



Office of the
Medicaid Inspector
General

DENNIS ROSEN
Medicaid Inspector General

**Audit of
Retroactive Disenrollments
for Notifications Reported to OMIG
October 1, 2013 Through November 16, 2015**

**Final Audit Report
Audit #: 15-5801**

Hudson Health Plan, Inc.

Provider ID #: [REDACTED]



Office of the
Medicaid Inspector
General

ANDREW M. CUOMO
Governor

DENNIS ROSEN
Medicaid Inspector General

September 13, 2016

[REDACTED]
Hudson Health Plan, Inc.
625 State Street
Schenectady, New York 12305

Re: Final Audit Report
Audit #: 15-5801
Provider ID #: [REDACTED]

Dear [REDACTED]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Hudson Health Plan, Inc. (Plan).

In accordance with the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York Section 517.6, this Final Audit Report represents the final determination on the issues found during OMIG's audit.

After reviewing the Plan's March 23, 2016, response to OMIG's February 4, 2016 Draft Audit Report, OMIG has reduced the overpayments identified in the Draft Audit Report from \$434,027.49 to \$425,210.39 in this Final Audit Report. A detailed explanation can be found in the Audit Findings section of this report.

If you have any questions or comments concerning this report, please contact [REDACTED]
[REDACTED] Please refer to audit number 15-5801 in all correspondence.

[REDACTED]
Bureau of Managed Care and FFS Audit
Division of Medicaid Audit
Office of the Medicaid Inspector General

Table of Contents

Background	1
Objective	1
Audit Scope	1
Audit Findings	2
Hearing Rights	3
Contact Information	4

Attachments:

- I - Provider Response
- II - Paid Appropriate
- III - Final Report Overpayments

Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, the Office of the Medicaid Inspector General (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 DOH (Titles 10 and 18 of the New York Codes, Rules and Regulations), the regulations of the Department of Mental Hygiene (Title 14 of the New York Codes, Rules and Regulations), DOH's Medicaid Provider Manuals, *Medicaid Update* publications, and the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (Contract).

Section 3.6, Appendix H, and Section 19.7 of the Contract provides the OMIG, on behalf of the Department, the right to recover premiums ("capitation payments") paid to the Plan for enrollees listed on the monthly Roster who are later determined, for the entire applicable payment month, to have been in an institution; to have been incarcerated; to have moved out of the Plan's service area; to have died; are simultaneously in receipt of comprehensive health care coverage from a managed care organization (MCO) and are enrolled in the Medicaid managed care product of the same MCO; or have been enrolled without their consent. Prior to April 1, 2012, the Department has the right to recover capitation payments paid for infants weighing less than 1200 grams at birth and other infants under 6 months of age who meet the criteria for the SSI or SSI related category. The Department always has the right to recover duplicate capitation payments made under more than one Client Identification Number whether or not the Plan has made payments to providers.

Objective

The objective of this audit was to assess the Plan's adherence to applicable laws, regulations, rules and policies governing the New York State Medicaid program and to verify that:

- the Plan voided the capitation payments following notification of the retroactive disenrollment by the local district and the Department's Office of Health Insurance Programs/Division of Health Contracting and Oversight; and
- capitation payments were submitted in accordance with applicable rules and requirements.

Audit Scope

This audit identified instances where capitation payments were made to the Plan for enrollees who were retroactively disenrolled from the Plan for the entire applicable payment month. This audit included capitation payments made to the Plan with retroactive disenrollment notifications reported to OMIG beginning October 1, 2013, and ending November 16, 2015.

Audit Findings

OMIG issued a Draft Audit Report to the Plan on February 4, 2016, that identified \$434,027.49 in Medicaid overpayments due to capitation payments made to the Plan for enrollees who were retroactively disenrolled for the entire applicable payment month. The Plan's March 23, 2016, response (Attachment I) to the Draft Audit Report disputed 23 of the claims identified. After reviewing the Plan's response to the Draft Audit Report, OMIG agreed with the Plan and removed the 23 claims from the Final Audit Report findings (Attachment II). As a result, in this Final Audit Report, OMIG reduced the overpayments identified in the Draft Audit Report by \$8,817.10, from \$434,027.49 to \$425,210.39 (Attachment III). Pursuant to Section 3.6, Appendix H, and Section 19.7 of the Contract, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (18 NYCRR) Parts 517 and 518, OMIG, on behalf of DOH, may recover such overpayments.

In accordance with 18 NYCRR Section 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. 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.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR Section 518.1(c) is \$425,210.39. Subsequent to the issuance of the Draft Audit Report, the Plan voided claims in the amount of \$ 425,210.39. Therefore, there is no balance due the DOH (Attachment III).

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 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:

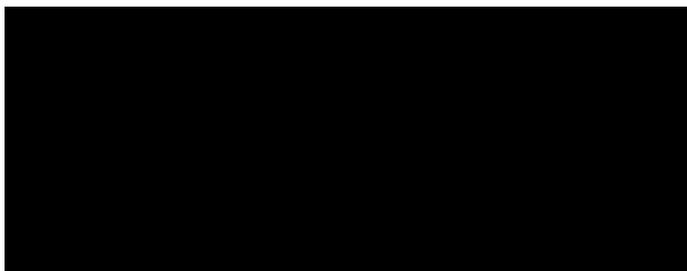
General Counsel
New York State
Office of the Medicaid Inspector General
Office of Counsel
800 North Pearl Street
Albany, New York 12204

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

If a hearing is held, the Plan may have a person represent it 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 its 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 its behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Contact Information



Office Address:

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

Mission

The mission of the Office of the Medicaid Inspector General is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

Vision

To be the national leader in promoting and protecting the integrity of the Medicaid program.