NEW YORK
state department of
HEALTH

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

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Executive Deputy Commissioner

July 1, 2014

Mr. Brian Mason
Acting Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2012-S-133 entitled, "Medicaid Payments Made Pursuant to Medicare Part C."

Please feel free to contact James Clancy, Assistant Commissioner, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,

Howard Zucker M.D.

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

Enclosure

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2012-S-133 Entitled
Medicaid Payments Made Pursuant to Medicare Part C

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2012-S-133 entitled, "Medicaid Payments Made Pursuant to Medicare Part C."

Recommendation #1:

Formally re-evaluate the existing methodology for processing and paying claims for Medicare Part C cost-sharing liabilities. Include review of other states' policies in performing the evaluation.

Response #1:

The audit report indicates that the Medicaid Program may save as much as $22 million dollars annually if Medicare Part C claims for dually eligible individuals were subject to the same cost sharing limits that are applied to Medicare Part B claims. As stated in the audit report, the Department advised the auditors that there is a large variance in cost sharing structures in the variety of Medicare Part C plan benefits offered across the State. For example, many Medicare Part C Advantage plans do not pay providers a fee-for-service payment but instead pay on a capitated basis. It is not possible to apply cost sharing limits to capitated payments. If the provider is paid on a capitated basis, there may be a corresponding coinsurance or deductible that is being billed to Medicaid but no discrete fee-for-service payment made to the provider. It is unclear if OSC took this into account in their savings estimate. If not, the estimated annual savings may be grossly overestimated.

OSC identifies a mix of Medicare Part A and Part B services reimbursed by Part C Medicare Advantage and recommends that Medicaid apply applicable cost sharing limits to these services. OSC recommends a very simplistic approach - revise Social Services law authorizing the Department to apply cost sharing limits to medical services reimbursed by a Medicare Advantage Plan. A number of very important factors were not considered by OSC in their recommendation:

- There is no statutory authority at this time to impose cost sharing limits on Medicare Part A hospital inpatient services. It is probable that the Department could not impose cost sharing limits on inpatient services reimbursed by a Medicare Part C Advantage Plan unless there was also corresponding statutory authority to apply cost sharing limits on Medicare Part A hospital inpatient services.

- Social Services Law 367-a specifically prohibits Medicaid from applying cost sharing limits to both transportation and psychologist services. This prohibition may apply to transportation and psychologist services reimbursed by a Medicare Advantage Plan.

- Cost sharing limits for Medicare Part B practitioner services is limited to 20% of the Part B coinsurance amount, not the full Part B coinsurance amount. OSC appears to be recommending that Medicaid pay $0 coinsurance amounts for physician services paid by Medicare Advantage. The Department may not have the authority to limit all cost sharing, but may potentially have the authority to limit cost sharing to 20% of the coinsurance amount. OSC also appears to have calculated potential cost savings for practitioner and other Part B services based on Medicaid paying $0 coinsurance rather than 20% of the coinsurance amount as is now dictated by statute (though, as indicated above, this is not absolutely evident since OSC provided no details on how they calculated potential savings).

- Social Services Law 367-a specifically requires the Medicaid Program to pay all Medicare Part B deductible amounts. The OSC report does not differentiate between coinsurance and deductible amounts in their fiscal projections. Without further research, it is not known if cost savings could be applied to Medicare Part C deductible amounts. Projections that include deductibles may therefore overstate savings.

All of the above questions are policy related questions that would need to be fully researched, discussed, and vetted by both Department counsel as well as the Centers for Medicare and Medicaid Services (CMS). It is important to note that no overpayments or incorrect payments were identified by OSC in this finding. The Department has paid and will continue to pay in accordance with state statute and federal requirements. It also needs to be pointed out that payment policy remains under the purview of the Department as the single state agency in accordance with state and federal statute. OSC does not dictate Medicaid payment policy.

In summary, OSC is recommending a rather simplistic approach to an extremely complex Medicare/Medicaid payment construct.

Recommendation #2:

Recover the $70,594 in Medicaid overpayments from the six providers who misreported Medicare Part C cost-sharing data.

Response #2:

The Office of the Medicaid Inspector General (OMIG) is reviewing the overpayments identified, and will pursue recoveries where appropriate and as resources permit.

Recommendation #3:

As resources and priorities permit, review payments for high-risk Medicare Part C claims, such as those that exceed certain pre-determined dollar limits. Recover any overpayments that are identified.

Response #3:

The OMIG is reviewing the overpayments identified, and will pursue recoveries where appropriate and as resources permit.

Recommendation #4:

Review the $1,637,291 in overpayments for Medicare Part C cost-sharing liabilities that providers billed incorrectly and recover funds where appropriate.

Response #4:

The OMIG is reviewing the overpayments identified, and will pursue recoveries where appropriate and as resources permit.

Recommendation #5:

Review the 1,259 instances when Medicaid made a Medicare Part C cost-sharing payment and paid a Medicaid Advantage premium for the same recipient in the same month. As warranted, recover any overpayments identified.

Response #5:

OSC's audit did not determine which claims in each case were incorrect. As a result, the total potential Medicaid overpayments range from $92,000 (if all the cost-sharing payments were incorrect) to $589,000 (if all the premiums were incorrect). Additionally, the OMIG is wary of carve outs within this population, which would make the dual billing of Fee For Service by the provider, and premium by the Managed Care Organization appropriate. Due to the difficulty in defining where the overpayments might reside for each claim, the OMIG has not formalized a recovery project, but will continue to evaluate these claims and pursue recoveries where appropriate.

Recommendation #6:

Assess eMedNY functionality that allows concurrent payments for Medicaid Advantage premiums and Medicare cost-sharing liabilities on behalf of the same recipient and correct the eMedNY system as necessary.

Response #6:

The Department has reviewed the claims in question and is in the process of composing a list of recommendations to be reviewed for Medicaid Advantage plans to prevent the duplication of payments for services. In addition, system edits that need to be implemented to prevent concurrent payments will be formulated.