



Office of the
Medicaid Inspector
General

NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF TOUCHSTONE HEALTH PRESTIGE M/M
RETROACTIVE DISENROLLMENTS
FOR NOTIFICATIONS REPORTED TO OMIG
OCTOBER 1, 2013 THROUGH NOVEMBER 16, 2015

FINAL AUDIT REPORT
AUDIT #15-5896

Dennis Rosen
Medicaid Inspector General

April 14, 2016

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ATTACHMENT I – Final Report Overpayments



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

April 14, 2016

[REDACTED]
Touchstone Health Prestige M/M
One North Lexington Avenue, 12th Floor
White Plains, New York 10601

Re: Final Audit Report
Audit # 15-5896
Provider # [REDACTED]

Dear [REDACTED]

The New York State Office of the Medicaid Inspector General (OMIG) has identified instances where Touchstone Health Prestige M/M (Plan) received monthly Medicaid capitation payments for enrollees who were retroactively disenrolled from the Plan. In accordance with the Medicaid Advantage Model Contract (Contract) and Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR), this Final Audit Report represents the final determination regarding capitation payments made on behalf of enrollees retroactively disenrolled from the Plan.

BACKGROUND

The New York State Department of Health (the Department) is the state agency responsible for the administration of the Medicaid program. As part of its responsibility as an entity within the Department, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of the Department (Titles 10 and 18 of NYCRR), the regulations of the Office of Mental Health (Title 14 of the NYCRR), and the Department's Medicaid Provider Manuals, *Medicaid Update* publications and the Contract.

PURPOSE AND SCOPE

The purpose of the audit was to identify instances where the Plan received a capitation payment from Medicaid and subsequently the enrollee was retroactively disenrolled for the entire payment month. The scope of the audit includes all retroactive disenrollment capitation payments with notifications reported to OMIG from October 1, 2013 through November 16, 2015.

FINDINGS

A Draft Audit Report was issued on February 4, 2016 identifying \$11,978.40 in overpaid capitation payments made to the Plan for enrollees who were retroactively disenrolled for the entire payment month. During the audit process a rate adjustment of \$497.11 occurred resulting in an overpayment of \$12,475.51 (Attachment I).

In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, Section 3.6 (SDOH Right to Recover Premiums), Appendix H and Section 19.7 (OMIG Audit Authority), the OMIG, on behalf of the Department, has a right to recover premiums paid to the Plan for enrollees listed on the monthly roster who are later determined for the entire applicable payment month, to have been disenrolled from the Contractor's Medicaid Advantage Product.

In accordance with 18 NYCRR Section 518.4(a), interest may be collected on any overpayments identified in this audit. Per 18 NYCRR Section 518.4(e) interest may be waived. For this audit, the interest has been waived however it may not be waived on future retroactive disenrollment audits.

Repayment of \$12,475.51 is due the New York State Department of Health (Attachment I). Subsequent to the issuance of the Draft Audit Report, the Plan submitted payment via check in the amount of \$11,978.40. Therefore, \$497.11 is due the New York State Department of Health (Attachment I).

PROVIDER RIGHTS

The Plan has the right to challenge this action and determination by requesting an administrative hearing within sixty (60) days of the date of this notice. In accordance with 18 NYCRR Section 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If the Plan wishes to request a hearing, the request must be submitted in writing within sixty (60) days of the date of this notice to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204

Questions regarding the request for a hearing should be directed to the Office of Counsel, at [REDACTED]
[REDACTED]

If a hearing is held, the Plan may have a person represent the Plan or the Plan may represent itself. If the Plan chooses to be represented by someone other than an attorney, the Plan must supply along with the Plan's hearing request a signed authorization permitting that person to represent the Plan at the hearing; the Plan may call witnesses and present documentary evidence on the Plan's behalf. For a full listing of hearing rights please see 18 NYCRR Part 519.

Should you have any questions, please contact [REDACTED]
[REDACTED]. Thank you for your cooperation.

Sincerely, [REDACTED]
[REDACTED]

Division of Medicaid Audit
Office of the Medicaid Inspector General

[REDACTED]

[REDACTED]