Medicare Crossover Recoupment: Examining the Issues

Presented by

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MISSISSIPPI DIVISION OF MEDICAID

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Objectives for this Session

- Examine the scope of Medicare crossover excessive payments requiring recoupment
- Examine how large the problem is on an individual claim basis
- Examine how states are seeking to address this issue
- Discuss and exchange best practices states have developed in addressing this issue

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What, exactly, is a Crossover Claim?

The term "crossover claim" applies when a Medicaid member has Medicare as their primary insurance, and:

- The Medicare coverage is from **traditional** Medicare and (usually) not a Medicare Advantage plan;
- Medicare issued a payment of *any* amount, or the entire payment was applied to the deductible.

A claim is not a "crossover claim" when:

- The member's primary insurance is not traditional Medicare;
- Medicare denied payment on the claim;
- The Medicare claim is a benefit exhaust claim.

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The Overall Scope of the Problem

- The Mississippi Division of Medicaid (DOM) recently conducted a massive recoupment which involved almost $4 million in excessive crossover payments for deductibles, co-pays and co-insurance.
- Other states have audited their crossover payments and found overpayment amounts exceeding $10 million to $16 million.
- This is not a new problem, as states have been auditing and recouping on crossover payments for many years.

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The Nature of the Problem

- Every State Medicaid Program has Medicaid recipients who are also enrolled in Medicare. These recipients are generally referred to as "dual eligibles."
- Generally speaking, Medicare is the primary payer for medical services provided to dual eligibles.
- Medicaid pays for any remaining balance not covered by Medicare, and this includes co-insurance amounts, co-pays, and deductibles.
- How any State Medicaid Agency chooses to process and pay for – and how much it pays for – these crossover charges, is by no means uniform across all states.

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The State Plan Listing Approach

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Item 1. Payment of Title XVIII Part A and Part B Deductible/ Coinsurance

The Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/ QMB Individual	Medicare-QMB Individual
Part A Deductible Inpatient Hospital	___ limited to State Plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Coinsurance Inpatient Hospital	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount
Part A Deductible Nursing Facility Hospice Home Health	_X_ limited to State plan rates* ___ full amount	_X_ limited to State plan rates ___ full amount	_X_ limited to State plan rates ___ full amount
Part A Coinsurance Nursing Facility Hospice Home Health	_X_ limited to State plan rates* __ full amount	_X_ limited to State plan rates ___ full amount	_X_ limited to State plan rates ___ full amount
Part B Deductible	__ limited to State plan rates _X_ full amount	__ limited to State plan rates _X_ full amount	__ limited to State plan rates _X_ full amount
Part B Coinsurance	__ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount	___ limited to State plan rates _X_ full amount

**** The Medicaid agency will not reimburse for services that are not covered under the Medicaid State Plan.***

Note: Some States simply have a listing of what they pay on crossover claims.

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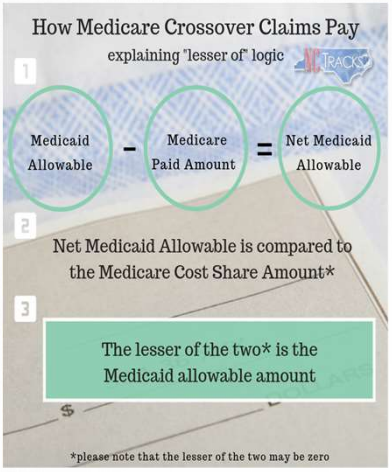
The "Lesser of" Approach



The following examples illustrate this calculation:

	Example #1	Example #2
Total Billed Charges	159.00	159.00
Medicare Allowed Amount	100.34	80.26
Medicare Paid Amount	79.95	64.21
Medicare Contractual adjustment	(58.66)	(78.74)
Medicare Cost Share Amount	20.39	16.05
Medicaid Allowable	84.29	85.20
Medicare Paid Amount	(79.95)	(64.21)
Net Medicaid Allowable	4.34	20.99
Lesser of Medicare Cost Share Amount** and Net Medicaid Allowable Amount	4.34	16.05

**Cost Share is the combination of Deductible, Coinsurance, and Copay amounts

Note: Not every State applies this "lesser of" logic to Medicare crossover claims.

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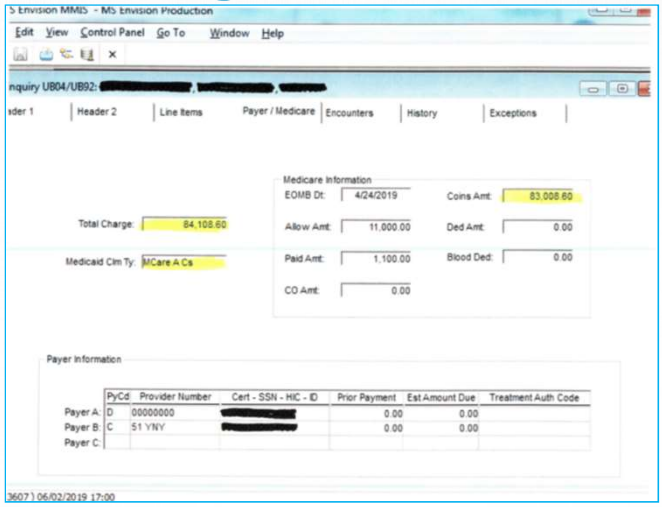
How Large is the Problem?



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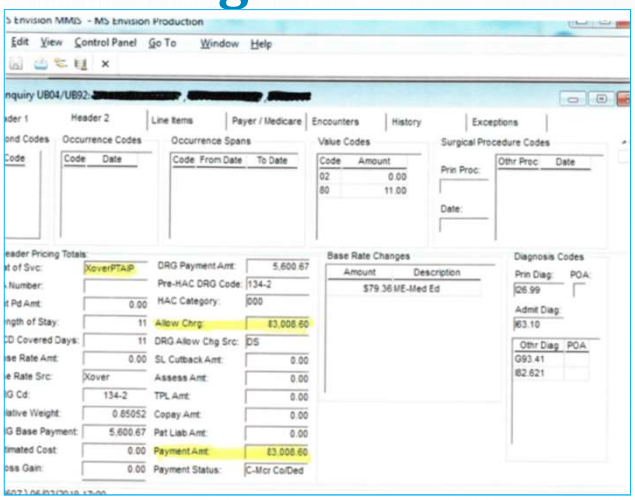

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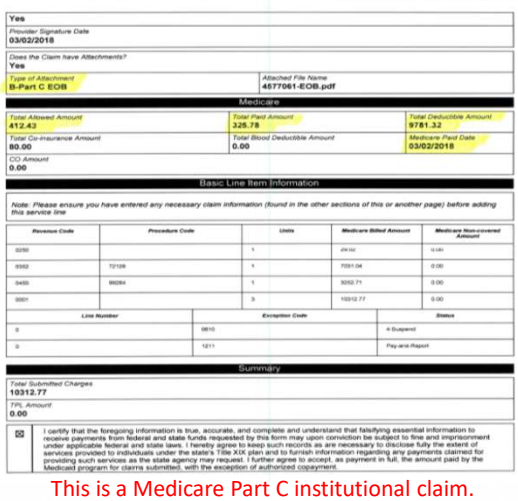

This is a Medicare Part C institutional claim.

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Is this a Program Integrity Problem, or a Third Party Liability Problem?

- Yes! It's both!

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When Should Medicare Crossover Claims Not Cross Over?

- In some instances, Medicare denies a claim when the services are not medically necessary.
- Other times, Medicare denies a claim as a duplicate because the services have been paid on another claim.
- When Medicare denies a claim for either reason, Medicaid should not pay anything on those claims.
- But often Medicaid claims processing systems do not properly interpret the Medicare reason/denial codes, and that results in Medicaid paying on crossover claims even when Medicare has denied the claim.

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What Causes Improper Medicare Crossover Payments?

- In states which have implemented some version of an automated/electronic crossover system, most Medicare crossover claims should be self-reported by Medicare to Medicaid, eliminating the need for a second claim from a provider.
- But many providers circumvent the automated systems and submit crossover claims directly to Medicaid, often inaccurately reporting the Medicare payment data, which also leads to improper overpayments by Medicaid.
- Many Medicaid programs have either inaccurate or inactive edits in the MMIS system for crossovers.

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Where to Look for Overpayments

- Premium amounts – Be sure that the proper premium for the date of service is being reported. For Part B, the 2019 premium ranges from $135.50/month up to $460.50/month.
- There is generally no annual premium for Part A (99% of beneficiaries have adequate work quarters to eliminate it altogether).
- Part C monthly premiums vary by plan. Be sure to confirm it with the actual plan(s) sold in your state.

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Where to Look for Overpayments

- Deductible amounts – the Part B annual deductible for 2019 is $185. The inpatient hospital Part A deductible is $1,364.00 for each stay in a benefit period in 2019.
- For many years, some Part C plans did not have a deductible. In recent years, some have begun to apply a deductible. Many states still specify in their State Plan that they will pay 100% of the Part C deductible, which is often improperly reported/overstated to Medicaid.

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Where to Look for Overpayments

- Co-pays/co-insurance are probably one of the most often improperly reported amounts provided to Medicaid by providers who submit crossover claims.
- For example, in a recent audit in NY, the Comptroller found that providers were billing coinsurance amounts that were 40% or more of the Medicare-approved amount (instead of the actual 20% co-insurance amount which they should have billed).

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Where to Look for Overpayments

- Annual deductibles would seem to be easy to program into the Medicaid claims adjudication process.
- However, some Medicaid programs are not programmed to examine deductible payments made on other claims in a dual-eligible's history. This can lead to overpayments when deductible amounts are reported over multiple claims.
- For example, NY identified approximately $1.1 million in excess Part B annual deductible payments in an audit of claims from 2012 through 2017. In one year, four providers billed and NY Medicaid paid $1,301.00 in Part B deductibles for a single dual eligible, when the annual deductible for the year in question was only $166 (thus, an overpayment of $1,135.00 in Part B deductibles alone for one dual eligible).

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Co-insurance Overpayment Example from a Recent Audit

For the remaining 27 claims, the providers reported incorrect Medicare payment information to eMedNY, which resulted in overpayments. For example, one provider claimed that the Medicare-approved amount for a radiology service was $300, and billed Medicaid for $280 in coinsurance (i.e., 93 percent of the reported Medicare-approved amount). However, according to the supporting documentation, the Medicare-approved amount was $249 and the coinsurance was $50. At the time of the claim, according to Medicaid policy, when Medicare's payment exceeded Medicaid's fee for a service, Medicaid would pay 20 percent of the coinsurance. Since Medicare's $199 payment ($249 × 80 percent) exceeded Medicaid's standard $127 fee for this service, Medicaid should have only paid the provider $10 ($50 × 20 percent). The incorrectly reported payment information caused Medicaid to make a $270 overpayment ($280 - $10).

Source: **Medicaid Overpayments for Medicare Part B Services Billed Directly to eMedNY** (report by New York State Office of the State Comptroller, December 2018).

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Where to Look for Help in Identifying Crossover Overpayments

- Auditing for Medicare crossover overpayments appears to be a task tailor made for the new UPIC contractors. As the successor to the Medi-Medi contractors, they have access to the Medicare billed/paid amounts to compare to crossover claims.
- Voided Medicare claims are also a good starting point, as Medicaid crossover payments are tied to the Medicare payment. Thus, if any Medicare payment source makes an adjustment that results in an overpayment by Medicaid, the provider should submit an adjustment so that the Medicaid crossover overpayment can be recoupled or reversed.

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Why to Stay Vigilant About Crossover Claims and Recoupment

- When a Medicare Administrative Contractor processes a claim for dual eligibles, it forwards them to the Benefits Coordination and Recovery Center (BCRC), which then sends the claims as crossovers to the appropriate State Medicaid Program.
- BCRC also sends adjustments to previously processed crossover claims to the appropriate State Medicaid Program. Thus, the State is expected to recoup overpayments due from providers (or refund amounts owed providers).
- HHS-OIG audits on crossover adjustments (*see* next slide).

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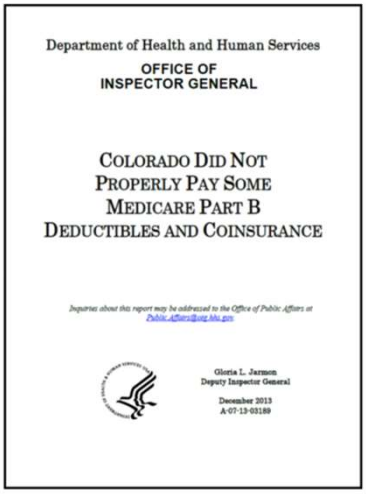
HHS-OIG is Watching Crossovers



Department of Health and Human Services

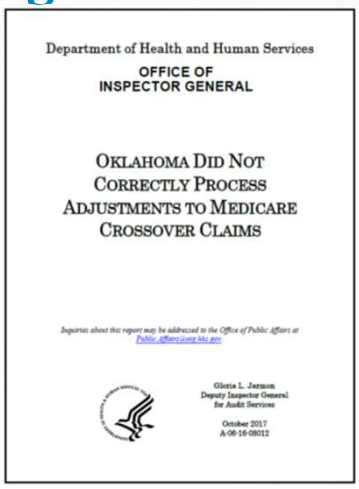
OFFICE OF INSPECTOR GENERAL

COLORADO DID NOT PROPERLY PAY SOME MEDICARE PART B DEDUCTIBLES AND COINSURANCE

Inquiries about this report may be addressed to the Office of Public Affairs at Public_Affairs@oig.hhs.gov

Gloria L. Jarmon
Deputy Inspector General

December 2013
A-07-13-03189



Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OKLAHOMA DID NOT CORRECTLY PROCESS ADJUSTMENTS TO MEDICARE CROSSOVER CLAIMS

Inquiries about this report may be addressed to the Office of Public Affairs at Public_Affairs@oig.hhs.gov

Gloria L. Jarmon
Deputy Inspector General for Audit Services

October 2017
A-06-16-08012

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How to Get a Handle on Crossovers and Recoupment

- Mississippi has put together a work group dealing specifically with crossovers.

Conduent Government Healthcare Solutions
MS Medicaid Project

CONDUENT

Agenda for Crossover Workgroup Meeting 08/2/2019

Meeting Information

Topic	Medicare Crossover Issues
Date and Time	August 2, 2019 10:00am- 11:30am
Location	Conference Call
Purpose and Goals	Discuss current Medicare Crossover claims.
Preparation	All workgroup members review agenda and issues prior to meeting.

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What are You Doing About Recouping Crossover Overpayments?

- This is your chance to join the dialogue: What is working for you in regard to crossover overpayments? What type of audits or other approaches have worked for you? How large is the problem in your state – do you know?

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Questions??????

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