H. CARL McCALL
STATE COMPTROLLER

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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

February 28, 2002

Mr. Frank J. Branchini
President and Chief Executive Officer
Group Health Incorporated
441 9th Avenue
New York, NY 10001

Re: New York State Health Insurance Program
Coordination of Medicare Coverage
Report 2001-S-17

Dear Mr. Branchini:

According 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 audited mental health and substance abuse claims processed for the New York State Health Insurance Program's Empire Plan (Plan). The scope of our financial related/compliance audit included claims of Plan members for the year ended December 31, 2000.

A. Background

The New York State Health Insurance Program (Program) provides hospital and surgical services and other medical and drug coverage to more than 773,000 active and retired State employees and their dependents. It also provides coverage for more than 367,000 other individuals, who are either active or retired employees of participating local government units and school districts or dependents of such employees.

The Plan is the Program's primary health benefits plan, providing services to about 966,000 individuals in the Program at an annual cost of more than $2.2 billion. The Department of Civil Service (Department) contracts with Group Health Incorporated (GHI) to administer the mental health and substance abuse portion of the Plan. During the year ended December 31, 2000, GHI approved 499,086 charges totaling $52.8 million and charged the State about $12 million for administrative and other related expenses.

Medicare is a Federal health insurance program created in 1965 to provide medical coverage for people aged 65 and older. In 1973, Congress passed legislation to extend Medicare coverage to those who are disabled or suffer from chronic renal failure. For eligible persons, Medicare hospital insurance (Part A) is premium-free, and pays most costs of inpatient hospital care and medically necessary care in a skilled nursing facility, hospice or home health care setting. Medicare medical insurance (Part B), which helps pay for doctor and outpatient hospital services and other products and services not covered by Part A, is optional and requires eligible persons to enroll and pay monthly premiums. Medicare requires individuals and providers of care to submit claims for payment timely (within 15 to 27 months, depending on the date of service). GHI processes certain claims that should be coordinated with Part A, and other claims that should be coordinated with Part B. Therefore, our audit included GHI's coordination with both Part A and Part B.

Generally, Medicare is the primary payer of medical expenses for retired enrollees. Medicare also assumes primary coverage for spouses and dependents of retired enrollees. The Plan requires all Plan members eligible for primary Medicare coverage to enroll in both parts of Medicare. If Plan members eligible for primary Medicare coverage do not enroll in Medicare, the members are responsible for the full cost of medical services that Medicare would have covered. Thus, by identifying Medicare-eligible Plan members, and coordinating payment of their claims with Medicare, the Plan can reduce its expenditures.

B. Audit Scope, Objective and Methodology

We audited the Plan's Medicare-related claims for the year ended December 31, 2000. The primary objective of our audit was to determine whether the Plan identifies Medicare eligibility when it processes claims for Medicare-eligible Plan enrollees and their spouses and dependents.

The Plan's enrollment system, for which the Department has primary responsibility, does not always capture Medicare eligibility information for Plan members. Therefore, we focused our audit on Plan members who were eligible for Medicare during the audit period according to Medicare eligibility data for Plan members that we obtained from the Federal Centers for Medicare and Medicaid Services. We compared this information with GHI claims data to identify claims that were not properly coordinated with Medicare.

We did our audit according to generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess those Department and GHI operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department and GHI and that we review these entities' compliance with the laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses on those operations that we identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where

and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit reports on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

C. Results of Audit

Because of weaknesses in the Plan's system for identifying Medicare eligibility, we estimate that, during the audit period, GHI paid as the primary insurer $329,539 of claims that should have been coordinated with Medicare.

We provided preliminary reports of our audit findings to GHI officials and considered their comments in preparing this report. GHI officials agree with our findings. The officials informed us that they are reviewing our audit findings and will apply the appropriate recovery procedures and remit recoveries to the Plan.

Inaccuracies in Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so their claims can be coordinated with Medicare, thereby reducing costs chargeable to the Plan. We compared data from the Federal Centers for Medicare and Medicaid Services (CMS) to claims information obtained from GHI. We identified 3,827 claims for services provided to Medicare-eligible Plan members that were not coordinated with Medicare. In some instances, certain information necessary to determine the Medicare eligibility of these claimants (e.g., employment status) was unavailable on the records provided by GHI.

To develop an estimate of the number of claims that were Medicare's responsibility, we statistically sampled claims and reviewed the selected claims with GHI officials. Based on this review, we determined, with 95 percent confidence, that GHI paid as the primary insurer between $314,972 and $344,105 in claims (with a midpoint of $329,539) that should have been coordinated with Medicare.

Our sample included 184 claims totaling $196,259. We determined that 118 claims totaling $129,874 were appropriately the responsibility of Medicare. The Plan paid claims that should have been paid by Medicare because, during the audit period, neither the Department nor the Plan's carriers tracked Medicare entitlement data on a comprehensive basis. Department officials informed us that they have obtained Medicare-eligibility data under a recently established agreement with CMS. However, this agreement provides for only a one-time sharing of Medicare-eligibility data, not the routine access necessary to ensure that Medicare-eligibility data is continually updated on a timely basis. In addition, the Department has not used this information to update its enrollment system.

We encourage the Department and GHI to work together to develop procedures to ensure that all Medicare-eligible claims are processed appropriately. The use of the Medicare data obtained from CMS could provide the basis for such procedures.

Persons Eligible for Medicare Part B Not Enrolled

The Plan requires all Plan members eligible for primary Medicare coverage to enroll in both Part A and Part B. If Plan members eligible for primary Medicare coverage do not enroll in Medicare, the members are responsible for the full cost of medical services that Medicare would have covered. Of the 184 sampled claims, 38 claims totaling $2,772 were paid on behalf of Plan members who were eligible for primary Medicare coverage, but who failed to enroll in Medicare Part B. Department officials informed us that cost recovery from the Plan members involved in some of these claims might not be appropriate. Therefore, GHI officials should work with the Department, the primary administrator of the Plan's enrollment system, to recover overpaid claims where appropriate, to ensure that Plan members enroll in Part B and to update the enrollment system accordingly.

Recommendations

1. *Review the population of questionable claims from which we estimated that $329,539 was overpaid. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.*

2. *For the claims attributed to members who are eligible for Medicare Part B, but not enrolled, work with the Department to pursue recovery of claims, where appropriate.*

3. *Work with the Department to develop a comprehensive system of procedures and internal controls to improve the processing of Medicare-eligible claims. Address such areas as:*

    - *Pursuing Federal Medicare eligibility data so that the Plan's enrollment system reflects accurate Medicare information;*

    - *Enrolling in Part B the Medicare-eligible members identified in our audit; and*

    - *Updating the Plan's enrollment system with the Medicare eligibility information identified in our audit.*

Major contributors to this report were Ronald Pisani, David Fleming, Laura Brown and Maria Harasimowicz.

We would appreciate receiving your response to the recommendations made in this report within 90 days, indicating any action planned or taken to implement them.

We wish to express our appreciation to the management and staff of GHI for the courtesies and cooperation extended to our auditors during this audit.

Yours truly,

Kevin M. McClune
Audit Director

cc: George Sinnott, Department of Civil Service
Deirdre A. Taylor, Division of the Budget
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