NEW YORK STATE | Office of the Medicaid Inspector General

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

Audit of Capitation Payments for Enrollees not Residing in the State

Final Audit Report
Audit #: 22-5419

Integra MLTC, Inc.

Provider ID #: 03475427

NEW YORK STATE | Office of the Medicaid Inspector General

KATHY HOCHUL
Governor

FRANK T. WALSH, JR
Acting Medicaid Inspector General

March 9, 2023

[redacted]
Integra MLTC, Inc.
1981 Marcus Avenue, Suite 100
Lake Success, New York 11042

Re: Final Audit Report
Audit #: 22-5419
Provider ID #: 03475427

[redacted]

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

In accordance with the Managed Long Term Care (MLTC) Partial Capitation 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 October 28, 2022 response to OMIG's September 29, 2022 Draft Audit Report, OMIG has reduced the overpayments identified in the Draft Audit Report from $45,141.63 to $4,499.25 in this Final Audit Report. Based on this determination, the final overpayment amount is $4,499.25. 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] or through email at [redacted]. Please refer to audit number 22-5419 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 0001 9900 3022
Return Receipt Requested

Table of Contents

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 Managed Long Term Care (MLTC) Partial Capitation Model Contract (Contract).

Pursuant to Social Security Act (SSA) Section1903(r)(3), the federal government requires states to have in operation an eligibility determination system which provides for data matching through the Public Assistance Reporting Information System (PARIS), including matching with medical assistance programs operated by other States. PARIS is a system for matching data for the purposes of maintaining program integrity and detecting improper capitation payments for individuals receiving public assistance in more than one state.

In accordance with Title 18 NYCRR Part 518 and pursuant to the Contract Article VI, (F) (1) (a) (Department Right to Recover Premiums), the OMIG, on behalf of DOH, has the right to recover capitation payments paid to the Plan for enrollees who are later determined, for the entire applicable payment month to have been residing and receiving public assistance in a state other than New York State.

Pursuant to *OMIG Audit Authority*, as contained in Article VIII(O) of the current Contract (January 1, 2017 to December 2021) and Article VIII(P) of the prior Contract (January 1, 2015 to December 31, 2016), and in accordance with New York State Public Health Law Sections 30 through 36, and as authorized by federal or state laws and regulations, the OMIG may review and audit claims 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.

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:

- capitation payments made to the Plan for enrollees who have been residing and receiving Medicaid in a state other than New York State

Audit Scope

This audit identified instances where capitation payments were made to the Plan for enrollees who were residing and receiving Medicaid in a state other than New York State for an entire applicable payment month. This audit included capitation payments made to the Plan for enrollees identified by PARIS Medicaid Interstate Matches between October 1, 2016 and December 31, 2018.

Audit Findings

OMIG issued a Draft Audit Report to the Plan on September 29, 2022 that identified $45,141.63 in Medicaid overpayments due to capitation payments made to the Plan for enrollees who were residing and receiving Medicaid in a state other than New York State for the entire applicable payment month. This audit included capitation payments made to the Plan for enrollees identified by the PARIS Medicaid Interstate Matches between October 1, 2016 and December 31, 2018. After reviewing the Plan's response to the Draft Audit Report, OMIG agreed with the Plan and removed the nine 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 $40,642.38 (Attachment B), from $45,141.63 to $4,499.25. Pursuant to Article VI, (F) (1) 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.

The total amount of overpayment, as defined in 18 NYCRR Section 518.1(c), is $4,499.25. Subsequent to the issuance of the Draft Audit Report, the Plan voided claims in the amount of $4,499.25, therefore, there is no 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.