New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Medicaid Overpayments for Medicare Advantage Plan Services

Medicaid Program
Department of Health

Report 2017-S-46 December 2018

Executive Summary

Purpose

To determine if the Department of Health overpaid health care providers' Medicaid claims for services also covered by Medicare Advantage plans. The audit covered the period from January 1, 2013 to July 31, 2017.

Background

Many Medicaid recipients are also enrolled in 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 (referred to as Medicare Advantage plans) tailored to the specific needs of Medicare beneficiaries. Some Medicare Advantage plans (Plans) also offer supplemental insurance benefits for services that are not covered by original Medicare (e.g., dental services). Plans reimburse health care providers for services provided to enrollees. Generally, Medicaid is the secondary payer, and covers any financial balances that are not covered by the Plans (typically deductibles and coinsurance).

If Plans deny a claim or pay a different amount than what a provider billed, Plans must communicate the reasons why to providers on the Explanation of Benefits (EOB) using Claim Adjustment Reason Codes (CARCs). Providers submit claims for unpaid amounts to Medicaid through eMedNY, the Department of Health's (Department) automated claims processing and payment system. When submitting claims, providers are required to include the Plan-reported CARCs. The eMedNY system uses the CARCs to determine whether a billed service is eligible for payment as well as the correct payment amount.

Key Findings

During the audit period, January 1, 2013 through July 31, 2017, Medicaid was the primary payer on 92,296 claims totaling almost $12.8 million for services typically covered by a recipient's Plan. We sampled 266 such claims (totaling $220,661 in Medicaid payments) to determine the appropriateness of the payments. Among our findings:

- For 187 claims (70 percent of the 266 claims), the provider either never billed the Plan for the services, incorrectly indicated a Plan payment of zero on its Medicaid claim, or did not follow the Plan's billing guidelines. Medicaid paid $183,019 on these claims, while its actual obligation amounted to only $5,484 – a difference of $177,535. During the audit, certain providers acknowledged receiving overpayments and repaid Medicaid $25,300, leaving $152,235 to be recovered.
- The Department does not enforce the CARC requirement on claims. Of 108 claims for which we obtained EOBs from providers, 98 claims were submitted to eMedNY without a CARC and 5 were submitted with an incorrect CARC. Without the appropriate CARC, eMedNY is at risk of improperly adjudicating – and overpaying – claims.

Key Recommendations

- Review and recover the remaining overpayments totaling $152,235, as appropriate.
- Formally assess the 92,030 higher-risk claims totaling almost $12.6 million and recover overpayments as warranted. Ensure prompt attention is paid to those providers that received the largest dollar amounts of payments.
- Develop a process to monitor whether providers are reporting CARCs appropriately.

Other Related Audits/Reports of Interest

Department of Health: Overpayments for Medicare Part C Coinsurance Charges (2011-S-33)
Department of Health: Medicaid Overpayments for Certain Medicare Part C Claims (2013-S-35)

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 11, 2018

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

Dear Dr. Zucker:

The Office of the State Comptroller is committed to helping State agencies, public authorities, and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities, and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Medicaid Program entitled *Medicaid Overpayments for Medicare Advantage Plan Services*. The audit was performed 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.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

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State Government Accountability Contact Information:
Audit Director: Andrea Inman
Phone: (518) 474-3271
Email: StateGovernmentAccountability@osc.ny.gov
Address:
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

Background

The Medicaid program is a federal, state, and locally funded program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The Department of Health (Department) administers the Medicaid program in New York State. For the State fiscal year ended March 31, 2018, New York's Medicaid program had approximately 7.3 million recipients and Medicaid claim costs totaled about $62.9 billion. The federal government funded about 55.7 percent of New York's Medicaid claim costs, and the State and the localities (City of New York and counties) funded the remaining 44.3 percent.

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-eligibles." Generally, Medicare is the primary payer for medical services provided to dual-eligible recipients. After Medicare adjudicates a claim, claims are transferred to Medicaid via the automated Medicare crossover system. Medicaid then pays the balance that is not covered by Medicare and that would otherwise be the financial obligation (typically a coinsurance or deductible) of the recipient.

The Medicare program has multiple parts. Medicare Part A provides hospital insurance, including inpatient care; and Medicare Part B provides medical insurance for doctors' services and outpatient care. In 1997, Congress established Medicare Part C, also known as Medicare managed care or Medicare Advantage. Under Medicare Part C, private companies administer Medicare benefits by offering different health care plans (referred to as Medicare Advantage plans) tailored to the specific needs of Medicare enrollees. Medicare Advantage plans (Plans) must include all Medicare-covered services traditionally provided under Parts A and B. Plans may also offer supplemental insurance benefits for services that are not covered by original Medicare (e.g., dental services).

Plans typically have networks of participating health care providers, which are reimbursed for services based on claims they submit to Plans. In certain circumstances, such as when a service was rendered by an out-of-network provider, Plans may deny a claim or pay a different amount than what was billed by the provider. In these scenarios, Plans must communicate the reason for an adjustment in payment to the provider on the Explanation of Benefits (EOB) using universal Claim Adjustment Reason Codes (CARCs). According to federal and State regulations, Medicaid is the payer of last resort. As such, certain claims for services that are not covered by a recipient's Plan can be submitted to eMedNY, the Department's automated claims processing system, for payment by Medicaid. These claims are not transferred to eMedNY via the automated Medicare crossover system. Rather, in submitting such claims to eMedNY, providers are required to self-report the CARCs as well as the group codes (which further describe adjustment amounts) from the EOB. The CARCs and group codes are essential for eMedNY to determine whether a billed service is eligible for payment as well as the correct payment amount.

Typically, when Plans deny a claim, Medicaid will pay the standard Medicaid fee for the service. However, there are circumstances where Medicaid can deny payment as well – for example, when providers fail to comply with all Medicare or other third-party billing requirements, as required by State regulations.

Audit Findings and Recommendations

Despite being the payer of last resort pursuant to federal and State regulations, we found that, during the period January 1, 2013 through July 31, 2017, Medicaid was the primary payer on 92,296 claims totaling almost $12.8 million for services typically covered by a Plan. Our high-risk analysis of a sample of these claims revealed a number of scenarios that allowed overpayments to occur:

- Providers did not always bill the Plan as the primary payer before billing Medicaid, as required.
- Providers inaccurately reported Plan payment information on their claims submitted to eMedNY.
- Providers submitted claims without CARCs or with incorrect CARCs, preventing eMedNY from verifying the appropriateness of the claim and the payment amount.

Specifically, in our sample of 266 claims (totaling $220,661), we found:

- For 187 claims (70 percent), the provider either never first billed the Plan for the services, incorrectly indicated a Plan payment of zero on its Medicaid claim, or did not follow the Plan's billing guidelines. Medicaid paid $183,019 on these claims, while its actual obligation amounted to only $5,484, resulting in an overpayment of $177,535.
- Of 108 claims for which providers did supply an EOB, 103 were submitted to eMedNY without the appropriate CARC. Without the appropriate CARC, eMedNY is at risk of improperly adjudicating claims.

We found the Department has not established adequate controls to help identify these types of improper claims. Instead, Department officials rely on providers to enter complete and accurate information when submitting claims to Medicaid – rendering Medicaid funds vulnerable to mispayment.

Using a risk-based analysis, the Department should review the remaining 92,030 claims, totaling almost $12.6 million in questionable payments, to assess the appropriateness of the Medicaid payments. A risk-based analysis would involve giving prompt attention to those providers that received the largest dollar amounts, and recovering overpayments where appropriate.

Improper Medicaid Payments for Medicare-Covered Services

Plans are required to cover all Medicare-covered services. Therefore, generally such claims should not be submitted to Medicaid with a Plan payment of zero. If, for example, a provider submits a claim to Medicaid and incorrectly reports that a Plan paid zero dollars for a Medicare-covered service, eMedNY might pay a higher amount than required as the (now-designated) primary payer on the claim. During our audit period, Medicaid made about $8.1 million in payments to providers on behalf of Plan recipients for Medicare-covered services where the providers reported a Plan

payment of zero (see Table 1). The payments were made to 3,341 providers for 55,786 claims.[1] Notably, 1 percent of the providers (35 of 3,341) account for 55 percent (or $4.4 million) of the total amount paid.

Table 1 – Plan Payment of Zero Reported for Medicare-Covered Services

Payment Range	Number of Providers	Total Payments	Percent of Total Payments
> $200,000	5	$1,825,486	23%
$100,000 – 200,000	9	1,136,448	14%
$50,000 – 100,000	21	1,434,872	18%
< $50,000	3,306	3,658,939	45%
Totals	**3,341**	**$8,055,745**	**100%**

To verify whether payments were improper, we judgmentally selected a sample of 132 claims, totaling $158,362, billed by 18 of the highest-paid providers. Based on our review, we determined 111 of the 132 claims were billed to Medicaid incorrectly, resulting in overpayments totaling $129,307 (or 82 percent of the $158,362 tested). The overpayments occurred under several scenarios:

- For 71 claims, totaling $86,905, providers did not provide adequate supporting documentation, such as EOBs, to support the claims.
- For 31 claims, totaling $44,922, the providers reported a Plan payment of zero, but the Plans had, in fact, reimbursed the providers for at least part of the services, resulting in overpayments of $39,884. For example, Medicaid paid one provider $2,291 for a Plan recipient's surgery. Although the provider reported a Plan payment of zero, the EOB indicated the Plan paid $545; thus, Medicaid was responsible for only $116 in coinsurance. As a result, Medicaid overpaid this provider $2,175.
- Another eight claims, totaling $2,318, were denied by Plans because the providers did not follow the Plans' billing guidelines (e.g., did not obtain prior authorization, did not bill timely) and, as such, should have also been denied by Medicaid.
- One claim for $200 was denied by a Plan because the services should have been billed to Medicare, the primary payer (because of the type of service rendered, the provider should have billed Medicare Part A). The provider instead billed Medicaid.

During the audit, five providers acknowledged receiving overpayments and voided or adjusted 20 claims submitted to eMedNY, resulting in repayments to Medicaid of $25,300. The Department needs to review and recover, as appropriate, $104,007 in overpayments resulting from the remaining 91 claims.

In response to our findings, Department officials stated they rely on providers to enter complete and accurate information when submitting claims to Medicaid. The Department does not have a process in place to identify improper claims and prevent overpayments. We question this approach when the Department is fully aware of the inevitable risk of overpayment of Medicaid dollars: In

1 These totals are net of 21 claims in our sample of 132 claims that we found were not overpaid.

the Department's 2014 *Medicaid Update,*[2] it cites "persistent misreporting" on Medicaid claims by providers for services that were, in fact, covered by a Plan. We encourage the Department to develop and routinely undertake risk-based activities, utilizing key high-risk indicators to identify improper claims for services that are covered by Plans and prevent or recover overpayments.

The Department should formally assess the 55,675 higher-risk claims (see footnote 1), totaling $7.9 million, that we did not examine in detail and recover overpayments as warranted.

Improper Medicaid Payments for Supplemental Dental Insurance

As mentioned, Plans may offer supplemental insurance benefits for services that are not covered by original Medicare. We conducted a high-risk assessment to identify Medicaid overpayments for supplemental dental insurance claims. (Because Plans may not cover services rendered by out-of-network providers and claims that are denied for this reason can then be submitted to Medicaid for payment, we excluded dental services provided by all known out-of-network providers from this analysis.)

Our high-risk assessment identified 36,431 claims[3] totaling about $4.7 million in Medicaid payments to providers for dental services provided to recipients enrolled in a Plan that offered supplemental dental coverage. The payments were made to 1,482 providers for 36,431 claims where the provider reported a Plan payment amount of zero (see Table 2). Notably, 1 percent of the providers (11 of 1,482) account for 40 percent (or $1.9 million) of the total amount paid.

Table 2 – Plan Payment of Zero Reported for Supplemental Services

Payment Range	Number of Providers	Total Payments	Percent of Total Payments
> $200,000	3	$1,107,299	24%
$100,000 – 200,000	3	387,993	8%
$50,000 – 100,000	5	361,439	8%
< $50,000	1,471	2,826,983	60%
Totals	**1,482**	**$4,683,714**	**100%**

To test the appropriateness of the Medicaid payments we identified, we judgmentally selected 18 of the highest-paid dental providers in our risk population, and for a sample of 134 of their claims totaling $62,299, we requested supporting documentation (e.g., EOBs) that the claim had been denied by the primary payer. Based on our review, we determined Medicaid overpaid 76 claims by $48,228 (or 77 percent of the $62,299 tested). The overpayments occurred under the following scenarios:

2 Department of Health. (2014, December). Providers urged to submit correct coordination of benefits (COB) Information to Medicaid for Medicare Advantage (Part C) recipients. New York State Medicaid Update 30(12). Retrieved from https://www.health.ny.gov/health_care/medicaid/program/update/2014/2014-12.htm#urg.

3 These totals are net of 58 claims in our sample of 134 claims that we found were not overpaid.

- For 75 claims, accounting for overpayments totaling $47,554, the providers never billed the primary payer first for the services, as required, and reported a Plan payment of zero on each claim. Nine providers, accounting for 66 of the 75 claims, stated they were unaware the Plans offered supplemental insurance.
- For one claim, totaling $1,120, the provider reported a Plan payment of zero to Medicaid but had, in fact, received partial reimbursement. Based on the provider's EOB, Medicaid was responsible for only $446 for the claim, resulting in an overpayment of $674.

The Department needs to review and recover, as appropriate, the $48,228 in overpayments we identified. Further, the Department should formally assess the 36,355 higher-risk claims (see footnote 3), totaling $4.6 million, that we did not examine in detail and recover overpayments as warranted.

Missing or Inaccurate Claim Adjustment Reason Codes

Medicare and other insurance providers use universal CARCs to inform medical providers why a claim was denied or paid differently than originally billed. As Medicaid is the payer of last resort, when providers submit claims to eMedNY for denied or unpaid amounts, they are required to include the Plan-reported CARC. CARCs are a critical tool to help eMedNY determine whether the claim is eligible for payment and the correct payment amount. We found, however, that the Department does not enforce the CARC requirement, and has made payments for claims where the CARC was missing or inaccurate.

Of the 266 sampled claims (132 claims + 134 claims) where a provider reported that the Plan had paid zero, we obtained EOBs from providers for 108 claims. Of these 108 claims, we determined 103 (95 percent) did not have the proper CARC codes:

- For 98 Medicaid claims (91 percent), the providers did not report a CARC code, as required.
- On 5 Medicaid claims, the providers submitted a different CARC than what was reported on the EOB.

As mentioned, the Department relies on providers to enter complete and accurate information when submitting claims to Medicaid. Without a proactive means to monitor claims for missing or inaccurate CARCS, however, the Department has no assurance that such claims are, in fact, eligible for payment by Medicaid and that the payment amount is accurate.

Recommendations

1. Remind providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid. Ensure attention is paid to dental providers.

2. Review the overpayments of $152,235 ($104,007 + $48,228) we identified that have not been adjusted by providers and recover as appropriate.

3. Using a risk-based approach, assess the remaining 92,030 (55,675 + 36,355) highly questionable claims totaling almost $12.6 million, and recover overpayments as warranted. Ensure prompt attention is paid to those providers that received the largest dollar amounts of questionable payments.

4. Develop and implement formal procedures for identifying and analyzing high-risk claims for services that are covered by Plans, including those that offer supplemental dental benefits.

5. Develop a process to monitor whether providers are reporting CARCs appropriately.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department overpaid health care providers' Medicaid claims for services also covered by Plans. The audit covered the period from January 1, 2013 through July 31, 2017.

To accomplish our objective and assess relevant internal controls, we interviewed officials from the Department, examined the Department's relevant Medicaid policies and procedures, and reviewed applicable federal and State laws, rules, and regulations. We used the Medicaid Data Warehouse and the eMedNY claims processing system to identify claims for services typically covered by Medicare. To identify services covered by Medicare, we reviewed claims for services paid through the automated Medicaid/Medicare crossover system; analyzed Medicaid claims for services covered by Plans; and researched the Centers for Medicare & Medicaid Services website. To review dental claims, we identified recipients enrolled in Plans that offered supplemental dental services administered by the four largest Dental Benefit Administrators. We also reviewed the highest-paid dental providers to determine if they were in-network and we removed all providers known to be out-of-network. We selected judgmental samples of 132 and 134 claims totaling $220,661 in payments, based on the highest-paid providers for claims for services that would be covered by the recipients' Plans but for which the provider reported the Plan paid zero. We analyzed paid Medicaid claims and reviewed medical records supporting provider claims for reimbursement. Additionally, we shared our methodology and provided data and findings to the Department and the Office of the Medicaid Inspector General officials during the audit for their review.

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 to

certain boards, commissions, and public authorities, some of whom have minority voting rights. 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.

Authority

The audit was performed 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.

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 the report. In their response, Department officials concurred with the audit recommendations and indicated the actions that 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.

Contributors to This Report

Andrea Inman, Audit Director
Christopher Morris, Audit Manager
Theresa Podagrosi, CGAP, Audit Supervisor
Joseph Paduano, CFE, Examiner-in-Charge
Timothy Garabedian, MPA, Senior Examiner
Mary McCoy, Supervising Editor

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.ny.gov

Tina Kim, Deputy Comptroller
518-473-3596, tkim@osc.ny.gov

Ken Shulman, Assistant Comptroller
518-473-0324, kshulman@osc.ny.gov

Vision

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Agency Comments

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

November 14, 2018

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 Draft Audit Report 2017-S-46 entitled, "Medicaid Overpayments for Medicare Advantage Plan Services."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
Donna Frescatore
Dennis Rosen
Erin Ives
Brian Kiernan
Timothy Brown
Elizabeth Misa
Geza Hrazdina
Daniel Duffy
Jeffrey Hammond
Jill Montag
Ryan Cox
James Dematteo
James Cataldo
Diane Christensen
Lori Conway
OHIP Audit SM

Empire State Plaza, Corning Tower, Albany, NY 12237 | health.ny.gov

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2017-S-46 entitled, Medicaid Overpayments for Medicare Advantage Plan Services

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2017-S-46 entitled, "Medicaid Overpayments for Medicare Advantage Plan Services."

Recommendation #1

Remind providers of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid. Ensure attention is paid to dental providers.

Response #1

The Department of Health (Department) will remind all dental providers in a Medicaid Update of their obligation to bill all applicable third parties that may be liable for a claim before billing Medicaid.

Recommendation #2

Review the overpayments of $152,235 ($104,007 + $48,228) we identified that have not been adjusted by providers and recover as appropriate.

Response #2

The Office of the Medicaid Inspector General (OMIG) will review the identified overpayments, and determine an appropriate course of action.

Recommendation #3

Using a risk-based approach, assess the remaining 92,030 (55,675 + 36,355) highly questionable claims totaling almost $12.6 million, and recover overpayments as warranted. Ensure prompt attention is paid to those providers that received the largest dollar amounts of questionable payments.

Response #3

OMIG will review the identified claims, and determine an appropriate course of action.

Recommendation #4

Develop and implement formal procedures for identifying and analyzing high-risk claims for services that are covered by Plans, including those that offer supplemental dental benefits.

Response #4

The Department will collaborate with OMIG to determine an appropriate course of action.

Recommendation #5

Develop a process to monitor whether providers are reporting CARCs appropriately.

Response #5

The Department will collaborate with OMIG to determine an appropriate course of action.