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STATE OF NEW YORK
**OFFICE OF THE STATE COMPTROLLER**

April 19, 2002

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

Re: Selected Medicaid Payments
for Medicare Part B Eligible
Recipients
Report 2000-D-3

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 for Medicaid recipients who were also eligible for Medicare Part B benefits during the 1998 calendar year. The purpose of this review was to identify instances in which Medicaid overpaid the Medicare deductible and coinsurance costs for Medicaid recipients who are eligible for Medicare.

## 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 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.

Medicare, the Federal health insurance program for people who are age 65 or older or disabled, provides both hospital insurance (Part A) and supplemental medical insurance (Part B) for its enrollees. Medicare pays for in-patient hospital costs and for a substantial portion of covered Part B services, such as outpatient clinic services. However, Part B coverage requires that the Medicare beneficiary pay an annual deductible of $100 and a coinsurance amount for each service. When a

Medicare beneficiary is also a Medicaid recipient, Medicaid pays for the recipient's annual Part B deductible, coinsurance amounts and for any services not covered by Medicare. By law, Medicaid is always the payer of last resort.

In New York, the Medicaid provider is responsible for determining whether the recipient's Medicare benefits allow coverage for the services provided. If the recipient's Medicaid identification card shows Medicare eligibility, the provider must bill Medicare unless the provider can show that Medicare does not cover such services. Upon being billed, the Medicare fiscal intermediary (Empire Medicare Services) sends providers an Explanation of Medical Benefits (EOMB), indicating the reimbursement for the services that were covered, less any deductible or coinsurance amount. When the Medicare beneficiary is also a Medicaid recipient, the provider can use the Medicare EOMB information to bill Medicaid for the deductible and coinsurance amount. The provider may bill Medicaid for the services provided only if Medicare has denied the provider's claim or if the provider knows the recipient does not have Medicare coverage. If the recipient has Medicare coverage and the provider fails to bill Medicare first, Medicaid will pay the provider for services that should be paid by Medicare.

MMIS pays providers for their services by one of two methods: fee-for-service or capitation. Under the fee-for-service method, providers are paid every time a recipient receives a Medicaid-eligible service. Under the capitation method, which is used by managed care organizations (MCO), the MCO is paid a capitation premium (monthly fee). In return, the MCO must ensure that each enrollee has adequate access to a full continuum of quality health care services. Medicare pays for a substantial portion of the cost of health care services provided to dual eligible recipients (i.e., persons who are eligible for both Medicare and Medicaid). Thus, Health does not allow these recipients to enroll in MCOs, since capitation premiums Medicaid paid on their behalf would result in overpaying for services.

## B. Methodology

Our prior audit, entitled Medicaid Payments For Selected Clinic Services Covered By Medicare Part B (Report 97-S-43, issued July 17, 1998) found that Medicaid overpaid certain providers of Medicare Part B services. The overpayments occurred because providers overstated the amounts Medicaid owed them for Medicare deductibles and coinsurance amounts, and because MMIS did not have adequate controls in place to prevent such overpayments. To determine if such overpayments continue to occur, we compared Medicare eligibility information obtained from Empire Medicare Services and Medicare claim data from the Federal Centers for Medicare and Medicaid Services for claims paid during the 1998 calendar year. This comparison identified about 622,000 recipients who were dual eligible during this period. We developed computer programs that allowed us to focus our review on Medicaid payments totaling $160.2 million ($118.9 paid to clinics and $41.3 million paid to MCOs) made on behalf of these dual eligible recipients. Our review compared the Medicaid claim payments to the Medicare claim deductible and coinsurance amounts to determine if providers had correctly reported these Medicare amounts when they submitted their claims to Medicaid for reimbursement.

## C. Results of Review

For the calendar year 1998, we found that Medicaid overpaid clinic providers about $15.6 million, of which Health had already recovered $6.8 million in overpayments from one provider. For the same period, we also found that MMIS inappropriately paid MCOs $3 million in capitation premiums for dual eligible recipients who should not be enrolled in Medicaid's managed care program.

### 1. Fee-for-Service Claims for Dual Eligible Recipients

We developed computer programs to review and compare Medicaid payments to clinics totaling $118.9 million to payments these clinics received from Medicare. We found that Medicaid overpaid these clinics for Medicare deductibles and coinsurance costs by $15.6 million. The overpayments were made because these clinics did not accurately report the Medicare deductible and coinsurance amounts. Since MMIS does not verify the accuracy of the Medicare amounts being reported on claims, it did not detect these overpayments.

The $15.6 million overpayment includes $6.8 million that Health had already recovered from a provider. However, we noted that Health did not adjust the claims related to this $6.8 million overpayment on MMIS. The recovery of overpayments without adjusting or voiding the original claims compromises the integrity of the MMIS payment files, thereby jeopardizing the accuracy and reliability of the MMIS claim processing system.

### 2. Capitation Claims for Dual Eligible Recipients Enrolled in Managed Care

When a Medicaid recipient is covered by Medicare, the Medicaid service costs are significantly reduced. Therefore, Health has a policy not to enroll such recipients in an MCO. Health's model managed care contract specifically excludes dual eligible recipients from enrolling in the Medicaid managed care program. However, out of $41.3 million MMIS paid to MCOs during the 1998 calendar year, we found that $3 million was for capitation premiums for dual eligible recipients. These payments were made in violation of Health's policy and the MCO contracts, and result in Medicaid's spending more than necessary to provide medical services for these recipients.

Health officials agreed to identify such recipients and to take steps to disenroll them from the MCOs. However, they do not agree to recover the $3 million in capitation premiums. According to Health officials, the MCOs had accepted full financial risk for providing an unlimited amount of service to these recipients for a negotiated prepaid monthly premium.

## Recommendations

1. *Investigate and recoup the overpayments identified in this report.*

2. *Develop and implement procedures to ensure that the Medicaid payment file is adjusted when inappropriate claims are identified and corrected.*

*3. Develop a process that identifies dual eligible recipients and prevents their enrollment in the Medicaid managed care program.*

*4. Investigate the MCO-enrolled dual eligible recipients identified in this review, and require them, as appropriate, to enroll with fee-for-service providers.*

Major contributors to this report were Ken Shulman, Bill Clynes, Don Paupini, Dominick DiFiore, Amritesh Singh, Alex Pietkiewicz, Casey O'Connor and Nancy Varley.

We would appreciate receiving your response to the recommendations made in this report within 30 days, indicating any action planned or taken to implement the recommendations. 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: Ms. Dierdre A. Taylor