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September 6, 2012

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

Re: Report 2012-F-9

Dear Dr. Shah:

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 (Department) to implement the recommendations contained in our audit report, *Medicaid Payments to Selected Providers for Services to Recipients with Medicare Part C Coverage* (Report 2010-S-22).

Background, Scope and Objective

Under Medicare Part C (also known as Medicare Managed Care), private health insurance companies administer Medicare benefits by offering different health care plan options that are tailored to the specific needs of Medicare enrollees. These plans, including health maintenance organizations and preferred provider organizations, are commonly referred to as Medicare Advantage Plans (Plans).

Plans have networks of participating providers that they reimburse directly on a fee-for-service basis. For certain services, Plan enrollees may be responsible for cost-sharing liabilities such as deductibles and coinsurance. These liabilities, however, may be paid by Medicaid if the individual is also enrolled in Medicaid. Providers who bill Medicaid for enrollees' cost-sharing liabilities must process their Medicaid claims by using a Claim Filing Indicator Code of 16.

Our initial audit report, which was issued on December 23, 2010, examined whether the Department established and implemented adequate controls over Medicaid payments to selected providers for recipients who also have medical coverage under the Medicare Part C program. For the period from January 29, 2007 through March 31, 2010, we identified three providers who incorrectly reported recipients' cost-sharing liabilities on Medicaid claims which resulted in $758,000 in actual overpayments and an additional $1.4 million in potential overpayments. The

objective of our follow-up was to assess the extent of implementation, as of June 5, 2012, of the five recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

Department officials made some progress in correcting the problems we identified in the initial audit. This included the recovery of $279,500. However, further actions are still needed. In particular, the Department must develop controls to prevent Medicaid overpayments resulting from excessive charges, for coinsurance and other recipient cost-sharing liabilities, on claims related to Medicare Part C. Of the five prior audit recommendations, one was implemented, three were partially implemented, and one was not implemented.

Follow-up Observations

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.

Status - Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. At the time of our follow-up, the OMIG had reviewed one provider's Code 16 claims (for the period January 29, 2007 through March 31, 2010) pertaining to the actual and potential overpayments we identified in the initial audit. The OMIG recovered $279,500 from that provider. Recoveries from the other two providers, however, have not been made. OMIG officials have contacted both providers and anticipate recoveries from them.

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.

Status - Partially Implemented

Agency Action - As noted previously, the OMIG reviewed actual and potential overpayments of one provider's Code 16 claims and recovered $279,500. A portion of that recovery pertained to the potential overpayments we identified. In addition, the OMIG has negotiated self-disclosure agreements with the other two providers. One provider has agreed to review all of its Code 16 claims for the six years ending December 31, 2010, report (to the OMIG) the overpayments it received, and reimburse the State, as appropriate. Regarding the remaining provider, the OMIG is determining if the agreement covers the claims we identified in our initial audit.

Recommendation 3

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

Status - Implemented

Agency Action - The Department reminded providers of the requirements for the proper preparation and processing of Code 16 claims in the June 2010 edition of *Medicaid Update*, the Department's official publication for Medicaid providers. The update included formally reminding providers to bill Medicare prior to Medicaid. In addition, OMIG instructed two of the providers, identified in our initial audit, on the proper way to bill Medicaid for Code 16 claims. OMIG officials also plan to advise the third provider of corrective actions it should take to ensure its Code 16 claims are prepared properly.

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.

Status - Partially Implemented

Agency Action - In March 2012, the Department initiated a project to design an edit to prevent Medicaid payments of Code 16 claims when the recipient is not enrolled in a Plan. Once activated, the edit will prevent some of the overpayments identified in our initial audit. However, the Department has not established a control to prevent Medicaid overpayments for excessive charges on claims for recipients who are enrolled in a Plan. According to Department officials, this type of control is not feasible because of the large variances in charges for coinsurance and other patient liabilities existing among the many different Plans offered in the State.

(Auditors Comment: In general, a Plan's base payment amount should exceed the amount of coinsurance [and other patient liability] paid by Medicaid. However, many of the overpayments we identified resulted from claims with coinsurance charges that exceeded the amounts of Plans' base payments. Thus, we maintain that the Department should develop a control to detect excessive claims, particularly when charges for coinsurance exceed Plan's base payments, to prevent Medicaid overpayments.)

Recommendation 5

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

Status - Not Implemented

Agency Action - The Department had not taken action on this recommendation.

Major contributors to this report were Warren Fitzgerald, Christopher Morris and Emily Wood.

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 also thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Andrea Inman
Audit Manager

cc: Stephen Abbott, Department of Health
Stephen LaCasse, Department of Health
James Cox, Office of the Medicaid Inspector General
Thomas Lukacs, Division of the Budget