



**NEW YORK STATE
DEPARTMENT OF HEALTH
OFFICE OF THE MEDICAID INSPECTOR GENERAL**

**REVIEW OF HIP/HEALTH INSURANCE PLAN OF NEW YORK/
WESTCHESTER
RETRO DISENROLLMENT VOIDS DUE OVER 90 DAYS BASED ON
NYSDOH/MANAGED CARE QUARTERLY RETRO DISENROLLMENT
PREMIUM RECOVERY REPORT 3RD QUARTER 2010**

FINAL AUDIT REPORT

**James G. Sheehan
Medicaid Inspector General
June 28, 2011**

OFFICE OF THE MEDICAID INSPECTOR GENERAL

www.omig.ny.gov

The mission of the Office of the Medicaid Inspector General (OMIG), as mandated by New York Public Health Law § 31 is to preserve 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.

DIVISION OF MEDICAID AUDIT

The Division of Medicaid Audit professional staff conducts audits and reviews of Medicaid providers to ensure compliance and program requirements and, where necessary, to recover overpayments. These activities are done to monitor the cost-effective delivery of Medicaid services for prudent stewardship of scarce dollars; to ensure the required involvement of professionals in planning care to program beneficiaries; safeguard the quality of care, medical necessity and appropriateness of Medicaid services provided; and, to reduce the potential for fraud, waste and abuse.

DIVISION OF MEDICAID INVESTIGATIONS

The Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by inserting covert and overt investigators into all aspects of the program, scrutinizing provider billing and services, and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, penalties, and improves the quality of care for the state's most vulnerable population.

DIVISION OF TECHNOLOGY AND BUSINESS AUTOMATION

The Division of Technology and Business Automation will continue to support the data needs for the OMIG in the form of audit and investigative support, data mining and analysis, system match and recovery, through the use of commercial data mining products and procurement of expert service consultants.

OFFICE OF COUNSEL TO THE MEDICAID INSPECTOR GENERAL

The Office of Counsel to the Medicaid Inspector General promotes the OMIG's overall statutory mission through timely, accurate and persuasive legal advocacy and counsel.

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**STATE OF NEW YORK
OFFICE OF THE MEDICAID INSPECTOR GENERAL**

800 North Pearl Street
Albany, New York 12204

ANDREW M. CUOMO
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

June 28, 2011

[REDACTED]
HIP Health Insurance Plan of NY/ Westchester
55 Water Street
New York, NY 10041

Re: Final Audit Report
Audit # 11-3232
Provider # [REDACTED]

Dear [REDACTED]

The New York State Office of the Medicaid Inspector General (OMIG) has identified Medicaid and Family Health Plus capitation payments made to HIP Health Insurance Plan of New York/Westchester (the Plan) that were paid on behalf of retroactively disenrolled members that presented no risk to the managed care organization. In each instance the Plan had been previously notified of the retroactive disenrollment and inappropriate payments and was instructed to void the capitation payments. This review identified those retro disenrollment capitation payments that did not have a subsequent claim void submitted by the Plan. 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 issues found during the OMIG's review.

After reviewing the Plan's May 26, 2011 response to the OMIG's April 13, 2011 draft report, the OMIG has reduced the draft report disallowances from \$4,738.27 to \$0.00 in the final report. A detailed explanation can be found in the Findings section.

BACKGROUND

The New York State Department of Health is responsible for the administration of the Medicaid program. As part of this responsibility, the OMIG conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at ensuring provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth by the Departments of Health and Mental Hygiene [Titles 10, 14 and 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York] and the Medicaid Provider Manuals.

In accordance with 18 NYCRR Part 518 and pursuant to the Medicaid Managed Care and Family Health Plus Contract, Section 3.6 (Compensation – State Department of Health Right to Recover Premiums) and Appendix H, the OMIG has the right to recover premiums paid to the Contractor for enrollees 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 the Plan received a capitation payment from Medicaid and subsequently the member was disenrolled retroactively for the payment month. Following notification of the retro disenrollment by the local district and the State Department of Health/Division of Managed Care via the Quarterly Retro Disenrollment Premium Recovery Report, the Plan had not voided the capitation payment. The scope of the audit includes all retro disenrollment capitation payments listed repeatedly on both the 2010 2nd Quarter and 2010 3rd Quarter Retro Disenrollment Premium Recovery Reports.

FINDINGS

A draft report was issued April 13, 2011 identifying \$4,738.27 in capitation payments inappropriately paid to the Plan for Medicaid recipients who were disenrolled retroactively for the payment month. In response to the draft report, the Plan submitted documentation contesting a portion of the claims. Upon reviewing the documentation, the OMIG agreed with the Plan and reduced the overpayments in the Draft Report by \$4,738.27 (Attachment II). As a result, there are no overpayments identified on the final report. As stated in the Medicaid Managed Care and Family Health Plus Contract, Section 3.6 (Compensation – State Department of Health Right to Recover Premiums) and Appendix H, the OMIG has a right to recover premiums paid to the Contractor for enrollees listed on the monthly roster who are later determined to have been ineligible for the entire applicable payment month.

In accordance with 18 NYCRR Section 518.4, interest may be collected and will accrue at the current rate from the date of overpayment. Interest was calculated on overpayments identified in the final report using the Federal Reserve Prime rate, with a begin date of interest of October 1, 2010 and the end date of April 13, 2011. Since all overpayments from the draft report have been determined to have been paid appropriate, no interest is due.

As a result, the total amount of overpayment, inclusive of interest, as defined in 18 NYCRR § 518.1, is \$ 0.00 and there is no amount due the New York State Department of Health.

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 to:

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

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

If you have any questions regarding the above, please contact [REDACTED] at [REDACTED] or via e-mail at [REDACTED]

Thank you.

Sincerely,

[REDACTED]

Bureau of Managed Care Audit & Provider Review
Office of the Medicaid Inspector General

CERTIFIED MAIL # [REDACTED]
RETURN RECEIPT REQUESTED