



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

Division of State Government Accountability

# Overpayments for Medicare Part C Coinsurance Charges

## Medicaid Program Department of Health



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# Executive Summary

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## Purpose

To identify Medicaid overpayments made to medical providers for services rendered to recipients enrolled in a Healthfirst Medicare Advantage Plan. The audit covers the period July 1, 2006 through September 30, 2011.

## Background

Medicare Advantage Plans, also known as Medicare Part C (or Medicare Managed Care), are health plan options available to Medicare enrollees. Persons who join a Medicare Advantage Plan receive their Medicare benefits through a health plan, which has networks of participating providers that the plan reimburses directly. Medicare Advantage Plan enrollees may be responsible for cost-sharing liabilities such as deductibles and coinsurance. However, these liabilities may be paid by Medicaid if the individual is also enrolled in Medicaid. When this occurs, plan providers bill Medicaid directly for enrollees' cost-sharing liabilities.

Healthfirst is one of the largest Medicare Advantage organizations in New York, offering individuals different health care options under several Medicare Advantage Plans. During the audit period, Medicaid paid about 64,000 Medicaid claims (totaling \$5.6 million) for clinic services provided to persons enrolled in a Healthfirst Medicare Advantage Plan.

## Key Findings

- Healthfirst misreported the cost-sharing liabilities of Medicaid recipients to some of its healthcare providers. As a result, 14 providers billed excessive amounts of coinsurance on 497 Medicaid claims for clinic services. Because of the excessive claims, Medicaid made overpayments totaling \$699,258 to the providers. Healthfirst has taken actions to prevent further errant claims and overpayments.
- As a result of our audit, plan providers submitted claim adjustments to reimburse Medicaid for some of the overpayments we identified. At the time our audit fieldwork was completed, providers submitted adjustments for 126 (of the 497) errant claims, and Medicaid had recovered \$195,835.

## Key Recommendation

- Review the remaining 371 errant claims and the related \$503,423 in Medicaid overpayments identified in this report and recover funds where appropriate.

## Other Related Audits/Reports of Interest

[Department of Health: Medicaid Payments to Selected Providers for Services to Recipients with Medicare Part C Coverage \(2010-S-22\)](#)

**State of New York**  
**Office of the State Comptroller**

**Division of State Government Accountability**

September 26, 2012

Nirav R. Shah, M.D., M.P.H.  
Commissioner  
Department of Health  
Corning Office Building  
Empire State Plaza  
Albany, New York 12237

Dear Dr. Shah:

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 *Overpayments for Medicare Part C Coinsurance Charges*. This audit was performed pursuant to the State Comptroller's authority under 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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This report is also available on our website at: [www.osc.state.ny.us](http://www.osc.state.ny.us)

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## Background

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The New York State Department of Health (Department) is responsible for administering the State's Medicaid program. Medicaid 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. For the fiscal year ended March 31, 2011, New York's Medicaid program had more than five million enrollees and costs approximately \$53 billion. The federal government funds about 49 percent of Medicaid costs; the State funds 34.4 percent; and the localities (the City of New York and counties) fund the remaining 16.6 percent.

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal healthcare program for people 65 years of age and older and people under 65 years old with certain disabilities. For people who are enrolled in both Medicaid and Medicare, Medicaid pays the costs of Medicare deductibles and coinsurance. Medicare commonly pays 80 percent of the Medicare-approved amount for covered services and the remaining 20 percent is coinsurance owed by Medicaid. Medicaid payments are made through eMedNY, the Department's computerized claims and payment processing system.

The Medicare program has multiple parts: Part A provides hospital insurance, including inpatient care; and Part B provides medical insurance for doctors' services and outpatient care. In 1997, Congress established Medicare Part C, also known as Medicare Advantage Plans or Medicare Managed Care. Under Medicare Part C, private companies administer Medicare benefits by offering different health care plans tailored to the specific needs of Medicare enrollees. Medicare Advantage Plans must include all traditional (Parts A and B) Medicare-approved services. Also, Medicare Advantage Plans may provide additional benefits, such as no coinsurance charges for certain services or reductions in other cost-sharing charges normally covered by Medicaid.

For enrollees in Medicare Part C, Medicare pays a fixed amount for each enrollee every month to companies offering Medicare Advantage Plans. Medicare Advantage Plans typically have networks of participating providers that they reimburse directly for services. For individuals who are also enrolled in Medicaid, plan providers bill Medicaid directly for the enrollee's cost-sharing liabilities.

Healthfirst is one of the largest Medicare Advantage organizations in New York, offering individuals different health care options under several Medicare Advantage Plans. During our audit period, eMedNY processed about 64,000 Medicaid claims (totaling \$5.6 million) for clinic services provided to persons enrolled in a Healthfirst Medicare Advantage Plan.

## Audit Findings and Recommendation

### Overpayments Result From Incorrect Data Distributed by Healthfirst

Medicaid made overpayments totaling \$699,258 on 497 clinic claims that were submitted by 14 providers participating in a Healthfirst Medicare Advantage Plan, as summarized in the following table:

Provider	Amount of Overpayments	Number of Overpaid Claims
Provider 1	\$266,682	196
Provider 2	\$212,103	131
Provider 3	\$125,525	95
Remaining 11 Providers	\$94,948	75
<b>Totals</b>	<b>\$699,258</b>	<b>497</b>

As the table shows, three providers accounted for 604,310 (or 86.4 percent) of the \$699,258 in overpayments we identified. The overpayments occurred because Healthfirst reported incorrect recipient cost-sharing data (for coinsurance) to its providers. Thereafter, the providers used the incorrect coinsurance data to bill Medicaid. Based on the results of our audit, Healthfirst has taken actions to ensure the cost-sharing data it distributes is accurate. This should help prevent similar excessive claims and overpayments from occurring in the future.

Medicaid pays Medicare Part C deductibles and coinsurance for Medicaid recipients enrolled in Medicare Advantage Plans. Healthfirst reports this cost-sharing information to their plan providers using electronic files. Providers then bill Medicaid for any deductible or coinsurance amounts indicated by the files. However, we found that the electronic files often used the difference between a provider's submitted charges and the plan's negotiated fee as the amount of a recipient's coinsurance (instead of the proper coinsurance amount). We shared our observation with Department officials, and they confirmed the information Healthfirst distributed to its providers was incorrect.

We determined that 476 (of the 497) errant clinic claims were paid in full by Healthfirst, and there were no deductibles or coinsurance to pay. Therefore, Medicaid should not have paid any of these claims. Generally, contracts between Medicare Advantage organizations and their participating providers specify the services covered and whether or not the enrollee is responsible for deductibles and coinsurance. Hence, plan providers should have known that the patients had no cost-sharing liabilities for many of the services in question - and the providers should not have billed Medicaid for them. The remaining 21 claims included amounts for coinsurance, but providers overstated those amounts when submitting the claims to Medicaid. Consequently, Medicaid overpaid the 21 claims.

We visited five of the providers who received the larger amounts of overpayments due to excessive coinsurance charges. At the providers, we reviewed claims' supporting documentation, and we matched that information with the corresponding electronic claims data to identify the

overpayments. We found, for example, that Medicaid overpaid a claim for ambulatory surgery by \$4,990. Further, we determined the provider used incorrect coinsurance data from Healthfirst to bill Medicaid. Because Healthfirst paid the full approved amount of the claim (\$440), there was no coinsurance for Medicaid to pay - and, therefore, Medicaid should not have made a payment for the service.

The providers we visited acknowledged the overpayments and submitted adjustments to eMedNY to reimburse Medicaid for some of the claims. At the time we completed our audit fieldwork, providers had adjusted 126 of the improper claims and reimbursed \$195,835 to Medicaid. Thus, the providers still need to take corrective actions on 371 (497 - 126) claims corresponding to overpayments totaling \$503,423 (\$699,258 - \$195,835).

## **Recommendation**

1. Review the remaining 371 claims and the related \$503,423 in Medicaid overpayments identified in this report that had not been corrected at the time our audit fieldwork was completed. Take actions to recover any remaining overpayments as appropriate.

## **Audit Scope and Methodology**

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The objective of our audit was to identify Medicaid overpayments for services rendered to Medicaid recipients enrolled in a Healthfirst Medicare Advantage Plan. Our audit tests and analysis were based on Medicaid payments for recipients' cost-sharing responsibilities related to claims for clinic services. Medicaid paid these claims from July 1, 2006 through September 30, 2011. During this period, the Department's Medicaid claims processing system, eMedNY, adjudicated about 64,000 claims (totaling \$5.6 million) for recipients' portions of claims related to Healthfirst Medicare Advantage Plans.

To accomplish our objective, we interviewed officials from the Department and the Office of the Medicaid Inspector General. We also reviewed applicable sections of federal and State regulations, and examined the Department's relevant Medicaid policies and procedures. Additionally, we worked with officials from Healthfirst to identify participating providers at risk of billing incorrect Healthfirst cost-sharing information. Healthfirst provided claims data, which included cost-sharing responsibilities, for services provided by these facilities. We matched payment information in this file to related Medicaid claims paid by eMedNY to identify overpayments. Also, to assess the propriety of Medicaid payments, we identified five providers with high coinsurance charges on their Medicaid claims. We interviewed officials responsible for billing Medicaid at these facilities and also reviewed supporting documentation for claims.

We did 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 objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.



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

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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

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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 agreed with our recommendations. Specifically, officials noted that the Office of the Medicaid Inspector General had recovered \$490,000 of the \$503,423 in overpayments in question after our audit field work was completed.

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

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### Vision

A team of accountability experts respected for providing information that decision makers value.

### Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

# Agency Comments



Nirav R. Shah, M.D., M.P.H.  
Commissioner

Sue Kelly  
Executive Deputy Commissioner

August 27, 2012

Mr. Brian E. Mason  
Audit Director  
Office of the State Comptroller  
Division of State Government Accountability  
110 State Street - 11th Floor  
Albany, NY 12236-0001

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2011-S-33 on "Overpayments for Medicare Part C Coinsurance Charges."

Thank you for the opportunity to comment.

Sincerely,

 A handwritten signature in black ink, appearing to read "Robert W. LoCicero".
 

Robert W. LoCicero, Esq.  
Deputy Director for Administration

Enclosure

cc: Sue Kelly  
Michael Nazarko  
James C. Cox  
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**Department of Health  
Comments on the  
Office of the State Comptroller's  
Draft Audit Report 2011-S-33 on  
Overpayments for Medicare Part C Coinsurance Charges**

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The following are the Department of Health's comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2011-S-33 on "Overpayments for Medicare Part C Coinsurance Charges."

**Recommendation:**

Review the remaining 371 claims and the related \$503,423 in Medicaid overpayments identified in this report that had not been corrected at the time our audit fieldwork was completed. Take actions to recover any remaining overpayments as appropriate.

**Response:**

The Office of the Medicaid Inspector General has recovered \$490,000 in overpayments identified by OSC. The remaining overpayments are currently being reviewed.