The State of New York

Department of Health

HCRA Compliance Reviews Orientation Session

June 28, 2007

ADVISORY

AUDIT ▪ TAX ▪ ADVISORY

Introductions

- Department of Health (DOH) Team Members
  - Rick Pellegrini
  - Tony Naglieri
  - Phyllis Stanton
  - Bill Hogan
  - Mary Ryan
  - Lynne Ryan
- KPMG Team Members
  - Anthony Monaco
  - Rory Costello
  - Marcella Junco
- FCC Team Members
  - Merle Tousant
  - Steve Golden
  - Christine Cook
  - John Milligan
- Association Representatives

Opening Remarks

- The purpose of this session is to inform the payer and provider community of the upcoming audits and communicate the payor/provider expectations moving forward.
- During this session, we will discuss the new audit approach, changes to procedure and protocols, and the timing/duration of the reviews.

Session Ground Rules

- Ask all the questions you would like pertaining to the reviews as we move forward.
- Issues relating to current Audits, past Audit results, and member concerns should be communicated to DOH at another time.

Session Topics

- New Audit Process
  - Previous Audits
  - Moving Forward
  - Audit Approach
  - Reviewing Multiple Years/TINs
  - Areas of Focus
- Changes and Updated Protocols
  - Surcharges (including Financial Risk Sharing Arrangements)
  - Covered Lives Assessment
  - New Timeline/Audit Duration
  - Requesting Extensions

Previous Audits

- The Stage 1 Audit focused on general compliance, by testing two months worth of relevant data.
- The Stage 2 Audit consisted of a more quantitative approach by focusing on significant exceptions noted during the first stage and applying test procedures which encompassed the entire year.

Stage 1 Objectives	Stage 2 Objectives
• **Review policies and procedures for calculating and remitting the pool liability** • **Test detailed claim files for two sample months** • **Test detailed membership files for two sample months** • **Test a sample of risk sharing arrangements**	• **Test a sample of the detailed claim files for the year under review** • **Test detailed membership files for the year under review** • **Test a sample of risk sharing arrangements** • **Calculate difference in post-audit obligations and auditee remitted payments for audited year(s).**

Moving Forward

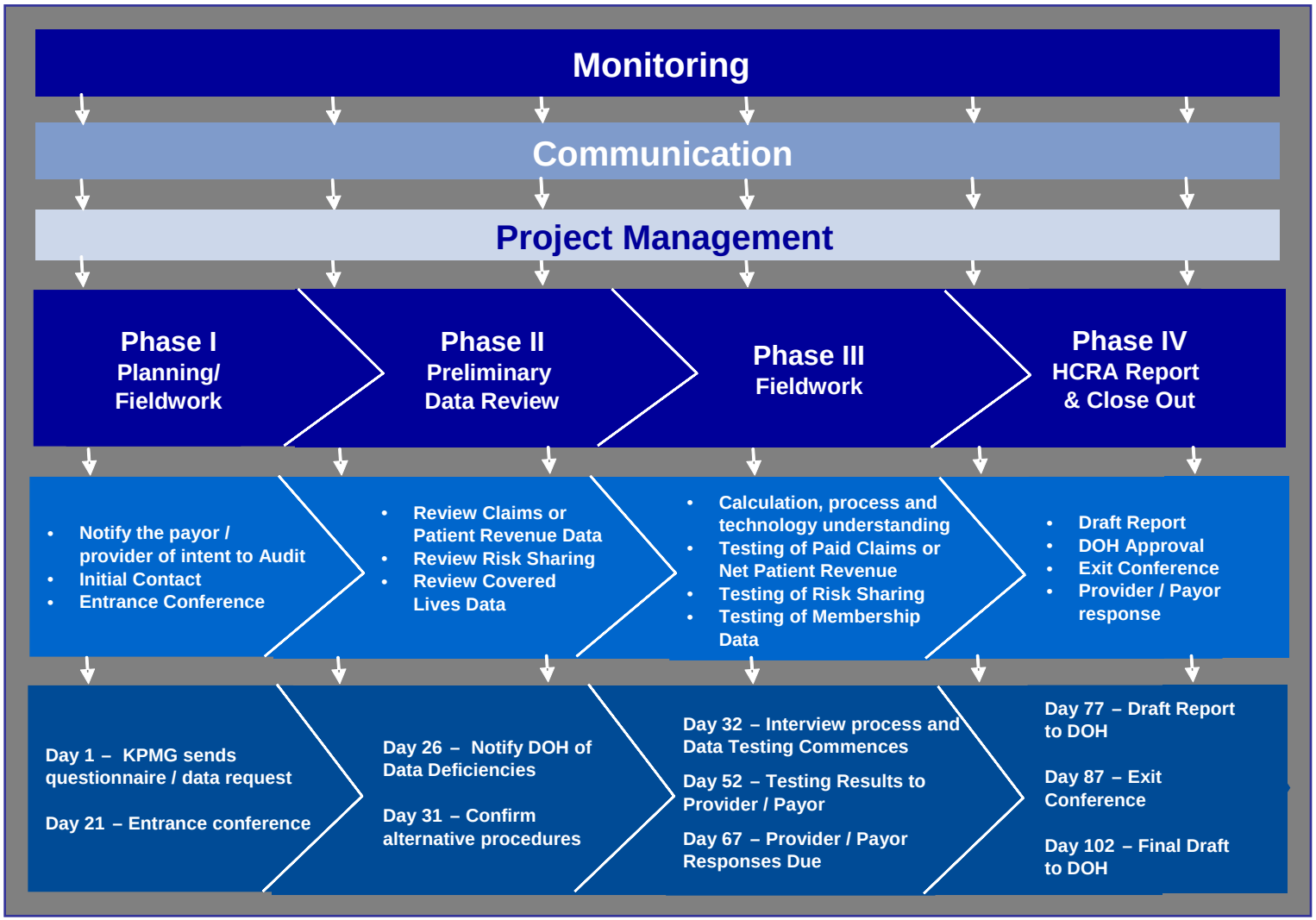
The Stage 1 and Stage 2 audits will be combined into one audit, incorporating all of the general compliance elements from the Stage 1 audit with the quantitative approaches employed during the Stage 2.

Audit Objectives
• **Review policies and procedures for calculating and remitting HCRA Surcharge and Assessment payments**
• **Test a sample of the detailed claim files for the year(s) under review**
• **Test detailed membership files for the year(s) under review**
• **Test a sample of risk sharing arrangements for the year(s) under review**
• **Calculate difference in post-audit obligations and auditee remitted payment for audited year(s)**

Scope – Reviewing Multiple Years/TINs

- For the majority of the audits conducted to date, the scope has been for only one year generally between 2000-2002.
- Under our new procedures and protocols, multiple years will be reviewed concurrently in an effort to bring the audits up to date.
- KPMG will also be reviewing multiple Tax Identification Numbers at the same time for auditees reporting for more than one business unit.
- Since KPMG will be reviewing many different years and TINs concurrently, this will extend the timeline and duration of the audits as noted later in the presentation.

Audit Approach



Areas of Focus

Surcharges

- Review policies and procedures relating to the surcharge calculation in the following areas:
  - Finance/Accounting
  - Provider Relations
  - IT
- Review methodologies and re-perform calculations made by the auditee for the period under review.
- Review detailed paid claim files for each year under review to identify instances of non-compliance and potential payment discrepancies.
- Review supporting reconciliations of the paid claim files to the Audited Financial Statements and accompanying General Ledger support.

Areas of Focus, *continued*

Surcharges (cont.)

- Obtain supporting documentation for non-claim experience risk sharing arrangements in place for the year under review including the following:
  - Contracts
  - Payment History
  - Claims Activity
  - Surcharge Calculation Methodology
- Review the supporting documentation noted above to identify instances of non-compliance and potential payment discrepancies.

Areas of Focus , *continued*

Covered Lives Assessment

- Review policies and procedures relating to the assessment calculation in the following areas:
  - Finance/Accounting
  - Member Relations
  - IT
- Review methodologies and re-perform calculations made by the auditee for the period under review.
- Review detailed membership files for each year under review to identify instances of non-compliance and potential payment discrepancies.

BREAK

Surcharges

Common Issues

- Inability to identify claims paid for member eligible under the Federal Employee Health Benefits Act (FEHBA)
- Inability to identify claims paid related to Medicaid
- Inability to identify claims paid related to Medicare – Including identification of exhausted benefits and non-covered services
- Provider information noted in the paid claims file does not reflect the location where services were performed
- Discrete Physician Billing – Only claims related to private practicing physicians are excludable
- Inability to identify claims that were included or excluded from the surcharge calculation during the period under review.

Surcharges, *continued*

Protocols

- When unable to identify claims as FEHBA, Medicaid, or Medicare, the auditor will note the claims as non-eligible for the program in question .
- When unable to identify the location where the service was provided, the auditor will note the location as New York State.
- When there is a lack of sufficient evidence to support that a claim was paid as part of discrete physician billing for a private practicing physician, the auditor will include the claim as surchargeable.
- When unable to identify claims that were included or excluded from the surcharge calculation during the period under review, testing procedures will be performed in aggregate making specific under/overpayments difficult to identify.

Covered Lives Assessment

Common Issues

- Inability to identify members eligible under the Federal Employee Health Benefits Act (FEHBA)
- Inability to identify members eligible for Medicaid
- Inability to identify members eligible for Medicare – For both over 65 years of age and disability related
- Inability to assign a member to a HCRA Region due to the lack of the following:
  - Historical address information
  - Lack of county information
  - Zip code (alternative procedure for county) and/or state code
- Inability to determine coverage type due to a lack of dependent information

Covered Lives Assessment , *continued*

Protocols

- When unable to identify members as FEHBA, Medicaid, or Medicare, the auditor will note the member as non-eligible for the program in question .
- When unable to identify the HCRA Region for a member due to the lack of sufficient information, the member will be assigned to the highest assessed Region determined to be appropriate by DOH.
- When unable to determine coverage type due to a lack of dependent information, all related members will be noted as “Family” for the assessment calculation.

Audit Timeline, including Reviewee Responsibilities

- Review Timeline for 1 year / 1 TIN (see “Audit Milestones” Handout)
- In reviewing multiple years concurrently, the audit timeline as well as number of staff assigned to the team will increase, but the time allotted will not be the number of days noted for 1 year for each audit. The increase in time and staff will be as follows:
  - Initial Data/Documentation Requests – the amount of time allotted for this will increase by 2 weeks for the second year, from 4 to 6 weeks, and by 1 week for each additional year
  - Responses to Testing Results – the amount of time allotted for this will increase by 1 week for each additional year
  - Staff Resources – The number of staff will vary depending on the number of years assigned
- For examples of the extended timelines resulting from the above increases, see “Audit Milestones” Handout.

Requesting Extensions

- The audit timeline presented has been agreed to and approved by DOH.
- If the reviewee requires additional time to gather documentation in order to meet the needs of the audit, a formal request for an extension must be submitted to DOH with a copy sent to KPMG.
- This request must include the amount of time requested, as well as an explanation of the need for the extension.
- All requests for extensions will be decided by DOH on a case by case basis.

Closing Remarks/Questions and Answers

- Review of Session Topics
  - Audit Approach
  - Multiple Years/TINs
  - Protocols
  - Audit Timeline
- Thoughts on moving forward
- Questions and Answers