Office of the
Medicaid Inspector
General

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF SYRACUSE PHSP RETROACTIVE DISENROLLMENT DUE TO PLACEMENT IN FOSTER CARE JULY 1, 2010 THROUGH DECEMBER 31, 2013

FINAL AUDIT REPORT
AUDIT #15-4206

Dennis Rosen
Medicaid Inspector General

November 24, 2015

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ATTACHMENT I – Provider Response
ATTACHMENT II – Final Report Overpayments

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

November 24, 2015

[redacted]
Syracuse PHSP
c/o Syracuse Community Health Center
819 South Salina Street
Syracuse, New York 13202

Re: Final Audit Report
Audit # 15-4206
Provider # [redacted]

Dear [redacted]:

The New York State Office of the Medicaid Inspector General (OMIG) has identified Medicaid monthly capitation payments made for children enrolled in Syracuse PHSP (Plan) while simultaneously covered by Medicaid's foster care program which provided a medical per diem for the child's medical coverage. 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 Final Audit 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 both a monthly capitation payment and a foster care daily rate payment were made by Medicaid for the same child, for the same payment month. The scope of the audit includes the period from July 1, 2010 through December 31, 2013.

In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, specifically 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 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, 2015 identifying $5,959.27 in overpaid capitation payments made to the Plan while the enrollee was simultaneously covered by Medicaid's foster care program which provided a medical per diem for the child's medical coverage. In accordance with 18 NYCRR Parts 517 and 518 and pursuant to the Contract, specifically 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 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 November 16, 2015 response (Attachment I) to the Draft Audit Report, the Plan confirmed 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.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR §518.1(c), is $5,959.27 (Attachment II). Repayment of $5,959.27 is due the New York State Department of Health.

EFFECTIVE DATE

The OMIG, on behalf of the Department, is seeking to recover the amount remaining due of $5,959.27 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 # 15-4206
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 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

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.

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. Should you have any questions please contact Thank you for your cooperation.

Sincerely

Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachment
CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

ADDRESS OF AUDITEE

Syracuse PHSP
819 South Salina Street,
Syracuse, New York 13202

AMOUNT DUE: $5,959.27

PROVIDER #: [redacted]

AUDIT # 15-4206

AUDIT TYPE

- ☐ PROVIDER
- ☐ RATE-LTC
- ☐ RATE-NH
- ☒ MANAGED CARE

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 # 15-4206
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.