NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

REVIEW OF TOTAL CARE, INC.
RETROACTIVE DISENROLLMENT DUE TO PLACEMENT IN FOSTER CARE
DATES OF SERVICE FROM JUNE 1, 2007 THROUGH JUNE 30, 2010

FINAL AUDIT REPORT

James C. Cox
Medicaid Inspector General
August 28, 2013

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ATTACHMENTS

ATTACHMENT I – Provider Response to Draft Report
ATTACHMENT II – Final Audit Report Claims Remaining to be Recovered

STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL
800 North Pearl Street
Albany, NY 12204

ANDREW M. CUOMO
GOVERNOR

JAMES C. COX
MEDICAID INSPECTOR GENERAL

August 28, 2013

[redacted]
Total Care, Inc
819 South Salina Street
Syracuse, NY 13218-1507

Re: Final Audit Report
Audit # 13-2404
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 Total Care, Inc (Plan), previously known as Syracuse PHSP, while simultaneously covered by Medicaid's foster care program which provided a medical per diem for the child's medical coverage. In accordance with Section 517.6 of Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR), this 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 of Health (Titles 10 and 18 of the 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 Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan Model Contract (Contract).

Pursuant to Section 3.6, 6.1, and Appendix H and M of the Contract, and Chapter 2: Eligible Populations of the New York State Operational Protocol for the Partnership Plan, the OMIG, on

behalf of the Department, has a right to recover premiums paid to the Plan for members listed on the monthly roster who are later determined to have been ineligible for the entire applicable payment month.

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 June 1, 2007 to June 30, 2010.

FINDINGS

A Draft Audit Report was issued May 23, 2013 identifying $8,082.46 in capitation payments inappropriately made to the Plan while the child was receiving a foster care daily rate paid for medical coverage by Medicaid during the same month. After reviewing the Plan's June 4, 2013 response to OMIG's May 23, 2013 Draft Audit Report, your comments have confirmed the audit findings. As a result, the findings in the Final Audit Report remain unchanged to those cited in the Draft Audit Report. As stated in the Contract, Section 3.6 (Compensation – State Department of Health Right to Recover Premiums) and Appendix H and 18 NYCRR Parts 517 and 518, the OMIG has a right to recover overpayments 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.

The total amount of overpayment, as defined in 18 NYCRR 518.1, is $8,082.46. Repayment of $8,082.46 is due the New York State Department of Health (Attachment II).

EFFECTIVE DATE

The OMIG, on behalf of the Department, is seeking to recover an overpayment in the amount of $8,082.46 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 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 #13-2404
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 15% withhold after 20 days until the agreement is established. The OMIG may require financial information from you to establish the terms of the repayment agreement. If additional information is requested, the OMIG must receive the information within 30 days of the request or a 50% withhold will be imposed. 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. The OMIG will notify you no later than 5 days after initiating such action.

If you wish to enter into a repayment agreement, you must forward your written request within 20 days to the following:

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

If within 20 days, you fail to make full payment or contact the OMIG to make repayment arrangements, the OMIG will establish a withhold equal to 50% of your Medicaid billings to secure payment and liquidate the overpayment amount, interest and/or penalty, not barring any other remedy allowed by law. The OMIG will provide notice to you no later than 5 days after the withholding of any funds.

In addition, if you receive an adjustment in your favor while you owe funds to the State, such adjustment will be applied against the amount owed.

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 to:

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

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 the hearing, the Plan may call witnesses and present documentary evidence on the Plan's behalf.

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. If you have any questions regarding the above, please contact or by email at Thank you for your cooperation.

Sincerely,

Division of Medicaid Audit
Office of the Medicaid Inspector General

CERTIFIED MAIL #
RETURN RECEIPT REQUESTED

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE

Total Care, Inc
819 South Salina Street
Syracuse, NY 13218-1507

PROVIDER [redacted]

AUDIT # 13-2404

PROVIDER TYPE

- ☐ Fee For Service
- ☐ Rate - LTC
- ☐ Rate - NH
- X Managed Care
- ☐ Other

AMOUNT DUE: $8,082.46

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
Albany, New York 12237-0016

Thank you for your cooperation.