NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF SCHC TOTAL CARE, INC. RETROACTIVE DISENROLLMENT VOIDS DUE OVER 90 DAYS BASED ON NYSDOH/MANAGED CARE QUARTERLY RETRO DISENROLLMENT PREMIUM RECOVERY REPORTS FOR THE 1st, 2nd AND 3rd QUARTERS OF 2013

FINAL AUDIT REPORT
AUDIT # 14-4539

James C. Cox
Medicaid Inspector General

December 19, 2014

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ATTACHMENT

ATTACHMENT I – Final Report Overpayments

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, New York 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

December 19, 2014

[redacted]
SCHC Total Care, Inc.
819 South Salina Street, PO Box 11507
Syracuse, New York 13202

Re: Final Audit Report
Audit # 14-4539
Provider #[redacted]

Dear [redacted]

The New York State Office of the Medicaid Inspector General (OMIG) has identified Medicaid and Family Health Plus capitation payments made to SCHC Total Care, Inc. (formerly known as Syracuse PHSP) (Plan) which the Plan was later instructed to return because the enrollees were retroactively disenrolled from the Plan. The OMIG review determined that the Plan had failed to return the payments. In accordance with the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan 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 (18 NYCRR), this report represents the final determination on the issues found during the OMIG's review.

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. Following notification of the retroactive disenrollment by the local district and the Department's Office of Health Insurance Programs/Division of Health Plan Contracting and Oversight, the Plan has not voided the capitation payments. The scope of the audit includes all retroactive disenrollment capitation payments with dates of service from September 1, 2008 through September 30, 2013.

In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, Section 3.6 (Compensation – State Department of Health Right to Recover Premiums) and Appendix H, the OMIG, on behalf of the Department, has the right to recover premiums paid to the Plan for enrollees listed on the monthly roster who are later determined to have been ineligible for the entire applicable payment month.

FINDINGS

A Draft Audit Report was issued on September 24, 2014 identifying $120,308.26 in overpaid capitation payments made to the Plan and not subsequently returned to Medicaid when the Plan received monthly capitation payments for enrollees who were project description. As of the date of this Final Audit Report, OMIG has received no response from the Plan to the September 24, 2014 Draft Audit Report. As a result, the findings in the Final Audit Report remain unchanged to those cited in the Draft Audit Report.

In accordance with 18 NYCRR 518.4, interest may be collected on any overpayments identified in this audit and will accrue at the current rate from the date of the overpayment. Interest was calculated on the overpayments identified in the Final Audit Report using a Federal Reserve Prime Rate of 3.25% from the date of each overpayment through the date of the Draft Audit Report.

The total amount of overpayment, inclusive of interest, as defined in 18 NYCRR §518.1(c) is $127,391.79. Repayment of $127,391.79 is due the New York State Department of Health (Attachment I).

EFFECTIVE DATE

The OMIG, on behalf of the Department, is seeking to recover the amount remaining due of $127,391.79 from the Plan, effective 20 days from the date of this Final Audit Report.

PAYMENT OPTIONS

In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

OPTION #1:

Make full payment by check or money order within 20 days of the date of the Final Audit Report. The check should be made payable to the New York State Department of Health, include the audit number and be sent with the attached Remittance Advice to:

New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File # **14-4539**
Albany, New York 12237-0016

OPTION #2: Enter into a repayment agreement with the Office of the Medicaid Inspector General. If your repayment terms exceed 90 days from the date of the Final Audit Report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. If the process of establishing the repayment agreement exceeds 20 days from the date of the final audit report, the OMIG will impose a 50% withhold after 20 days until the agreement is established. OMIG acceptance of the repayment agreement is based on your repaying the Medicaid overpayment as agreed. The OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against any amount owed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days at the following:

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

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 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

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.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid program, take action where appropriate, and recover any associated overpayments. Please contact at or via e-mail at if you have any questions regarding the above. Thank you for your cooperation.

Sincerely,

Division of Medicaid Audit, Albany Office
Office of the Medicaid Inspector General

Attachments

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

SCHC Total Care, Inc.
819 South Salina Street, PO Box 11507
Syracuse, New York 13202

PROVIDER #: [redacted]

AUDIT # 14-4539

AUDIT TYPE
[ ] PROVIDER
[ ] RATE-LTC
[ ] RATE-NH
[X] MANAGED CARE

AMOUNT DUE: $127,391.79

CHECKLIST

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: *New York State Department of Health*
3. Record the Audit Number on your check.
4. Mail check to:

[redacted]

New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File # 14-4539
Albany, New York 12237-0016

5. If the provider number shown above is incorrect, please enter the correct number below.