NEW YORK
state department of
HEALTH

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

Sue Kelly
Executive Deputy Commissioner

January 15, 2014

Mr. Brian Mason
Acting Assistant Comptroller
New York State Office of the State Comptroller
110 State Street, 10th Floor
Albany, New York 12236

Dear Mr. Mason:

Pursuant to the provisions of Section 170 of New York State Executive Law, I hereby transmit to you a copy of the New York State Department of Health's comments related to the Office of the State Comptroller's final audit report 2012-S-27 entitled, "Overpayments for Services Also Covered by Medicare Part B."

Please feel free to contact James Clancy, Assistant Commissioner, Office of Governmental and External Affairs at (518) 474-2011 with any questions.

Sincerely,

Nirav R. Shah

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

Enclosure

Department of Health
Comments on the
Office of the State Comptroller's
Final Audit Report 2012-S-27 Entitled
Overpayments For Services Also
Covered by Medicare Part B

The following are the New York State Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) Final Audit Report 2012-S-27 entitled, "Overpayments for Services Also Covered by Medicare Part B."

Recommendation #1:

Review and recover the Medicaid overpayments (totaling about $7.1 million) for providers that improperly reported Part B coinsurance data.

Response #1:

The Office of the Medicaid Inspector General (OMIG) has received approval from Centers for Medicare and Medicaid Services (CMS) on a State Plan Amendment to extend the look-back period on recovery audit contractor (RAC)-related work from 3 years to 6 years. Our RAC has prepared a pilot mailing that is in process.

It is also important to note that the Department implemented an automated Medicare/Medicaid crossover system to prevent overpayments similar to those identified in this draft report finding and other audit findings previously issued on this topic. This automated system was implemented on December 3, 2009, and these audit findings were conducted primarily prior to the implementation of this system from the period January 1, 2009 through December 31, 2009.

Using this new automated crossover system, providers need to submit a claim for a dual eligible recipient only to Medicare. Medicare will pay its portion of the claim and then automatically forward the claim's data to eMedNY to enable Medicaid to pay the coinsurance charge. With correct Medicare claim data, eMedNY can now pay Medicaid claims (including those identified in this audit) for dual eligible recipients more accurately. As a result, the Department has taken a corrective action on this audit finding.

It should be noted, this automated crossover system process was designed to improve the ability of the Medicaid Program to identify Medicare cost sharing amounts and pay providers appropriately. Even with the automated crossover process, there are still legitimate reasons for directly submitting crossover claims to Medicaid. For example, if a claim is submitted to Medicare, crossed over to Medicaid for payment, and subsequently denied Medicaid payment due to an administrative reason, (e.g., failing to provide a Medicaid rate code on their Medicare claim), the provider will have to resubmit the claim directly to Medicaid after making the necessary corrections. We have since determined that some providers may be circumventing the

automatic crossover process intentionally by billing Medicaid directly for Medicare deductibles/coinsurance amounts, resulting in potential overpayments. Therefore, the Department is reviewing this issue and if it can be systematically resolved, a systems project will be initiated and prioritized. If it cannot be systematically resolved, the Department will determine what other options are available to promote the fiscal integrity of crossover claims. The Department expects to initiate a systems project during the summer of 2014. This may include Medicaid Update articles and/or working with the OMIG to identify outlier claims for possible recoveries.

Recommendation #2:

Review and recover the Medicaid overpayments (totaling $238,842) made to providers who were incorrectly designated as federally qualified health centers (FQHCs).

Response #2:

The OMIG will recover the overpayments made to providers who were incorrectly designated as FQHC's.

Additionally, the Department identified and corrected the improper FQHCs designations prior to the completion of OSC's audit findings. The Department will also continue to monitor, track and establish rates of reimbursement and work on internal controls to reduce risk moving forward.