which replaced references to “marketing” with the term “outreach”) and the updated 2012 MMCOR instructions (which explained that MCOs should not report marketing expenses) did not provide adequate instruction regarding reporting marketing, outreach, and facilitated enrollment expenses.

In response to our prior audit, the Department took steps to review and amend the MMCOR instructions and provided us with the second quarter of 2016 release of these instructions. However, we noted the revised instructions still failed to provide clear and consistent guidance. While the updated MMCOR instructions included separate categories for outreach and marketing and both are now considered non-allowable expenses, the definition of outreach makes reference to the model contract, which integrates outreach activities *with* facilitated enrollment. More specifically, because the language in the contract commingles facilitated enrollment activities (which are reimbursable per the MMCOR instructions) with outreach activities (which are not reimbursable per the MMCOR instructions), and the contract explains which of these activities are allowable – but not necessarily reimbursable – the guidance is unclear and creates an opportunity for MCOs to continue to report non-allowable expenses as facilitated enrollment.

Consequently, the Department cannot achieve the full savings that should occur as a result of the MRT proposal if it continues to allow MCOs to report marketing and outreach expenses under facilitated enrollment on the MMCORs. Therefore, to ensure the Medicaid program fully achieves these savings, the Department should review current MCO practices for reporting marketing, outreach, and facilitated enrollment expenses, and provide appropriate guidance to make certain MCOs are no longer being reimbursed for marketing or outreach activities and are accurately reporting these and facilitated enrollment activities. The Department’s guidance should include specific examples in the MMCOR instructions of the types of goods and services that are allowable and not allowable.

MMCOR Guidance on Legal Expenses

The MMCOR is similar to other types of cost reports that contracted service providers submit to government agencies. Given the complex nature of these types of cost reporting forms, administering agencies need to provide clear, comprehensive instructions to assist providers in completing such reports completely and accurately. Notable examples include the New York State Education Department’s Reimbursable Cost Manual to help education providers identify which costs are reimbursable; the Federal Acquisition Regulations (FAR) for use by federal agencies in purchasing goods and services with appropriated funds; and the Centers for Medicare & Medicaid Services’ Provider Reimbursement Manual, which is used by Medicare MCOs to report their expenses.

We reviewed the MMCOR instructions for reporting administrative expenses and found they are not as specific, clear, or complete as similar cost reporting instructions regarding certain categories of expenses. For example, in addition to the ambiguous and conflicting instructions regarding marketing expenses previously discussed, the MMCOR instructions regarding the reporting of legal expenses provide a much broader definition of allowable expenses than the FAR. Specifically, legal fees and expenses are defined in a way that does not expressly exclude

legal expenses incurred for the defense of questionable, illegal, and fraudulent practices (see excerpt below from the MMCOR). (Conversely, the FAR specifies various instances where such expenses would not be allowable.)

Legal Fees and Expenses – Court costs, penalties and all fees or retainers for legal services or expenses in connection with matters before administrative or legislative bodies. Does not include salaries and expenses of company personnel. Does not include legal expenses in connection with investigation, litigation and settlement of policy claims. Does not include legal fees associated with real estate transactions.

Furthermore, this broad definition conflicts with another MMCOR instruction, which specifically considers certain other expenses as non-allowable, such as fines and monetary penalties (expenses imposed for violations of federal, State, or local laws). In fact, under the “legal fees and expenses” category, WellCare reported \$125,519 (\$100,172 Medicaid) in legal expenses for a law firm that represented it before the New York State Department of Taxation and Finance regarding unpaid taxes and related interest and penalties. Without clear and adequate cost reporting instructions, improper expenses could be used to inappropriately increase MCO premium rates. We question the appropriateness of the \$100,172 and, as such, assessed the impact of this on the administrative cost cap and corresponding premium payments. The impact of a lower cap and the corresponding premium overpayments is discussed in greater detail later in this report; see “Impact of Audit Determinations on Rates.”

While the MCOs are required to follow the MMCOR instructions, the Department can further ensure premium rates are appropriate by clarifying these instructions to prevent the improper reporting of certain legal expenses. In response to similar findings from our prior audit (*Mainstream Managed Care Organizations – Administrative Costs Used in Premium Rate Setting*, Report 2014-S-55), Department officials agreed to review and update the MMCOR instructions as appropriate. However, when reviewing the second quarter of 2016 release of these instructions, we noted the same lack of guidance regarding legal fees.

Recommendations

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.
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.
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.

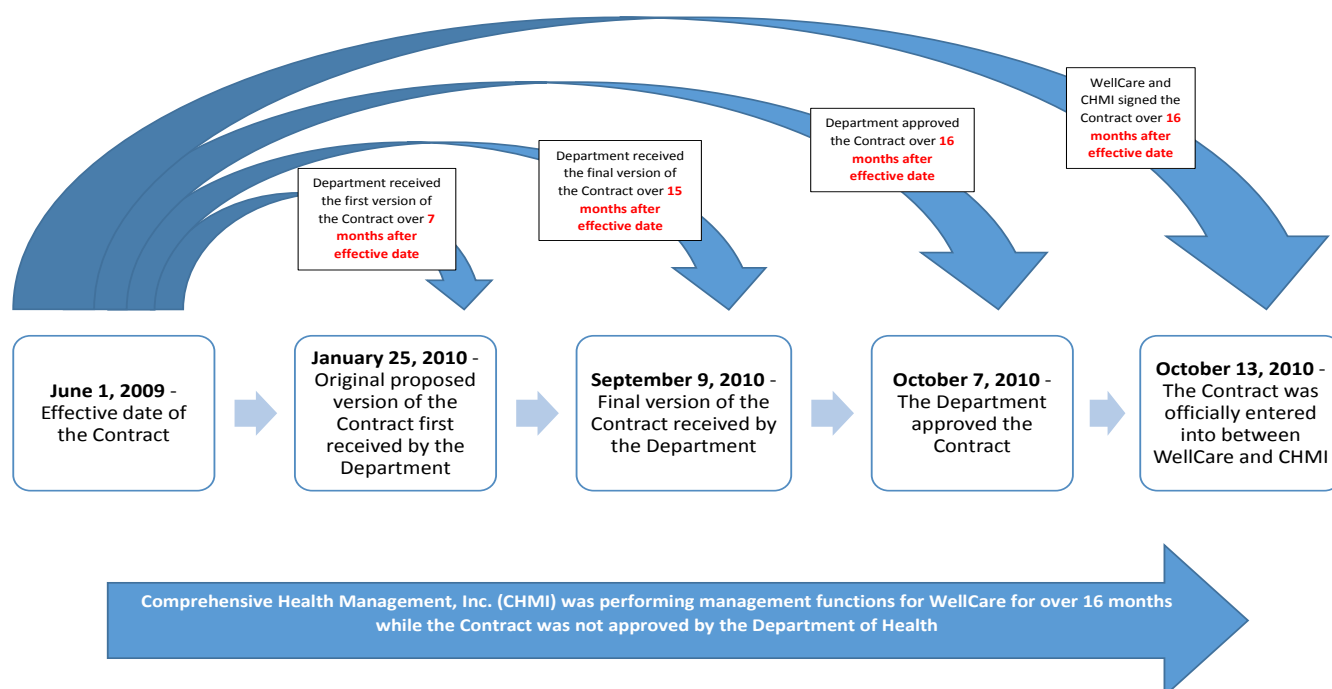
WellCare Management Contract With CHMI

To administer plan benefits, an MCO can enter into service contracts with separate companies. The MCO maintains authority and responsibility over the administrative functions, but the subcontractor can provide services such as payroll, accounting, provider relations, facilitated enrollment, and quality assurance. Part 98 of Title 10 of the New York Codes, Rules and Regulations (NYCRR) establishes certain conditions that such contracts must meet, including a time frame for submission to the Department for review and approval and a determination by the Department that contract terms are reasonable.

WellCare entered into a five-year management contract (Contract) with CHMI to provide administrative and management services on its behalf. In 2012, WellCare spent over \$69 million on these services across all of its insurance products (approximately \$25 million was allocated to mainstream Medicaid managed care). WellCare and CHMI are related parties, owned by the same parent company: WellCare Management Group, Inc. CHMI also provides administrative and management services for numerous other subsidiaries of the WellCare Management Group, Inc., which are located throughout the United States.

Delay in Approval

According to NYCRR Part 98-1.11(k), “A proposed management contract must be submitted to the department for its prior approval at least 90 days prior to the management contract’s proposed effective date.” In addition, “Management contracts shall be effective only with the prior written consent of the Commissioner.” However, the Department did not monitor compliance with these regulations. 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 WellCare’s compliance with NYCRR. In reviewing the Contract, we noted that WellCare did not submit the proposed Contract to the Department within the required 90 days prior to the Contract’s proposed effective date of June 1, 2009 (note: this date was also the Contract’s actual effective start date because CHMI was performing services as of this date). In fact, the Department did not receive the original proposed version of the Contract from WellCare until January 25, 2010 (over seven months after the effective date), and the final version of the Contract was not received until September 9, 2010 (over 15 months after the effective date). The Department finally approved the Contract on October 7, 2010 – over 16 months after the effective date. As a result of these delays, CHMI was performing management functions for WellCare for more than 16 months without the Department’s formal approval of the Contract. The following figure presents a timeline of the Contract submissions and approval.



Reasonableness

According to NYCRR Part 98-1.11(k)(7), management contracts must include “specification of payment terms that are reasonable and do not jeopardize the financial security of the MCO.” Part 98.1-11(l)(5) also states that the MCO must submit “evidence that it is financially feasible for the MCO to enter into the proposed management contract.” Also, according to Part 98-1.10, under certain conditions the Department must review significant transactions between companies within a holding company system, such as the Contract between WellCare and CHMI (a company wholly owned by WellCare’s parent company). According to Department officials, the terms of the Contract were determined to be reasonable based on the following considerations:

- Compensation terms that were expected to be 9.5 percent of premium revenue based on WellCare’s membership;
- Total net worth of WellCare based on previous MMCORs;
- Solvency of WellCare based on audited financial statements; and
- A letter from WellCare’s Chief Financial Officer stating that it would be less expensive for CHMI to perform administrative functions rather than have them performed by WellCare.

After reviewing the process undertaken by the Department to approve the Contract, it appears the Department assessed the financial feasibility of WellCare in entering into the Contract, but did not adequately assess the reasonableness of the amount of compensation received by CHMI from WellCare. The Contract called for monthly payments from WellCare to CHMI ranging from 9.5 percent to 11.5 percent of premium revenue, based on plan membership. In comparison, when setting mainstream managed care premium rates for all plans, the Department allocates between 6 and 7 percent of the premium for administrative expenses. Furthermore, according to WellCare officials, the management fee paid to CHMI did not cover all of WellCare’s administrative expenses. As a result, WellCare spent at least 35 percent more (i.e., the difference between 9.5

percent and 7 percent [or 2.5 percent] divided by 7 percent) for administrative expenses than the amount that the Department normally factored into the premium – even before accounting for its additional expenses that were not covered by the Contract, such as rent for office space and office equipment. As explained subsequently, these higher costs could have increased the premium rates paid to all MCOs.

Under the Contract, WellCare paid CHMI at least 9.5 percent of the premium for administrative expenses, although WellCare only received 7 percent of the premium for those costs. Department officials contend that approval of the Contract is not dependent on whether the MCO is fully reimbursed for management services through the rate, since administrative expenses exceeding the administrative cap are not included in the rates paid. However, because WellCare paid a higher percentage of administrative expenses in 2012 than the percentage reimbursed by the Department in the premiums, WellCare reported PMPM (per-member per-month) costs that were roughly \$30 above the administrative cap (\$60.27 vs. \$29.80). Additionally, the Department used these administrative costs, in part, to calculate the revised administrative cost cap, which contributed to raising the cap from \$25 to \$29.80. This higher cap was used to set premium rates for all plans, thereby increasing premium payments to all MCOs.

As mentioned, the Contract excluded certain expenses that would be incurred along with the management services being provided. These excluded costs were paid directly by WellCare, further widening the variation between actual expenses incurred and amounts reimbursed through the rate. This also contributed to the large variance of WellCare's PMPM administrative expenses over the cap.

Department officials indicated that, in assessing contracts, they use Department-established guidelines, which include the requirement that management contract payment terms be reasonable. However, we note that these guidelines do not define what constitutes reasonableness, specifically whether amounts paid are excessive. The officials also referred to certain Department of Financial Services regulations that allow the Department, on an exception basis, to permit a contractor performing services for a related party to charge its usual and customary fee for an unrelated party. However, the Department was not able to provide us with copies of such regulations. More importantly, the Department is still obligated to comply with its own regulations. Additionally, since WellCare and CHMI are wholly owned by the same corporate parent, the terms of the Contract should have received greater scrutiny to ensure reasonableness.

Recommendations

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.
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.

Inappropriately Reported Management Contract Expenses

Personal Service Costs

The Contract indicates that CHMI employees would be performing administrative and management services for WellCare as “leased employees,” and states that: “CHMI shall remain responsible for the cost of all Leased Employees furnished to Lessee, including salaries, applicable taxes, employee benefits, any out-of-pocket expenses related thereto, and any other costs and payroll records related to such Leased Employees.” A list of these employees was included with the Contract submitted to the Department by WellCare in 2010. Of the more than \$18.4 million in salaries and related expenses that WellCare reported on its 2012 MMCOR, \$7,660,086 was reported as direct (non-contracted) expenses. The remaining costs were reported as contracted expenses related to the Contract.

However, WellCare improperly reported the \$7,660,086 in direct salaries, fringe benefits, and payroll taxes for employees who were included in the Contract – because such costs were to be borne by CHMI. These employees worked in WellCare’s Medicaid Sales Unit, providing services such as facilitated enrollment for the Medicaid program.

To show that the employees in WellCare’s Medicaid Sales Unit were leased CHMI employees covered by the Contract, we considered the following:

- The Contract between CHMI and WellCare states that leased employees would provide “product marketing services.” The Contract clearly indicates that “product marketing services” are administrative services that were to be provided by CHMI under the Contract. (Note: At the time of the contract, MCO marketing services was an all-inclusive term that included marketing services as well as facilitated enrollment.)
- We compared the Contract list of leased employees from 2010 (the only list of leased employees provided by WellCare) to WellCare’s 2012 payroll reports. The 2010 list of CHMI’s leased employees included 62 individuals who provided Medicaid sales services (e.g., facilitated enrollment) for WellCare – identified by two specific Medicaid Sales Unit department codes. WellCare’s 2012 payroll reports included 159 employees who worked in these same two Medicaid Sales Unit departments. (Note: 40 of the 62 employees from the list of leased employees were among the 159 employees; the remaining 22 employees were likely no longer employed or were no longer working in the Medicaid Sales Unit based on the testing we performed. Further, based on a review of the 2010 and 2012 MMCOR reports, the Medicaid Sales Unit expanded in 2012, which explains the increase from 62 employees in 2010 to 159 employees in 2012.)
- We reviewed initial job offer letters for a judgmental sample of 10 employees from WellCare’s 2012 payroll reports. Although WellCare was only able to provide nine of these letters, each one clearly identifies CHMI as the employer.
- We reviewed documents relating to a class action suit under the Fair Labor Standards Act which showed that the entire Medicaid Sales Unit was employed and managed by CHMI. This is further supported by certain statements of fact offered by CHMI in opposition to the formation of the class action, which specified that “CHMI employs the sales force

responsible for selling various WellCare health plans to Medicare- and Medicaid-eligible individuals.”

WellCare officials assert that the inclusion of the 62 Medicaid Sales Unit employees on the list of leased employees was an error, and that all remaining names on the list were appropriate. We question the likelihood that only the employees whom we questioned were erroneously included and all the other names were appropriate. WellCare officials stated that while CHMI employees were leased to WellCare to provide various services, including facilitated enrollment, the Contract did not cover these 62 employees or the cost of facilitated enrollment activities.

Department officials added that they believe the costs in question were only reported once on the MMCOR, as a direct WellCare expense. According to Department officials, if the entire amount that WellCare reported as direct salaries was reported instead as a contracted expense (i.e., part of the Contract), WellCare would be reporting zero dollars for direct salary expenses, and would need to report direct salaries for quality and executive management functions that, by regulation, could not be delegated by the Contract. However, we noted that this practice is not uncommon, as other MCOs have reported zero dollars as direct payroll expenses on their MMCORs.

Despite officials’ contentions, the Contract, list of leased employees, court documents, and sample of job offer letters we reviewed all support our conclusion that such reported direct expenses were the responsibility of CHMI and should not have been charged to the State as an expense on WellCare’s MMCOR.

Other Than Personal Service Costs

According to the Contract, CHMI “shall provide certain management services relative to day-to-day operations of [WellCare] including but not limited to ... processing of claims (including adjudicating claims and issuing payment, which shall be made using [WellCare] checks directly attached to a [WellCare] bank account).” The Contract also indicates the CHMI fee would cover health care quality assurance services. After reviewing a sample of expenses that WellCare reported on its 2012 MMCOR, we determined that some were for services that were already covered under the Contract. Specifically, WellCare reported paying a total of \$55,777 to three additional outside vendors – which were procured by CHMI – for the same services that WellCare was already paying CHMI a flat fee to perform. While the Contract was non-exclusive and WellCare had the right to use other contractors, WellCare should not separately report costs to the Department for services already paid for through the Contract.

We assessed the impact of the audit findings (\$7,660,086 and \$55,777) on the administrative cost cap and corresponding premium payments. The impact of a lower cap and the corresponding premium overpayments is discussed in greater detail in the next section (“Impact of Audit Determinations on Rates”).

Recommendations

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.

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

Impact of Audit Determinations on Rates

Administrative Cost Cap

The first step in estimating the impact of the audit findings is to recalculate the administrative cost cap. The Department set the administrative cap for State fiscal year 2014-15 and beyond at \$29.80. The calculation of the cap was based on all MCOs' calendar year 2012 allowable administrative expenses on a PMPM basis (see Table 4). However, based on the non-allowable expenses we identified, we recalculated the administrative cap and determined it should be lower, as shown in Table 4.

Table 4
Recalculation of 2012 Total Allowable Administrative Expenses and the
Administrative Cost Cap

	Statewide Allowable Administrative Expenses	Statewide Member Months	Average Statewide Allowable Administrative Expenses (PMPM)	OSC Calculated Savings in FY 2014-15 Based on Lower Cap	OSC Estimated Savings Over Three Years Based on Lower Cap
Department of Health Calculation					
Administrative Cost Cap	\$1,130,760,516	37,947,991	\$29.80		
Office of the State Comptroller Calculation					
WellCare Adjustments					
Improper Expenses Related to Audit Sample	(\$2,035,774)				
Leased CHMI Employee Expenses	(\$7,660,086)				
Unnecessary Service Contracts	(\$55,777)				
Total Audit Adjustments	(\$9,751,637)				
Changes Due to Audit Adjustments	\$1,121,008,879	37,947,991	\$29.54		
Changes Due to Audit 2015-S-76 Adjustments	(\$9,751,637)		(\$0.26)	\$4,009,673	\$12,029,019
Changes Due to Audit 2014-S-55 Adjustments	(\$50,028,060)		(\$1.32)	\$18,954,805	\$56,864,415
Effect of Combined Audit Adjustments and New Cost Cap	(\$59,779,697)		\$28.22	\$22,964,478	\$68,893,434

In a prior report (2014-S-55, issued October 13, 2016), we estimated that the Department overpaid more than \$18.9 million in State fiscal year 2014-15, based on our recalculated administrative cap of \$28.48 PMPM (\$29.80 – \$1.32), and \$56.9 million over three years. This current audit identified an additional \$4 million in overpayments in fiscal year 2014-15 based on a further cap reduction, to \$28.22 (\$28.48 – \$0.26). We estimated that this would result in further savings, totaling \$12 million over the following three State fiscal years. Because these annual overpayments (identified by the two audits) would exist for every year the \$29.80 administrative cap was used, we estimated the Department could save a total of \$68.9 million over three fiscal years (2015-16, 2016-17, and 2017-18) by using a lower cap (\$28.22) and recovering the overpayments.

Factors in Recalculating the Rate

We note that there are several factors that could impact a recalculation of the rate. Every year there are expected changes in: the number of enrolled individuals, the costs of administrative and medical services, and policy matters that could increase or decrease estimated savings. Further, any recalculation of the premium rate based on the findings identified in this report needs to consider the federal requirement that the State create an actuarially sound rate. While the Department and Mercer independently calculate rates and rate ranges, each determines part of the administrative component based on the costs reported by the MCOs on the MMCORs. Because some of our findings identified administrative amounts that should not have been reported as allowable, both entities would, if warranted, need to incorporate the disallowed amounts into their premium rate recalculation process. We acknowledge that premiums must be actuarially sound and that implementation of our recommendations must be consistent with this requirement.

MCO Facilitated Enrollment

Cost and Oversight of MCO Facilitated Enrollment

Facilitated enrollment is the one-on-one assistance of individuals who need help with the Medicaid application and enrollment process, including renewals. The Department utilizes several entities to provide assistance including, but not limited to, MCOs, community-based organizations (CBOs), Local Departments of Social Services, and the Department's contracted enrollment broker. Since January 2014, certain individuals have also been enrolled through the New York State of Health (NYSOH), the State's health plan marketplace.

In setting the mainstream managed care premium rate, the Department includes amounts to cover MCOs' reported costs of facilitated enrollment (e.g., costs of enrollment personnel to assist in completing Medicaid applications, conducting interviews, and collecting appropriate enrollee documentation). In addition, the Department has multiple contracts, totaling over \$33 million a year, with CBOs to provide assistance to individuals applying both within and outside NYSOH.

For the 2014-15 fiscal year, we estimate that the Department paid MCOs more than \$127.4 million for facilitated enrollment through premium rate payments. Despite the magnitude of these payments, Department officials were unaware of how much they actually paid MCOs for facilitated enrollment activities because they did not directly track these amounts. Moreover, we found several weaknesses in the Department's oversight of MCO facilitated enrollment activities and corresponding compensation.

The Department's MCO model contract does not require MCOs to perform any facilitated enrollment. However, due to the Department's rate-setting methodology, all MCOs are paid the same amount in the rate for facilitated enrollment, regardless of the extent to which facilitated enrollment services are performed. While the Department makes MCO-specific adjustments to an MCO's premium for meeting certain performance measures, such as high quality of care, the

Department does not adjust the premium to reflect a given MCO's actual facilitated enrollment activity. MCOs are thus disproportionately compensated for facilitated enrollment services. For example, in 2014, we estimated that one MCO received over \$1 million to provide facilitated enrollment. However, as of September 2014, this MCO did not provide the full range of facilitated enrollment assistance, because it was limited by the Department to enrolling newborns only. Despite the decrease in the MCO's facilitated enrollment services, the MCO's premium rate did not change.

Furthermore, while the Department has contract requirements to monitor and evaluate the CBOs' performance, the Department's MCO model contract does not contain similar provisions despite the larger amounts of funding involved. The performance of CBOs is monitored because it can be a factor in renewing contracts. However, MCOs may not be compensated based solely on the number of individuals assisted because federal regulations prohibit such performance-based payments. (Note: Department officials could not provide us with the federal regulations they referred to.)

According to Department officials, they started to share facilitated enroller productivity reports with MCOs in December 2015. These reports measure various aspects of MCO facilitated enrollers, such as the number of applications submitted, people enrolled, and people assisted by the MCO. Also, in addition to MMCOR data, the Department has access to various sources of facilitated enrollment information. The Department should take steps to use the range of facilitated enrollment information to review its rate-setting methodology to ensure each MCO's compensation for facilitated enrollment is appropriate and commensurate with activities actually performed rather than paying each MCO the same rate without considering such factors.

Assessment of Future Need

After certain provisions of the Affordable Care Act were enacted, such as Medicaid eligibility expansion and the creation of an insurance marketplace, the number of uninsured individuals in the State decreased significantly. According to the Henry J. Kaiser Family Foundation,¹ in 2014, an estimated 2.2 million non-elderly New Yorkers were uninsured, 946,000 (43 percent) of whom were eligible for Medicaid. By 2015, the number of uninsured non-elderly New Yorkers decreased to about 1,476,000, of whom approximately 546,120 (37 percent) were Medicaid eligible, and decreased further still in 2016 (see Table 5).

While Medicaid recipients may need assistance renewing, the State has taken efforts to automate recertification for certain populations, thus decreasing the need for facilitated enrollment for certain Medicaid renewals. Based on the data in Table 5 and the decrease in the number of uninsured, the Department should assess whether the current level of spending and allocation per MCO for facilitated enrollment (totaling an estimated \$127.4 million for fiscal year 2014-15) is necessary based on current and projected future needs.

¹ In lieu of its own estimates on the uninsured, the Department used estimates from the Henry J. Kaiser Family Foundation, a non-profit organization that informs the public on national health issues. We obtained additional estimates from the same organization.

Table 5
Estimate of Uninsured Individuals Eligible for Medicaid, 2014–2016

Year	Uninsured Non-Elderly Individuals	Uninsured Non-Elderly Individuals Eligible for Medicaid	Percent of Uninsured Non-Elderly Individuals Eligible for Medicaid
2014	2,200,000	946,000	43%
2015	1,476,000	546,120	37%
2016	1,183,000	425,880	36%

Recommendations

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

Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether mainstream MCOs are submitting accurate administrative costs to the Department and whether the Department is appropriately applying the administrative costs in determining MCO premium rates. Our audit covered the period January 1, 2011 through October 31, 2016.

To accomplish our objectives and assess internal controls, we interviewed Department officials to gain an understanding of the premium rate-setting methodology; analyzed MMCORs submitted by MCOs; interviewed Mercer officials as well as WellCare officials; and reviewed expenses reported by WellCare on its 2012 MMCOR. We used the 2012 MMCOR as the basis for our review because the administrative costs reported in 2012 were used to establish the new administrative cap and 2012 was one of the two years of cost data used to determine the premium rates for State fiscal year 2014-15. We reviewed applicable sections of federal and State laws and regulations, and examined the Department's Medicaid payment policies and procedures. We also reviewed Henry J. Kaiser Family Foundation estimates of uninsured Medicaid-eligible individuals in New York.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of the report. In their response, Department officials indicated the steps they would take to implement many of the audit recommendations. However, officials disagreed with certain audit recommendations. Our rejoinders to those disagreements, as well as to various inaccuracies in the Department's response, are included in the report's State Comptroller's Comments.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

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Vision

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To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Exhibit



Agency Comments



ANDREW M. CUOMO
Governor

Department of Health

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

August 10, 2017

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, New York 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2015-S-76 entitled, "Administrative Costs Used in Premium Rate Setting of Mainstream Managed Care Organizations."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink, appearing to read "Sally Dreslin".

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Marybeth Hefner
Jason A. Helgeson
Dennis Rosen
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft 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) Draft 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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to \$8,305 in 2015, 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 & 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

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* See State Comptroller's Comments, Page 36.

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.

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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.

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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 98-1.11(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).

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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.

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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 completing 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.

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Comment
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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

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.
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.
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.

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.
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.
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.