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June 26, 2015

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

Re: Overpayments for Services Also Covered
By Medicare Part B
Report 2015-F-4

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 for Services Also Covered by Medicare Part B* (Report 2012-S-27).

Background, Scope and Objectives

The New York State Medicaid program provides a wide range of medical services to those who are economically disadvantaged and/or have special health care needs. For the year ended March 31, 2014, New York's Medicaid program had approximately 6.5 million enrollees. Many of the State's Medicaid recipients are also enrolled in Medicare Part B, which provides supplementary medical insurance for a broad range of outpatient medical services, physicians' fees, and medical supplies. Individuals enrolled in both Medicaid and Medicare are referred to as "dual-eligible."

For dual-eligible recipients, Medicare is generally the primary payer while Medicaid is a secondary payer. As a secondary payer, Medicaid pays the balance not covered by Medicare which would otherwise be the financial obligation of the patient (such as deductibles and coinsurance).

Certain health care providers receive higher reimbursements than other providers for the Part B services they provide. Federally qualified health centers (FQHCs) are "safety net" providers, such as community health centers and public housing centers, that provide medical services to underserved areas or populations. Accordingly, FQHCs receive enhanced reimbursements from Medicare and Medicaid.

We issued our initial audit report on July 9, 2013. The audit objective was to determine if the Medicaid program overpaid health care providers for Medicaid claims for Medicare Part B coinsurance. The audit covered the period January 1, 2009 through December 31, 2009. Our initial audit identified overpayments totaling about $7.1 million. Most of the overpayments occurred because providers overstated the amounts of Medicare coinsurance for Part B services. We also determined that Medicaid overpaid an additional $238,842 because the Department incorrectly designated certain providers as FQHCs. This allowed the providers to receive higher reimbursements than they were entitled to for Part B services. At the time of our initial audit, the Department corrected the improper FQHC designations.

The objective of our follow-up was to assess the extent of implementation, as of May 1, 2015, of the two recommendations included in our initial audit report.

Summary Conclusions and Status of Audit Recommendations

Department officials have made minimal progress in recovering the $7.3 million in Medicaid overpayments we identified. At the time of our follow-up, $3,125 was recovered, but more than $1 million in potential recoveries were likely lost due to the inaction on overpayments for claims that are now more than six years old. Our initial report's two recommendations have been partially implemented.

Follow-Up Observations

Recommendation 1

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

Status - Partially Implemented

Agency Action - As of March 31, 2015, the overpayments identified in our initial report had not been recovered. The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. OMIG contracts with HMS to identify and recover Medicaid overpayments involving third party insurance payments. OMIG officials reported that HMS reviewed our findings and initiated a collection process in September of 2013. At that time, HMS drafted collection letters to providers; however, the letters were never sent because, according to officials, the HMS project manager was reassigned. As a result, the project was mishandled, and recovery efforts stalled. Further, OMIG officials did not follow up with HMS on the status of the recovery effort until we engaged our follow-up review in March of 2015. As a result of our review, HMS' recovery efforts resumed.

As of May 1, 2015, approximately $1.1 million in potential overpayments may no longer be recoverable under federal look-back rules that prohibit the Department from recovering a payment more than six years after the date the corresponding claim was filed. To avoid

further loss of recoverable overpayments, we strongly encourage OMIG and HMS to place sufficient priority on the pursuit of the remaining overpayments that are still recoverable.

Recommendation 2

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

Status - Partially Implemented

Agency Action - When conducting a review of Medicaid providers unrelated to our original audit finding, OMIG recovered $3,125 of the overpayments we identified in our initial audit. However, OMIG has not recovered the remaining $235,717, and, as of May 1, 2015, $63,458 (27 percent) is barred from future recoveries under the federal six-year look-back rule. Again, we encourage OMIG to expedite their recovery efforts of the remaining overpayments.

Major contributors to this report were Karen Bogucki, Kate Merrill, and Shannon Younkin.

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,

Warren Fitzgerald
Audit Manager

cc: Ms. Diane Christensen, Department of Health
Mr. Dennis Rosen, Medicaid Inspector General