STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

December 22, 2014

Howard A. Zucker, M.D., J.D.
Acting Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Overpayments of Certain Medicare
Crossover Claims
Report 2014-F-17

Dear Dr. Zucker:

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, *Overpayments of Certain Medicare Crossover Claims* (Report 2011-S-28).

Background, Scope and Objectives

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 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 cost-sharing balances include Medicare coinsurance, copayments, and deductibles.

A Medicare "crossover claim" entails the transfer of processed claim information from Medicare to Medicaid or other health insurance payers that provide supplemental insurance benefits to Medicare beneficiaries. On December 3, 2009, the Department implemented its automated Medicare/Medicaid crossover system. Under this system, providers submit medical claims for dual-eligible individuals to Medicare. After Medicare processes the claims, they are electronically transferred to the Medicaid claims processing system (eMedNY) for payment of Medicare coinsurance, copayments, or deductibles. Prior to the automated crossover system,

the Department relied on providers to self-report accurate information to eMedNY regarding how much Medicare paid and how much Medicaid owed, which often led to incorrect Medicaid payments.

We issued our initial audit report on January 10, 2013. Our objectives were to determine if Medicaid overpaid Medicare crossover claims for physician and other outpatient services and to identify the claims processing control weaknesses that allowed the overpayments to occur. The audit covered the period December 3, 2009 through March 31, 2012. Our initial audit identified flaws in certain eMedNY computer programs designed to process electronic Medicare crossover claims. As a result, Medicaid incorrectly processed Medicare crossover claims for physician and other outpatient services, causing actual overpayments totaling about $10 million. Also, because some providers bypassed the crossover system and the controls that it affords, an additional $16.4 million was potentially overpaid on similar claims.

We recommended that the Department review and recover the overpayments we identified. We also recommended the Department correct weaknesses in pertinent eMedNY computer programs and design and implement pertinent eMedNY controls to properly process and pay Medicare crossover claims. The objective of our follow-up was to assess the extent of implementation, as of November 11, 2014, of the five recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Officials made some progress in addressing the problems we identified in the initial audit report. This included the recovery of $977,343 in Medicaid overpayments. However, further significant actions are still needed. Of the initial report's five audit recommendations, one was implemented and four were partially implemented.

Follow-Up Observations

Recommendation 1

Review and recover the $10 million in actual overpayments attributable to the eMedNY control deficiencies we identified.

Status - Partially Implemented

Agency Action - Overpayments of $6.9 million occurred because eMedNY incorrectly interpreted Medicare crossover claim information and, as a result, improperly paid for services that Medicare denied. The Office of the Medicaid Inspector General (OMIG) contracted with Health Management Systems (HMS) to review these claims and make recoveries. OMIG officials stated these overpayments should be recovered by May 2015. As of October 29, 2014, HMS has recovered $52,856.

The remaining $3.1 million in overpayments occurred because eMedNY did not properly

apply New York State Medicaid reimbursement limits to electronic Medicare crossover claims for certain services. At the time of our follow-up, the OMIG was reviewing the claims and had recovered $1,060 of overpayments.

Recommendation 2

Design and implement eMedNY controls to properly process and pay Medicare crossover claims submitted by group providers. In particular, these controls should ensure that eMedNY properly limits crossover claims for professional services to 20 percent of the coinsurance charge.

Status - Partially Implemented

Agency Action - The Department developed eMedNY controls designed to limit payment of crossover claims submitted by group providers for professional services to 20 percent of the coinsurance charge. Department officials stated the controls are scheduled for implementation on December 18, 2014.

Recommendation 3

Review the $16.4 million in potential Medicaid overpayments attributable to providers directly billing crossover claims to Medicaid and recover overpayments, where appropriate.

Status - Partially Implemented

Agency Action - As of October 29, 2014, OMIG has recovered $923,427. The OMIG will review the remaining potential overpayments identified and determine appropriate action.

Recommendation 4

Implement the controls necessary to prevent providers from billing crossover claims directly to the Medicaid program. Consider denying crossover claims providers submit directly to Medicaid.

Status - Implemented

Agency Action - Department officials have considered the risks of providers submitting crossover claims directly to Medicaid. However, Department officials do not plan to automatically deny these claims because there are legitimate reasons for directly billing crossover claims to Medicaid. For example, according to the Department, Medicare and Medicaid do not always use the same procedure codes and providers would legitimately bill these services directly to Medicaid.

Alternatively, the Department has taken steps to prevent providers from billing crossover claims directly to the Medicaid program. The Department has implemented eMedNY system controls to identify potentially duplicate claims (wherein a claim is directly

submitted to Medicaid by a provider and another claim, for the same service, is submitted to Medicaid through the Medicare crossover system) and pend those claims for manual review. Further, the OMIG has audit criteria in place to identify and recoup duplicate claims, as well as criteria to identify and recoup direct bill claims that should have been submitted to Medicare first, but were not. In addition, since 2011, the Department has sent letters to 5,538 providers notifying them their claims are being monitored.

Recommendation 5

Follow-up with providers and billing service bureaus (including the bureau identified in this report) who routinely submit claims for Medicare coinsurance charges for services provided to dual-eligible persons directly to Medicaid.

Status - Partially Implemented

Agency Action - The Department has identified and followed-up with providers who repeatedly bill Medicaid directly (as noted in the agency actions regarding Recommendation #4). However, the Department had not followed-up with any billing service bureau, including the one we identified in the original report.

Major contributors to this report were Warren Fitzgerald, Gail Gorski, and Andrea LaBarge.

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 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 Director

cc: Ms. Diane Christensen, Department of Health
Mr. James Cox, Medicaid Inspector General