



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

Division of State Government Accountability

Managed Long Term Care Premium Rate Setting

Department of Health Medicaid Program



Executive Summary

Purpose

To determine whether managed care organizations (MCOs) provided the Department of Health (Department) with complete and accurate Medicaid cost information and whether the Department appropriately set Managed Long Term Care (MLTC) premium rates. The audit covered the MLTC premium rates for the period April 1, 2013 to March 31, 2014.

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. For the State fiscal year ended March 31, 2016, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about \$56 billion.

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 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 MLTC. The MLTC MCOs provide long term care services (e.g., home health care, adult day care, nursing home care) and other health-related services (e.g., dentistry, eye care, durable medical equipment).

The Department is responsible for setting monthly MLTC premium rates. The rate-setting methodology is based largely on MCOs' medical costs and administrative costs, which MCOs report annually to the Department on Medicaid Managed Care Operating Reports (MMCORs), along with other detailed financial information. MLTC premium rates are prospectively set based on two years of MCOs' actual costs submitted on the MMCORs. The two years of data are combined to help ensure the reasonableness of future rates. The Department issues MMCOR instructions to guide MCOs on how to report medical costs and administrative costs.

Key Findings

- Two MCOs reported a total of \$82.3 million in medical costs for services procured through a corporate affiliate that we found would have been more accurately classified as administrative costs. These costs, which should have been subject to an administrative cap, were included in the medical costs component of the premium rate, which is not capped. Based on our analysis of the corresponding impact on the 2013-14 MLTC premium rates, we estimated the misclassification of costs led to questionable payments of at least \$82.3 million. We determined the Department does not have a process in place to properly evaluate unique MCO cost reporting situations and differences in MCO operations and corporate structures that would impact the completeness, accuracy, and consistency of the financial data used to set the premium rates. Furthermore, the MMCOR form itself does not provide a means for MCOs with unique corporate payment structures to properly report their costs in a manner that allows for consistent reporting of

costs across all MCOs.

- The Department overpaid at least \$2.8 million in MLTC premiums between April 1, 2013 and March 31, 2014 as a result of improper reporting of medical costs by MCOs on the MMCORs. The MCOs reported costs for non-enrolled individuals and the Department used these costs in its 2013-14 premium rate calculations, which ultimately resulted in inflated premium rates for MCOs.
- MCOs did not always identify and prevent inappropriate payments to providers for health care services. We identified \$262,197 in duplicate payments to providers, which were reported as costs on the MMCORs and factored into the 2013-14 premium rates.

Key Recommendations

- We made seven recommendations to the Department to review the appropriateness of the reported medical costs we identified and recover overpayments where appropriate; amend the MMCOR and its instructions, as appropriate, to ensure proper cost reporting by MCOs; and ensure MCOs take certain steps to remedy inappropriate reporting of costs on the MMCOR.

Other Related Audit/Report of Interest

[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 27, 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 entitled *Managed Long Term Care Premium Rate Setting*. 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 health care services to those who are economically disadvantaged and/or have special health care needs. The Centers for Medicare & Medicaid Services (CMS) oversees the Medicaid program at the federal level, and the Department of Health (Department) administers the Medicaid program in New York. For the fiscal year ended March 31, 2016, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about \$56 billion. The federal government funded about 53.2 percent of New York's Medicaid claim costs; the State funded about 30.6 percent; and the localities (the City of New York and counties) funded the remaining 16.2 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 New York'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 services. MCOs arrange for the provision of services their members require and reimburse providers for services provided to their enrollees.

The Department offers different types of Medicaid managed care coverage depending upon individual eligibility. Managed long term care (MLTC) provides long term care services to people who are chronically ill or disabled and who wish to stay in their homes and communities. MCOs that provide MLTC services arrange and pay for a large array of health and social services, such as home health care, adult and social day care, nursing home care, dentistry, vision care, and durable medical equipment. For the fiscal year ended March 31, 2014, MCOs received \$3.1 billion in MLTC premium payments for 93,051 Medicaid enrollees.

The Department sets the monthly premium rates for MLTC. There are two major components that go into the creation of the premium rates: MCOs' medical costs and administrative costs, which MCOs report annually to the Department on Medicaid Managed Care Operating Reports (MMCORs), along with other detailed financial information (e.g., balance sheets, supporting schedules). The Department issues MMCOR instructions to guide MCOs on how to report their medical and administrative costs.

CMS requires that the Department create actuarially sound rates, and issues guidance outlining federal standards for establishing the premium rates. One of the requirements is that the data used to arrive at the premium rates needs to be complete, accurate, and consistent across all sources.

Rate-Setting Methodology

On the MMCORs, MCOs report medical costs by type of service provided (e.g., personal care, dental care, nursing home care), and report administrative costs by categories set forth by the Department (e.g., rent, salaries, fringe benefits). In addition to medical and administrative costs, MCOs also provide enrollment data, which is reported as member months. The Department defines a member month as equivalent to one person for whom the MCO recognized premium revenue for one month.

The Department uses two consecutive years of MMCOR data to establish premium rates by region (NY Metro, Mid-Hudson/Northern, Northeast/West, Rest of the State) to help ensure reasonableness of new rates. For instance, the fiscal year 2013-14 premium rates were calculated using 2010 and 2011 calendar year MMCOR data.

In calculating the premium rate, the Department establishes an administrative cost component and a medical cost component. To prevent excessive administrative costs from inflating the premium rate, the Department calculates a cap for the administrative cost component of the premium rate. (For example, for the NY Metro region for fiscal year 2013-14, the administrative component of the premium rate was capped at \$231.) To calculate the medical costs component of the premium rate, the Department totals the medical costs of all MCOs within a given region, and divides the sum by the total number of reported member months to arrive at the average monthly cost of providing medical care per member, commonly referred to as a per-member per-month (PMPM) amount. The Department then applies necessary adjustments to account for differences in medical trends and patient acuity (the overall health of individual enrollees) to derive a unique premium rate for each MCO within a specific region.

Between April 1, 2013 and March 31, 2014, NY Metro, the largest of the regions – comprising New York City, Long Island, and Westchester – had 25 MCOs that received approximately \$3 billion in premiums, which accounted for over 97 percent of all MLTC premiums paid statewide. MLTC premium rates for the region ranged from about \$3,145 to \$4,874 per month. This audit included a review of MMCORs for nine of ten MCOs that operated in the NY Metro region during the State fiscal years (April–March) 2010 and 2011, which were used to calculate the 2013-14 premium rates.

Audit Findings and Recommendations

We found two MCOs reported a total of \$82.3 million in medical costs that, based on the nature of the costs, would have been more accurately classified as administrative costs. These costs, which should have been subject to the administrative cap, were included in the medical costs component of the 2013-14 MLTC premium rates. We estimated the misclassification of costs led to inflated MLTC premium rates for MCOs, resulting in at least \$82.3 million in questionable payments. In addition, the Department overpaid at least \$2.8 million in 2013-14 MLTC premiums to MCOs. The overpayments stem from MCOs' improper reporting of medical costs on the MMCORs. The Department used these costs in its premium rate calculations, ultimately resulting in inflated premium rates for MCOs. Additionally, we determined MCOs did not always identify and prevent inappropriate payments to providers for health care services and, as a result, we identified \$262,197 in duplicate payments to providers which were reported as costs on the MMCORs and factored into the 2013-14 premium rates.

Although the Department performs regular reviews of MMCOR data, these are high-level analyses; its process does not entail a closer examination of MCOs' MMCOR entries for potential errors or unusual cost reporting. Furthermore, the MMCOR form itself does not provide a means for MCOs with unique corporate payment structures (e.g., payments to affiliate/parent organizations for services or allocated expenses) to properly report their costs in a manner that allows for consistent reporting of costs across all MCOs. We made seven recommendations to the Department to review the costs we identified and recover overpayments as warranted, revise the MMCOR and its instructions as necessary, and ensure the MCOs take certain steps to remedy inappropriate reporting of costs on the MMCOR.

MCOs' Reporting of Costs for Atypical Affiliations

Two of the MCOs reviewed in this audit reported a total of \$82.3 million in medical costs that we found were administrative costs. For both of these MCOs, their unique corporate structure allowed certain costs that were administrative in nature to be captured on the MMCOR as medical, which the Department then factored into the PMPM medical costs component – directly impacting the premium rate. (As previously stated, administrative costs that are used in the determination of the premium rates are capped, while medical costs are not, and these MCOs' administrative costs were already above the cap.) The Department does not have a process in place to identify atypical situations such as these on MMCORs, and thus did not evaluate them for potential errors.

Typically, MCOs contract with vendors to provide medical and administrative services, and the reporting of these costs on the MMCORs as either medical or administrative is straightforward. In contrast, each of the two MCOs used an affiliate organization to provide medical services to their enrollees. The affiliates charged the MCOs not only costs for medical services but costs for administrative functions as well. On the MMCOR, however, each MCO reported the full amount of its payment to the corporate affiliate, including the allocated corporate administrative overhead, as medical costs. These costs were then factored into the Department's medical costs base calculation, inflating premium rates for all MCOs in the NY Metro region. Based on our

analysis of the corresponding impact on the 2013-14 MLTC premium rates, we estimated the misclassification of costs led to questionable payments of at least \$82.3 million.

Examples of some of the administrative overhead costs included:

- \$14.2 million in equipment, software, and related personnel costs to operate the corporation's computer data center (e.g., for claims processing);
- \$3.5 million in costs for MLTC member Intake and Enrollment (I&E); and
- \$2.9 million in costs for the recruitment and retention of staff.

According to the MMCOR instructions, costs such as claims processing, I&E, and staff recruitment and retention are administrative expenses.

We note that one MCO has since closed its MLTC line of business and for the other, its corporate structure has changed (i.e., it no longer contracts with the affiliate for medical services); thus, any corrective actions by the MCOs in these cases are moot. More importantly, however, it is clear that unique reporting situations do arise that, if left unaddressed, can skew the rate-setting calculations and result in inflated premium rates for MCOs. Especially in light of any anticipated expansion of the MLTC program, the Department should have a process in place to properly evaluate unique situations, such as the examples presented above, and differences in MCO operations and corporate structures that would impact completeness, accuracy, and consistency of the financial data used to set premium rates.

In the Department's response to our preliminary audit findings, officials indicated that, in general, they do not consider the indirect administrative overhead cost of the service provider being reported as medical expenses to be inappropriate. Officials stated that, in 2006, the Department's actuary advised one of the MCOs to include overhead costs associated with the provision of medical services as medical services purchased from non-related entities. According to Department officials, however, the actuary also stated that services provided by an affiliate not included as part of the direct provision of medical services would be considered administrative, and should be reported as contracted administrative services on the MMCOR.

Despite the instruction, it was effectively up to the MCOs to decide what expenses were related to the direct provision of medical services. At the time the MCOs submitted their MMCORs, neither the actuary nor the Department reviewed the details of the expenses we identified nor provided specific instruction upon reviewing the details of these expenses; officials left it up to the MCOs to interpret the guidance and decide where to report costs.

We found that had both MCOs handled these services themselves, as opposed to a contracted affiliate, the MCOs would have been required to report the expenses as administrative costs. In fact, we observed that other MCOs reported such services (not performed by contracted affiliates) as administrative expenses. Further, one of the two MCOs subsequently assumed the responsibilities performed by the affiliate, and after that we observed that the MCO's reported ratio of administrative costs to medical costs increased. After reviewing the Department's comments to our preliminary findings, we maintain that the expenses we identified would have been more

accurately classified as administrative costs. Therefore, we maintain that the Department should reassess the appropriateness of \$82.3 million in reported medical costs.

Recommendations

1. Review and reassess the appropriateness of the \$82.3 million in reported medical costs associated with services purchased from the MCOs' affiliated providers and recover overpayments as warranted.
2. Review the MMCOR and its instructions and, as necessary, revise them to ensure MCOs accurately capture their costs for situations such as the atypical affiliations we identified, in a manner that allows for consistent reporting of costs across all MCOs.
3. Routinely review the underlying transactions reported on the MMCORs to identify situations, such as the atypical affiliations we identified, that would warrant adjustments to the rate-setting calculation.

Costs Reported for Non-Enrolled Individuals

For each of the nine MCOs reviewed in this audit, we examined the reported medical costs on the MMCORs and compared them with the supporting medical claims provided by the MCOs. We identified \$2,810,875 in improperly reported medical costs that should not have been factored into the medical costs component, as follows:

- \$2,394,082 for I&E administrative services;
- \$404,812 for medical services provided after members' disenrollment; and
- \$11,981 for medical services provided in error to individuals not yet enrolled.

The costs of these services were included in the Department's rate-setting calculation, and as a result the medical costs component of the premium rate was overstated by at least \$2.8 million.

In each of these scenarios, we found MCOs' medical cost entries on the MMCOR did not include a corresponding member month. Each medical cost on the MMCOR must be reported with the number of member months in order for the Department to accurately determine an average monthly cost (medical cost ÷ member month) and then calculate the PMPM medical costs component of the MLTC premium rate. When medical costs are reported without a corresponding member month, the rate-setting calculation is out of balance, which will have an inflationary impact on the premium rate established.

Although the Department requires that all medical costs be reported with the corresponding member month, the Department has not issued any specific guidance – in the MMCOR or otherwise – to instruct the MCOs of this. Further, although the Department performs regular reviews of MMCOR data, these are high-level – rather than “line item” – analyses; the Department does not specifically examine MCOs' medical costs and the corresponding member months on

the MMCOR for accuracy and appropriateness. As a result, these improper entries go undetected and the entire medical cost, unadjusted for monthly average, is inappropriately included in the calculation.

Incorrect Reporting of Intake and Enrollment Costs

According to the MMCOR instructions, costs related to activities that occur prior to an individual's enrollment in the MCO (e.g., recruitment, enrollment processing, initial care) should be reported as I&E administrative costs. We determined six MCOs incorrectly reported \$2,394,082 in I&E costs as medical costs, and this amount was thus improperly factored into the PMPM medical costs component. For example, an MCO incorrectly reported costs of \$2,900 to provide home health and personal care for two months prior to a member's enrollment in the plan as medical costs when the costs should have been reported as administrative I&E costs.

One MCO accounted for about \$2.2 million of the misreported costs. When we brought it to their attention, MCO officials confirmed that these costs should have been reported as I&E, and attributed the errors to an internal system flaw that was reportedly identified and fixed later in 2013. (Following OSC's inquiry, the MCO realized that it had also misreported \$57,440 as medical costs on its 2012 and 2013 MMCORs.)

As a result of these errors, the medical costs base was inflated by approximately \$2.4 million, which, based on our analysis of the corresponding impact on the premiums, we believe would lead to at least this amount in excessive premium payments to MCOs. (Note: Had the I&E expenses been reported as administrative costs instead of medical costs, the errors likely would not have impacted the administrative component of the premium rate because the Department caps the administrative cost component of the rate and the MCOs' administrative costs were above the cap.)

Costs Reported for Services Provided Post-Disenrollment

All nine MCOs improperly reported medical costs for services provided post-disenrollment, totaling \$404,812. This occurred because MCOs did not always update members' eligibility status in their internal enrollment system in a timely manner, which allowed the provision of services to continue. In some cases, the MCOs knew that members had been disenrolled but provided services anyway "in good faith" in anticipation of the members' re-enrollment.

For example, according to officials at one MCO, in cases where disenrollment is due to loss of Medicaid coverage, its policy is to cover services for up to 90 days as it expects the member to regain Medicaid eligibility and re-enroll. Similarly, we found an MCO that paid for services in good faith after members lost Medicaid eligibility or left the MCO. In one example, the MCO continued to provide services for a month following the member's disenrollment – at a total cost of \$4,386 – and the member never re-enrolled.

As stated, medical costs on the MMCOR must be reported with the corresponding number of member months. The expenses we identified lacked a corresponding member month. As such,

the expenses should not have been factored into the medical component of the premium. We determined the Department lacks a policy on how MCOs should properly report these non-allowable expenses on the MMCOR.

Costs Reported for Services Prior to Enrollment

Two MCOs reported medical costs, totaling \$11,981, for services provided in error to individuals not yet enrolled. One MCO accounted for \$10,597 (88 percent) of the improper costs. The MCO attributed the error to a problem in its internal enrollment process, which improperly allowed individuals to be added to the system as enrolled and active members – and to obtain care – before receiving enrollment confirmations. According to an official, the MCO expected that these individuals' active membership would be retroactive to the initial date of enrollment, and when this did not happen the MCO "felt compelled to pay" the claims. Since the MCO could not receive any premium payments for services provided pre-enrollment, there were no member months to report.

We determined the Department lacks a policy on how MCOs should properly report these non-allowable expenses on the MMCOR.

Recommendations

4. Review the \$2,810,875 in inappropriately reported medical costs to determine the amount of incorrect premium payments, and recover where appropriate.
5. Issue instructions for the proper reporting of medical costs and member months on the MMCOR, including costs incurred without a corresponding member month.

Duplicate Payments

Under federal regulations and Department directives, Medicaid providers are required to submit accurate and complete claims for their services. Under managed care, the MCOs assume primary responsibility for addressing improper payments within their provider networks, such as duplicate payments. We found the MCOs did not always identify and prevent inappropriate payments during 2010 and 2011 and, as a result, we identified \$262,197 in inappropriate claims that were factored into the 2013-14 premium rates.

The MLTC model contract specifies the right of the MCO to audit its network providers' claims and to recoup any overpayments discovered as a result of an audit. It is important for the MCOs to timely identify and prevent inappropriate payments to their providers because all payments are reported as medical expenses on the MMCORs, and improper payments (such as duplicate claim payments) could inflate the medical expenses reported on the MMCOR. The Department would then use the inappropriately inflated medical expense information to calculate a higher medical component for the premium rate.

The MCOs confirmed that \$245,811 in payments were duplicative of other payments made by the MCOs for the same medical service. The inappropriate claim payments were reported by the MCOs on their MMCORs as medical expenses. For example, one plan paid two claims each for 24 hours of home health care provided to its member on one day. In another example, a home health provider erroneously billed duplicate claims for the same service under two different revenue codes. The plans could not explain why the remaining \$16,386 in inappropriate payments occurred.

The plans made duplicate payments due to various limitations in their claims processing systems (for instance, to detect and prevent duplicate billings for the same service). Because the plans did not timely identify and recover the overpayments, the payments were inappropriately included on the MMCORs, causing the medical expenses to be overstated and ultimately inflating the medical component of the premium rate.

Recommendations

6. Ensure the MLTC MCOs timely recover the inappropriate payments and properly account for the recoveries on their MMCORs.
7. Ensure the MLTC MCOs take corrective actions to remedy the internal system control weaknesses that allowed the improper claims.

Audit Scope, Objectives, and Methodology

The objectives of our audit were to determine whether MCOs provided the Department with complete and accurate cost information on MMCORs and whether the Department appropriately set MLTC premium rates. The audit covered the costs reported by MCOs on the 2010 and 2011 MMCORs. The Department used these costs to set the MLTC premium rates for the contract year starting April 1, 2013 to March 31, 2014. These premium rates are identified as rate code 3478 (MLTC Partial Cap Age 18+) within the Medicaid program.

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 ten MCOs, interviewed MCO officials, and reviewed costs reported by the MCOs on their 2010 and 2011 MMCORs. We used the 2010 and 2011 MMCORs as the basis for our review because the costs reported on these MMCORs were used to determine the premium rates starting April 1, 2013 to March 31, 2014. We reviewed applicable sections of federal and State laws and regulations, and examined the Department's Medicaid payment policies and procedures. We shared our methodology and provided data and findings to Department and Office of the Medicaid Inspector General officials during the audit for their review.

We requested all ten MCOs operating in the NY Metro region in 2010 and 2011 to provide us with supporting documentation for the information reported on MMCORs. To determine if the MCOs appropriately reported medical costs and member months, we also requested expense

support (provider claims and other payments by the MCO) and member months. We received and analyzed the requested data from nine MCOs. One MCO was unable to provide any support for its costs because of its recent bankruptcy.

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 generally concurred with most of the audit recommendations and indicated that certain actions have been and will be taken to address them. Officials, however, disputed a significant portion of the MCO costs that we questioned and asserted that \$82.3 million in costs were properly paid. We maintain that the Department should reassess the appropriateness of these costs by conducting a detailed review of the costs, and recover overpayments as warranted. Our rejoinders to this matter and certain other Department comments 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.

Contributors to This Report

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Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

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

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

September 7, 2017

Ms. Andrea Inman
Audit Director
Office of the State Comptroller
Division of State Government Accountability
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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-30 entitled, "Managed Long Term Care Premium Rate Setting."

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
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2015-S-30 entitled,
Managed Long Term Care Premium Rate Setting**

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-30 entitled, "Managed Long Term Care Premium Rate Setting."

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 and reassess the appropriateness of the \$82.3 million in reported medical costs associated with services purchased from the MCOs' affiliated providers and recover overpayments as warranted.

Response #1

The Department of Health has reviewed the appropriateness of the \$82.3 million and has confirmed that it was correctly reported as medical. Furthermore, the Department assessed whether the findings associated with the reporting of medical costs in relation with affiliated providers would impact premium rates in a substantive manner and determined that it would not have a material effect on rate ranges or premium rates.

*
Comment
1

Recommendation #2

Review the MMCOR and its instructions and, as necessary, revise them to ensure MCOs accurately capture their costs for situations such as the atypical affiliations we identified, in a manner that allows for consistent reporting of costs across all MCOs.

Response #2

The MLTC Medicaid Managed Care Operating Reports (MMCORs) are updated and amended each time new populations and/or benefits are added into MLTC. The MMCOR instructions are considered a "living document", one that is updated with the policy and programmatic changes impacting MLTC. Additionally, the MMCOR instructions are revised on a quarterly basis to reflect

*See State Comptroller's Comments, page 19.

changes in reporting tables as necessitated by the programmatic and policy changes impacting health plans service provision and the MLTC MMCOR reporting financial reporting requirements.

The Department is working with the NYS-ITS on converting and modernizing the MLTC MMCOR operating software from the VB.6 platform to the VB.Net operating platform. The upgrade will allow the Department to change and modify the MLTC-MMCOR software in a more efficient manner. As part of this software conversion process, the Department will revise the MLTC-MMCOR instructions to add clearer guidance and more specificity to the proper and accurate reporting of medical costs and corresponding member months as per OSC's recommendation.

Recommendation #3

Routinely review the underlying transactions reported on the MMCORs to identify situations, such as the atypical affiliations we identified, that would warrant adjustments to the rate-setting calculation.

Response #3

The Department, in conjunction with the Office of the Medicaid Inspector General (OMIG), reviews processes to monitor and ensure plan compliance. The Department will continue to provide guidance to managed care organizations and review compliance/reporting issues when necessary.

The OMIG issued its Work Plan on April 1, 2016; on page 11, OMIG references the audits that will be conducted of Managed Care Cost Reporting. These audits include MLTC plans. Additionally, OMIG has initiated four MLTC MMCOR audits, to determine compliance with reporting requirements.

Recommendation #4

Review the \$2,810,875 in inappropriately reported medical costs to determine the amount of incorrect premium payments, and recover where appropriate.

Response #4

The Department has assessed whether the findings associated with the reporting of inappropriate medical costs will impact the rates in a substantive manner. 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. Correcting for this finding would not move rate ranges or premium rates in a substantive manner, one way or the other, towards the lower or upper bounds of the actuarially certified rate range. Additionally, the cost of engaging the actuary in a complete recertification of the rates should be considered in relation to this recommendation. It is estimated the recertification cost would range between \$28,000 and \$35,000. Finally, any recalculation of these premiums would need the approval of CMS and the NYS Division of the Budget.

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Recommendation #5

Issue instructions for the proper reporting of medical costs and member months on the MMCOR, including costs incurred without a corresponding member month.

Response #5

Please see the Department's response to recommendation #2.

Recommendation #6

Ensure the MLTC MCOs timely recover the inappropriate payments and properly account for the recoveries on their MMCORs.

Response #6

The State Fiscal Year 2016-17 Budget included an administrative action that has been implemented that reduces managed care premiums by \$30 million to incentivize managed care organizations to improve their fraud, waste and abuse recovery process, including identifying and recovering potential duplicate and excessive claims. This budget action requires plans to increase their provider audit/fraud efforts to recover the targeted amount, and provide quarterly updates to OMIG on these recovery efforts. It is anticipated that these coordinative efforts between the Department, OMIG, and the Plans will continue to ensure the integrity of the Medicaid program.

Recommendation #7

Ensure the MLTC MCOs take corrective actions to remedy the internal system control weaknesses that allowed the improper claims.

Response #7

Please see the Department's response to recommendation #6.

State Comptroller's Comments

1. We disagree with the Department's assertion that the \$82.3 million in reported costs associated with services purchased from the MCOs' affiliated providers were correctly reported as medical costs. As indicated on page 7 of our report, we reviewed the costs in question and found they were administrative in nature. In fact, as stated on page 8, according to the MMCOR instructions, the costs that we identified – such as claims processing, I&E, and staff recruitment and retention – are administrative expenses. Furthermore, at the time the MCOs submitted their MMCORs, the Department did not review the details of the expenses we identified; rather, officials left it up to the MCOs to decide where to report the costs. Therefore, we urge the Department to perform a thorough assessment of the costs, and reconsider their determination on the \$82.3 million and recover overpayments as warranted. Lastly, contrary to the Department's response, reassigning \$82.3 million in costs as administrative would materially affect the premium rates.
2. The Department does not necessarily have to recalculate the premiums paid, and engage its actuary and recertify the premium rates, in order to recover the \$2,810,875 in inappropriately reported medical costs. Instead, at the Department's discretion, the inappropriately reported costs can be directly recovered from the MCOs that reported them. Therefore, we urge the Department to seek recoveries as warranted.