OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

New York State Department of Health

Excessive Medicaid Payments for Services to Recipients Receiving Medicare Benefits

2009-S-64

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

September 20, 2010

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

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 Department of Health entitled *Excessive Medicaid Payments for Services to Recipients Receiving Medicare Benefits*. 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

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine if the New York State Medicaid program was correctly paying provider claims for services to Medicaid recipients who have health insurance through Medicare.

Audit Results - Summary

New York's Medicaid program covers medical services to eligible low income recipients. The federal Medicare program covers medical services to the elderly and the disabled. Some New York Medicaid recipients also have Medicare. These individuals are called "dual eligible." For dual eligible individuals, Medicaid pays last - covering appropriate and remaining charges after Medicare has been billed.

We conclude that efforts by the Department of Health (Department) have not been proactive and comprehensive enough to prevent excessive Medicaid payments for services provided to dual eligible recipients. The absence of sufficient actions has cost taxpayers about $600 million over our four-year audit period. In particular, New York could have saved about $500 million by adopting certain policies that other states follow when paying claims for dual eligible individuals. Also, the Department made about $100 million of Medicaid overpayments as it processed medical claims pertaining to dual eligible individuals. In this regard, provider fraud may have occurred in certain instances. Strikingly, certain of the overpayments persisted even though they were chronicled in prior State Comptroller audit reports and even though Department management pledged to correct deficiencies.

The policy of states like Florida and California significantly reduces or even eliminates altogether Medicaid payment to a provider when Medicare has already paid the provider as much or more than their State would pay for the same service to a recipient who is only entitled to Medicaid. If New York similarly limited its provider Medicaid liability for dual eligible individuals, New York's Medicaid program would save an estimated $125 million annually ($500 million over the four year audit period).

For example, the federal Medicare program paid a New York hospital $67,181 for rehabilitation services to a dual eligible individual. Under Medicare rules, the recipient was responsible for $32,040 of coinsurance in connection with this service. Under existing New York State

Medicaid rules for dual eligible individuals, the Department paid the provider the full $32,040 of coinsurance in connection with the hospital service. Yet, if the recipient only had Medicaid, the provider would only have been entitled to and would have only obtained $23,406 for the same service under New York's Medicaid fee structure. Consequently, New York's Medicaid paid the provider nearly a $8,600 premium ($32,040 - $23,406) simply because the recipient was dual eligible. The policies of Florida and California would not have allowed the provider to be reimbursed beyond the amount covered by their State fee structure for Medicaid regardless of dual eligibility.

Department officials acknowledged that significant savings could accrue to the State from the implementation of policies like those used by Florida and California. However, they stated that legislatively approved amendments to existing New York State Medicaid laws would be necessary to implement the policy reform. In this regard, it should be noted that a new Law in New York did make some progress in this area by establishing a 20 percent cap on the amount of Medicare coinsurance that Medicaid would pay for certain outpatient service claims for dual eligible individuals.

However, we found that Medicaid overpaid providers about $70 million because the Department failed to program appropriate preventive controls into its automated claims processing system (eMedNY) to properly apply provisions of the new law. This includes over $7.2 million in overpayments that occurred when eMedNY allowed $9.1 million to be paid for about 820,000 claims for therapeutic massage services, when the payments should have been no more than $1.9 million.

As with previous audits, we also continue to find providers that either have not billed Medicare first or fail to properly report the Medicare payments they receive. In other cases, even when Medicare payments were reported, providers misclassified the patients' remaining balances on their claims, thereby avoiding limits on certain payments like coinsurance. In total, these problems resulted in another $27 million of overpayments during our audit period, including almost $20 million for cases where providers failed to properly report Medicare payments received. Some providers failed to report payments so often as to cause us to question whether their claims were fraudulent. We referred data on 13 such providers to the Office of the Medicaid Inspector General for comprehensive audit and follow up.

We identified most of these problem claims by applying relatively simple detection controls, including comparisons of Medicaid claim information with data on Medicare payments, which is available to the Department from the federal Centers for Medicare and Medicaid Services. Yet, after years of recurring problems, the Department still does not routinely perform these tests on its own.

With nearly $150 million in annual savings at stake, New York's current fiscal situation cannot afford a piecemeal approach to addressing issues surrounding dual eligible individuals. The Department must develop a comprehensive strategy that couples improved prevention and detection controls with up-to-date policy initiatives designed to ensure that Medicaid is truly the payer of last resort.

Our report contains three recommendations directed to recover overpayments, correct the specific problems we identified and to take proactive steps to better ensure that Medicaid is the payer of last resort.

In response to our draft audit report, Department officials indicated that certain steps are planned or have been taken which address our report's recommendations. Officials also questioned most of the potential savings we cited, stating that the Medicaid payments in question were made pursuant to the applicable State Law. Further, officials noted that the Department implemented its automated Medicare/Medicaid cross-over system (effective December 3, 2009) that will help to reduce excessive Medicaid payments for recipients also covered by Medicare.

Auditor's Comment: We question why Medicaid would pay any amount when the Medicare reimbursement has already exceeded what New York's Medicaid reimbursement would have paid for the service for someone who had only Medicaid coverage. We believe such policies are inconsistent with the prudent use of limited public funds, particularly in light of the State's tenuous financial condition. Moreover, we maintain that Medicaid could have realized savings approaching $125 million annually, if it employed certain reimbursement policies already in use in other states. Thus, we urge the Department to take the necessary steps, including the preparation of legislative amendments, to implement policies that will help avoid excessive Medicaid payments for recipients also covered by Medicare.

This report, dated September 20, 2010, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or
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Introduction

Background

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 amount 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. 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 at the state level by the Department of Health (Department) and, at the local level by county social service districts and by the Human Resource Administration within New York City.

The Department relies on an automated claims processing system (eMedNY) to reimburse medical service providers for their Medicaid claims, including claims that pertain to individuals who qualify for and obtain both Medicare and Medicaid. Medicaid provides coverage for the cost of Medicare deductibles and coinsurance for these dual eligible individuals.

Our past audits have repeatedly identified instances where the Department (and its predecessor in administering Medicaid, the Department of Social Services) has not ensured that providers properly bill Medicare when appropriate, and adjust their Medicaid claims accordingly. These reports chronicle weaknesses that have cost New Yorkers millions of dollars each year, including $27 million from a 1995 audit of Medicare coinsurance and deductible payments (Report 95-S-40, issued February 1, 1996), $13 million from an audit of payments in 1999 for inpatient services (Report 2000-D-4, issued May 9, 2001), $28 million from a similar audit of payments from 2003 (Report 2004-S-51, issued September 14, 2005) and $2.7 million from another audit issued in 2009 (Report 2008-S-128, issued January 16, 2009).

This audit focuses primarily on the Department's efforts to ensure compliance with Section 367-a of the New York State Social Services Law (Law), which establishes a limit on the amount that Medicaid should pay for coinsurance associated with most Medicare Part B coverage for dual eligible individuals when the Medicare payment exceeds what Medicaid would normally pay for the service. Since July 2003, in these instances the Law has limited Medicaid coverage to 20 percent of any Medicare coinsurance amount. The Law does not limit the amount Medicaid should pay for the Medicare Part B deductible or for the Medicare Part A deductible or coinsurance. Medicaid generally pays 100 percent of these amounts for dual eligible individuals.

Audit Scope and Methodology

Our audit determined whether Medicaid overpaid for certain medical services rendered to dual eligible individuals for the period of July 1, 2005 through June 30, 2009. To accomplish this objective, we interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined the Department's relevant policies and procedures. We also reviewed other states' Medicaid reimbursement methodologies for services rendered to dual eligible individuals. For the period July 1, 2005 through June 30, 2009, we obtained from eMedNY all claims for inpatient, clinic, practitioner, durable medical equipment, and transportation services where Medicare was the primary payer. As appropriate, we reviewed supporting documentation of selected paid claims.

In December 2009, after our audit started, the Department implemented an electronic automated Medicare/Medicaid cross-over system which is intended to reduce problems with claims for dual eligible recipients. We did not assess this system during our audit.

We conducted our performance 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 that 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 indicated that certain steps are planned or have been taken which address our report's recommendations. Department officials also questioned most of the potential savings we cited, stating that the Medicaid payments in question were made pursuant to the applicable State Law. Our rejoinders to the Department's response are included in our 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 therefor.

Contributors to the Report

Major contributors to this report include Paul Alois, Arnold Blanck, Taryn Davila-Webster, Christopher Morris, Earl Vincent, Steve Sossei, and Brian Mason.

Audit Findings and Recommendations

We identified about $600 million in Medicaid payments made between July 2005 and June 2009 that could have been avoided had the Department taken more comprehensive and proactive steps to administer Medicaid reimbursements for services provided to dual eligible individuals. About $500 million of this amount occurred because the Department has not ensured New York's regulatory structure has kept pace with other states' efforts to limit Medicaid payments in areas where Medicaid and Medicare programs overlap. Although the Department does reduce Medicaid reimbursements based on the payments already made by private insurers, the same practices generally do not apply to Medicare payments. In contrast, other states usually will not make an additional Medicaid payment if Medicare has already paid more than the typical Medicaid rate for a service. By adopting rules similar to those in place in other states like Florida and California, we estimate the program could save $125 million annually.

One area where New York does already limit payments for services provided to dual eligible individuals is in funding for patients' coinsurance requirements. When Medicare Part B services are provided to dual eligible individuals, the Law generally limits the amount Medicaid will pay to 20 percent of the Medicare coinsurance amount, provided that Medicare has already paid more than the standard amount that Medicaid would normally pay for the service on its own. The Law excludes certain services from this 20 percent limitation, in which case Medicaid will generally fund the entire coinsurance amount. The Department is responsible for ensuring that eMedNY pays claims in accordance with the Law. To accomplish this, eMedNY must be programmed with preventive controls that compare claims against certain criteria, such as those that trigger the 20 percent limitation on Medicare coinsurance charges.

We identified certain claim payments made by the eMedNY system between July 1, 2005 and June 30, 2009 on behalf of dual eligible recipients based on claims for services that should have been subject to the 20 percent limitation. Our analysis of these payments determined the Department overpaid providers almost $100 million for these claims because of three specific causes: 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 reported that Medicare had not made any payment toward the billed charges. Many of these same problems have been identified in

previous audits. Despite repeated pledges to recover overpayments and correct deficiencies, the same problems continue to exist year after year.

Comparison with Policies in Other States

As noted previously, State Law limits Medicaid payments on certain Medicare Part B claims to 20 percent of the full coinsurance amount. We surveyed other states to determine how they reimbursed providers for services to dual eligible individuals and found some variance in those policies. Nearly all of the other states compare their typical Medicaid service fees with the amounts providers have already received from Medicare. These comparisons generally reduce or eliminate Medicaid payments, depending on the differences between the Medicare and Medicaid fees.

Specifically, several states limit Medicaid payments by comparing the total payment a provider receives from all sources (Medicare, Medicaid, and private insurance) to the maximum amount that Medicaid would otherwise pay. For example, Florida and California limit their Medicaid reimbursement for Medicare Part A and B services (including coinsurance and deductible) to their normal Medicaid fee. If the amount already paid by Medicare exceeds the normal Medicaid fee, Medicaid will not make an additional payment on the claim. Although New York's Medicaid program uses a similar process to limit payments for claims involving private insurance, this process is not applied to Medicare. Consequently, New York's methodology for paying claims for dual eligible recipients is more generous than many other states.

We identified and analyzed claims data from eMedNY for all inpatient, clinic, practitioner, durable medical equipment, and transportation payments for dual eligible recipients during our audit period. We compared the payments that providers received from Medicare and all other sources to the amounts Medicaid would have paid if there were no other coverage. In many instances, we found providers received payments from Medicare and other sources that already exceeded the amounts that Medicaid would otherwise have paid. The following example illustrates the difference between New York and other states' policies for paying claims for dual eligible recipients.

Medicare paid a hospital $67,181 for rehabilitation services provided to a dual eligible individual who was hospitalized for 60 days. The amount of the Medicare coinsurance requirement was $32,040. Under New York's current rules, Medicaid would have paid the hospital the full $32,040, even though the standard Medicaid fee for this admission was only $23,406; nearly $8,600 less than the Medicare coinsurance. In contrast, the Medicaid programs in Florida and California would have paid nothing on this claim because Medicare had already paid more than

the amount of their standard Medicaid payment. If New York used an approach similar to California and Florida, we estimate the Department could have saved over $500 million during our audit period, or more than $125 million per year on average.

Department officials acknowledged that New York's Medicaid program could realize costs savings by adopting policies (similar to those in California, Florida, and other states) that limit certain payments for dual eligible beneficiaries. Officials added, however, that changes in the affected payment policies would require amendments to the State's existing Medicaid laws, which would have to be approved by the State Legislature and the Governor.

Coinsurance Amounts Are Not Properly Limited by eMedNY

We identified two situations where the Department's reimbursement practices do not apply the 20 percent limitation on Medicare Part B coinsurance requirements required by existing law. These practices resulted in overpayments totaling $70 million during our audit period, as illustrated in the following paragraphs.

The Department has chosen to fully reimburse Medicare coinsurance charges for services where it does not have a standard Medicaid price programmed into the eMedNY system. As a result, when eMedNY compares the amount of the Medicare payment on a claim to the Medicaid fee schedule and does not find a price listed, it does not limit the coinsurance payment. For example, we found Medicaid paid over $9.1 million for 819,725 claims for therapeutic massage. This procedure that has been inactive in the eMedNY system since April 2005 and therefore had no programmed standard price. As a result, even though the Law does not exempt this service from the 20 percent limitation, Medicaid paid the full Medicare Part B coinsurance charge for each of these claims. Had the limitation been properly applied, these payments would have been reduced by 80 percent, or about $7.2 million.

We also found that eMedNY does not limit coinsurance payments for any claims that the Department has otherwise chosen to authorize and/or price manually. Consequently, if the Department does not specifically limit the payment for each of these claims, the system will ultimately pay the full coinsurance claim. For example, we found Medicaid paid $4.7 million in coinsurance for certain food supplements based on claims that contained a procedure code which the Department had chosen to review manually before authorizing payment. As a result of this practice, eMedNY did not limit the coinsurance payment as required by the Law resulting in overpayments totaling over $3.7 million.

Department officials contend that claims for services that have no Medicaid fee amount should be excluded from the 20 percent coinsurance limitation. According to officials, the Law requires a mathematical comparison between the Medicaid and Medicare payment amounts, and consequently, no comparison can be made without a specific Medicaid fee listed. However, we believe this interpretation is wrong. The fact is that when no Medicaid fee is listed for a particular service (i.e., procedure code), Medicaid makes no payment. As a result, in these cases, the Medicare payment will always exceed the amount ($0) Medicaid would otherwise pay for the service /procedure, and the amount of coinsurance should be limited. One might reasonably question whether a State law should even require Medicaid to fund 20 percent of the coinsurance amount for services/procedures that it would not otherwise cover at all. However, we believe it is entirely counterintuitive for the Department to suggest that the law would intend the program to pay five times that amount.

Providers Continue to Incorrectly Report Medicare Information

As noted previously, a provider must bill Medicare before submitting a claim to Medicaid. Medicaid will then pay the provider all or a portion of the patient's contribution such as the coinsurance and deductibles. When eMedNY processes a claim for reimbursement, it relies on certain information reported by service providers to determine the proper payment amount. In applying the 20 percent limitation on coinsurance payments for dual eligible information, eMedNY relies heavily on Medicare claim and payment information reported by providers as part of their Medicaid claims. If Medicare-related data is reported incorrectly on Medicaid claims, there is considerable risk that Medicaid will overpay the claim.

We determined that Medicaid overpaid providers over $27 million because the Department did not develop and implement controls necessary to detect and prevent payment of claims with inaccurate Medicare information. Specifically, we determined that overpayments occurred because providers entered Medicare coinsurance amounts on their claims as deductibles and because providers omitted Medicare payment data on other claims. We have addressed inaccurate Medicare data in previous audit reports, but this issue continues to be a problem for New York's Medicaid Program.

As part of our examination, we reviewed the supporting documentation for 1,185 claims filed by 30 providers and found Medicare information on 356 claims totaling about $150,000 was either incorrect or wholly unsupported. Thirteen of the 30 providers we examined either had significant error rates or were unable to provide documentation to support their claims; increasing the risk that these claims may be fraudulent. We

believe the Office of the Medicaid Inspector General (OMIG) should conduct a comprehensive audit of the billings for these 13 providers as they relate to Medicare beneficiaries. We have forwarded the relevant provider and claim information to OMIG to initiate this process.

Medicare Coinsurance Amounts Reported as Deductibles

Medicare patients are responsible for paying an annual deductible, which generally has been about $135 in recent years. We found providers sometimes incorrectly report the amount of Medicare coinsurance as a deductible when billing Medicaid and, as a result, eMedNY overpays the claim. For example, one provider billed Medicaid $660 for a Medicare deductible for a laser surgery procedure. However, the $660 was actually the patient's coinsurance requirement, which eMedNY should have limited to 20 percent (or $132) under the Law. Because the $660 was incorrectly billed as a deductible, eMedNY overpaid the claim by $528 ($660 - $132).

This claim illustrates a problem that should have been detected by eMedNY. As noted, the amount of the coinsurance, $660, was incorrectly reported as a deductible and eMedNY used this amount to compute the payment. However, the Medicare deductible limit is $135; substantially lower than the $660 claimed. Although eMedNY has a claims processing edit designed to stop excessive deductibles, it did not work for a significant number of claims for our audit period. We concluded that coinsurance amounts were incorrectly recorded as deductibles on 477,367 claims, resulting in overpayments totaling as much as $7.7 million. Many of these claims were submitted by physicians' groups that have service affiliations with a large New York City-based hospital.

Medicare Payment Data Omitted From Claims

According to the Law, to limit coinsurance to 20 percent of the amount claimed, the amount Medicare pays for a claim must be greater than the amount Medicaid would have paid for the same service. Therefore, if a Medicaid claim submitted by a provider for a dual eligible recipient indicates that Medicare made no payment, the service is excluded from the 20 percent coinsurance limitation and Medicaid pays the full amount of the coinsurance claimed. Using CMS Medicare data for 2007, we identified a significant number of Medicaid claims where the provider incorrectly indicated no Medicare payment was received. As a result, these claims were improperly excluded from the 20 percent coinsurance limitation. Furthermore, our analysis of CMS data failed to show a single instance where Medicare imposed a coinsurance requirement without either making a payment or applying a deductible against the claim. As a

result, we concluded that any Medicaid claim for a dual-eligible recipient that does not include either a Medicare payment or deductible amount is likely improperly submitted to Medicaid.

For example, we identified more than 1,000 claims submitted by one provider that billed Medicaid for coinsurance of $83.71 (per claim) without indicating any Medicare payment or deductible. Because no Medicare payment was reported, these claims were excluded from the 20 percent coinsurance limitation and Medicaid paid the provider about $84,000. However, CMS data indicated that Medicare payments had, in fact, been made on the claims. Based on that data, we determined the actual coinsurance requirement for each claim was really only $14.57, and this amount should have been subject to the coinsurance limitation because Medicare had already paid more than Medicaid would normally allow. Therefore, Medicaid should have paid only $2.91 ($14.57 times 20 percent) in coinsurance on each claim, overpaying this provider almost $81,000 for the 1,000 claims in question.

In total, we identified more than 489,000 Medicaid payments for dual eligible individuals that were made to practitioners and providers of durable medical equipment, supplies, and transportation services which lacked data on Medicare payments and deductibles (including the 1,000 claims previously discussed). Using the CMS data, we determined the amounts of Medicaid payments which should have been made on these claims and concluded that Medicaid overpaid providers by about $16.8 million.

We also found overpayments can occur when Medicare data is incorrectly reported even if the specific service is exempt from the 20 percent limitation under the Law. Because Medicaid is the payer of last resort, eMedNY processes claims for dual eligible individuals differently that it does claims where Medicaid is the primary insurance. When Medicaid is the primary payer, claims are paid based on approved fee schedules. However, for dual eligible individuals, payments are based on the Medicare deductible and coinsurance requirements. If the service is exempt from coinsurance limitations, eMedNY will pay the full amount, even if it exceeds the amount Medicaid would normally pay as the primary insurer.

We reviewed an additional group of claims for clinic services provided to dual eligible individuals, which are generally not subject to the 20 percent coinsurance limitation. Our objective was to determine if Medicaid overpayments occurred because providers had reported no Medicare payment data on the claim, but had requested payment based on a Medicare coinsurance amount. We visited the billing agency for

one provider and determined that the provider received over $800,000 in overpayments. Our work disclosed that the services should not have been submitted as a request for a Medicare coinsurance payment, but rather as a direct Medicaid claim because Medicare had already denied the provider's original claims. In these cases, Medicaid became the primary payer and the resulting payments should have been based on the approved fee schedule. The provider's billing agency told us that a computer error caused these claims to be submitted improperly to Medicaid.

We concluded that similar problems are likely to have occurred with the remaining claims of this type. In total, we identified 77,600 clinic service claims where providers reported no Medicare payment data and claimed coinsurance amounts that were more than Medicaid would have paid if it was billed as the primary payer. We estimate that, in total, about $2.8 million in overpayments have likely occurred because Medicaid was not properly considered the primary of payer on these claims.

Recommendations

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.

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.

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.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 13, 2010

Brian E. Mason, Audit Manager
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Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-64 on "Excessive Medicaid Payments for Services to Recipients Receiving Medicare Benefits."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Donna Frescatore
Diane Christensen
Dennis Wendell
Stephen Abbott
Stephen LaCasse
Ron Farrell
Mary Elwell
Irene Myron
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Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2009-S-64 on
"Excessive Medicaid Payments for Services to Recipients Receiving Medicare Benefits"

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2009-S-64 on "Excessive Medicaid Payments for Services to Recipients Receiving Medicare Benefits", including a general comment followed by responses to the specific recommendations contained in the report.

General Comment:

The Department finds that the estimated savings referenced in this audit are considerably overstated, with $500 million of the $600 million that OSC identified as potential savings to Medicaid related to co-insurance payments that are paid in accordance with existing State legislation. Though federal rules permit Medicaid programs to limit cost sharing, New York State Social Services Law requires the Medicaid program to reimburse certain providers (hospitals, clinics, psychologists and ambulance) the full Medicare Part B coinsurance and all other providers 20 percent of the Medicare Part B coinsurance. Considering that the Department is in compliance with existing law, it is the Department's position that the $500 million savings figure as well as any findings associated with it should be removed from the report.

* Comment 1

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.

* See State Comptroller's Comments, page 27.

Response #1:

The Department takes issue with the assertion that it has not taken a proactive and comprehensive approach to ensure that Medicaid is the payer of last resort, including OSC's statement that "Despite repeated pledges [by the Department] to recover overpayments and correct deficiencies, the same problems continue to exist year after year." OSC is aware that on December 3, 2009, the Department implemented an electronic automated Medicare/Medicaid cross-over system that addresses the majority of the audit's findings. While the audit period is only through June 30, 2009, OSC should acknowledge in its report that this is an appropriate step carried out by the Department to assure accurate claim payments.

* Comment 2

The following is the Department's response to each of the specific steps recommended by OSC:

- The Department will re-evaluate the Medicaid reimbursement methodology utilized when Medicare payments for the services provided already exceed the amount that Medicaid would normally pay and, subsequent to that review, will determine additional actions needed.

- OSC's interpretation of Medicaid policy relating to procedure codes is inaccurate. It is incorrect to conclude that if no Medicaid fee is listed for a (HCPSC) procedure code for which Medicare has paid a portion of the claim, Medicaid does not cover the service and the Medicaid co-insurance should be zero. Medicaid's use of HCPCS coding is not identical to Medicare's, as Medicare's coding may be more specific than Medicaid's. As a result of these differences, Medicaid may not have a fee listed for a specific code, however, upon review, the claim would be paid using a more generic HCPCS code to identify the service. The Department will review this issue and related current policy to determine if system changes are needed.

* Comment 3

- The Office of the Medicaid Inspector General (OMIG) has recently received Medicare/Medicaid data from the Centers for Medicare and Medicaid Services (CMS) which it will utilize to pursue appropriate recoveries of Medicare coinsurance claims that do not include either a Medicare payment or a deductible.

- With the implementation of Medicare/Medicaid cross-over billing in December 2009, Medicaid claims are paid based on Medicare deductible data furnished by CMS or are otherwise denied if the Medicare deductible amount reported by the provider is greater than the $135 annual Medicare deductible.

- With the implementation of Medicare/Medicaid cross-over billing in December 2009, the Medicare claim processing data identified by OSC is obtained directly from CMS, eliminating the need for OSC's recommended data verification.

* Comment 4

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.

* See State Comptroller's Comments, page 27.

Response #2:

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

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.

Response #3:

The OMIG agrees to routinely audit claims involving Medicaid payments for Medicare beneficiaries and to review the claims for the 13 providers identified as having significant billing problems regarding Medicare beneficiaries.

State Comptroller's Comments

1. We do not dispute the Department's technical compliance with existing State Law in making certain payments under the Medicaid program. However, we question why Medicaid would pay any amount when the Medicare reimbursement has already exceeded what New York Medicaid would have paid for the service to someone who had only Medicaid coverage. Thus, we maintain that New York Medicaid could have saved more than $500 million during our audit period, if it employed certain reimbursement policies, such as those already used in Florida and California. Moreover, we urge the Department to take the necessary steps, including the preparation of legislative amendments, to implement policies that will help avoid excessive Medicaid payments in the future for services to dual eligible recipients.

2. On page 12 of our report, we acknowledge that the Department implemented its automated Medicare/Medicaid cross-over system (effective December 3, 2009) that will help reduce inappropriate Medicaid payments for recipients also covered by Medicare. However, we maintain that additional actions, as detailed in our report, need to be taken to prevent significant amounts of excessive Medicaid payments for Medicare recipients. We have also revised certain language in our report relating to the sufficiency of proactive and comprehensive steps taken by the Department to prevent excessive Medicaid payments.

3. We did not inaccurately interpret Medicaid policy relating to procedure codes. Also, we understand that claims that cannot be processed because Medicaid does not recognize specific Medicare procedure codes could, upon further review, be processed using more generic codes. Consequently, we have modified our report language to further clarify the matter. Moreover, our report does not conclude that the Medicaid co-insurance amount should be reimbursed at zero when there is no Medicaid fee on file for a procedure. Rather, our report states that these claims should be reimbursed at 20 percent of the Medicare coinsurance amount. We do, however, "question" why any reimbursement for Medicare coinsurance should be made if the service is not even part of the Medicaid system.

4. The Department's statement is accurate to the extent that claims for services to recipients, eligible for both Medicare and Medicaid, are subjected to the automated cross-over billing system. However, certain claims are not subjected to the cross-over system. Consequently, we maintain that the Department should verify Medicare payment, deductible and coinsurance amounts reported by providers to Medicare data obtained from CMS for claims not subjected to the automated cross-over system.