THOMAS P. DiNAPOLI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 26, 2013

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

Re: Excessive Medicaid Payments for
Services to Recipients Receiving
Medicare Benefits
Report 2012-F-29

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, *Excessive Medicaid Payments for Services to Recipients Receiving Medicare Benefits (*Report 2009-S-64).

Background, Scope and Objective

The Medicare program covers medical services to eligible persons who are elderly or disabled. The Medicare program has a Part A and a Part B. Part A covers inpatient, nursing home and home health services. Medicare Part B covers doctor visits and outpatient care. Under the Medicare program, covered individuals are responsible for an annual deductible before Medicare will cover their claims. In addition, once the deductible amount is reached, Medicare covered individuals are also responsible for a coinsurance amount for certain claims. Medicare is a federal program and is administered by the Centers for Medicare and Medicaid Services (CMS).

The Medicaid program covers inpatient and outpatient medical services to low-income individuals. Medicaid is a federal, state and local government program where funding is shared by each level of government. Some New York Medicaid recipients also have Medicare. These recipients are called "dual eligibles." However, Medicaid is always the payer of last resort. This means that all other insurance, including Medicare, must first be billed before Medicaid can be billed for any remaining unreimbursed amount. At the federal level, the Medicaid program is administered by CMS. In New York, the Medicaid Program is administered by the Department,

county departments of social services, and the New York City Human Resource Administration.

Our initial audit report was issued on September 20, 2010. Our objective was to determine whether the Department correctly paid claims for services to Medicaid recipients who also have Medicare coverage. The audit included the period from July 1, 2005 through June 30, 2009. For this period, we identified about $600 million in Medicaid payments the Department could have avoided if certain steps were taken to process Medicaid claims for services provided to dual eligibles. Medicaid incurred about $500 million of the avoidable costs because the Department did not ensure that New York's regulatory structure sufficiently limited Medicaid payments when Medicaid and Medicare overlapped. The remaining $100 million in avoidable payments occurred for the following reasons: the Department did not require the eMedNY system to properly apply the 20 percent limitation on coinsurance charges in all cases where it was applicable; providers did not properly report Medicare coinsurance amounts on the claims they submitted; and providers' claims incorrectly indicated that Medicare made no payments for the services billed.

The objective of our follow-up was to assess the extent of implementation, as of October 17, 2012, of the three recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made progress in addressing the problems we identified in the initial report. However, further actions are still needed. All three of the initial report's recommendations were partially implemented.

Follow-up Observations

Recommendation 1

Establish a more proactive culture that seeks to ensure that Medicaid is the payer of last resort for services provided to dual eligible individuals. Specific steps toward this goal include, but are not limited to:

- Re-evaluating the existing reimbursement methodology used when Medicare payments for services provided to dual eligible individuals already exceed the amount Medicaid would normally pay and proposing legislation to limit additional payments in line with other states,
- Programming the eMedNY system to apply coinsurance limitations in all cases not specifically excluded by law,
- Investigating all Medicare coinsurance claims that do not include either a Medicare payment or a deductible;
- Rejecting claims that report a Medicare deductible which exceeds established limits; and
- Periodically verifying Medicare payment, deductible and coinsurance amounts reported by providers against Medicare payment data maintained by CMS.

Status - Partially Implemented

Agency Action - Over time, the Department has taken several steps to reduce costs and ensure Medicaid is the payer of last resort for services provided to dual eligibles. On December 3, 2009, the Department implemented its automated Medicare/Medicaid cross-over system. Under the cross-over system, the Department directed providers of services to dual eligibles to submit their claims to Medicare. After processing these claims, Medicare electronically transfers (or crosses-over) pertinent claims data to the State's eMedNY system for Medicaid adjudication. As such, Medicaid claims for dual eligibles are now processed using Medicare payment, deductible and coinsurance data provided by CMS. The receipt of this data directly from CMS reduces the risk that Medicaid will make excessive payments for services provided to dual eligibles.

Prior to the cross-over system, providers submitted claims for dual eligible services directly to eMedNY and self-reported the amounts paid by Medicare and owed by Medicaid. Because providers often submitted inaccurate Medicare data, Medicaid overpaid many of these claims. According to Department officials, the cross-over system has reduced the amount of Medicaid overpayments. However, some claims for dual eligibles are not submitted to the cross-over system. Therefore, these claims are not subjected to the system's improved controls, and the risk of overpayment of these claims remains significant.

Further, subsequent to the issuance of our initial report, the Department took additional actions, as follows:

- Under the Medicaid Redesign Team's Proposal #164, the Department modified its reimbursement method for certain claims for dual eligible services. For hospital outpatient departments and diagnostic and treatment centers, Medicaid now limits payments for certain services covered by Medicare Part B. Under this limitation, the total payments from Medicare and Medicaid cannot exceed the amount Medicaid would otherwise have paid if the patient was covered solely by Medicaid. The Department revised the applicable Medicaid regulations pertaining to these claims. However, the Department has not applied this limit to services covered by Medicare Part A and other Medicare Part B services (such as physician treatment, laboratory work, eye care and transportation).
- Effective October 1, 2011, Medicaid no longer reimburses any portion of coinsurance for a claim for physician services covered by Medicare Part B, if the procedure is not covered by Medicaid. At the time of our follow-up, however, the Department had not applied this limitation to claims for other services that were covered by Medicare, but not Medicaid.
- The Office of the Medicaid Inspector General (OMIG) recently received Medicare/Medicaid claim payment data from CMS. OMIG officials intend to use this data to recover Medicaid payments for Medicare coinsurance when the related claims lack a Medicare payment or a deductible. However, at the time of our follow-up, the CMS data received by the OMIG was limited, and OMIG officials had not used it yet to recover improper Medicaid payments.

Recommendation 2

Review the potential overpayments identified in this audit, including claims where Medicare data that was incorrect or missing from claims, and recover the overpayments where appropriate.

Status - Partially Implemented

Agency Action - Our initial audit identified $27.3 million in questionable payments resulting from providers incorrectly reporting Medicare information on their claims. The Office of the Medicaid Inspector General (OMIG) and its contractor began audits to identify and recover overpayments resulting from such occurrences. These audits identified $4.5 million in improper payments, of which more than $1.6 million had been recovered at the time of our follow-up review. Further, OMIG officials indicated they will continue these audits and pursue additional recoveries, as appropriate.

Recommendation 3

Routinely audit claims involving Medicaid payments for Medicare beneficiaries. Audit claims for the 13 providers identified as having significant billing problems regarding Medicare beneficiaries.

Status - Partially Implemented

Agency Action - The OMIG reviewed claim payments made to four of the 13 providers we identified in our initial audit and recovered about $665,000 in improper payments from them. In addition, OMIG's contractor recovered about $675,000 in improper payments from another provider. (Note: These amounts are included in the aforementioned recoveries totaling $1.6 million.) Further, the OMIG will continue to audit claim payments for dual eligible services made to specific Medicaid providers.

Major contributors to this report were Paul Alois, Theresa Podagrosi and Rebecca Tuczynski.

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 of Health for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Dennis Buckley
Audit Manager

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