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NEW YORK STATE OF OPPORTUNITY. Department of Health

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

August 25, 2022

CERTIFIED MAIL/RETURN RECEIPT

Michael Derevlany, Esq.
NYS Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

MetroPlus Health Plan, Inc.
160 Water Street, 3rd Floor
New York, New York 10038

Harold Iselin, Esq.
Greenberg Traurig
54 State Street, 6th Floor
Albany, New York 12207

RE: In the Matter of Metroplus Health Plan, Inc.

Dear Parties:

Enclosed please find the Decision After Hearing in the above referenced matter.

If the appellant did not win this hearing, the appellant may appeal to the courts pursuant to the provisions of Article 78 of the Civil Practice Law and Rules. If the appellant wishes to appeal this decision, the appellant may wish to seek advice from the legal resources available (e.g. the appellant's attorney, the County Bar Association, Legal Aid, OEO groups, etc.). Such an appeal must be commenced within four (4) months after the determination to be reviewed becomes final and binding.

Sincerely,

Sean D. O'Brien
Acting Chief Administrative Law Judge
Bureau of Adjudication

SDO:nm
Enclosure

STATE OF NEW YORK
DEPARTMENT OF HEALTH

COPY

In the Matter of the Appeal of **METROPLUS HEALTH PLAN, INC.** Medicaid ID: 00894519 from a determination by the NYS Office of the Medicaid Inspector General to recover Medicaid Program overpayments.	**DECISION AFTER HEARING** Audit Number: 21-2299

Before: Natalie J. Bordeaux
Administrative Law Judge

Hearing Date: June 21, 2022
The record closed August 9, 2022

Held via: WebEx videoconference

Parties: New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
By: Michael Derevlany, Esq.

MetroPlus Health Plan, Inc.
160 Water Street, 3rd Floor
New York, New York 10038
By: Harold Iselin, Esq.
Greenberg Traurig
54 State Street, 6th Floor
Albany, New York 12207

JURISDICTION

The New York State Office of the Medicaid Inspector General (OMIG) determined to impose the penalty authorized by Social Services Law (SSL) § 364-j(38) on MetroPlus Health Plan, Inc. (Appellant), totaling two times the amount of the Appellant's misstated administrative costs in its Medicaid Managed Care Operating Report (MMCOR) for the year 2014. The Appellant requested a hearing pursuant to SSL § 364-j(38)(e) and SSL § 22 and Department of Social Services regulations at 18 NYCRR § 519.4 to review the OMIG's determination.

HEARING RECORD

OMIG witness:	Brian Bibler, Auditor 3, Medicaid
OMIG exhibits:	1-12
Appellant witness:	Lauren Leverich-Castaldo, Chief Financial Officer, MetroPlus
Appellant exhibits:	A, B

A transcript of the hearing was made. (T 1-104.) Each party submitted a post-hearing brief.

FINDINGS OF FACT

1. The Appellant is a managed care provider pursuant to SSL § 364-j(1)(b) that provides or arranges for the provision of Medicaid services and supplies to participants in the New York City Metropolitan Region and is authorized to operate pursuant to Article 44 of the Public Health Law. (T 22.)

2. The Appellant receives payment in the form of a monthly premium capitation payment from the New York State Medicaid Program per member based in part on allowable administrative costs reported on its MMCOR. (Exhibits 1, 3, 5; T 22.)

3. Auditors from the OMIG reviewed the Appellant's MMCOR for the year 2014, along with documentation to support reported expenses. (Exhibits 1, 3, 5.)

4. By Notice of Proposed Agency Action dated November 17, 2021, the OMIG advised the Appellant that its 2014 annual MMCOR contained misstatements of fact because it improperly included marketing and advertising expenses of $2,821,523 attributable to its Medicaid lines of business as allowable expenses. The OMIG determined preliminarily to impose a monetary penalty in the amount of $5,643,046, or two times the total amount misstated in the MMCOR. The notice also advised the Appellant of the opportunity to submit additional documentation and written arguments in objection to the proposed determination and action within 30 days of receiving the notice pursuant to 18 NYCRR § 516.2. (Exhibit 3.)

5. The Appellant objected to the OMIG's proposed agency action on the grounds that the penalty was "neither fair nor reasonable and would not be in the interests of justice." (Exhibit 4.)

6. By Notice of Agency Action dated March 15, 2022, the OMIG advised the Appellant of its determination to uphold its preliminary determination to impose a penalty of $5,643,046. (Exhibit 5.)

7. On April 11, 2022, the Appellant requested this hearing to review the March 15, 2022 determination. (Exhibit 6.)

8. The Appellant does not contest the OMIG's finding that reported Medicaid-related advertising and marketing expenses were not allowable costs, nor does it dispute the OMIG's finding regarding the amount of the improperly reported costs. The Appellant does object to the OMIG's determination to impose a penalty totaling two times the amount misstated. (Exhibit 6.)

ISSUE

Was the OMIG's determination to impose a penalty of two times the amount of the Appellant's improperly reported advertising and marketing expenses correct?

APPLICABLE LAW

The Department of Health is the single state agency for the administration of the Medicaid Program in New York State. PHL § 201(1)(v); SSL § 363-a. The OMIG is an independent office within the Department of Health with the authority to pursue civil and administrative enforcement actions against any individual or entity that engages in fraud, abuse, or illegal or improper acts or unacceptable practices perpetrated within the Medicaid Program. Such actions may include the imposition of administrative sanctions and penalties. PHL §§ 30-32.

Managed care programs (also referred to as "managed care plans") are established under the Medicaid Program in accordance with applicable federal law and regulations. SSL § 364-j(2)(a). A managed care provider participates in one or more of these programs and renders or arranges for the provision of Medicaid services and supplies to participants directly or indirectly, including case management. SSL § 364-j(1)(b).

The Department of Health has developed reimbursement methodologies and fee schedules for managed care programs, including capitation arrangements (also referred to as premium rates), that consider costs borne by the managed care program. SSL §§ 364-j(18)(a)&(c).

Managed care providers report their costs in quarterly and annual financial statements (MMCORs). Annual statements are due by April 1 following the report closing date and must include a completed certification attesting to the accuracy, completeness and truthfulness of the

data being submitted. Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract dated March 1, 2014 (Model Contract). *See also* Exhibit 9. Medicaid providers must comply with these rules and official directives of the Department of Health. 18 NYCRR § 504.3(i).

When a filed cost report contains a misstatement of fact in the form of unsubstantiated or improper costs, the Medicaid inspector general may, in his or her discretion and in consultation with the commissioner of health, impose a penalty. For misstatements of fact including unsubstantiated or improper costs, "the penalty shall be equal to the amount of the misstatement multiplied by two." SSL §§ 364-j(38)(b)-(c)(i).

A Medicaid provider is entitled to a hearing to review the OMIG's final determination to impose a penalty. 18 NYCRR § 516.1(a) and § 519.4(a)(3). The Appellant has the burden of showing that the OMIG's determination was incorrect and that all costs claimed were allowable. 18 NYCRR § 519.18(d)(1); SAPA § 306(1).

DISCUSSION

Effective April 1, 2011, advertising and marketing expenses are not allowable costs to be considered in determining a managed care provider's capitation or any other payment made by the Medicaid Program. Managed care providers were informed of this change in multiple ways. Instructions to the 2014 MMCOR (the year at issue) specifically state that advertising costs relating to Medicaid plans must be reported as a non-allowable expense. Those instructions also note that Medicaid plans "should have no expenses reported for marketing." (Exhibit 9; T 33, 44-45.)

A provider is also directed in multiple ways to insert its Medicaid-related advertising and marketing expenses in the "non-allowable administrative expenses" section in the pre-populated

portions of MMCOR, which is comprised of a series of spreadsheets. In the "Administrative Expenses" section of the Appellant's annual MMCOR for the year ending December 31, 2014 (Table 22A), spreadsheet cells for Medicaid-related advertising and marketing expenses were shaded gray to indicate that expenses were not to be inserted in those slots with total allowable administrative expenses. (T 32.) Despite those visual cues and obstructions to categorizing those costs as allowable, the Appellant inserted its Medicaid-related advertising and marketing expenses further down that page in the write-in section for allowable administrative expenses and labelled those costs as "advertising" and "marketing" with expenses totaling $1,115,456 and $1,568,542, respectively. The Appellant also inserted its total expenses for a vendor, McMurry, in the write-in section for allowable administrative expenses, even though a portion of those expenses ($137,525) were non-allowable expenses for advertising and marketing related to the Appellant's Medicaid lines of business. (Exhibits 10-12.)

Tables 22A and 22A-1 of the 2014 MMCOR afford space for non-allowable administrative expenses. Although certain categories of non-allowable administrative expenses are separately identified on those tables, the Appellant had the opportunity to include its Medicaid-related advertising and marketing expenses in the row aptly entitled, "Other Nonallowable Administrative Expenses." It did not include any expenses in that row. (Exhibits 10-12.)

The Appellant concedes that advertising and marketing costs are not allowable but argues that it should not be subjected a penalty for its improper reporting because its error does not constitute a misstatement of fact. (Appellant's Brief, p. 1; T 15-16.) A misstatement of fact includes unsubstantiated or improper costs. SSL § 364-j(38)(b)(i). The Appellant asserts "that to find a 'misstatement of fact'…in these circumstances, there must be a factual inaccuracy in the

form of categorizing a non-allowable cost as an allowable cost." (Appellant's Brief, p. 3.) The hearing record reflects that the Appellant did exactly that when it improperly categorized and reported non-allowable marketing and advertising expenses as allowable costs.

The Appellant's current Chief Financial Officer, Lauren Leverich-Castaldo, testified that the Department of Health had begun using a new MMCOR reporting platform in 2015, just before 2014 MMCORs were due, which posed difficulties in reporting expenditures. Ms. Leverich-Castaldo affirmed that the Appellant was required to report Medicaid-related advertising and marketing expenses as non-allowable expenditures and said she believed that the expenses were inputted into the software appropriately. (T 86, 88, 91-92.) The evidence is not consistent with the excuses she offered.

In March 2015, Ms. Leverich-Castaldo sent an inquiry to the Department of Health's Division of Health Plan Contracting and Oversight regarding Table 22 of the MMCOR, which details categories of allowable administrative expenses and nonallowable administrative expenses. Her stated concern was that numbers from those lines attributable to Medicaid were not being added automatically to Table 6 (Medicaid Statement of Revenue & Expenses) of the same MMCOR. Table 6 also precluded entering marketing expenses as allowable administrative expenses attributable to Medicaid lines of business by shading that cell in gray, offering an additional reminder that those expenses were not allowable. (Exhibit B; T 84-85.) Ms. Leverich-Castaldo's inquiry does not show that the Appellant inadvertently reported the disallowed expenditures as allowable expenditures or that the Appellant was concerned that nonallowable expenditures would be improperly considered as allowable ones.

The Appellant had previously advised the auditors that it did not know why the reporting error occurred but acknowledged that the expenses should have been classified as non-allowable

administrative expenses. (Exhibit 12.) The Appellant claimed that it was the MMCOR software that caused non-allowable expenses to be reported as allowable administrative expenses. Brian Bibler, the OMIG auditor assigned to this audit, conferred with Department of Health staff overseeing the MMCOR software to explore the possibility of such a software glitch, and was advised that such a defect did not exist. He also confirmed that the write-in section for allowable administrative expenses was blank and not pre-populated by the Department of Health. As such, the Appellant's insertion of expenditures required not only the insertion of a category or vendor's name, but also a dollar amount. (T 37-38, 41, 70.)

No inconsistencies were identified between the format of the 2014 MMCOR and its instructions. Nor was any explanation provided as to why the Appellant took the added steps of inserting its expenditures in the write-in section for allowable administrative expenses, or why it made no attempt to distinguish allowable and non-allowable expenses tied to a vendor (McMurry), despite the Appellant's repeated assurances that it understood that advertising and marketing expenses were not allowable Medicaid expenses. The advertising and marketing expenditures relating to the Appellant's Medicaid plan reported as allowable administrative expenses were improper, and the evidence fails to support the Appellant's claims that this improper reporting was either inadvertent or attributable to the Department of Health's reporting systems.

While the sheer dollar amount of the improperly reported costs exceeded two million dollars, it is important to note that the impact of the misstatement also extended beyond the Appellant's Medicaid reimbursements. Rates of payment to managed care providers are set for each region (managed care rating region) established by the Department of Health. SSL §§ 364-j(1)(t)&(21). The Appellant's improperly reported costs ultimately resulted in higher rates for all

Medicaid plans operating within the Appellant's managed care rating region and inflated costs to the Medicaid Program. SSL § 364-j(18)(c).

SSL § 364-j(38)(c)(i) explicitly states that the penalty for improperly reported costs "shall" be double the amount of the misstated costs in an appropriate case. The OMIG's determination to apply that penalty in this case was a reasonable exercise of its authority and well within its discretion. The Appellant has failed to meet its burden of establishing that the OMIG's determination to impose a penalty of twice the total amount misstated as allowable advertising and marketing expenses was not correct.

DECISION

The OMIG's determination to impose a penalty of two times the total amount of the Appellant's improperly reported advertising and marketing expenses was correct and is affirmed.

Dated: August 25, 2022
Menands, New York

Natalie J. Bordeaux
Administrative Law Judge