

New York State  
Office of the Medicaid Inspector General



Review of Americhoice of New York, Inc  
Supplemental Newborn Capitation Payments

Final Audit Report

James C. Cox  
Medicaid Inspector General

June 21, 2012



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

ANDREW M. CUOMO  
GOVERNOR

JAMES C. COX  
MEDICAID INSPECTOR GENERAL

June 21, 2012

[REDACTED]  
Americhoice of New York, Inc.  
77 Water Street, 14<sup>th</sup> Floor  
New York, NY 10005

Re: Final Audit Report  
Audit #11-6192

Dear [REDACTED]

Enclosed is the Office of the Medicaid Inspector General ("OMIG") final audit report entitled "Review of Americhoice of New York (the "Plan") Supplemental Newborn Capitation Payments", covering specific claim submissions by the Plan.

In the attached final report, the OMIG has detailed our objectives and scope, laws, regulations, rules, and policies, findings, and provider rights.

After reviewing written responses to the OMIG's November 21, 2011 draft report, the OMIG has reduced the disallowances in the final report. A detailed explanation of the revision is included in the final report.

If the Plan has any questions or comments concerning this report, please contact [REDACTED] at [REDACTED] or through email at [REDACTED]. Please refer to audit number 09-11-6192 in all correspondence.

Sincerely,

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

Certified Mail # [REDACTED]  
Return Receipt Requested

## **Office of the Medicaid Inspector General**

[www.omig.state.ny.us](http://www.omig.state.ny.us)

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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## **Introduction**

### **Background**

#### **Medicaid Program**

Pursuant to Title XIX of the Social Security Act, the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State governments jointly fund and administer the Medicaid program.

#### **New York State's Medicaid Program**

In New York State, the Department of Health (DOH) is the State agency responsible for operating the Medicaid program. Within DOH, the Office of Health Insurance Programs administers the Medicaid program. DOH uses the electronic Medicaid New York Information system (eMedNY), a computerized payment and information reporting system, to process and pay Medicaid claims, including newborn birth claims.

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.

#### **Newborn Fee-for-Service & Managed Care Crossover**

An infant whose mother is in receipt of Medicaid at the time of the infant's birth is entitled to Medicaid for the first 12 months from their date of birth. If a mother is enrolled in a managed care plan, the newborn becomes a member of that same plan, and the hospital is required to bill the plan directly for costs associated with the newborn's birth using the newborn's client identification number. Exceptions to this billing routine occur when the newborn weighs less than 1200 grams, is determined eligible for the SSI related category, or the mother is enrolled in certain special needs or a partial capitation plan. Sections 3.8 of the Medicaid Managed Care/Family Health Plus Contract (MMC/FHPC) also provides for a supplemental newborn capitation payment be made to a managed care organization ("MCO") after the MCO makes payment to the hospital for the birth/delivery.

## Objective and Scope

### Objective

The objective of our audit was to ensure Americhoice of New York ("the Plan") compliance with applicable Federal and State laws, regulations, rules and policies governing the New York State Medicaid program and to verify that:

- the Plan sought reimbursement from liable third parties;
- claims for payment were submitted in accordance with DOH regulations and the appropriate provider manuals.

### Scope

A review of three supplemental newborn capitation payments made to the Plan whereas the newborn's hospital or birthing center reported not receiving payment from the Plan for the newborn services they rendered to three of the Plan's Medicaid enrollees.

### Laws, Regulations, Rules and Policies

The following are applicable laws, regulations, rules, and policies of the Medicaid program referenced when conducting this audit:

- Department 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 (10 NYCRR, 14 NYCRR, 18 NYCRR)].
- Medicaid Management Information System ("MMIS") and eMedNY Provider Manual.
- Specifically, 18 NYCRR §540.6
- In addition to any specific detailed findings, rules and/or regulations which may be listed below, the following regulations pertain to all audits:

Regulations state: "By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department."

*18 NYCRR Section 504.3*

Regulations state: "All bills for medical care, services and supplies shall contain: . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . ; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . . ; and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided. . . ."

*18 NYCRR Section 540.7(a)*

Regulations state: "An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake."

*18 NYCRR Section 518.1(c)*

Furthermore, according to regulations, all providers must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. In addition, the provider must keep, for a period of six years, all records necessary to disclose the nature and extent of services furnished and the medical necessity therefore, including any prescription or fiscal order for the service or supply. This information is subject to audit for a period of six years and must be furnished, upon request.

*18 NYCRR Section 517.3(b)*

## Detailed Findings

A draft report that identified inappropriate payments of \$6,553.87 was issued to the Plan on November 21, 2011 for instances where the Plan was paid a supplemental newborn capitation payment for services the birthing center reported were not paid by the Plan; a violation of MMC/FHPC §3.9(d).

The Plan's written responses (Attachment I) to the OMIG's November 21, 2011 draft report stated that the Plan disputed two (recipient ID's: [REDACTED]) of the three claims identified in the report due to the newborn claims being paid under the mother's CIN ID. Upon receipt of the Plan's response, the OMIG contacted the birthing hospital and confirmed that the newborn claim for recipient [REDACTED] was paid through this process. Upon discussion with the Plan for recipient [REDACTED] the Plan stated it recouped payment from the birthing hospital through a settlement agreement and the Plan needs to return the supplemental newborn capitation payment. The Plan agreed with the remaining draft finding. As a result, the findings identified in draft report have been reduced by \$2,097.31 (Attachment II) from \$6,553.87 to \$4,456.56.

In accordance with 18 NYCRR §518.4, interest may be collected and will accrue at the current rate from the date of the overpayment. For the net overpayments identified in this audit, the OMIG has determined that accrued interest of \$1,036.28 is owed. Interest was calculated using the Federal Reserve Prime Rate, with the begin date of interest being the date of overpayment and the end date of interest being the date of the OMIG's draft report; November 21, 2011.

Based on this determination, the total amount of overpayment, as defined in 18 NYCRR §518.1 is \$5,492.84 inclusive of interest (Attachment III). As a result, repayment of \$5,492.84 is now due to the New York State Department of Health.

## Provider Rights

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 report. The check should be made payable to the New York State Department of Health and be sent with the attached Remittance Advice to:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management  
GNARESP Corning Tower, Room 2266  
Albany, New York 12237-0048

**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 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 report, the OMIG will impose a 15% withhold after 20 days until the agreement is established.

Furthermore, 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 recover payment, 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.**

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

Questions regarding the request for a hearing should be directed to Office of Counsel, at [REDACTED]

Issues you may raise shall be limited to those issues relating to determinations contained in the final audit report. Your hearing request may not address issues regarding the methodology used to determine the rate, or any issue that was raised at a proceeding to appeal a rate determination.

At the hearing you have the right to:

- a) be represented by an attorney or other representative, or to represent yourself;
- b) present witnesses and written and/or oral evidence to explain why the action taken is wrong; and
- c) cross examine witnesses of the Department of Health and/or the OMIG.

The OMIG reserves the right to conduct further reviews of your participation in the Medicaid program, take action where appropriate, and recover monies owed through the initiation of a civil lawsuit or other legal mechanisms including but not limited to the recovery of state tax refunds pursuant to Section 206 of the Public Health Law and Section 171-f of the State Tax Law.

**New York State  
Office of the Medicaid Inspector General  
Remittance Advice**

Americhoice of New York  
77 Water Street, 14<sup>th</sup> Floor  
New York, New York 10005

Provider ID [REDACTED]

Audit #11-6192

Amount Due: \$5,492.84

AUDIT	<input type="checkbox"/> Provider
	<input type="checkbox"/> Rate
	<input type="checkbox"/> Part B
TYPE	<input checked="" type="checkbox"/> Other: Newborn FFS/MC Crossover

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  
GNARESP Corning Tower, Room 2266  
File #11-6192  
Albany, New York 12237-0048

*Thank you for your cooperation.*