NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF HIP WESTCHESTER
CAPITATION PAYMENTS FOR INCARCERATED ENROLLEES
JANUARY 1, 2013 - DECEMBER 31, 2013

FINAL AUDIT REPORT
AUDIT # 14-2396

James C. Cox
Medicaid Inspector General

November 4, 2014

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ATTACHMENTS

ATTACHMENT I – Provider Response
ATTACHMENT II – Paid Appropriate
ATTACHMENT III – 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

November 4, 2014

[redacted]
Government Associated Programs
HIP Westchester
55 Water Street, 4th Floor
New York, New York 10041

Re: Final Audit Report
Audit #: 14-2396
Provider ID #: [redacted]

Dear [redacted]

The New York State Office of the Medicaid Inspector General (OMIG) has identified instances where HIP Westchester (Plan) received monthly Medicaid and/or Family Health Plus capitation payments for incarcerated enrollees during the period from January 1, 2013 through December 31, 2013. In accordance with the Medicaid Managed Care and 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 any applicable contracts.

PURPOSE AND SCOPE

The purpose of this audit was to identify instances where the Plan received a capitation payment from Medicaid when the enrollee was incarcerated for the entire payment month. The review includes capitation payments made to the Plan during the period from January 1, 2013 through December 31, 2013. These cases were identified by a computerized match comparing Medicaid and/or Family Health Plus managed care enrolled recipients to information provided by the New York State Department of Correctional and Community Supervision (DOCCS) and Division of Criminal Justice Services (DCJS).

In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, specifically Section 3.6 (SDOH 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 July 8, 2014 identifying $31,855.23 in overpaid capitation payments made to the Plan for periods subsequent to the enrollee's incarceration. In its August 5, 2014 response the Plan submitted documentation contesting a portion of the claims (Attachment I). Upon reviewing the documentation, the OMIG agreed to reduce the overpayments in the Draft Audit Report by $5,032.35 (Attachment II) resulting in an overpayment of $26,822.88 (Attachment III).

The total amount of overpayment, as defined in 18 NYCRR §518.1(c) is $26,822.88. Repayment of $26,822.88 is due the New York State Department of Health (Attachment III).

EFFECTIVE DATE

The OMIG, on behalf of the Department, is seeking to recover an overpayment in the amount of $26,822.88 from the Plan, effective 20 days from the date of this Final Audit Report.

PAYMENT OPTIONS

18 NYCRR Part 518 governs overpayments; the Plan's 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:

[redacted]
New York State Department of Health
Medicaid Financial Management, B.A.M.
GNARESP Corning Tower, Room 2739
File # 14-2396
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]

HEARING 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]

Pursuant to 18 NYCRR §519.8, at the hearing you have the right to:

(a) request the department to reschedule the hearing (adjournment);
(b) be represented by an attorney, or other representative, or to represent himself/herself;
(c) have an interpreter, at no charge, if the appellant does not speak English or is deaf and cannot afford one (the appellant must advise the department prior to the hearing if an interpreter will be needed);
(d) produce witnesses and present written and/or oral evidence to explain why the action taken was wrong; and
(e) cross-examine witnesses of the department.

The OMIG reserves the right to conduct further reviews of the Plan's 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: 3

CERTIFIED MAIL [redacted]
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

HIP Westchester
55 Water Street, 4th Floor
New York, New York 10041

PROVIDER [redacted]

AUDIT # 14-2396

PROVIDER TYPE

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

AMOUNT DUE: $26,822.88

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 # 14-2396
Albany, New York 12237-0016

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

Thank you for your cooperation.