

19. MCO FINANCIAL REPORTING AND MONITORING

Introduction

This chapter describes MCO financial reporting requirements and the manner in which the State uses these reports to monitor contractor solvency. The chapter also describes the reinsurance program being offered to MCOs. It concludes with a description of the State's contingency plan for assuring continued access to care for enrollees of MCOs whose contracts are terminated due to insolvency.

Financial Reporting and Monitoring

The State Insurance Department has primary responsibility for licensing and monitoring the fiscal solvency of HMOs in New York State, while the Department of Health has equivalent responsibility for Prepaid Health Services Plans (PHSPs). Both departments require the MCOs under their jurisdiction to meet reserve, escrow, and capitalization requirements as a condition of licensure. Both HMOs and PHSPs must demonstrate adequate financial resources and sources of revenue to properly establish and operate the MCO. All MCOs must conform to the financial and reporting requirements in Department of Health regulations at Part 98 of Title 10 NYCRR.

In June 2005 State Health Department regulations at 10 NYCRR Part 98-1.11 were amended revising managed care plan solvency standards and monitoring requirements. The amendment phased in a more stringent contingent reserve requirement. The amended Part 98 phases in over 7 years, a reserve requirement of 12.5%, to be consistent with the requirement for other health insurers in NYS. Plans have also been required to have an escrow account, consisting of cash and certain marketable securities, equal to 5% of the plan's projected medical costs for the upcoming year. Part 98 was amended to add a provision requiring each plan's escrow account be in the form of a trust account with a custodian (the NYS Insurance Department), using a prescribed agreement, and deposit the required escrow amount for each year by March 31st of that year into such account. Funds can only be withdrawn from that account with the consent of the Superintendent of Insurance. Part 98 continues to require each plan to maintain a net worth that is at least equal to or greater than its contingent reserve requirement or escrow deposit requirement, whichever is higher.

The determination of financial solvency for each plan is an overall test including all lines of business of each plan, and is based on the plan's annual cost report, filed with the Department of Health and the State Insurance Department by March 31st of the following year. Projected plan enrollment for the upcoming year in the annual cost report is used to calculate the required escrow amount, and the plan must have on deposit no later than March 31st in its escrow account an amount equal to or greater than the required amount. This is verified by bank statement. DOH verifies that the plan's reported net worth is at least equal to the greater of the reserve or escrow deposit requirement at this time, and monitors each plan for continued compliance with these requirements on a quarterly basis, ensuring that the plan's net worth is maintained at the proper level.

As part of the 1996 procurement (see Chapter 16), the Department of Health incorporated these and other financial reporting requirements for plans seeking to enroll Medicaid clients. Specifically, MCOs were required to provide:

- Audited financial statements for the two most recent fiscal years for which the statements were available. The statements were required to include a balance sheet, income statement, and a statement of cash flows. Statements also were required to be complete with opinions, notes and management letters. If no audited financial statements were available, applicants were required to explain why and to submit unaudited financial statements and any other supporting narrative and financial data.
- Projected monthly balance sheets and income statements for the provision of services under the New York Medicaid managed care line of business for the two-year contract period.
- Projected balance sheet as of the start-date of the program.

Upon receipt of MCO proposals, the State evaluated the financial data to ensure that applicants demonstrated satisfactory fiscal soundness to enroll and serve Medicaid beneficiaries. As part of this evaluation, the State compared, for consistency purposes, the MCOs' projected income statements, balance sheets, and budgets with their projected enrollment and proposed capitation rates. Where discrepancies were identified, the State followed-up with these MCOs and obtained clarification or additional assurances as necessary prior to qualifying the MCOs for contract award.

Under The Partnership Plan, the Departments of Health and Insurance will collaborate to monitor MCOs on an on-going basis, through review of the regularly submitted financial reports. The State will use the information from these filings to measure each MCO's financial performance using, at a minimum, the following ratios:

- Current Ratio - Current assets divided by current liabilities
- Plan Equity per Enrollee - Net worth divided by total membership
- Administrative Expenses as a Percent of Capitation - Administrative costs divided by total premium revenue
- Net Medical Expenses as a Percent of Capitation - Medical costs divided by total premium revenue
- IBNR and RBUC Levels, Including Days Claims Outstanding - Incurred but not reported claims (estimate of outstanding claims for services rendered that have not been received) and reported but unpaid claims (estimate of outstanding claims received but not paid), including claims payable divided by average expense per

day (average expense per day is total expenses divided by 365)

If the State determines that a particular MCO is facing potential financial distress, it may require more frequent reporting and, as necessary, may perform a targeted audit for purposes of developing a corrective action plan. To facilitate such audits, MCOs are contractually required to make available, upon request, all financial records and statistical data that the State or CMS may require, including books, accounts, journals, ledgers, and all financial records relating to capitation payments, third party health insurance recovery, and other revenue received and expenses incurred. MCOs also must make available upon request appropriate financial records to document fiscal activities and expenditures, including records relating to the sources and application of funds to the capacity of the MCO or its subcontractors to bear the risk of potential financial losses. MCOs must maintain all financial records and statistical data according to generally accepted accounting principles.

Reinsurance Program

The State requires MCOs participating in The Partnership Plan to obtain reinsurance for their enrollees. MCOs are permitted to purchase reinsurance on the commercial market (or to self-reinsure), subject to State review of the adequacy of their coverage. The State also makes directly available to MCOs optional reinsurance/stop-loss coverage for inpatient hospital service costs.

The State's reinsurance program is structured as follows:

- MCOs are solely responsible for the first \$50,000 in inpatient hospital expenses incurred by any single enrollee during a calendar year period. The dollar value of such expenses is calculated on the basis of the rates paid to the hospital(s) by the MCO (negotiated rates) or the Medicaid payment rate for the hospital(s), whichever is less.
- The reinsurance program provides for the State to pay 85% (through December 1997) of the inpatient costs for any individual whose inpatient costs exceed \$50,000, up to \$250,000. Thereafter, the State will pay 100% of the costs. The 85% applies to the amount over \$50,000 but under \$250,000 and does not include the first \$50,000. Again, the dollar value of the enrollee's costs will be determined on the basis of the rates paid to the hospital(s) by the MCO (negotiated rates) or the Medicaid payment rate for the hospital(s), whichever is less.
- During the second full calendar year (beginning January 1998) and in subsequent years, the State will pay eighty percent (80%) of the inpatient hospital costs incurred during a calendar year, after the first \$50,000 and until a \$250,000 level is reached. Again, the dollar value of the enrollee's costs will be determined on

the basis of the rates paid to the hospital(s) by the MCO (negotiated rates) or the Medicaid payment rate for the hospital(s), whichever is less.

- The State will pay one hundred percent (100%) of the inpatient hospital expenses incurred during a calendar year beyond the \$250,000 stop-loss threshold.
- MCOs that have elected to purchase reinsurance coverage from the State also must submit a claim for a case within one hundred eighty (180) days of the end of claims activity. The State then seeks to pay the claims within thirty (30) days of their validation. MCOs are responsible for making all payments to providers.

In addition to the reinsurance component, the managed care program also includes a stop loss provision for mental health and chemical dependence services, based on numbers of visits/days, and are part of all MCO contracts. The specific stop loss thresholds are:

- 20 outpatient visits for mental health services;
- 30 inpatient days for mental health and inpatient chemical dependence rehabilitation or treatment services combined.

When individuals exceed the mental health day/visit thresholds, the MCO continues to provide services but is reimbursed for the visits/days above the limits under a state-sponsored stop-loss program. Plans must collect and submit mental health and chemical dependence provider level billing information in accordance with State requirements in order to receive payment from the State.

Contingency Plan

The State's reserving, reinsurance, and reporting policies are designed to minimize the potential for MCO insolvency. However, should the State, in conjunction with the contracting local district, find it necessary to terminate an MCO's participation due to insolvency, the MCO will be issued a Notice of Termination instructing it to:

1. Stop work under the contract on the date and to the extent specified in the Notice of Termination.
2. With approval of the State and local district, settle all outstanding liabilities and all claims arising of such termination of orders and subcontracts (drawing on reserves), the cost of which would be reimbursable in whole or in part, in accordance with the provision of the contract.
3. Complete the performance of such part of the work as has not been terminated by the Notice of Termination.

4. Provide all necessary assistance to the State and local district in transitioning members out of the MCO and into others. Such assistance would include, but not be limited to, forwarding medical and other records, facilitating and scheduling medically necessary appointments, and identifying chronically ill, high risk, hospitalized, and pregnant members in their last four weeks of pregnancy.
5. Provide the State and local district, on a monthly basis, a claims aging report by provider/creditor that includes IBNR amounts, a monthly summary of cash disbursements, and copies of all bank statements.

Concurrent with directing the orderly shutdown of the MCO, the State will suspend new enrollments (other than newborns) and will issue a letter to all members informing them that a special open enrollment will be held to allow them to select a new MCO. The open enrollment will be scheduled so as to allow members 30 days to select a new MCO. In the event that capacity does not exist in the remaining MCOs to enroll all members of the closing MCO, these members will be returned to the fee-for-service program until such time as additional managed care capacity can be made available.

To facilitate the transition process for members, the State and the affected district will form a temporary "transition team", comprised of personnel from their respective Offices of Managed Care, to work on-site at the MCO for whatever period of time is necessary. The highest priority for this transition team will be to monitor the accessibility of care for MCO members, and to ensure that medically necessary services continue to be furnished under the terms of the contract or that other arrangements are made.

19. MCO FINANCIAL REPORTING AND MONITORING IN FHPlus

FHPlus financial reporting and monitoring of MCOs is the same for FHPlus with the exception of the Reinsurance Program. The SDOH does not operate a reinsurance program for FHPlus. MCOs must purchase reinsurance coverage unless they can demonstrate that they are able to self-insure or they have comparable and satisfactory (in the State's judgment) coverage from another source. Also, stop-loss provisions do not apply to FHPlus.