NEW YORK STATE | Office of the Medicaid Inspector General

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

Audit of Retroactive Disenrollment Notifications Reported to OMIG Through December 31, 2019

Final Audit Report
Audit #: 20-6682

WellCare of New York, Inc.

Provider ID #: 01182503

NEW YORK STATE | Office of the Medicaid Inspector General

ANDREW M. CUOMO
Governor

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

August 19, 2021

[redacted]
WellCare of New York, Inc.
c/o Fidelis care
25-01 Jackson Avenue
Long Island City, New York 11101

Re: Final Audit Report
Audit #: 20-6682
Provider ID #: 01182503

Dear [redacted]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for WellCare of New York, 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 December 24, 2020 response to OMIG's November 12, 2020 Draft Audit Report, OMIG has reduced the overpayments identified in the Draft Audit Report from $112,417.79 to $105,761.72 in this Final Audit Report. Based on this determination, the final overpayment amount is $105,404.33, inclusive of rate adjustments. A detailed explanation can be found in the Audit Findings section of this report.

The attachments referred to in this Final Audit Report will be sent via the Health Commerce System (HCS). Please provide a contact person with a dedicated HCS account. If you have any questions, or to obtain your copy of the attachments via HCS, please contact [redacted] through email at [redacted]. Please refer to audit number 20-6682 in all correspondence.

[redacted]
Bureau of MC Audit & Program Reviews
Division of Medicaid Audit
Office of the Medicaid Inspector General

Attachments
Certified Mail Number: 7021-0350-0000-6247-3174
Return Receipt Requested

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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, Section 19.7 and Appendix H of the Contract provides OMIG, on behalf of DOH, the right to recover 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, in addition to other scenarios. DOH 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:

- capitation payments made to the Plan for enrollees who were retroactively disenrolled from the Plan are recovered; 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 through December 31, 2019.

Audit Findings

OMIG issued a Draft Audit Report to the Plan on November 12, 2020 that identified $112,417.79 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 December 24, 2020 response (Attachment A) to the Draft Audit Report disputed 97 of the claims identified. After reviewing the Plan's response to the Draft Audit Report, OMIG partially agreed with the Plan and removed 13 claims from the Final Audit Report findings. As a result, in this Final Audit Report, OMIG reduced the overpayments identified in the Draft Audit Report by $6,656.07 (Attachment B), from $112,417.79 to $105,761.72. During the course of the audit, rate adjustments occurred reducing the overpayment by $357.39 to $105,404.33 (Attachment C). Pursuant to Section 3.6, Section 19.7, and Appendix H 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. Interest has not been charged for this audit; however, it may be charged on future retroactive disenrollment audits.

The total amount of overpayment, as defined in 18 NYCRR Section 518.1, is $105,404.33 (Attachment C). Subsequent to the issuance of the Draft Audit Report, the Plan voided claims in the amount of $105,404.33. Therefore, the is no remaining balance due to DOH (Attachment C).

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.