



New York State Office of the State Comptroller
Thomas P. DiNapoli

Division of State Government Accountability

Overpayments for Services Also Covered by Medicare Part B

Medicaid Program Department of Health



Report 2012-S-27

July 2013

Executive Summary

Purpose

To determine if the Department of Health overpaid health care providers for Medicaid claims for Medicare Part B coinsurance. The audit covers the period January 1, 2009 through December 31, 2009.

Background

Medicare is a federal health program for the elderly and disabled. It consists of several parts. Medicare Part B helps pay for medical care provided in outpatient settings. Medicaid is a joint state and federal health program for certain individuals and families with low incomes. People who qualify for both Medicare and Medicaid are referred to as “dual eligibles.” For dual eligible recipients, Medicare is generally the primary payer while Medicaid is the secondary payer. Usually, Medicare pays 80 percent of the charges for approved Part B services, and Medicaid pays the remaining balances (typically for coinsurance) for dual eligible beneficiaries. About 570,000 of New York’s Medicaid recipients received Medicare Part B services totaling \$740 million in 2009. These services were provided in outpatient settings such as doctors’ offices, clinics, and health centers.

Some health centers are federally qualified health centers (FQHCs). FQHCs are “safety net” organizations that receive enhanced reimbursements from Medicare and Medicaid because they provide health care to an underserved area or population.

Key Findings

- The Department overpaid providers more than \$7.1 million for 210,000 claims billed to Medicaid with incorrect Medicare Part B payment information. Most of the overpayments were attributable to excessive charges for coinsurance.
- The Department overpaid Medicaid providers \$238,842 because it incorrectly designated them as FQHCs which made them eligible for enhanced Medicaid reimbursements they were not entitled to.

Key Recommendations

- Review and recover the Medicaid overpayments (totaling about \$7.1 million) for providers that improperly reported Part B coinsurance data.
- Review and recover the Medicaid overpayments (totaling \$238,842) made to providers who were incorrectly designated as FQHCs.

Other Related Audits/Reports of Interest

[Department of Health: Overpayments for Services Also Covered by Medicare Part B \(2010-S-50\)](#)
[Department of Health: Medicaid Overpayments of Coinsurance Fees for Medicare Beneficiaries \(2008-S-128\)](#)

**State of New York
Office of the State Comptroller**

Division of State Government Accountability

July 9, 2013

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

Dear Dr. Shah:

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 Medicaid Program entitled *Overpayments for Services Also Covered by Medicare Part B*. This audit was done according 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*

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State Government Accountability Contact Information:

Audit Director: Brian Mason

Phone: (518) 474-3271

Email: StateGovernmentAccountability@osc.state.ny.us

Address:

Office of the State Comptroller
 Division of State Government Accountability
 110 State Street, 11th Floor
 Albany, NY 12236

This report is also available on our website at: www.osc.state.ny.us

Background

Medicaid is a federal, state and local government program that provides a wide range of medical services to those who are economically disadvantaged or have special health care needs. The federal government funds about 49 percent of New York's Medicaid costs, the State about 34.4 percent, and the localities (the City of New York and counties) the remaining 16.6 percent. For the year ended March 31, 2012, New York's Medicaid program had more than 5.5 million enrollees, and the program's claims costs totaled about \$50 billion.

The Department of Health (Department) administers the Medicaid program in New York State. Medicaid claims are processed and paid by an automated system called eMedNY. When eMedNY processes claims, they are subject to various automated controls, or edits. The purpose of the edits is to determine whether the claims are eligible for reimbursement and if the amounts claimed for reimbursement are appropriate. Specifically, some edits verify the eligibility of the Medicaid recipient, other edits verify the eligibility of the medical service, and other edits verify the appropriateness of the amount billed for the service.

Many of the State's Medicaid recipients are also eligible for Medicare, and as such, they are referred to as "dual eligibles." 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 (typically a coinsurance or deductible) of the recipient.

The Centers for Medicare and Medicaid Services (CMS) administer the Medicare program. The Medicare program has multiple parts: Part A pays for hospital insurance and skilled nursing care; and Part B provides supplementary medical insurance coverage for a range of outpatient medical services, physicians' fees, and medical supplies. To be covered under Part B, services must be either medically necessary or one of several prescribed preventive benefits. In 2009, about 570,000 Medicaid recipients received services (costing about \$740 million) that were covered by Medicare Part B.

When services are provided under Medicare Part B, recipients are generally required to pay coinsurance. The coinsurance amount for a Part B service is usually 20 percent of the allowable charge, with certain exceptions. Providers who accept dual eligible recipients cannot bill them for Medicare coinsurance. Instead, the coinsurance must be billed to Medicaid.

Federal qualified health centers (FQHCs) meet certain criteria, under Section 330 of the Public Health Service Act, which entitles them to enhanced Medicare and Medicaid reimbursements. FQHC's are "safety net" providers, such as community health centers and public housing centers, which provide medical services to an underserved area or population. Therefore, FQHCs typically receive higher reimbursements than other health care providers for the Part B services they provide.

Audit Findings and Recommendations

In 2009, Medicaid overpaid more than \$7.3 million for about 213,000 claims related to Medicare Part B services. About \$7.1 million of the overpayments were attributable to incorrect Medicare coinsurance data that providers included on their Medicaid claims. In addition, other overpayments totaling almost \$239,000 occurred because Medicaid incorrectly designated certain providers for FQHC-enhanced payments.

Problems With Coinsurance and FQHC Designations

We obtained Medicare Part B payment data from CMS and compared that data to the Medicare amounts providers reported to eMedNY for Medicaid claims processed in 2009. Our review focused on claims for physician, clinic, lab, eye care, and transportation services as well as durable medical equipment. We determined that Medicaid overpaid more than 210,000 claims by more than \$7.1 million, primarily because providers overstated the amounts of Medicare coinsurance charges. Medicaid made the overpayments to 8,727 providers, of which 24 received overpayments totaling more than \$41,000. Three providers received overpayments exceeding \$114,000 each - with one of those receiving overpayments of more than \$192,000.

The overpayments occurred because providers reported their own charges for Part B services to Medicaid instead of the Medicare-approved amounts. The providers' charges were typically higher than the actual Medicare-approved amounts and resulted in Medicaid paying excessive coinsurance fees. For example, a provider reported his own charge (of \$250) to Medicaid for a session of psychotherapy instead of the Medicare-approved amount (of \$102). As a result, Medicaid overpaid the provider \$148 (\$250 - \$102) for this claim.

We provided the details of the overpayments to the Department and the Office of the Medicaid Inspector General (OMIG) for review and recovery. At the time we concluded our fieldwork, the overpayments had not been recovered. Given the number of providers (8,727) who received excessive payments, we believe Department and OMIG officials should focus attention on the investigation and recovery of funds from those providers who received the most overpayments.

On December 3, 2009, the Department implemented an automated Medicare/Medicaid crossover system to prevent overpayments similar to those identified in this report and other audit reports we have issued. Using the new 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 our audit) for dual eligible recipients more accurately.

We also determined that Medicaid overpaid 3,359 claims (by \$238,842) that certain providers submitted under the FQHC program. These providers were not entitled to FQHC-enhanced payments. Most of the overpayments (\$190,696) were made to two providers the Department incorrectly designated as FQHCs. One provider, for example, submitted a claim for \$216 to cover

a Medicare Part B coinsurance charge. However, because the Department incorrectly designated the provider as an FQHC, Medicaid paid \$745 for this claim - resulting in an overpayment of \$529 (\$745 - \$216). The Department identified and corrected the improper FQHC designations prior to the completion of our audit fieldwork. Nonetheless, at the time we completed our fieldwork, the overpayments (totaling \$238,842) had not yet been recovered.

Recommendations

1. Review and recover the Medicaid overpayments (totaling about \$7.1 million) for providers that improperly reported Part B coinsurance data.
2. Review and recover the Medicaid overpayments (totaling \$238,842) made to providers who were incorrectly designated as FQHCs.

Audit Scope and Methodology

The objective of our audit was to determine if Medicaid made overpayments to health care providers who did not properly report Medicare Part B information on their Medicaid claims for dual eligible recipients. Our audit period was from January 1, 2009 through December 31, 2009.

To accomplish our objective, we interviewed officials from the Department and the OMIG. We reviewed applicable sections of Federal and State regulations and examined the Department's relevant Medicaid policies and procedures. We received electronic data from CMS (part of the federal Department of Health and Human Services) for claim payments for Medicare Part B services made in 2009. We matched this data to the related Medicaid claims paid by the Department. Our review focused on claims for physician, laboratory, clinic, eye care, and transportation services as well as durable medical equipment. In 2009, Medicaid paid more than \$581 million for these services and equipment.

To confirm the accuracy of our data match, we visited three providers and reviewed their supporting documentation. We also reviewed supporting documentation for other providers where our data match indicated the potential for significant overpayments. We provided our findings population to the OMIG to facilitate its claims review and recovery process.

We did 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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 generally concurred with our recommendations and indicated that certain actions will be taken to address them.

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 why.

Contributors to This Report

Brian Mason, Audit Director
Dennis Buckley, Audit Manager
Warren Fitzgerald, Audit Supervisor
Christopher Morris, Examiner-in-Charge
Emily Proulx, Staff Examiner

Division of State Government Accountability

Andrew A. SanFilippo, Executive Deputy Comptroller
518-474-4593, asanfilippo@osc.state.ny.us

Elliot Pagliaccio, Deputy Comptroller
518-473-3596, epagliaccio@osc.state.ny.us

Jerry Barber, Assistant Comptroller
518-473-0334, jbarber@osc.state.ny.us

Vision

A team of accountability experts respected for providing information that decision makers value.

Mission

To improve government operations by conducting independent audits, reviews and evaluations of New York State and New York City taxpayer financed programs.

Agency Comments

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

NEW YORK
state department of
HEALTH

Sue Kelly
Executive Deputy Commissioner

May 2, 2013

Mr. Brian Mason, Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street -11th Floor
Albany, NY 12236-0001

Dear Mr. Mason:

Enclosed are the New York State Department of Health's comments regarding Office of the State Comptroller's Draft Audit Report 2012-S-27 entitled, "Overpayments For Services Also Covered by Medicare Part B."

Thank you for the opportunity to comment.

Sincerely,



Sue Kelly
Executive Deputy Commissioner

Enclosure

cc: Michael Nazarko
James C. Cox
Jason A. Helgeson
Diane Christensen
Dennis Wendell
Stephen LaCasse
Ronald Farrell
John Brooks

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**Department of Health
Comments on the
Office of the State Comptroller's
Draft 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) Draft 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:

At this time, the Office of Medicaid Inspector General (OMIG) third party Recovery Audit Contractor (RAC) has not initiated any mailings or recoveries of this audit. After claim analysis, it was determined recovery on most of the claims, with dates of services in 2009, would have been time barred under the current Center for Medicaid and Medicare Services (CMS) three year look back rules related to RAC work. Formal approval on a State Plan Amendment allowing a six year look back period is imminent. Once effective, the OMIG's RAC intends to initiate a pilot mailing, resolve any issues arising from this mailing, and then commence a mass mailing to applicable providers producing the highest level of recoveries in a timely and efficient manner.

It is important to note the Department implemented an automated Medicare/Medicaid crossover system to prevent overpayments similar to those identified in this draft report finding. 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.

Recommendation #2:

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

Response #2:

The Department identified and corrected the improper Federally Qualified Health Centers (FQHC) designations prior to the completion of the OSC audit. The Department will continue to monitor, track and establish rates of reimbursement and work on internal controls to reduce risk.

The OMIG will recover the overpayments in accordance with the OMIG's audit directives.