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

REVIEW OF MVP HEALTH CARE
RETRO DISENROLLMENT
DATES OF SERVICE FROM JUNE 1, 2004
THROUGH DECEMBER 31, 2009

FINAL AUDIT REPORT

James G. Sheehan
Medicaid Inspector General
November 10, 2010

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

DAVID A. PATERSON
GOVERNOR

JAMES G. SHEEHAN
MEDICAID INSPECTOR GENERAL

November 10, 2010

[redacted]
MVP Health Care
625 State Street
Schenectady, NY 12305-1702

Re: Final Audit Report
Audit # 10-3355
Provider # [redacted]

Dear [redacted]

The New York State Office of the Medicaid Inspector General (the "OMIG") has identified Medicaid and Family Health Plus capitation payments made to MVP Health Care (the "Plan") that were inappropriately paid for retroactively disenrolled members. The Plan was previously notified of the inappropriate payments and instructed to void the payments. The OMIG review identified the 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 August 4, 2010 response to the OMIG's July 14, 2010 draft report the findings in the final report have changed from those cited in the draft report, with disallowances, inclusive of interest , of $40,615.64. A detailed explanation of the findings is included in the final report.

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, B.A.M.
GNARESP Corning Tower, Room 1237
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 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. 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:

Collections Management Group
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, New York 12204
[redacted]

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 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.

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

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

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.

TABLE OF CONTENTS

	PAGE
BACKGROUND	1
OBJECTIVE AND SCOPE	1
FINDINGS	1
REMITTANCE ADVICE	2
ATTACHMENTS AND SCHEDULES	
ATTACHMENT I – Draft Report Overpayments	
ATTACHMENT II – Voids Prior to Draft	
ATTACHMENT III – Paid Appropriate	
ATTACHMENT IV – Final Report Overpayments	

BACKGROUND

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. In New York State, the Department of Health (DOH) administers 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.

As per the Medicaid Managed Care and Family Health Plus Contract, Section 3.6 (Compensation – State Department of Health Right to Recover Premiums), 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.

OBJECTIVE AND SCOPE

The purpose of the audit was to identify instances where the Plan received a capitation payment from Medicaid when the recipient was retroactively disenrolled for the entire payment month. The Plan was previously notified of the inappropriate payments and was instructed to void the payments. This review identified those payments that did not have a subsequent claim void submitted by the Plan in a timely manner. The review included capitation payments that were listed repeatedly on both the 2009 4th Quarter and the 2010 1st Quarter Retro Disenrollment Premium Recovery Reports.

FINDINGS

The audit found that $43,890.27 in capitation payments were inappropriately paid to the Plan for Medicaid recipients who were retroactively disenrolled for the payment month (Attachment I). As stated in the Medicaid Managed Care and Family Health Plus Contract, Section 3.6 (Compensation – State Department of Health Right to Recover Premiums), the OMIG has a right to recover premiums paid to the Contractor for enrollees listed on the monthly roster who are later determined to have been ineligible for the entire applicable payment month. The plan submitted voids just prior to issuance of the draft report in the amount of ($ 4,678.07)(Attachment II). The plan also submitted documentation that confirmed claims in the amount of $482.86 were paid appropriately (Attachment III) and these claims were removed from the audit, leaving a balance of $38,729.34 in claims to be recovered.

In accordance with 18 NYCRR Section 518.4, interest may be collected and will accrue at the current rate from the date of overpayment. For the overpayments now identified in Attachment IV, the OMIG has determined that accrued interest of $ 1,886.30 is owed.

As a result, the total amount of overpayment, as defined in 18 NYCRR § 518.1, is $ 40,615.64 (Attachment IV) and is due the New York State Department of Health.

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL
REMITTANCE ADVICE

NAME AND ADDRESS OF AUDITEE	PROVIDER # [redacted]
MVP Health Care 625 State Street Schenectady, NY 12305-1702	AUDIT # 10-3355
AMOUNT DUE: $ 40,615.64	PROVIDER TYPE ☐ Fee For Service ☐ Rate - LTC ☐ Rate - NH X Managed Care ☐ Other

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 1237
Albany, New York 12237-0016

Thank you for your cooperation.