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**OFFICE OF THE STATE COMPTROLLER**

July 1, 2020

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

Re: Medicaid Overpayments for Medicare Advantage Plan Services
Report 2020-F-2

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 Medicare Advantage Plan Services* (Report 2017-S-46).

**Background, Scope, and Objective**

The Department of Health (Department) administers the State's Medicaid program. Many Medicaid recipients are also enrolled in Medicare Part C, commonly referred to as Medicare Managed Care or Medicare Advantage. Under Part C, managed care companies administer Medicare benefits and offer different health care plans (referred to as Medicare Advantage plans [Plans]) to meet the specific needs of Medicare enrollees. When a health care service is covered by a Medicaid recipient's Plan, Medicaid is generally the secondary payer and reimburses providers for any financial balances not covered by the Plan (typically deductibles and coinsurance).

We issued our initial audit report on December 11, 2018. The audit objective was to determine if the Department overpaid health care providers' Medicaid claims for services covered by Plans. The audit covered the period January 1, 2013 to July 31, 2017. During this period, we found Medicaid was the primary payer on 92,296 claims totaling nearly $12.8 million for services typically covered by a recipient's Plan. Of 266 sampled claims totaling $220,661, we found the Department made improper payments on 187 claims (70 percent). The inappropriate payments occurred because the Department failed to establish adequate controls to identify these types of improper claims and did not enforce providers' use of Claim Adjustment Reason Codes (CARCs) on claims that indicate when Plans deny a claim or pay an amount different than the amount billed by a provider.

The objective of our follow-up was to assess the extent of implementation, as of April 2, 2020, of the five recommendations included in our initial audit report.

## Summary Conclusions and Status of Audit Recommendations

Department officials made some progress in addressing the problems identified in the initial audit report; however, additional action is needed. In particular, the Office of the Medicaid Inspector General (OMIG) had yet to recover the overpayments identified in the audit sample or recover overpayments, as warranted, for nearly $11 million of the $12.6 million in claims where Medicaid was the primary payer for services typically covered by Plans. Of the initial report's five audit recommendations, one was implemented, three were partially implemented, and one had not yet been implemented.

## Follow-Up Observations

### 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.*

Status – Implemented

Agency Action – In the September 2018 edition of the *Medicaid Update* (the Department's official publication for Medicaid providers), providers were reminded of their responsibility to bill any applicable third parties prior to billing Medicaid, and to retain evidence of denial of payment from third-party payers. In the December 2018 edition, dental providers were reminded of their responsibility to bill the Plans, or the Plan's Dental Benefit Administrators, for dental services on behalf of dual-eligible recipients covered by a Plan offering supplemental dental insurance.

### 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.*

Status – Not Implemented

Agency Action – In the initial audit, we sampled 266 claims totaling $220,661 in two groupings, as follows. We sampled 132 claims totaling $158,362 that were billed by 18 of the highest-paid (non-dental) providers and, based on our testing, determined 111 of the claims were overpaid by $129,307. Five of the providers acknowledged receiving overpayments and repaid 20 claims totaling $25,300, leaving $104,007 for recovery. We also sampled 134 claims totaling $62,299 billed by 18 of the highest-paid dental providers, and determined 76 of the claims were overpaid by $48,228.

OMIG investigates and recovers improper Medicaid payments on behalf of the Department. As of April 2, 2020, OMIG had provided no evidence of its review or recovery of these claims. We estimate that OMIG may not be able to recover $23,566 in inappropriate payments due to regulatory lookback restrictions. We encourage OMIG to take prompt action to recover the inappropriate payments and prevent additional loss of recoveries due to lookback restrictions.

## 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.*

Status – Partially Implemented

Agency Action – As stated previously, the initial audit found Medicaid was the primary payer on 92,296 claims that totaled nearly $12.8 million for services typically covered by recipients' Plans. We sampled 266 of the claims totaling $220,661 (see Recommendation 2, Agency Action), leaving 92,030 claims totaling almost $12.6 million for review. As of March 27, 2020, OMIG had recovered $1.7 million of the identified claims, leaving about $10.9 million in unrecovered claims. Due to regulatory lookback restrictions, however, we estimate that OMIG may have lost the opportunity to recover almost $2.1 million of these payments. We encourage OMIG to take prompt action on the remaining $8.8 million in payments to prevent further loss of recoveries.

## 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.*

Status – Partially Implemented

Agency Action – According to OMIG officials, in July 2016, OMIG's recovery contractor (Health Management Systems [HMS]), began a project to identify and pursue recovery on claims specific to Part C, including those Plans with supplemental dental coverage. We note that, in addition to our audit findings, as early as 2014, the Department identified persistent misreporting on claims for services covered by Plans. However, as of April 2, 2020, HMS had identified only 5,163 claims that may have been overpaid and, while HMS' ongoing project represents some progress, there is still a significant amount of work remaining. We strongly encourage the Department and OMIG to bolster efforts to identify and recover overpayments for Part C services incorrectly billed to Medicaid.

## Recommendation 5

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

Status – Partially Implemented

Agency Action – The Department has made progress in monitoring some areas of provider CARC usage. In October 2019, a new claims processing edit was implemented to flag certain zero-fill claims. Zero-fill claims (claims indicating no third-party payment was made) generally require CARCs, which provide evidence of payment denial or adjustment by third-party payers, to help Medicaid determine the correct payment amount. Issues found with the edit's functionality were not resolved until January 22, 2020, and the Department did not begin requesting supporting claim documentation from providers until March 5, 2020. Our testing of this edit as of March 4, 2020 revealed over $803,000 in additional questionable claim payments.

While the Department has taken positive steps in the development and implementation of this edit to identify claims with missing CARCs, the edit does not address claims submitted with inappropriate CARCs. Department officials acknowledge the potential for overpayment due to incorrect CARC reporting, but question the feasibility of detecting misreported CARCs, short of manual review of each claim. While we agree with the difficulty of addressing this issue, one of the criterion developed in the October edit allows the Department to flag claims containing selected CARCs for review, but, at the time of our follow-up review, this particular edit functionality was disabled. We recommend the Department develop a process to help identify inappropriately reported CARCs.

Major contributors to this report were Laurie Burns, Tim Garabedian, and Emily Schwartz.

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: Mr. Thomas McCann, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General