H. CARL MCCALL
STATE COMPTROLLER

A.E. SMITH STATE OFFICE BUILDING
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

May 9, 2001

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Claims Paid for Medicare Part A Eligible Recipients - 1999 Report 2000-D-4

Dear Dr. Novello:

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 reviewed Medicaid claims processing activity for Medicaid recipients who were also eligible for Medicare Part A benefits (dual eligible recipients) during the 1999 calendar year. The purpose of this review was to identify instances where Medicaid had paid providers inappropriately for dual eligible recipients.

A. Background

The New York State Department of Health (Health) administers the State's Medical Assistance Program (Medicaid), which was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Health's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process Medicaid claims and to pay providers for medical services they render to eligible Medicaid recipients. In New York, the Federal, State and local governments jointly fund the Medicaid program.

Most of New York's aged or disabled Medicaid recipients are also covered by Medicare. Medicare, which is Federally-funded, covers inpatient hospital expenses - except for deductibles and coinsurance - for eligible beneficiaries during a 90-day benefit period. If a recipient needs more than 90 days of inpatient care during a benefit period, Medicare will allow up to 60 "lifetime reserve" (LTR) days of coverage. LTR days can be used only once in the recipient's lifetime; for each one the

recipient uses, Medicare will pay all covered services except for a daily LTR coinsurance amount. When a Medicaid recipient also has Medicare coverage, Medicaid pays for Medicare deductibles, coinsurance and remaining expenses after the recipient has exhausted all Medicare benefits. By law, Medicaid is always the payer of last resort.

In New York, it is the responsibility of the Medicaid provider to determine whether the recipient's Medicare benefits allow coverage for the services being provided. If the recipient's Medicaid identification card shows available Medicare coverage, the provider must bill Medicare even if the recipient denies having Medicare coverage. Upon being billed, Medicare sends providers an Explanation of Medical Benefits (EOMB), indicating the services that were covered, less any deductible or coinsurance amount. Using this information, the provider may bill Medicaid for the deductible or coinsurance amount plus any expenses for time periods not covered by Medicare. If the provider submitted a claim to Medicare that was denied, or knows that the recipient does not have Medicare coverage, the provider may bill Medicaid for all services. If the recipient has Medicare coverage and the provider fails to bill Medicare first, Medicaid could overpay claims by the amount that Medicare should have paid. Health maintains a Benefit Recovery System to identify incorrectly paid Medicaid claims where Medicare eligibility began prior to the date the Medicaid eligibility information was added to the Medicaid files.

B. Methodology

To determine which recipients were dual eligible, we provided Empire Medicare Services (Empire), the fiscal intermediary in New York State that processes Medicare claims for the Social Security Administration, with the social security numbers of the 5,331,579 recipients eligible for Medicaid at the time of our review. Empire compared these numbers with those in their Medicare files, and identified 771,383 potential dual eligible recipients. Of these, we identified 300,655 recipients who were dual eligible during the 1999 calendar year.

Based on audit risk criteria for claiming activity that we determined from prior audit experience showed a high risk for Medicaid overpayment, we selected 3,810 recipients from this dual eligible group and compared their 1999 Medicaid claims with their Medicare claims. Our review consisted of analyzing these individuals' Medicare and Medicaid claims histories to determine whether hospital providers had fully utilized the recipients' Medicare benefits before billing Medicaid. For 2,468 of these recipients who had Medicare claims, Empire provided us with information that enabled us to compare the two types of claims and determine whether the Medicaid payments had been appropriate.

We asked providers to verify the Medicare eligibility of the remaining 1,342 recipients, and to send us a copy of the EOMB as proof that Medicare had been billed on behalf of 967 of them. We did not request such verification for the remaining 375 recipients because we determined that they were at low risk for having overpayments.

C. Results of Review

We reviewed claims from Medicaid and Medicare calendar year 1999 for the selected recipients, and found that Medicaid had overpaid providers about $12.9 million. This amount

includes almost $7.6 million for recipients who had billings for both Medicare and Medicaid even though the Medicare reimbursement had not been maximized, as well as $5.3 million for recipients who were potentially eligible for Medicare but had no Medicare billings.

1. Claims for Recipients with Both Medicare and Medicaid Payments

Medicaid paid providers about $84.7 million on behalf of 2,468 recipients. Using computer-assisted audit techniques, we evaluated the appropriateness of these payments. Analyzing 16,772 Medicare and 11,510 Medicaid claims, we found that Medicaid had overpaid providers almost $7.6 million on behalf of 714 recipients. The overpayments were made for the following reasons:

Reasons Provided	**Overpayments**
Provider did not bill Medicare; instead, billed Medicaid for the entire claim period.	$4,004,005
Provider billed both Medicare and Medicaid for the full amount during the same claim period.	2,585,723
Medicare information recorded on the Medicaid claims was not accurate.	187,958
Provider did not bill for available LTR days.	135,769
Provider billed Medicaid for services provided to recipients who were listed as deceased on the Medicare records.	37,985
Provider billed Medicaid, despite evidence of another third-party resource (e.g., Medicare HMO, private insurance, etc.).	614,927
Total Overpayments	$7,566,367

2. Claims for Recipients with Potential Medicare Eligibility, but No Medicare Billings

Medicaid paid providers $16.1 million on behalf of 967 recipients in 1999. We contacted these providers, and requested a copy of each Medicare EOMB to verify that they had maximized Medicare before billing Medicaid. For 420 recipients, we found that Medicaid had overpaid the providers $5.3 million because Medicare coverage was available but was never billed. Of the $5.3 million, providers agreed to refund Medicaid $2.1 million. For the other $3.2 million, providers are awaiting a Medicare determination regarding their billing. Once Medicare makes a determination on these claims, the Medicaid claims will be adjusted accordingly.

Recommendation

Investigate and recoup the overpayments cited in this report.

Major contributors to this report were Lee Eggleston, Sheila Emminger, Dominick DiFiore, Ottavio Nicotina, Sharon Whitmore, Robert Elliott, Julie DeRubertis, Amritesh Singh, Carrie Zusy, Nichole Barrett and Marticia Madory.

We would appreciate receiving your response to the recommendation made in this report within 30 days, indicating any action planned or taken to implement the recommendation. We also wish to express our appreciation for the courtesies and cooperation extended to our auditors during their review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Mr. Charles Conaway