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

Division of State Government Accountability

Medicaid Payments to Medicare Advantage Plan Providers

Medicaid Program
Department of Health

Report 2016-S-54 September 2018

Executive Summary

Purpose

To determine whether Medicaid inappropriately paid for recipients' Medicare Part C cost-sharing liabilities. The audit covered the period January 1, 2012 through December 31, 2016.

Background

Many Medicaid recipients are also enrolled in Medicare. Such recipients are commonly referred to as "dual-eligibles." In 1997, Congress established Medicare Part C, the Medicare managed care program also known as Medicare Advantage. Under Medicare Part C, private managed care companies administer Medicare benefits through Medicare Advantage plans, which have networks of participating providers that they reimburse for services provided to enrollees. For dual-eligibles, Medicaid reimburses the plan providers for the enrollee's Part C cost-sharing liabilities (deductibles, coinsurance, and copayments).

Key Findings

- We reviewed selected Medicare Advantage plan contracts offered by Fidelis and WellCare and, based on judgmental sampling, determined certain providers reported inflated Part C cost-sharing liabilities on 7,072 Medicaid claims, resulting in overpayments of $770,935.

- We determined three of the providers were overpaid 58, 74, and 79 percent of the total Medicaid payments they received for claims in our review. We analyzed the remaining Part C cost-sharing claims billed by these providers during the audit period and found – if the rate of overpayment is consistent with our initial review – Medicaid potentially overpaid an additional $562,356 to these providers.

Key Recommendations

- Review the $1,333,291 in actual ($770,935) and potential ($562,356) Medicaid overpayments and recover as appropriate.
- Formally instruct the three providers identified in this report to bill Medicare Part C claims in accordance with existing requirements.
- Develop a risk-based approach to identify and prevent inappropriate Medicaid claims for Medicare Part C cost-sharing liabilities.

Other Related Audits/Reports of Interest

Department of Health: Medicaid Payments Made Pursuant to Medicare Part C (2012-S-133)
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

September 10, 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 Payments to Medicare Advantage Plan Providers*. 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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Background

Medicaid is a federal, state, and locally funded program administered by the Department of Health (Department) that provides a wide range of health care services to those who are economically disadvantaged and/or have special health care needs. For the State fiscal year ended March 31, 2017, New York's Medicaid program had approximately 7.4 million enrollees and Medicaid claim costs totaled about $58 billion. The federal government funded about 55.3 percent of New York's Medicaid claim costs; the State funded about 29 percent; and the localities (the City of New York and counties) funded the remaining 15.7 percent.

The Department's Office of Health Insurance Programs administers the State's Medicaid program. The Department's eMedNY computer system processes Medicaid claims submitted by health care providers for services rendered to Medicaid-eligible recipients and generates payments to reimburse the providers for their claims.

Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health insurance program for the elderly and disabled. Individuals enrolled in both programs are referred to as "dual-eligibles." Generally, Medicare is the primary payer for medical services provided to dual-eligibles. Medicaid then typically pays for any remaining balance not covered by Medicare. These remaining balances include cost-sharing liabilities for Medicare coinsurance, copayments, and deductibles.

The Medicare program has multiple parts. Part A provides hospital insurance, including inpatient care. 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 managed care companies administer Medicare benefits and offer different health care plans (Medicare Advantage plans) tailored to the specific needs of Medicare beneficiaries. Medicare pays a fixed amount for each Medicare Part C beneficiary every month to companies offering Medicare Advantage plans, and plans reimburse health care providers directly for services provided to enrollees. For dual-eligibles, plan providers bill Medicaid for Medicare Part C cost-sharing liabilities.

Prior to July 1, 2016, Medicaid generally paid the entire cost-sharing liability billed by a Medicare Advantage plan provider, regardless of the amount. In prior Office of the State Comptroller audits, we concluded that providers often misreported Medicare Part C cost-sharing amounts on Medicaid claims, which resulted in significant overpayments. We recommended the Department re-evaluate the methodology for processing such claims. In response, effective July 1, 2016, New York State Social Services Law was amended changing the Medicaid reimbursement of Medicare Part C copayment and coinsurance to 85 percent of the amounts billed. Medicaid continues to reimburse providers for the entire deductible amount.

WellCare Health Plans, Inc. and Fidelis Care are insurance companies that offer Medicare Advantage plans to New York State Medicaid recipients.

Audit Findings and Recommendations

The Department continues to rely on providers to accurately report Medicare Part C cost-sharing amounts on Medicaid claims. Consequently, Medicaid continues to make overpayments for services provided to dual-eligible Medicare Advantage enrollees when providers do not accurately report such cost-sharing amounts.

Our audit identified $770,935 in Medicaid overpayments to providers that billed inflated Medicare Part C cost-sharing amounts. The overpayments were for services rendered to recipients enrolled in selected Medicare Advantage plans (Plans) offered by one of the following insurance companies: WellCare Health Plans, Inc. (WellCare) or Fidelis Care (Fidelis). Three providers in our review received significant overpayments. As a result, we analyzed all other Part C cost-sharing claims billed by these providers during the audit period and identified potential additional overpayments of $562,356.

Medicaid Overpayments for Part C Claims

We analyzed Medicaid Part C cost-sharing claims billed on behalf of recipients enrolled in the Plans. We requested Part C payment data from the insurance companies for a judgmentally selected sample of 100 providers (50 providers from each insurance company). Providers were selected for review based on total Medicaid payments for Part C cost-sharing liabilities or based on analyses performed to identify claims at high risk of being overpaid.

We compared the Part C claims payment data received from the insurance companies to the amount providers reported on Medicaid claims. Our test identified overpayments of $770,935 for services provided between January 1, 2012 and December 31, 2016. The overpayments occurred because providers reported inflated Part C cost-sharing amounts on claims to eMedNY, and eMedNY lacks sufficient controls to detect and prevent such claims. Instead, the Department relies on providers to accurately report the Part C cost-sharing amounts.

For example, one physician reported $1,147 in Part C coinsurance on a Medicaid claim for the repair of an eardrum. However, according to the payment data received from Fidelis, the actual coinsurance for this service was only $88. We obtained the Explanation of Benefits (EOB) document to support this service from the provider and verified the accuracy of our data match. We confirmed the provider reported inflated coinsurance on the claim and this resulted in a Medicaid overpayment of $1,059 ($1,147-$88) for the service.

We also identified three providers who were overpaid a significant amount of the total Medicaid payments they received for the claims in our review, as shown in Table 1:

Table 1

Provider	Medicaid Paid	Overpayments	Percentage Overpaid
Provider 1	$139,777	$81,448	58.3%
Provider 2	50,773	40,293	79.4
Provider 3	17,309	12,841	74.2
Totals	**$207,859**	**$134,582**	

As a result, we analyzed all other Medicaid claims for Part C cost-sharing billed by these three providers during our scope. This analysis revealed that there is a significant risk that many more claims were overpaid. In fact, if the rate of overpayment on these claims is consistent with the results of our data match, Medicaid potentially overpaid an additional $562,356 to these providers (Table 2).

Table 2

Provider	Medicaid Paid	Percentage Overpaid	Potential Overpayments
Provider 1	$240,161	58.3%	$140,014
Provider 2	224,595	79.4	178,328
Provider 3	328,860	74.2	244,014
Totals	**$793,616**		**$562,356**

Recommendations

1. Review the actual ($770,935) and potential ($562,356) Medicaid overpayments we identified and recover as appropriate.

2. Formally instruct the three providers identified in this report to bill Medicare Part C claims in accordance with existing requirements.

3. Develop a risk-based approach to identify and prevent inappropriate Medicaid claims for Medicare Part C cost-sharing liabilities.

Audit Scope, Objective, and Methodology

The objective of our audit was to determine whether the Department inappropriately paid for Medicaid recipients' Part C cost-sharing liabilities during the period January 1, 2012 through December 31, 2016. Our audit tests and analyses were based on Medicaid payments for services rendered to recipients enrolled in selected Plans offered by Fidelis and WellCare. From January 1, 2012 through December 31, 2016, Medicaid paid almost $91 million for approximately 1 million claims on behalf of 65,009 Medicaid recipients enrolled in one of these Plans. Plans were selected based on total Medicaid dollars for services rendered to Plan enrollees.

To accomplish our audit objective and assess related internal controls, we interviewed officials from the Department as well officials from three Medicare Advantage plans. We reviewed applicable sections of federal and State regulations, and examined the Department's relevant Medicaid policies and procedures. Our audit focused on the following claim types: inpatient, practitioner, durable medical equipment, referred ambulatory, laboratory, eye care, and clinic.

To identify overpayments, our audit test compared the Medicaid paid amount to the cost-sharing liability amounts obtained from the Plans. Our test was designed to identify instances where Medicaid payment amounts exceeded the Part C cost-sharing liability amounts. We obtained EOBs for a judgmental sample of nine overpaid providers to verify the accuracy of our data match. These providers were selected based on providers who had the highest overall differences between the Medicaid paid amount and the cost-sharing liability amounts obtained from the Plans, and providers who had the highest proportion of such differences compared to the amounts paid by Medicaid.

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

This 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 that certain actions have been and 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.

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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

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

July 17, 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 2016-S-54 entitled, "Medicaid Payments to Medicare Advantage Plan Providers."

Thank you for the opportunity to comment.

Sincerely,

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

Enclosure

cc: Marybeth Hefner
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report entitled,
"Medicaid Payments to Medicare Advantage Plan Providers"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2016-S-54 entitled, "Medicaid Payments to Medicare Advantage Plan Providers."

Recommendation #1

Review the actual ($770,935) and potential ($562,356) Medicaid overpayments we identified and recover as appropriate.

Response #1

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

Recommendation #2

Formally instruct the three providers identified in this report to bill Medicare Part C claims in accordance with existing requirements.

Response #2

The Department will remind and instruct the three providers identified in this report on billing requirements for Medicare Part C claims that are submitted to Medicaid for payment of patient responsibility. Additionally, the Department will refer the providers to OMIG for investigation and follow-up.

Recommendation #3

Develop a risk-based approach to identify and prevent inappropriate Medicaid claims for Medicare Part C cost-sharing liabilities.

Response #3

The Department will review the payment and reasonability edits currently in place for Medicare Part C claims, such as eMedNY edit 02255, and assess if they can be strengthened to help mitigate provider billing errors that may result in Medicaid overpayments.