NEW YORK
STATE OF
OPPORTUNITY.

Department of Health

ANDREW M. CUOMO
Governor

HOWARD A. ZUCKER, M.D., J.D.
Commissioner

SALLY DRESLIN, M.S., R.N.
Executive Deputy Commissioner

January 5, 2017

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

Dear Ms. Inman:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's Follow-Up Audit Report 2016-F-18 entitled, "Medicaid Overpayments for Certain Medicare Part C Claims." (2012-S-35)

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Jason A. Helgerson
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Department of Health
Comments on the
Office of the State Comptroller's
Follow-Up Audit Report 2016-F-18 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) Follow-Up Audit Report 2016-F-18 entitled, "Medicaid Overpayments for Certain Medicare Part C Claims."

Background

New York State (NYS) is a national leader in its oversight of the Medicaid Program. The Office of the Medicaid Inspector General (OMIG) conducts on-going audits of the Medicaid program and managed care plans. The Department and OMIG will continue to focus on achieving improvements to the Medicaid program and aggressively fighting fraud, waste and abuse.

Under Governor Cuomo's leadership, the Medicaid Redesign Team (MRT) was created in 2011 to lower health care costs and improve quality of 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 1,475,319 fragile and low income New Yorkers. Additionally, Medicaid spending per recipient decreased to $8,305 in 2015, consistent with levels from a decade ago.

Recommendation #1

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

Status – Partially Implemented

Agency Action – The OMIG investigates and recovers improper Medicaid payments on behalf of the Department. The OMIG's Recovery Audit Contractor (RAC) reviewed the overpayments we identified and recovered $11,390. According to OMIG officials, the RAC sent letters to providers seeking recovery of another $20,403. However, during our follow-up review, the OMIG could not provide evidence to support that letters were sent to providers to recover these overpayments or that the recoveries were made. Further, OMIG officials stated the remaining $6,544 in overpayments were adjusted, voided, or determined appropriate. However, the OMIG was unable to identify the claims that were adjusted, voided, or determined to have been paid appropriately.

Response #1

OMIG's Recovery Audit Contractor (RAC) sent letters to providers seeking recovery.

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.

Status – Implemented

Agency Action – In the December 2014 edition of the *Medicaid Update* (the Department's official publication for Medicaid providers), the Department issued billing guidance and instructed all Medicaid providers to bill Medicare Part C claims in accordance with existing requirements to ensure Medicaid claims are accurately billed. Moreover, providers were reminded that when primary payers make claim adjustments, they must make the appropriate corresponding Medicaid claim adjustments.

Response #2

The Department confirms our agreement with this report.

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.

Status – Partially Implemented

Agency Action – Our initial audit identified 5,446 claims that had unreasonably high patient cost-sharing amounts or indicated United Healthcare did not cover the service. The OMIG's RAC reviewed the high-risk claims and determined 1,292 were questionable. According to the OMIG, the RAC recovered $10,258, sent letters to providers seeking another $52,448 in recoveries, and determined the remaining claims were paid appropriately upon review of documentation sent by providers. However, the OMIG was unable to provide auditors with any evidence demonstrating letters were sent to providers requesting additional recoveries of $52,448 or that the recoveries were made, or a listing of which claims were determined to have been paid appropriately.

Response #3

In addition to the $10,258 OMIG previously indicated was recovered, OMIG's RAC validated an additional 57 claims totaling $8,000 had been paid appropriately after a review of documentation submitted from the providers.