



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

**REVIEW OF NEW YORK STATE CATHOLIC HEALTH PLAN, INC.  
RETROACTIVE DISENROLLMENT DUE TO PLACEMENT IN  
FOSTER CARE**

**DATES OF SERVICE FROM  
JUNE 1, 2007 THROUGH JUNE 30, 2010**

**FINAL AUDIT REPORT  
AUDIT #13-2391**

James C. Cox  
Medicaid Inspector General

November 6, 2013

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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

November 6, 2013

[REDACTED]  
NYS Catholic Health Plan, Inc. c/o Fidelis Care  
95-25 Queens Boulevard, 8th Floor  
Rego Park, New York 11374

Re: Final Audit Report  
Audit # 13-2391  
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 NYS Catholic Health Plan, Inc. (Plan) 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, through June 30, 2010.

## **FINDINGS**

A Draft Audit Report was issued on May 23, 2013, identifying \$1,016,440.10 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. In response to the Draft Audit Report the Plan submitted documentation contesting a portion of the claims (Attachment I). Upon reviewing the documentation, the OMIG agreed to reduce the overpayments in the Draft Audit Report by \$5,308.12. (Attachment II). As a result the Final Audit Report identified an overpayment of \$1,011,131.98 (Attachment III). 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(c) is \$1,011,131.98. Subsequent to the issuance of the Draft Audit Report, the Plan voided claims in the amount of \$1,010,931.76 (Attachment IV). Repayment of \$200.22 is due the New York State Department of Health (Attachment V).

## **EFFECTIVE DATE**

The OMIG, on behalf of the Department, is seeking to recover an overpayment in the amount of \$200.22 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:

[REDACTED]  
New York State Department of Health  
Medicaid Financial Management, B.A.M.  
GNARESP Corning Tower, Room 2739  
File #13-2391  
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

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

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.

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, or to obtain the password for the enclosed disc, please contact [REDACTED] or by email at [REDACTED]. Thank you for your cooperation.

Sincerely,

[REDACTED]  
Division of Medicaid Audit, Albany Office  
Office of the Medicaid Inspector General

Attachments

CERTIFIED MAIL # [REDACTED]  
RETURN RECEIPT REQUESTED

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

**NAME AND ADDRESS OF AUDITEE**

NYS Catholic Health Plan, Inc.  
c/o Fidelis Care  
95-25 Queens Boulevard, 8th Floor  
Rego Park, NY 11374

**PROVIDER** [REDACTED]

**AUDIT #** 13-2391

**PROVIDER  
TYPE**

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

**AMOUNT DUE:** \$200.22

**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.*