THOMAS P. DiNAPOLI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 16, 2015

Howard A. Zucker, M.D., J.D.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Overpayments for Certain
Medicare Part C Claims
Report 2013-S-35

Dear Dr. Zucker:

Pursuant to the State Comptroller's authority as set forth in Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law, we conducted an audit of the Department of Health (Department) to determine if Medicaid overpaid Medicare Part C claims on behalf of Medicaid recipients enrolled in UnitedHealthcare's Medicare Advantage plan: UnitedHealthcare Dual Complete. The audit covered the period September 1, 2008 through August 31, 2013.

Background

Medicaid is a federal, state, and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the year ended March 31, 2014, New York's Medicaid program had approximately 6.5 million enrollees and Medicaid claim costs totaled about $50.5 billion. The federal government funded about 49.25 percent of New York's Medicaid claim costs, the State funded about 33.25 percent, and the localities (City of New York and counties) funded the remaining 17.5 percent.

The Department's Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims.

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health care program for people 65 years of age and older and people under 65 years old with certain

disabilities. Individuals enrolled in both programs are referred to as "dual-eligibles." Generally, Medicare is the primary payer for medical services provided to dual-eligibles. Medicaid then typically pays for any remaining balance not covered by Medicare. These remaining cost-sharing balances include Medicare coinsurance, copayments, and deductibles.

The Medicare program has multiple parts. Part A provides hospital insurance, including inpatient care. Part B provides medical insurance for doctors' services and outpatient care. In 1997, Congress established Part C, the Medicare managed care program known as Medicare Advantage. Under Medicare Part C, private companies administer Medicare benefits and offer different health care plans tailored to the specific needs of Medicare beneficiaries. Medicare pays a fixed amount for each Medicare Part C beneficiary every month to companies offering Medicare Advantage plans. Plans typically have networks of participating providers that they reimburse directly. For dual-eligibles, plan providers bill Medicaid for Medicare Part C coinsurance, copayments, and deductibles.

UnitedHealthcare administers many Medicare Advantage plans. From September 1, 2008 through August 31, 2013, Medicaid paid nearly $7 million for approximately 69,000 claims on behalf of 7,164 dual-eligibles enrolled in UnitedHealthcare Dual Complete.

Results of Audit

Excessive Payments of Medicare Part C Liabilities

As reported in OSC Audit Report 2012-S-133, the Department has not implemented controls to prevent overpayments on claims for Medicare Part C coinsurance, copayments, and deductibles. Rather, the Department relies on providers to accurately report cost-sharing amounts to be paid by Medicaid. Medicaid then pays the entire amount billed by the provider, regardless of the amount requested by the provider.

We examined Medicare Part C claims for services rendered to Medicaid recipients enrolled in UnitedHealthcare Dual Complete and identified 5,571 claims that either had unreasonably high patient cost-sharing amounts or indicated UnitedHealthcare did not cover the service. From a review of a judgmental sample of 125 Medicaid claims totaling $151,069, we determined Medicaid overpaid 54 (43.2 percent) claims by $61,711. Twenty-six providers billed the overpaid claims. Most overpayments occurred because the providers billed claims with incorrect Medicare coinsurance, copayment, or deductible amounts. Ten providers adjusted and re-submitted their claims to eMedNY, resulting in Medicaid repayments totaling $23,374. The overpayments occurred under several scenarios, as follows:

- Twenty-five claims were overpaid by $42,963 because the providers billed Medicaid excessive Medicare Part C coinsurance, copayments, or deductibles. For example, one provider of diagnostic imaging services billed Medicaid $3,370 for the recipient's Medicare coinsurance charge. However, according to UnitedHealthcare, the coinsurance charged was only $140. As a result, Medicaid overpaid the provider's claim by $3,230 ($3,370 - $140);

- Twelve claims were overpaid by $3,841 because the providers indicated on their Medicaid claims that UnitedHealthcare did not cover the service when in fact they did;
- Ten claims were overpaid by $10,062 because the providers did not adjust their Medicaid claims after UnitedHealthcare adjusted the original claims. In each case, UnitedHealthcare's adjustment claim decreased the Medicaid recipients' Medicare Part C liability; and
- The remaining seven claims totaling $4,845 were unsupported. We requested from the providers documentation to support their Medicaid claims. However, three providers did not supply any.

During the audit, ten providers acknowledged receiving overpayments and submitted 13 adjustments to eMedNY to repay Medicaid $23,374. As such, the Department needs to recover $38,337 in overpayments resulting from the remaining 41 claims. In addition, the Department should formally assess the 5,446 higher risk claims totaling $506,239 that we did not examine in detail and determine if overpayments were made that warrant recovery. As previously noted, 43.2 percent of the higher risk claims we examined in detail were problematic, and the overpayments associated with those claims were material.

Recommendations

1. Review and recover the remaining overpayments totaling $38,337.

2. Formally instruct providers, including those identified in this report, to bill Medicare Part C claims in accordance with existing requirements to ensure Medicaid claims are accurately billed. In particular, instruct providers that when primary payers make claim adjustments, they must make the appropriate corresponding Medicaid claim adjustments.

3. Formally assess the 5,446 higher risk claims totaling $506,239 that we did not examine in detail. Determine if overpayments were made that warrant recovery.

Audit Scope, Objective, and Methodology

The objective of our audit was to identify Medicaid overpayments for services rendered to Medicaid recipients enrolled in UnitedHealthcare's Medicare Advantage plan: UnitedHealthcare Dual Complete (NYC only; carrier code H3387). Our audit tests and analyses were based on Medicaid payments for recipients' Medicare Part C cost-sharing responsibilities related to claims for physician, laboratory, durable medical equipment, transportation, referred ambulatory, clinic, and inpatient services. The services were performed from September 1, 2008 through August 31, 2013.

To accomplish our audit objective, and assess internal controls related to our objective, we interviewed officials from the Department and UnitedHealthcare. We reviewed applicable federal and State regulations, and examined the Department's relevant Medicaid policies and procedures. We also obtained Medicare Part C payment information from UnitedHealthcare and compared it with paid Medicaid claims. Our review focused on Medicare Part C claims for unreasonably high patient cost-sharing responsibility and claims that indicated UnitedHealthcare

did not cover the service. We identified 5,571 high-risk claims totaling $657,308. We contacted 42 providers to obtain supporting documentation for a judgmental sample of 125 claims. We compared the claims and supporting documentation in order to validate the appropriateness of the payment.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials concurred with our recommendations and indicated that certain actions have been and will be taken to address them.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons why.

Major contributors to this report were Warren Fitzgerald, Gail Gorski, Andrea LaBarge, and Arnold Blanck.

Very truly yours,

Andrea Inman
Director

cc: Ms. Diane Christensen, Department of Health
Mr. James Cox, Medicaid Inspector General

Agency Comments

NEW YORK
state department of
HEALTH

Howard A. Zucker, M.D., J.D.
Acting Commissioner of Health

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

December 5, 2014

Ms. Andrea Inman, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, NY 12236-0001

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2013-S-35 entitled, "Medicaid Overpayments for Certain Medicare Part C Claims."

Thank you for the opportunity to comment.

Sincerely,

Sally Dreslin, M.S., R.N.
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
Jason A. Helgerson
James C. Cox
Diane Christensen
Robert Loftus
Joan Kewley
Lori Conway
Ronald Farrell
Brian Kiernan
Elizabeth Misa
Ralph Bielefeldt
OHIP Audit BML

Department of Health Comments on the Office of the State Comptroller's Draft Audit Report 2013-S-35 entitled, "Medicaid Overpayments for Certain Medicare Part C Claims"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2013-S-35 entitled, "Medicaid Overpayments for Certain Medicare Part C Claims."

Background

New York State is a national leader in its oversight of the Medicaid Program. Through the efforts of the Department and the Office of the Medicaid Inspector General (OMIG), over the last five years, New York State alone accounted for 54.9 percent of the national total of fraud, waste, and abuse recoveries. These results reflect a trend of increased productivity and enforcement. Over the last three calendar years, the administration's Medicaid enforcement efforts have recovered over $1.73 billion, a 34 percent increase over the prior three-year period.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality care for its Medicaid members. Since 2011, Medicaid spending has remained under the Global Spending Cap, while at the same time providing health care coverage to an additional 840,000 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient has decreased to $7,929 in 2013, consistent with levels from a decade ago.

Recommendation #1

Review and recover the remaining overpayments totaling $38,337.

Response #1

The OMIG's Recovery Audit Contractor (RAC) has recovered $12,052 to date. They will continue recovery efforts on the remaining $26,285.

Recommendation #2

Formally instruct providers, including those identified in this report, to bill Medicare Part C claims in accordance with existing requirements to ensure Medicaid claims are accurately billed. In particular, instruct providers that when primary payers make claim adjustments, they must make the appropriate corresponding Medicaid claim adjustments.

Response #2

The Department's eMedNY Customer Relations Outreach Unit will be re-issuing the article previously published in the February 2014 Medicaid Update to include the changes to the language that will address the concerns of OSC regarding the instruction to providers to make appropriate corresponding Medicaid claim adjustment when primary payers make claim adjustments. The revised Medicaid Update is as follows:

Providers Urged to Submit Correct Coordination of Benefits (COB) Information to Medicaid for Medicare Advantage (Part C) Recipients

A recent review of claims has uncovered persistent misreporting of patient responsibility when the patient is enrolled in both the Medicare Advantage Plan (Part C) and Medicaid. The following practices were uncovered:

- A Medicare Advantage Plan made an adjustment to a claim after the claim was billed to Medicaid, and the billing provider did not make an adjustment to the Medicaid claim, resulting in an overpayment,
- Overpayments resulted because excessive Medicare Advantage Plan coinsurance, deductible and/or co-payments were reported on COB claims to Medicaid, and
- Reporting Cost Avoidance (formerly known as ZERO FILL) on a service that was in fact covered by a Medicare Advantage Plan

Provider Responsibilities

It is the responsibility of a provider who renders services to a Medicaid recipient to verify their eligibility before treatment. All payers reported in the eligibility response must be accounted for in the COB reporting on the claim to Medicaid.

The misreporting of information on COB claims may at times result in inappropriate payments to a provider. Providers are reminded that both Federal and State laws specify that providers participating in the Medicaid program must not retain any inappropriate payments. Knowingly retaining inappropriate payments violates the Fraud Enforcement and Recovery Act (FERA), which amended the Federal False Claims Act.

In addition, effective May 22, 2010, the Affordable Care Act (ACA) amended the Social Security Act (SSA) to include a variety of Medicare and Medicaid program integrity provisions. A new section under SSA, §1128J (d), requires providers of Medicare or Medicaid services or supplies to notify the program and return any inappropriate payments to the program(s) within sixty (60) days of identifying the overpayment.

It is imperative that COB claims submitted to Medicaid after Medicare or other Third Party adjudication contain all information as provided in the Remittance Advice, in accordance with Section 1.4.1.1 (COB Models) of the HIPAA 837 Claims Implementation Specifications or Technical Reports. The information is to include the Claim Adjustment Group Codes (CAGCs) and Claim Adjustment Reason Codes (CARCs) received from the previous payer(s).

Billing Remedies

Medicare Advantage Plan adjusts a previously adjudicated claim that has been billed to Medicaid:

The provider must send an adjusted claim with the corrected information - the Medicaid claim must be adjusted to accurately reflect Medicare's reprocessing of the claim.

Provider billed an incorrect coinsurance, deductible, or co-payment:

The Medicaid claim must be adjusted. In order to correctly bill the patient responsibility to Medicaid, the adjustments on the remit from Medicare Advantage Plan must be cross-walked, **without any modification**, to the Medicaid Claim.

Reporting Cost Avoidance on a claim covered by the Medicare Advantage Plan:

The Primary insurance, a Medicare Advantage Plan, must be billed. Upon receiving the Medicare Advantage Plan remit, the submitter must adjust the Medicaid claim. The adjusted claim must report all adjustments from the remit, without modification, in the Coordination of Benefits 837 claim to Medicaid.

Providers who may need technical assistance complying with COB claims submission requirements should contact **eMedNYHIPAASupport@csc.com.**

The revised Medicaid Update will be issued prior to the end of December 2014.

Recommendation #3

Formally assess the 5,446 higher risk claims totaling $506,239 that we did not examine in detail. Determine if overpayments were made that warrant recovery.

Response #3

The OMIG's RAC will review the higher risk claims, and recover as appropriate.