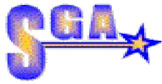
Office of the New York State Comptroller

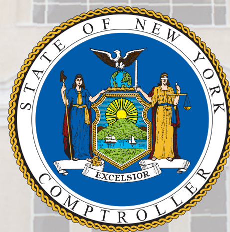


Division of State Government Accountability

New York State Department of Health

Medicaid Payments to Selected Providers for Services to Recipients with Medicare Part C Coverage

Report 2010-S-22



Thomas P. DiNapoli

This page is left intentionally blank.

Table of Contents

Page

Authority Letter 5

Executive Summary 7

Introduction 9
- Background 9
- Audit Scope and Methodology 10
- Authority 11
- Reporting Requirements 11
- Contributors to the Report 11

Audit Findings and Recommendations 13
- Overpayments to Selected Providers 13
- Recommendations 15

Agency Comments 17

State Comptroller's Comment 19

This page is left intentionally blank.

State of New York
Office of the State Comptroller

Division of State Government Accountability

December 23, 2010

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

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.

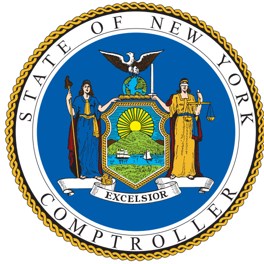
Following is a report of our audit of the Department of Health entitled *Medicaid Payments to Selected Providers for Services to Recipients with Medicare Part C Coverage.* This audit was done according to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article 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

This page is left intentionally blank.



State of New York
Office of the State Comptroller

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine if the Department of Health had established and implemented adequate controls over Medicaid payments made to selected providers for recipients who also have medical coverage under the Medicare Part C program.

Audit Results - Summary

Individuals who qualify for both Medicare and Medicaid are commonly referred to as "dual eligible." To receive payment, healthcare providers who render services to dual eligible recipients must bill Medicare prior to Medicaid, the payer of last resort. Generally, Medicaid is responsible for such recipients' monetary obligations, including coinsurance, co-payments and/or deductibles.

Medicare Part C is the segment of Medicare that allows private health insurance companies to administer Medicare benefits. The private health insurance plans, including health maintenance organizations and preferred provider organizations, are often referred to as Medicare Advantage plans. Providers who bill Medicaid for Part C recipients must process their Medicaid claims using Claim Filing Indicator Code 16. Between January 29, 2007 and March 31, 2010, Medicaid paid clinics and practitioners more than $16.5 million for claims processed under Code 16.

We reviewed 270 claims from four providers who received among the highest amounts of Code 16 payments. For three (of the four) providers, we found overpayments totaling about $758,000 for 221 of the claims we tested. This included overpayments totaling almost $645,000 to one particular provider. The overpayments to two other providers totaled about $107,000 and $5,500, respectively. There were no overpayments made to the remaining provider.

We found the providers often billed amounts in excess of recipients' monetary obligations. On one claim, for example, an Advantage plan paid a provider $1,478, and the recipient's obligation was only $164. However, instead of billing Medicaid for the $164, the provider billed for the difference between its submitted charges ($14,437) and the sum ($1,642) of the Advantage plan payment and the recipient's obligation. This resulted in an overpayment of $12,795.

In addition to the 270 claims we tested, the three providers received Medicaid payments for 19,401 additional Code 16 claims (totaling about $1.7 million) during our audit period. Based on the results of our review, we conclude these claims are of high risk of overpayment. If the results of our reviews of the payments tested hold true for the remaining (untested) payments made during our audit period, the additional overpayments may total as much as $1.4 million.

The Department could have prevented many of the overpayments we identified if certain eMedNY system controls were in place. In most circumstances, Advantage plan payments exceed the amounts of the recipient's monetary obligation (the amount Medicaid normally pays). However, for many payments, eMedNY indicated that Advantage plans made no payments, or the payments were less than the recipients' obligations. Medicaid overpaid many of these claims, and the absence of eMedNY system edits to pend or deny such claims allowed the overpayments to occur.

Further, if controls flag a Code 16 claim for an apparent overcharge of a recipient's obligation, a process is needed to determine the correct amount of that obligation. The Department, however, had not established a sufficient process to determine the amounts that Advantage plans designated as patient obligations. For example, the Department did not obtain Explanations of Benefits (EOBs) for Advantage plan payments to help ensure that providers reported these payments accurately on their Medicaid claims. The Department could obtain the EOB's, on a sample basis or for claims exceeding a certain dollar threshold, to help verify the propriety of Code 16 claims.

Our report contains five recommendations to improve the controls over the processing of Code 16 claims and to recover the overpayments made to certain providers. In their response to our draft report, Department officials generally agreed with our recommendations and indicated that certain steps are planned or have been taken to address them.

This report, dated December 23, 2010, is available on
our website at: http://www.osc.state.ny.us.
Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Introduction

Background

Medicare and Medicaid are two distinct public programs which provide medical and health-related services to specific groups of people in the United States. Medicare is a primary health insurance program that provides medical services to most people 65 years of age and older, certain people with disabilities, and some people with permanent kidney failure. The Medicaid program is the "payer of last resort" which typically provides services to low-income and financially-needy individuals, including many of those also covered by Medicare. The Department of Health (Department) administers New York State's Medicaid program, whereas Medicare is administered and funded solely by the Federal Government.

Individuals who qualify for both Medicare and Medicaid are commonly referred to as "dual-eligible," and providers must bill all other applicable insurances prior to Medicaid, the payer of last resort. As such, services for dual eligible recipients must be billed initially to Medicare, and the remaining unpaid balance may then be billed to Medicaid. Generally, the unpaid balances consist of recipients' monetary obligations, including coinsurance, co-payments and deductibles. Coinsurance is an amount, set by a recipients' insurance carrier, that the recipient pays the provider after the insurer pays. A deductible is the amount recipients pay for services before their health insurance begins to pay. A co-payment is an amount paid by recipients for each medical service received. Medicare program providers must accept the Medicare-approved amounts for the medical services or items they provide.

Medicare has several coverage categories or "parts." For example, Medicare Part A provides coverage for hospitalization, post-hospital nursing home care, and home health care. Medicare Part B covers the costs for doctors, laboratory fees, and certain outpatient medical services. Medicare Part C is the segment of Medicare that allows private health insurance companies to administer Medicare benefits. For the purposes of Medicare Part C, the private health plans (including Health Maintenance Organizations and Preferred Provider Organizations) are referred to as Medicare Advantage plans. Providers billing Medicaid for Part C recipients must process their claims under the Medicaid Claim Filing Indicator of Code 16 (Code 16).

Although the amount of Medicaid's supplemental payments to participating providers may vary depending on which Medicare "part" the recipient is enrolled in, providers must bill Medicaid for the Medicare-

approved amounts of recipient's monetary obligations for the services rendered. As such, providers may not bill Medicaid in excess of Medicare's approved amount, even if they charge non-Medicare recipients more for the same service or item. The Department is responsible for the Medicaid management information and claims processing system, eMedNY, which uses various automated controls and edits to detect inappropriate claims and prevent improper payments. These controls help ensure health care providers bill Medicaid properly.

From January 29, 2007 through March 31, 2010, Medicaid processed claims for more than 106,000 recipients under Code 16. During the same period, the Department paid more than $118.3 million, under Code 16, for services provided to these recipients.

Audit Scope and Methodology

Our audit determined whether adequate controls existed to prevent Medicaid overpayments, under Code 16, for dual-eligible Part C Medicare beneficiaries for the period from January 29, 2007 through March 31, 2010.

To accomplish our objectives, we interviewed Department officials, reviewed applicable sections of Federal and State laws and regulations, and examined the Department's relevant policies and procedures. Due to their relatively higher risk, we focused our audit on Code 16 claims for services provided by clinics and practitioners. Between January 29, 2007 and March 31, 2010, Medicaid paid clinics and practitioners more than $16.5 million for about 292,000 claims processed under Code 16. We selected a judgmental sample of 270 payments to four of the providers with the highest amounts of Code 16 claims during our audit period. We also conducted site visits of two of the four providers, reviewed pertinent provider records, and interviewed appropriate provider officials.

We did our performance audit according to 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 that 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

The audit was performed according 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 it. In their response, Department officials generally agreed with recommendations and indicated that certain steps are planned or have been taken to address them. Our rejoinder to the Department's response is included in our State Comptroller's Comment.

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 therefor.

Contributors to the Report

Major contributors to this report include Robert Wolf, Mark Breunig, Danielle Rancy, Steven Sossei, and Brian Mason.

This page is left intentionally blank.

Audit Findings and Recommendations

Overpayments to Selected Providers

Department policy states that Medicaid will pay all coinsurance, co-pays, and deductibles for Medicaid recipients enrolled in a Medicare Advantage plan (Part C) as long as the provider is also a Medicaid enrolled provider. According to NYCRR Title 18 Section 540.6(e), a Medicaid provider must review and examine information relating to available health insurance and other potential third-party resources for each Medicaid recipient to determine if prior or other approval is required for medical services. If prior approval is required as a condition of reimbursement by a liable third party, the provider must obtain for the recipient, or ensure that the recipient has obtained, any necessary approval before submitting the claim for reimbursement. The provider must also comply with all Medicare or other third-party billing requirements to ensure that Medicaid does not bear costs that should be paid by another party. If a provider fails to comply with these requirements, the Department can recover the related Medicaid payments. The Department is responsible for ensuring that Medicaid's claims processing system, eMedNY, pays claims according to the prescribed requirements.

For the four providers we reviewed, we examined a total of 270 claims made under Medicaid Code 16, indicating that the recipients also had Medicare Advantage plan coverage. We determined that all 40 of one provider's claims were processed correctly. However, we also found that 221 (96 percent) of the remaining 230 claims (paid to the other three providers) were prepared and processed incorrectly. The overpayments resulting from these 221 errant claims totaled $757,738 and are detailed as follows:

- For Provider A, Medicaid overpaid 148 of 150 Code 16 claims we reviewed by $644,986. Provider A inappropriately submitted 145 (of the errant 148) claims to Medicaid after the recipients' Advantage plans denied payments because the required prior authorizations were not obtained. For example, on a claim for outpatient services, the recipient's Advantage plan denied payment because no one obtained the required prior authorization. Nonetheless, Provider A subsequently submitted this claim to Medicaid for coinsurance charges and received a payment of $9,011. However, because Provider A had not complied with the applicable requirement, it was not entitled to the payment.

  On its remaining three errant claims, Provider A inappropriately billed Medicaid for the difference between its submitted charges

and the Advantage plan payment amount (instead of the amounts of coinsurance, co-payment, and/or deductible the recipient owed). For example, on one claim, the Advantage plan paid $1,478, and the recipient's responsibility was $164. However, Provider A billed Medicaid for the difference between its submitted charges ($14,437) and the sum ($1,642) of the Advantage plan payment and the recipient's obligation. As a result, Medicaid overpaid this claim by $12,795 ($14,437-$1,642).

- For Provider B, Medicaid made overpayments totaling $107,243 for all 40 claims we reviewed. Provider B inappropriately billed Medicaid for the difference between his submitted charges and the Advantage plan payment amounts for all 40 claims. For example, on a claim for a cataract removal, the recipient's Advantage plan paid $571, and the recipient's coinsurance was $143. However, instead of billing Medicaid for the coinsurance ($143), the provider billed for the difference between his submitted charges ($3,120) and the Advantage plan payment and coinsurance (which totaled $714). This resulted in an overpayment of $2,406 ($3,120-$714).
- For Provider C, we found that 33 of the 40 claims reviewed were incorrect and resulted in overpayments totaling $5,509. Provider C either did not bill Medicare or did not have evidence that Medicare was billed, as required, for 24 (of the 33 errant) claims. For eight other claims, Provider C billed Medicaid incorrectly - for the difference between its submitted charges and the Medicare payment amount. Also, Medicare denied one claim because the time limit to file had expired. We further determined that Provider C indicated improperly that certain Medicare Part B (as opposed to Part C) claims were Advantage plan claims. The proper form of third party insurance must be identified when billing Medicaid to ensure that claims are paid correctly.

We did not examine in detail the remaining 19,401 Code 16 claim payments (totaling about $1.7 million) that Medicaid made to the three providers between January 29, 2007 and March 31, 2010. Nonetheless, based on the results of our review, we conclude that these claims are of high risk of overpayment given the respective error rates (ranging from 79 to 99 percent by provider) in the amounts paid for the claims that were tested. If the results of our reviews of the payments tested hold true for the remaining (untested) payments made during our audit period, the additional overpayments may total as much as $1.4 million.

We concluded that the Department could have prevented many of the overpayments we identified if certain automated and manual eMedNY system controls were in place. In most circumstances, Advantage plan payments should exceed the amounts of the recipient's monetary obligations (the amounts Medicaid normally pays). However, for many of the Code 16 payments we examined, eMedNY indicated that Advantage plans made no payments to the providers - or when such plans made payments, they were less than the amounts of the recipient's obligations (generally coinsurance or co-payments). As we have detailed, Medicaid overpaid many of these claims, and we determined that the absence of eMedNY system edits to pend or deny such claims allowed the overpayments to occur.

Further, if control mechanisms (either automated or manual) flag a Code 16 claim for an apparent overcharge of a recipient's obligation, a process is needed to determine the correct amount of that obligation. The Department, however, had not established a sufficient process to determine the amounts that Advantage plans designated as patient obligations for Code 16 claims. For example, the Department did not obtain Explanations of Benefits (EOBs), corresponding to Advantage plan payments, to help ensure that providers reported Advantage plan payments accurately on their Code 16 claims. We concluded that the Department should consider obtaining EOB's for Advantage plan payments, on a sample basis or for claims exceeding a certain dollar threshold, to help verify the propriety of Code 16 claims.

Recommendations

1. Recover the $757,738 we identified as overpayments due to the 221 errant claims submitted by the three providers as detailed in our report.
2. Review the $1.4 million we identified as potential overpayments for the 19,401 Code 16 claims that we did not examine in detail. Recover any overpayments as appropriate.
3. Formally remind providers of the requirements for the proper preparation and processing of Code 16 claims.
4. Design and implement eMedNY system edits, with particular focus on excessive charges for coinsurance or co-payments, to detect and prevent overpayments for Code 16 claims.
5. Consider requesting providers to submit EOBs, on a sample basis and/or for claims exceeding a certain dollar threshold, to help verify the propriety of Code 16 claims.

This page is left intentionally blank.

Agency Comments

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

December 10, 2010

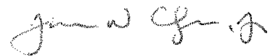
Brian E. Mason, Audit Manager
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

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 2010-S-22 on "Medicaid Payments to Selected Providers for Services to Recipients with Medicare Part C Coverage."

Thank you for the opportunity to comment.

Sincerely,



James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Donna Frescatore
Diane Christensen
Dennis Wendell
Stephen Abbott
Stephen LaCasse
Ron Farrell
Mary Elwell
Irene Myron
Lynn Oliver

Department of Health
Comments on the Office of the State Comptroller's
Draft Audit Report 2010-S-22
on Medicaid Payments to Selected Providers for Services to
Recipients with Medicare Part C Coverage

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2010-S-22 on "Medicaid Payments to Selected Providers for Services to Recipients with Medicare Part C Coverage."

Recommendation #1:

Recover the $757,738 we identified as overpayments due to the 221 errant claims submitted by the three providers as detailed in our report.

Recommendation #2:

Review the $1.4 million we identified as potential overpayments for the 19,401 Code 16 claims that we did not examine in detail. Recover any overpayments as appropriate.

Responses #1 and #2:

The Office of the Medicaid Inspector General (OMIG) will review the payments identified and pursue appropriate recoveries.

Recommendation #3:

Formally remind providers of the requirements for the proper preparation and processing of Code 16 claims.

Response #3:

The June 2010 edition of the Department's monthly *Medicaid Update* provider publication reinforced the necessity for providers to bill Medicare prior to billing Medicaid. Providers were additionally reminded of the requirement to enroll in the Medicare health plans' provider networks, since the plans must be billed initially for all services included in their benefit packages.

Recommendation #4:

Design and implement eMedNY system edits, with particular focus on excessive charges for coinsurance or co-payments, to detect and prevent overpayments for Code 16 claims.

Response #4:

The Department will further evaluate this OSC recommendation, although based on initial review it appears that it would be very difficult and most likely not possible to implement with

any accuracy given the complexity of scenarios. There are many Medicare insurers, most with multiple plans, and each with their own benefit package and co-payment and coinsurance amounts. These differences could vary widely amongst insurers as well as between plans within particular insurers. Further, insurers are not required to report this level of information to eMedNY.

* Comment

Recommendation #5:

Consider requesting providers to submit Explanation of Benefits (EOBs) on a sample basis and/or for claims exceeding a certain dollar threshold, to help verify the propriety of Code 16 claims.

Response #5:

The OMIG will evaluate the feasibility of requesting providers to submit EOBs on a sample basis.

* State Comptroller's Comment: We acknowledge that certain characteristics of these claims could add complexity to eMedNY system edits designed to prevent overpayments of such claims. Nonetheless, given the State's precarious fiscal condition, the State can ill afford to continue to overpay these claims. Consequently, we maintain that the Department should develop and implement automated and/or manual controls to prevent overpayments, particularly to the higher risk providers referenced in our report. Such controls could, for example, include steps to pend and review claims with Medicare coinsurance and/or co-payments that exceed certain pre-determined dollar limits.