



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

Division of State Government Accountability

Medicaid Payments Made Pursuant to Medicare Part C

Medicaid Program Department of Health



Executive Summary

Purpose

To determine if Medicaid made excessive payments for Medicare Part C cost-sharing liabilities. The audit covered the period January 2008 through November 2012.

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, also known as Medicare managed care or Medicare Advantage. Under Medicare Part C, private managed care companies administer Medicare benefits. These Medicare Advantage Plans typically have networks of participating providers they reimburse directly for services provided to enrollees. For dual-eligible persons, plan providers bill Medicaid directly for the enrollee’s Part C cost-sharing liabilities (deductibles, coinsurance and copayments). In New York, Medicaid pays the entire Part C cost-sharing amount claimed, regardless of the amount.

Key Findings

- During the audit period, Medicaid could have saved up to \$69 million if it limited payments of Medicare Part C cost-sharing liabilities such that the total Medicare and Medicaid payment for a service did not exceed Medicaid’s normal service fee. Other states already use this approach and New York uses this approach to limit payments for certain other Medicare cost-sharing liabilities.
- For example, a Medicaid recipient with Medicare Part C coverage received outpatient surgery for a pacemaker, for which a Medicare Advantage Plan paid the provider \$25,322. In comparison, Medicaid’s fee for the procedure was \$13,180 - far less than Medicare’s payment. Nevertheless, Medicaid paid the provider \$5,848 for coinsurance because there are no limits on Part C cost-sharing. If the Department limited payment of Part C coinsurance so that the Medicare and Medicaid payment in total did not exceed Medicaid’s fee, Medicaid would not have paid the coinsurance.
- In addition, we determined Medicaid made \$1.6 million in overpayments for Medicare Part C cost-sharing because recipients were not enrolled in Part C.

Key Recommendations

- Re-evaluate the reimbursement methodology for Medicare Part C cost-sharing, including a review of other states’ policies.
- Review the \$1.6 million in Medicaid payments for Medicare Part C cost-sharing liabilities for recipients who were not covered by Part C. Recover overpayments as appropriate.

Other Related Audits/Reports of Interest

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

[Department of Health: Excessive Medicaid Payments for Services to Recipients Receiving Medicare Benefits \(2009-S-64\)](#)

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

Division of State Government Accountability

May 9, 2014

Dr. Howard Zucker
Acting 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 Made Pursuant to Medicare Part C*. 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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Background

Medicaid is a federal, State and local government program that provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. The federal government funds about 48.25 percent of New York's Medicaid claim costs; the State funds about 34.25 percent; and the localities (the City of New York and counties) fund the remaining 17.5 percent. For the fiscal year ended March 31, 2012, New York's Medicaid program had more than 5.5 million enrollees and Medicaid claim costs totaled about \$50 billion.

The Department of Health (Department) administers the Medicaid program in New York State. Many of the State's Medicaid recipients are also enrolled in Medicare, the federal health care program for people 65 years of age and older and people under 65 years old with certain disabilities. Individuals enrolled in both programs are commonly referred to as "dual-eligibles." Generally, Medicare is the primary payer for medical services provided to dual-eligible recipients. Medicaid typically pays for any remaining balance not covered by Medicare. These cost-sharing liabilities include Medicare deductibles, coinsurance and copayments. Medicaid payments, including those for Medicare cost-sharing liabilities, are made through eMedNY, the Department's automated claims processing and payment system.

The Medicare program has multiple parts. Medicare Part A provides hospital insurance, including inpatient care; and Medicare Part B provides medical insurance for doctors' services and outpatient care. In 1997, Congress established Medicare Part C, also known as Medicare Advantage 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 Medicare-approved services traditionally provided under Parts A and B. Also, Medicare Advantage Plans may provide additional benefits such as dental and vision coverage, or reductions in cost-sharing liabilities for certain services.

Under 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 provided to their enrollees. For dual-eligible individuals also enrolled in Medicaid, plan providers bill Medicaid directly for the enrollee's cost-sharing liabilities (such as coinsurance). In New York, the Medicaid program pays the entire cost-sharing liability billed by the provider, regardless of the amount requested.

The number of New York State Medicaid recipients enrolling in a Medicare Advantage Plan has grown in recent years. Consequently, so have Part C Medicaid expenditures. About 259,000 Medicaid recipients were enrolled in a Medicare Advantage Plan on January 1, 2012, up 44 percent from about 179,000 on January 1, 2008. Medicaid expenditures for Medicare Part C claims for the five years ended December 31, 2012 totaled almost \$902 million. Of that amount, about \$497 million occurred in 2012 alone.

Audit Findings and Recommendations

During the audit period, Medicaid could have saved about \$69 million if eMedNY limited payments of Medicare Part C cost-sharing liabilities (i.e., coinsurance, copayments and deductibles) similar to the way it limits certain payments for Medicare Part B cost-sharing liabilities. The potential savings averaged about \$14 million per year. In addition, Medicaid overpaid about \$1.6 million for Part C cost-sharing liabilities because recipients were not enrolled in Part C at the time services were rendered. Also, we determined that Medicaid made payments for Part C cost-sharing during the same months it made premium payments for recipients' enrolled in Medicaid managed care plans (or Advantage Plans). When recipients are covered by Medicaid Advantage Plans, Medicaid should not pay Part C cost-sharing liabilities.

Excessive Payments of Medicare Part C Cost-Sharing Liabilities

The Department of Health has not taken sufficient steps to prevent excessive Medicaid payments for Medicare Part C cost-sharing liabilities. According to Department officials, they have been reluctant to implement controls to prevent overpayments on claims for Medicare Part C coinsurance, copayments and deductibles because of the variations in Medicare Advantage cost-sharing amounts among the various plans. Nevertheless, for the period January 2008 through November 2012, New York Medicaid could have saved about \$69 million (paid on nearly 949,000 claims) if the Department limited payments for Medicare Part C cost-sharing liabilities similarly to the way it limits Medicaid payments for certain Medicare Part B services. Other states apply similar limits to their Medicaid payments for Part C claims as well.

According to the Social Security Act, a state's Medicaid Plan is not required to provide payment for any Medicare cost-sharing to the extent that the Medicare payment for the service would exceed the amount Medicaid would typically pay. Our audit determined that other states (including Florida, Indiana, Pennsylvania, Tennessee, and Texas) have applied such limits to payments for Medicare Part C cost-sharing. For example, Florida's Medicaid program will reduce or deny payment of Part C cost-sharing liabilities (coinsurance, copayments and deductibles) so that a provider's combined Medicare and Medicaid reimbursement does not exceed the Medicaid fee for the service. We analyzed New York's Medicaid payments for Medicare Part C charges according to the policy used by Florida.

As illustrated in the following table, the potential for cost savings would have been significant if New York placed similar limits on Medicaid payments for Part C cost-sharing liabilities. Further, there have been considerable increases in the number of Part C claims processed and, therefore, the potential cost savings in recent years.

Year	Number of Claims	Amount of Potential Savings
2008	42,286	\$ 4,268,811
2009	144,472	\$ 11,113,587
2010	181,860	\$ 13,487,735
2011	260,200	\$ 18,291,887
2012	319,923	\$ 21,921,680
Total	948,741	\$ 69,083,700

Department officials believe the policy reform in question would probably require amendment of the State's Social Services Law, which currently does not provide for limitations on Part C claims as it does for Part B claims. In the past, the Department sought legislative action to prevent excessive Medicare Part B cost-sharing payments. For example, in 2003, Section 367-a(1)(d) of the Social Services Law limited Medicaid payments of Medicare Part B coinsurance charges to 20 percent of such charges for certain services when Medicare's reimbursement exceeded Medicaid's standard fee. More recently (as was recommended in OSC Audit 2009-S-64), legislative amendments to the Social Services Law allowed the Department to implement changes proposed by the State's Medicaid Redesign Team (MRT). This included: (1) limiting payments of Part B coinsurance on outpatient and diagnostic and treatment center services so that Medicare's and Medicaid's combined payment does not exceed the normal Medicaid fee and (2) the elimination of certain coinsurance payments on Part B services not covered by Medicaid.

The following example details how New York Medicaid, in accordance with the recent MRT change, limits payments for certain Medicare Part B services. A provider performed outpatient surgery to insert a cardio-defibrillator pacemaker for a dual-eligible recipient. Medicare paid the provider \$26,094 for the procedure. In comparison, Medicaid's fee for the same procedure was only \$12,348. Thus, Medicare's payment exceeded the Medicaid fee by \$13,746. The provider billed Medicaid \$1,164 for coinsurance on the related claim. However, consistent with the MRT policy change, Medicaid paid no coinsurance charge because Medicare already paid more than Medicaid's fee for the service.

In contrast, Medicaid's payments of Medicare Part C cost-sharing liabilities are not subjected to the types of limitations applied to Part B claims. Further, the Department has not formally assessed the potential financial benefit of limiting payments of Medicare Part C cost-sharing liabilities. Thus, we analyzed certain types of claims (including clinic, dental, durable medical equipment, eye care, inpatient, laboratory, physician, referred ambulatory, and transportation services) to estimate the potential savings if Medicaid applied certain limits to the Part C claims we selected. During our audit period, Medicaid paid about \$267 million for these Part C claims.

We determined Medicaid could have saved approximately \$69 million (about 26 percent of the \$267 million) if eMedNY limited payments of Medicare Part C cost-sharing liabilities. In doing our

analysis, we deemed the entire Medicaid payment to be a potential savings when the Medicare Advantage Plan paid more than the standard Medicaid fee for the service. When the standard Medicaid fee exceeded the Advantage Plan's payment, we allowed the lesser of the cost-sharing amount billed (coinsurance, copayment, and/or deductible) or the difference between the Advantage Plan payment and the standard Medicaid fee. This approach emulates other states' policies and is similar to the aforementioned MRT change.

To illustrate, we calculated the potential savings for a radiological procedure which typically costs Medicaid \$1,154. In this instance, the recipient's Medicare Advantage Plan paid the provider \$1,551 (or \$397 more than the Medicaid fee). In addition, Medicaid paid the provider \$388 for Part C coinsurance. We concluded, however, that Medicaid could have withheld the payment of \$388 because the Advantage Plan already reimbursed the provider more than the Medicaid fee for the service.

In another instance, a Medicaid recipient with Part C coverage received outpatient surgery for a cardio-defibrillator pacemaker (the same procedure detailed previously for the person with Part B coverage). This recipient was covered by a Medicare Advantage Plan, which paid the provider \$25,322 for the procedure. Because there are no limitations on Medicare Part C cost-sharing liabilities, the provider also billed Medicaid \$5,848 for coinsurance, and Medicaid paid the claim. Thus, the provider received payments totaling \$31,170 (\$25,322 + \$5,848), considerably more than Medicaid's fee (\$13,180). If the Department limited payment of Part C coinsurance similarly to the limits placed on Part B claims, Medicaid would have paid nothing (not \$5,848) for coinsurance.

Further, in December 2009, the Department implemented an automated Medicare crossover system to process claims for recipients covered by Medicare and Medicaid. Under the crossover system, providers generally submit claims for dual-eligibles to Medicare, which pays its portion of the claims and then forwards the claims' data to eMedNY for Medicaid processing and payment. However, Medicare Part C claims data (from Advantage Plans) is not processed through the crossover system. Instead, providers submit claims for Part C cost-sharing directly to eMedNY. When this occurs, the Department relies on providers to accurately report cost-sharing liabilities, and Medicaid pays the related claims, regardless of their amounts.

In prior audits, we concluded that providers often misreported Medicare cost-sharing amounts for certain claims, which resulted in significant Medicaid overpayments. We reviewed the supporting documentation for a sample of 55 claims (from six providers) that resulted in Medicaid payments totaling \$273,876. Based on our review, we found that 37 (67 percent) of the claims were overpaid by \$70,594 (26 percent). For example, a physician billed and Medicaid paid \$643 for Part C coinsurance for an echocardiography (image of the heart). However, according to the Advantage Plan's Explanation of Benefits (EOB), the coinsurance for this claim was only \$64. As a result, Medicaid overpaid this provider \$579 (\$643 - \$64).

According to Department officials, eMedNY controls to prevent overpayments of Medicare Part C cost-sharing liabilities are not feasible with any accuracy due to the numerous Medicare Advantage Plans and many variations in their deductible, coinsurance and copayment amounts.

Absent certain policy changes to limit Part C payments, Medicaid will continue to make excessive payments for Part C claims. As previously indicated, the potential for Medicaid cost savings is significant if New York placed limits on payments for Part C cost-sharing liabilities. Therefore, we recommend that the Department re-evaluate the existing reimbursement methodology for Part C claims.

Recommendations

1. Formally re-evaluate the existing methodology for processing and paying claims for Medicare Part C cost-sharing liabilities. Include reviews of other states' policies in performing the evaluation.
2. Recover the \$70,594 in Medicaid overpayments from the six providers who misreported Medicare Part C cost-sharing data.
3. As resources and priorities permit, review payments for high-risk Medicare Part C claims, such as those that exceed certain pre-determined dollar limits. Recover any overpayments that are identified.

Overpayments for People Not Enrolled in Medicare Part C

Medicaid overpaid nearly 115,000 claims for Medicare Part C cost-sharing liabilities by \$1,637,291 because 21,339 recipients were actually enrolled in Medicare Part B (not Part C) at the time the services in question were rendered. As of July 1, 2003, the State's Social Services Law limits Medicaid payment of Medicare Part B coinsurance for many common services to 20 percent of the coinsurance charge when Medicare's payment exceeds Medicaid's normal fee. If the providers correctly submitted these claims, for Part B coinsurance, eMedNY would have limited the payments to 20 percent of the coinsurance charges. However, because providers incorrectly submitted the claims as Part C coinsurance, Medicaid overpaid them.

For example, a physician billed Medicaid \$255 for Medicare Part C coinsurance for a coronary procedure performed on a dual-eligible recipient. We reviewed the claim's Medicare EOB and verified the recipient had Part B coverage and, therefore, the provider should have claimed Medicare Part B (not Part C) coinsurance. According to the EOB, Medicare reimbursed the provider \$1,022 for the procedure. Because the standard Medicaid fee for the service was \$504, Medicaid should have limited its coinsurance payment to \$51 ($\255×20 percent). Instead, Medicaid paid the physician's full coinsurance charge (\$255), resulting in an overpayment of \$204 ($\$255 - \51).

In responding to this issue, the Department activated an eMedNY edit on January 22, 2013 to deny a claim for Medicare Part C cost-sharing when eMedNY indicates the recipient does not have Part C coverage. The edit should help prevent overpayments similar to those we identified. However, at the time our audit fieldwork concluded, the Department had not yet recovered the aforementioned overpayments totaling \$1,637,291.

Recommendation

4. Review the \$1,637,291 in overpayments for Medicare Part C cost-sharing liabilities that providers billed incorrectly and recover funds where appropriate.

Questionable Payments for People Enrolled in Medicaid Advantage Plans

People who enroll in a Medicare Advantage Plan have the option to enroll in the same organization's Medicaid Advantage Plan (a Medicaid managed care plan for dual-eligible people). Medicare will pay the premium for the recipient's participation in the Medicare Advantage Plan, and Medicaid pays the premium for participation in the Medicaid Advantage Plan. Medicaid's premium payment covers the recipient's cost-sharing liabilities associated with the Medicare Advantage benefit. Therefore, Medicaid should not pay providers for any cost-sharing liabilities for covered services of the Plan.

Nevertheless, Medicaid made 1,259 payments totaling \$94,306 for Medicare Part C cost-sharing during the same months it made premium payments totaling \$552,327 for Advantage Plan recipients. According to eMedNY, the recipients were enrolled in Medicare Advantage Plans and Medicaid Advantage Plans. Under those circumstances, Medicaid should not have paid for Part C cost-sharing liabilities. However, because certain eMedNY data might not have been up-to-date, it was unclear whether the payments for cost-sharing liabilities or the payments for Advantage Plan premiums were incorrect. As such, the Department should verify recipients' enrollments in Medicaid Advantage Plans. If the recipients were enrolled in a Medicaid Advantage Plan, the Department should seek recovery of the Part C cost-sharing payments. If, however, the recipients were not enrolled in a Medicaid Advantage Plan, the Department should seek recovery of the Advantage Plan premium payments.

The following example details how Medicaid paid an Advantage Plan premium and a Part C cost-sharing liability for a recipient during the same month. Medicaid paid \$1,724 for a Medicare Part C deductible for inpatient services for a particular recipient. However, this recipient was also enrolled in a Medicaid Advantage Plan at the time of the service, and Medicaid paid a monthly premium of \$98 for this person. Thus, it appears Medicaid should not have paid the Medicare cost-sharing charge of \$1,724.

For another recipient, Medicaid paid \$68 for a Medicaid Advantage Plan premium payment and \$1,156 for a Medicare Part C deductible in the same month. In this case, the recipient's participation in the Medicaid Advantage Plan was terminated retroactively and, therefore, Medicaid's payment of the Part C deductible appears to be valid. Consequently, the Department should recover the Medicaid Advantage Plan premium of \$68.

Recommendations

5. Review the 1,259 instances when Medicaid made a Medicare Part C cost-sharing payment and paid a Medicaid Advantage premium for the same recipient in the same month. As warranted, recover any overpayments identified.
6. Assess eMedNY functionality that allows concurrent payments for Medicaid Advantage premiums and Medicare cost-sharing liabilities on behalf of the same recipient and correct the eMedNY system as necessary.

Audit Scope and Methodology

The objective of our audit was to determine if Medicaid made excessive payments for Medicare Part C cost-sharing liabilities. Our audit period was from January 1, 2008 through November 30, 2012.

To accomplish our objective, we interviewed officials from the Department and the Office of the Medicaid Inspector General. We reviewed applicable sections of federal and State regulations, and examined the Department's relevant Medicaid policies and procedures. Also, we reviewed certain other states' Medicaid reimbursement methodologies for services rendered to dual-eligible recipients enrolled in a Medicare Advantage Plan. Our review focused on Medicare Part C claims for clinic, dental, durable medical equipment, eye care, inpatient, laboratory, physician, referred ambulatory, and transportation services.

We re-priced Medicaid claims for Medicare Part C cost-sharing. For each claim, we determined the Medicaid fee for the service provided. We calculated the potential savings on each claim to the extent that the combined Medicare and Medicaid payment exceeded Medicaid's normal fee. As appropriate, we reviewed supporting documentation of selected paid claims. In addition, we provided a listing of overpaid claims to the Office of the Medicaid Inspector General for review and recovery.

We performed our 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

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

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 concurred with most of our recommendations and indicated that certain actions have been and will be taken to address them. Our rejoinders to certain Department comments are included in the report's State Comptroller's Comments.

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

Andrea Inman, Audit Manager
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Vision

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Agency Comments



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

Sue Kelly
Executive Deputy Commissioner

November 13, 2013

Mr. Brian Mason, Acting Assistant Comptroller
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 Department of Health's comments on the Office of the State Comptroller's Draft Audit Report 2012-S-133 entitled, "Medicaid Payments Made Pursuant to Medicare Part C."

Thank you for the opportunity to comment.

Sincerely,

A handwritten signature in black ink that reads "Sue Kelly". The signature is fluid and cursive.

Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael J. Nazarko
Robert W. LoCicero, Esq.
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**Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2012-S-133 Entitled
Medicaid Payments Made Pursuant to Medicare Part C**

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Draft Audit Report 2012-S-133 entitled, "Medicaid Payments Made Pursuant to Medicare Part C."

Recommendation #1:

Formally re-evaluate the existing methodology for processing and paying claims for Medicare Part C cost-sharing liabilities. Include reviews of other states' policies and consider proposing legislation to limit payments of Medicare Part C cost-sharing liabilities.

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Comment 1

Response #1:

The audit report indicates that the Medicaid Program may save as much as \$22 million dollars annually if Medicare Part C claims for dually eligible individuals were subject to the same cost sharing limits that are applied to Medicare Part B claims. As stated in the audit report, the Department advised the auditors that there is a large variance in cost sharing structures in the variety of Medicare Part C plan benefits offered across the State. For example, many Medicare Part C Advantage plans do not pay providers a fee-for-service payment but instead pay on a capitated basis. It is not possible to apply cost sharing limits to capitated payments. If the provider is paid on a capitated basis, is there a corresponding coinsurance or deductible that is being billed to Medicaid but no discrete fee-for-service payment made to the provider? It is unclear if the OSC took this into account in their savings estimate. If not, the estimated annual savings may be grossly overestimated.

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Comment 2

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Comment 3

The OSC identifies a mix of Medicare Part A and Part B services reimbursed by Part C Medicare Advantage and recommends that Medicaid apply applicable cost sharing limits to these services. The OSC recommends a very simplistic approach - revise Social Services law authorizing the Department to apply cost sharing limits to medical services reimbursed by a Medicare Advantage Plan. A number of very important factors were not considered by the OSC in their recommendation:

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Comment 1

- There is no statutory authority at this time to impose cost sharing limits on Medicare Part A hospital inpatient services. It is probable that the Department could not impose cost sharing limits on inpatient services reimbursed by a Medicare Part C Advantage Plan unless there was also corresponding statutory authority to apply cost sharing limits on Medicare Part A hospital inpatient services.
- Social Services Law 367-a specifically prohibits Medicaid from applying cost sharing limits to both transportation and psychologist services. This prohibition may apply to transportation and psychologist services reimbursed by a Medicare Advantage Plan.

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Comment 1

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Comment 4

* See State Comptroller's Comments, page 17.

- Cost sharing limits for Medicare Part B practitioner services is limited to 20% of the Part B coinsurance amount, not the full Part B coinsurance amount. The OSC appears to be recommending that Medicaid pay \$0 coinsurance amounts for physician services paid by Medicare Advantage. The Department may not have the authority to limit all cost sharing, but may potentially have the authority to limit cost sharing to 20% of the coinsurance amount. The OSC also appears to have calculated potential cost savings for practitioner and other Part B services based on Medicaid paying \$0 coinsurance rather than 20% of the coinsurance amount as is now dictated by statute (though, as indicated above, this is not absolutely evident since the OSC provided no details on how they calculated potential savings).
- Social Services Law 367-a specifically requires the Medicaid Program to pay all Medicare Part B deductible amounts. The OSC report does not differentiate between coinsurance and deductible amounts in their fiscal projections. Without further research, it is not known if cost savings could be applied to Medicare Part C deductible amounts. Projections that include deductibles may therefore overstate savings.

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Comment 5

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Comment 6

All of the above questions are policy related questions that would need to be fully researched, discussed, and vetted by both Department counsel as well as the Centers for Medicare and Medicaid Services (CMS) prior to proposing authorizing legislation. It is important to note that no overpayments or incorrect payments were identified by the OSC in this finding. The Department has paid and will continue to pay in accordance with state statute and federal requirements. It also needs to be pointed out that payment policy remains under the purview of the Department as the single state agency in accordance with state and federal statute. The OSC does not dictate Medicaid payment policy.

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Comment 7

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Comment 8

In summary, the OSC is recommending a rather simplistic approach to an extremely complex Medicare/Medicaid payment construct.

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Comment 9

Recommendation #2:

Recover the \$70,594 in Medicaid overpayments from the six providers who misreported Medicare Part C cost-sharing data.

Response #2:

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

Recommendation #3:

As resources and priorities permit, review payments for high risk Medicare Part C claims, such as those that exceed certain pre-determined dollar limits. Recover any overpayments that are identified.

Response #3:

As resources and priorities permit, the OMIG will review Medicare Part C payments for high risk claims and pursue appropriate recoveries.

Recommendation #4:

Review the \$1,637,291 in overpayments for Medicare Part C cost-sharing liabilities that providers billed incorrectly and recover funds where appropriate.

Response #4:

The OMIG will review the overpayments identified and pursue appropriate recoveries.

Recommendation #5:

Review the 1,259 instances when Medicaid made a Medicare Part C cost-sharing payment and paid a Medicaid Advantage premium for the same recipient in the same month. As warranted, recover any overpayments identified.

Response #5:

The OMIG will evaluate the feasibility of assigning responsibility and recovering any overpayments.

Recommendation #6:

Assess eMedNY functionality that allows concurrent payments for Medicaid Advantage premiums and Medicare cost-sharing liabilities on behalf of the same recipient and correct the eMedNY system as necessary.

Response #6:

The Department will review the eMedNY edits.

State Comptroller's Comments

1. From recommendation number 1, we deleted the reference to a legislative proposal to limit Medicaid payments of Medicare Part C cost-sharing liabilities. Consequently, certain Department comments in response to recommendation number 1 are no longer applicable. We advised the Department of the revision prior to issuance of the final report.
2. The Department's comment is misleading. In fact, to estimate New York's potential cost savings, we used an approach similar to that used by other states (including Florida, Indiana, Pennsylvania, Tennessee, and Texas) to limit Medicaid payments for Part C cost-sharing liabilities. Specifically, this approach limited such payments so that a provider's combined Medicare and Medicaid service reimbursement did not exceed the normal Medicaid fee. The MRT's cost-sharing limits for Medicare Part B apply only to coinsurance. In contrast, our methodology included all forms of Part C cost-sharing liabilities.
3. The Department's comment is speculative. In fact, a Department program official acknowledged that the Department did not have any formal analysis demonstrating that we over-estimated the amount of the potential savings. Further, the question (scenario) presented by the Department likely has minimal relevance to our analysis and conclusions. From January through mid-December 2013, providers submitted only 242 Medicaid claims (totaling \$10,590) for Part C liabilities which included an indicator of a capitation agreement with a Medicare Advantage Plan.
4. We acknowledge that the Law prohibits cost-sharing limits on certain transportation and psychologist services. The costs for these services, however, are rather limited in relation to the costs for the broad range of other medical services and equipment funded by Medicaid. Moreover, the fact remains that Medicaid could achieve significant cost savings by placing reasonable payment limits on Part C claims.
5. We discussed our methodology with Department officials during the audit's fieldwork, and we provide details of our methodology on pages 5-7 and 10 of our report. Accordingly, when the Medicare Advantage Plan payment exceeded the standard Medicaid fee, we calculated our potential cost savings based on \$0 coinsurance for physician services. However, even if the Department reduced Medicaid payments to 20 percent of coinsurance charges, such payments (which are currently based on 100 percent of the coinsurance charges) would still be significantly less.
6. We acknowledge that the Law currently requires Medicaid to pay all Medicare Part B deductibles. Also, as referenced in our report, our estimation of potential cost savings was consistent with the approaches used by other states to limit Medicaid payments for Part C charges.
7. The Department's statement is incorrect. In fact, as detailed on page 7 of our report, we reviewed 55 claim payments (totaling \$273,876) and found that 37 (67 percent) of the claims were overpaid by \$70,594 (26 percent). Further, we recommended that the Department recover the overpayments.
8. OSC has never dictated Medicaid payment policy. Rather, pursuant to its constitutional authority, OSC audited this component of the Medicaid program to make constructive recommendations to help save limited taxpayer dollars in a period of considerable State fiscal challenge. We encourage Department officials to react to our recommendations

objectively and to take the appropriate actions to implement them.

9. We acknowledge that this matter is complex. Moreover, given the magnitude of the payments in question as well as the potential for millions of dollars of Medicaid cost savings, we encourage Department officials to research the factors which are integral to the modification of the reimbursement methodology for claims for Medicare Part C charges.