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UNITED STATES GENERAL ACCOUNTING OFFICE
REGIONAL OFFICE
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007

OCT 8 1975

Mr. Elmer W. Smith, Regional Commissioner
Social and Rehabilitation Service, Region II
Department of Health, Education and Welfare
26 Federal Plaza
New York, New York 10007

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Dear Mr. Smith:

On August 1, 1975, we met with Messrs. William Toby and Stanley Allen of your staff to discuss Medicaid overbillings by the New York City Health and Hospitals Corporation (HHC) for outpatient department clinic services applicable to individuals covered under both the Medicare and Medicaid programs (dual beneficiaries). This letter confirms the information we supplied at that meeting.

Outpatient hospital services are covered under part B of Medicare, and assuming the beneficiary has met the annual $60 part B deductible, are subject to a 20 percent coinsurance provision which is the responsibility of the beneficiary. The program reimburses the institution on the basis of 80 percent of reasonable costs, which are subject to retroactive audit and adjustment, and the coinsurance portion is usually calculated and collected on the basis of 20 percent of the reasonable charges. For a dual beneficiary however, the coinsurance and deductible amounts are paid by Medicaid.

The Code of Federal Regulations (CFR), Title 45, Parts 249.41(b) and (c)(2), 250.30(b)(3)(ii), and 250.31(b) taken together require, in effect, that (1) all providers should bill Medicare first, then, (2) bill Medicaid for the coinsurance and deductibles not covered by Medicare, and (3) the combined payments from Medicare and Medicaid should not exceed what would have been paid by the program and the beneficiary under Medicare. Both the Bureau of Health Insurance (BHI) Program Officer, Reimbursement Branch, Region II, and a SRS Medical Services Specialist have confirmed these requirements.

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Contrary to the CFR, HHC's policy has been to bill both Medicare and Medicaid at their full rates for the same patient visit. In other words, for dual beneficiaries receiving outpatient services, HHC billed Medicaid as though the patient had no Medicare coverage. An overpayment resulted because, HHC's Medicare intermediary, the Social Security Administration (SSA) in Baltimore, Maryland, paid HHC on the basis of 80 percent of HHC's reasonable cost, and Medicaid paid its full rate, rather than the dual beneficiary's deductible and coinsurance portion of the bill.

For the period July 1972 through June 1974, HHC received Medicare payments for about 485,000 outpatient visits, of which about 27,000 were also paid by Medicaid. In November 1974, at the request of the New York City Department of Social Services, HHC made an adjustment of about $282,000 to Medicaid for these overpayments. The adjustment was based on estimated rather than actual overpayments because HHC has no system for reconciling amounts billed with amounts paid by Medicare and Medicaid. The adjustment procedure was based on the erroneous premise that HHC was entitled to the higher of the two reimbursement programs. Consequently, HHC understated the adjustment. HHC is still following these practices.

HHC officials agreed that the practice of billing Medicaid as if it was the only coverage is improper but felt that it was necessary to continue to do so because SSA takes from 9 to 18 months to reimburse outpatient claims. As a result, HHC would, in effect, be advancing services for a like period, adversely affecting their cash flow. They told us they intended to ask the State and SRS to make an exception and allow HHC to bill in this manner. HHC officials told us, however, that they will revise their formula for estimating Medicaid overpayments and base adjustments on the premise that total reimbursement should not exceed what would have been paid if full payment had been received under Medicare. According to these officials, the revised method would be used for all reimbursements received after those previously adjusted, but that it would not be cost effective to make further retroactive adjustments.

Messrs. Toby and Allen told us they would consider fully the HHC position and that if an exception to the regulation is approved, SRS will determine whether HHC's new formula for estimating overpayments is equitable. SRS will also decide if it is feasible to require further retroactive adjustments.

We recommend that HHC discontinue the practice of billing Medicare then Medicaid for the same service as if the beneficiary was not covered by Medicare. HHC should accordingly, institute a record keeping system which will permit it to bill Medicare first and then bill Medicaid for the deductible and any coinsurance not reimbursable by Medicare.

Please advise us on the results of the action you take.

The following Federal and State officials are being sent copies of this letter:

Mrs. Bernice L. Bernstein, Regional Director, Region II
U.S. Department of Health, Education and Welfare

Mr. John L. Sullivan, Program Officer
Reimbursement Branch, Region II
Bureau of Health Insurance
Social Security Administration

Mr. Stephen Berger, Commissioner
New York State Department of Social Services

Mr. Robert Whalen, MD., Commissioner
New York State Department of Health

Mr. Robert J. Bradbury, Corporate Comptroller
New York City Health and Hospitals Corporation

Sincerely,

Alfonso J. Strazzullo
Regional Manager