NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF SYRACUSE PHSP MULTIPLE CLIENT IDENTIFICATION NUMBERS IN DIFFERENT MANAGED CARE PLANS WITH CONCURRENT DATES OF SERVICE STARTING BETWEEN OCTOBER 1, 2009 AND DECEMBER 31, 2009

FINAL AUDIT REPORT
AUDIT # 14-1715

James C. Cox
Medicaid Inspector General

July 9, 2014

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ATTACHMENTS AND SCHEDULES

ATTACHMENT I – Plan Response
ATTACHMENT II – 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

July 9, 2014

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

Re: Final Audit Report
Audit # 14-1715
Provider ID # [redacted]

Dear [redacted]

The New York State Office of the Medicaid Inspector General (OMIG) has identified Medicaid and/or Family Health Plus capitation payments made to Syracuse PHSP (Plan) which were paid for an individual who was concurrently enrolled in a different Managed Care Organization (MCO) under a different Client Identification Number (CIN). 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 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 for an individual who was concurrently enrolled in a different MCO under a different CIN, and then determine which of the concurrent capitation payments were paid inappropriately. These determinations are based on guidance provided by the Department Office of Health Insurance Programs (OHIP) and encounter data reported by the MCO, or lack thereof, during the concurrent enrollment period. If neither MCO reported encounter data during the concurrent enrollment period, the capitation payment will be recovered from the MCO affiliated with the CIN first closed by the local district. The scope of the audit includes capitation payments made to different MCOs with concurrent dates of service starting between October 1, 2009 and December 1, 2009 and continuing until the concurrent payments end.

In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, specifically Section 3.6 (SDOH Right to Recover Premiums), Section 6.1 (Populations Eligible for Enrollment), Section 19.7 (OMIG Audit Authority) and Appendix H and M, and Chapter 2: Eligible Populations of the New York State Operation Protocol for the Partnership Plan, 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 May 28, 2014 identifying $1,640.04 in inappropriately billed capitation payments for individuals concurrently enrolled in a different MCO under a different CIN. In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, Section 3.6 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. In its June 12, 2014 response (Attachment I) to the Draft Audit Report the Plan did not contest the findings of the Draft Audit Report. As a result, the findings of the Final Audit Report remain unchanged from those cited in the Draft Audit Report.

The total amount of overpayment, as defined in 18 NYCRR §518.1(c) is $1,640.04. Repayment of $1,640.04 is due the New York State Department of Health (Attachment II).

EFFECTIVE DATE

The OMIG, on behalf of the Department, is seeking to recover overpayments in the amount of $1,640.04 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 a 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 and be sent with the attached Remittance Advice to:

[redacted]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File #14-1715
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
[redacted]

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 a request for a hearing should be directed to the Office of Counsel, at [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.

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 [redacted] or via e-mail at [redacted] if you have any questions regarding the above. Thank you for your cooperation.

Sincerely,

[redacted]

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

Attachments

CERTIFIED MAIL [redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

Syracuse PHSP
819 South Salina Street
PO Box 11507
Syracuse, New York 13202

AMOUNT DUE: $1,640.04

PROVIDER # [redacted]

AUDIT # 14-1715

PROVIDER TYPE

- ☐ Fee For Service
- ☐ Rate - LTC
- ☐ Rate - NH
- ☒ Managed Care
- ☐ Other

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 #14-1715
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5. If the provider number shown above is incorrect, please enter the correct number below.

Thank you for your cooperation.