NEW YORK STATE | Office of the Medicaid Inspector General

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

Audit of Inappropriately Paid Enhanced Nursing Home Capitation Payments

Final Audit Report
Audit #: 21-1792

Capital District Physicians' Health Plan

Provider ID #: 01183013

NEW YORK STATE | Office of the Medicaid Inspector General

KATHY HOCHUL
Governor

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

September 9, 2021

[redacted]
Capital District Physicians' Health Plan
500 Patroon Creek Boulevard
Albany, New York 12206

Re: Final Audit Report
Audit #: 21-1792
Provider ID #: 01183013

Dear [redacted]

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for Capital District Physicians' Health Plan (Plan).

In accordance with the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery 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.

The Plan's April 19, 2021 response to OMIG's March 11, 2021 Draft Audit Report stated that the Plan agrees with the Draft Audit Report findings. As a result, the overpayments identified in this Final Audit Report remain unchanged from those cited in the Draft Audit Report. The final overpayment amount is $38,232.52.

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 21-1792 in all correspondence.

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

Attachments
Certified Mail Number: 7021-0350-0000-6247-3396
Return Receipt Requested

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Background

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, New York State Medicaid Program Information for All Providers General Billing, New York State Medicaid General Billing Guidelines-Institutional, *Medicaid Update* publications, and the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract (Contract).

New York State Medicaid General Billing Guidelines-Institutional (Versions 2013-02; 2015-01, pg.18) states an adjustment is submitted to correct one or more fields of a previously paid claim. Any field, except the Provider ID number or the Member's Medicaid ID number, can be adjusted. The adjustment must be submitted in a new claim form (copy of the original form is unacceptable) and all applicable fields must be completed. Adjustments cause the correction of the adjusted information in the claim history records as well as the cancellation of the original claim payment and the re-pricing of the claim based on the adjusted information.

New York State Medicaid Program Information for All Providers General Billing (Version 2014-1, pg. 2) provides that paid claims requiring correction or resubmission must be submitted as adjustments to the paid claim within 60 days of the date of notification. In most cases adjustments, rather than voids, must be billed to correct a paid claim.

Pursuant to Section 3.21(a) of the Contract (Versions dated March 1, 2014; October 1, 2015), *Payment for Long Term Placement in Residential Health Care Facilities (Nursing Homes),* the Plan shall receive the premium associated with Long Term Placement from the DOH after the Local Department of Social Services (LDSS) has determined an enrollee is eligible for Long Term Placement in a nursing home.

Pursuant to Section 19.7 of the Contract (Versions dated March 1, 2014; October 1, 2015), *OMIG Audit Authority,* provides OMIG the right to review and audit contracts, encounter data, cost reports, plan benefit design or any other information used, directly or indirectly, to determine expenditures, claims, bills and all other expenditures of medical assistance program funds to determine compliance with federal and state laws and regulations and take such corrective actions as are authorized by federal or state laws and regulations.

DOH letter dated December 20, 2019 (DOH letter), advised Plans that the Medicaid payment system, eMedNY, was configured to pay the enhanced Nursing Home (NH) rate based on the Restriction/Exception (R/E) N code on file. The active NH R/E N code resulted in instances where the Plan billed the standard rate (Rate Codes 2205, 2209) but was inappropriately paid the enhanced NH rate, resulting in an overpayment for each applicable payment month that the Plan billed for a NH resident who was no longer residing in the NH.

Objective and Audit Scope

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 identify and recover:

- enhanced nursing home capitation payments (Rate Codes 1821-1826) made to the Plan when the appropriate rate code should have been the standard rate (Rate Codes 2205, 2209); and
- identify instances where the plan failed to submit bill adjustments for improperly paid claims.

Audit Scope

The audit included a review of enhanced NH capitation payments paid to the Plan for dates of service beginning March 1, 2015 and ending December 31, 2015.

Audit Findings

OMIG issued a Draft Audit Report to the Plan on March 11, 2021 that identified $38,232.52 in Medicaid overpayments due to enhanced NH capitation payments made to the Plan on behalf of an enrollee when they were only entitled to the standard rate for the entire applicable payment month. The Plan's April 19, 2021 response (Attachment A) to the Draft Audit Report stated that the Plan agrees with the Draft Audit Report findings. Pursuant to Medicaid Billing Guidelines, Section 19.7 of the Contract, DOH letter, and 18 NYCRR Parts 517 and 518, the OMIG, on behalf of the Department, may recover such overpayments.

In accordance with 18 NYCRR 518.4(b), interest may be collected on any overpayments identified in this audit and will accrue at the current rate sixty (60) days from the date of the DOH letter. Section 518.4(e) allows for interest to be waived. For this audit, the interest has been waived, however, it may not be waived for future audits.

The total amount of overpayment, as defined in 18 NYCRR Section 518.1(c), is $38,232.52. As stated in the DOH letter, rather than voiding the claim, Plans should bill adjustments to their already paid claims to receive proper payment. Subsequent to the issuance of the Draft Audit Report, the Plan voided claims in the amount of $28,674.39 (Attachment B). Subsequent to the issuance of the Draft Audit Report, the Plan adjusted claims in the amount of $9,558.13 (Attachment C). Based on this determination, there is no balance due to DOH.

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 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 12204-2719

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.