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STATE OF NEW YORK
**OFFICE OF THE STATE COMPTROLLER**

December 8, 2016

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 2016-F-18

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 have followed up on the actions taken by officials of the Department of Health to implement the recommendations contained in our audit report, *Medicaid Overpayments for Certain Medicare Part C Claims* (Report 2013-S-35).

**Background, Scope, and Objectives**

The Department of Health (Department) administers the State's Medicaid program, which provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health insurance program for the elderly and disabled. Such recipients are commonly referred to as "dual-eligible." In 1997, Congress established Medicare Part C, also known as Medicare managed care or Medicare Advantage. Under Medicare Part C, private managed care 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 health care providers that they reimburse directly for services provided to enrollees. For dual-eligible persons, plan providers bill Medicaid directly for the enrollee's Part C cost-sharing liabilities (deductibles, coinsurance, and copayments). 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's Medicare Advantage plan: UnitedHealthcare Dual Complete.

We issued our initial audit report on January 16, 2015. The audit objective was to identify Medicaid Part C claim overpayments made to medical providers for services rendered to Medicaid

recipients enrolled in UnitedHealthcare Dual Complete (NYC only; carrier code H3387). The audit covered the period September 1, 2008 through August 31, 2013. Our initial audit identified 5,571 Medicare Part C claims that either had unreasonably high patient cost-sharing amounts or indicated UnitedHealthcare did not cover the service. We reviewed 125 Medicaid claims totaling $151,069 and found Medicaid overpaid 54 claims (43.2 percent) by $61,711. Most overpayments occurred because the providers billed claims with incorrect Medicare Part C coinsurance, copayments, or deductibles.

Of the 26 providers that billed the overpaid claims, ten adjusted and re-submitted their claims to eMedNY, resulting in Medicaid repayments of $23,374. We recommended the Department review and recover the remaining overpayments of $38,337 ($61,711 - $23,374) and instruct providers to bill Medicare Part C claims in accordance with the existing requirements. Additionally, our audit recommended the Department assess the propriety of the remaining 5,446 high-risk claims (5,571 - 125) totaling $506,239 that we did not examine in detail, and make recoveries where warranted.

The objective of our follow-up was to assess the extent of implementation, as of October 21, 2016, of the three recommendations included in our initial audit report.

**Summary Conclusions and Status of Audit Recommendations**

Department officials made progress in implementing the recommendations we made in our initial audit, which included recovering $21,648 in overpayments and instructing providers to bill Medicare Part C claims in accordance with the existing requirements. Of the initial report's three audit recommendations, one was implemented and two were partially implemented.

**Follow-Up Observations**

**Recommendation 1**

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

Status – Partially Implemented

Agency Action – The Office of the Medicaid Inspector General (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.

**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.

**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 UnitedHealthcare 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.

Major contributors to this report were Christopher Morris, Theresa Podagrosi, and Natesha Salmon.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issues discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Warren Fitzgerald
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General