

THOMAS P. DINAPOLI
COMPTROLLER



110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 6, 2014

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

Re: Overpayments for Services Also
Covered by Medicare Part B
Report 2013-F-30

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, *Overpayments for Services Also Covered by Medicare Part B* (Report 2010-S-50).

Background, Scope and Objective

Many of the State's Medicaid recipients are also eligible for Medicare Part B, which provides supplementary medical insurance covering a broad range of outpatient medical services, physicians' fees, and medical supplies. Individuals enrolled in both Medicaid and Medicare are commonly referred to as "dual eligible." Generally, Medicare is the primary payer of claims for services provided to dual eligible recipients. After Medicare adjudicates a claim, Medicaid pays the balance that is not covered by Medicare and would otherwise be the financial obligation of the recipient. As a result, for dual eligible recipients, Medicaid generally would pay deductibles and coinsurance not covered by Medicare.

We issued our initial audit report on June 20, 2012. Our objective was to determine if the Department overpaid health care providers' Medicaid claims for Medicare Part B deductibles and coinsurance. The audit covered the year 2008. For that period, we identified 259,152 Medicaid claims that were overpaid by almost \$8.5 million because providers did not properly report Medicare payment data on those claims. At the time of our initial audit, nine of the problem

providers we identified were under investigation by the Office of the Medicaid Inspector General. These providers accounted for nearly \$1.6 million of the \$8.5 million in overpayments that we identified. We recommended that the Department take the necessary actions to assess and recover, as appropriate, the remaining \$6.9 million in overpayments, and take steps to prevent future overpayments.

The objective of our follow-up was to assess the extent of implementation, as of January 31, 2014, of the three recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials made considerable progress in addressing the issues we identified in the initial audit. This included the recovery of improper payments totaling \$4.8 million from providers who inaccurately billed Medicare Part B claims. However, further actions are still needed. Of the three prior audit recommendations, one was implemented and two were partially implemented.

Follow-Up Observations

Recommendation 1

Review claim payments for the providers we identified who reported Medicare Part B payment data incorrectly. Investigate and recover the remaining \$6.9 million in Medicaid overpayments that the OMIG had not reviewed at the time of our audit fieldwork.

Status - Partially Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. OMIG contracts with HMS to review certain Medicaid claims and make recoveries where appropriate. HMS recovered \$4.8 million from providers who inaccurately billed Medicare Part B claims. Further, OMIG officials advised us that HMS will continue efforts to recover other overpayments and anticipates completion of such efforts in 2014.

Recommendation 2

Take steps to ensure that billing service bureaus have adequate systems in place for Medicaid providers to review their claims prior to the bureaus' submission of them to eMedNY.

Status - Partially Implemented

Agency Action - The Department issued a *Medicaid Update* article in June of 2013 that reminded service bureaus to have systems in place for providers to review and correct their claims prior to the bureaus' submissions of those claims to eMedNY. However, the Department has no formal mechanism to ensure service bureaus have actually implemented the

required provider claim verification function. Further, during the course of our follow-up, we surveyed four billing service bureaus that enrolled in Medicaid after our initial report was issued. In seeking Department approval of their enrollment applications, the four service bureaus attested that they had systems to notify providers of claims to be submitted on their behalf. Nevertheless, all four service bureaus told us they had not yet established such systems.

Recommendation 3

Optimize the number of claims for dual eligible persons that are processed through the crossover process. As part of this process, formally assess the propriety of requiring most (if not all) providers to submit all claims for dual eligible persons through the crossover system.

Status - Implemented

Agency Action - The Department has taken steps to optimize the number of claims for dual eligible persons that are processed through the crossover process. To increase the number of such claims, the Department regularly assesses relevant policies and practices and has implemented eMedNY system changes, where appropriate. For example, the Department initiated a project to allow institutional claims (that lack certain rate code information) to be billed through the Medicare crossover system. Also, according to Department officials, the Department continues to look for other ways to optimize the number of claims for dual eligible persons that are processed through the crossover system.

Major contributors to this report were Warren Fitzgerald, Amanda Strait and Lauren Bizzarro.

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,

A handwritten signature in dark ink, reading "Andrea M. Inman". The signature is fluid and cursive, with the first name "Andrea" and last name "Inman" clearly legible, and a middle initial "M." in between.

Andrea Inman
Audit Manager

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