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**OFFICE OF THE STATE COMPTROLLER**

October 14, 2003

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

Re: Report 2003-F-35

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 have reviewed the actions taken by officials of the Department of Health as of October 6, 2003, to implement the recommendations contained in our report, S*elected Medicaid Payments for Medicare Part B Eligible Recipients* (Report 2000-D-3). Our report, which was issued on April 19, 2002, assessed whether providers had correctly reported the Medicare Part B deductible and coinsurance on the Medicaid claims they submitted for reimbursement for calendar year 1998.

## Background

The New York State Department of Health (Department) administers the State's Medical Assistance program (Medicaid), which provides medical assistance to needy people. The Department's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay claims for services to Medicaid recipients. In New York, the federal, State and local governments jointly fund the Medicaid program.

Medicare is a federal health insurance program for persons who are age 65 and older or disabled. Medicare provides hospital insurance (Part A) and supplemental medical insurance (Part B) for physician, clinic and other medical services not covered by Part A. Although Part B covers a substantial portion of a service cost, the Medicare enrollee must pay an annual Part B deductible and a coinsurance amount for each service. If the enrollee is a Medicaid recipient, Medicaid pays the deductible and coinsurance.

Federal law and State regulations require that providers bill Medicare before submitting claims to Medicaid. 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 EOMB information to bill Medicaid for the deductible and coinsurance amount.

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 (MCOs), the MCO is paid a capitation premium (monthly fee). In return, the MCO must ensure that the 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, the Department does not allow these recipients to enroll in MCOs, since capitation premiums Medicaid paid on their behalf would result in overpaying for services. It is possible that after enrollment in an MCO, a recipient will gain Medicare coverage. Managed care contracts stipulate that local social services districts must disenroll recipients when they become aware of Medicare coverage. For the 1998 calendar year, Medicaid paid $160.2 million ($118.9 paid to clinics and $41.3 million paid to MCOs) to providers on behalf of dual eligible recipients.

**Summary Conclusions**

In our prior audit, we found that Medicaid had overpaid certain providers of Medicare Part B services by $15.6 million because providers did not accurately report the Medicare deductible and coinsurance amounts. The $15.6 million overpayment includes $6.8 million that the Department had recovered from a single provider during the course of the audit. We found, however, that the Department did not adjust the claims on MMIS relating to the $6.8 million overpayment. In addition, despite having a policy that prohibits dual eligibles from enrolling in the Medicaid managed care program, we found that MMIS paid MCOs $3 million in capitation premiums for dual eligible recipients during the calendar year 1998.

In our follow-up review, we found that the Department had recently initiated efforts to recover the identified overpayments. We also found that the Department is still discussing the possibility of adjusting claims history on the eMedNY system (eMedNY is the replacement system for MMIS) when a provider remits a check to correct an inappropriate payment. Regarding dual eligibles enrolled in managed care, the Department has disenrolled all the enrolled dual eligibles we identified in the audit, and established an edit to prevent any future enrollments.

**Summary of Status of Prior Audit Recommendations**

Department officials have implemented two and partially implemented two of the four prior audit recommendations.

## Follow-up Observations

### Recommendation 1

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

Status – Partially Implemented

Agency Action – Department officials recovered $6.8 million from one provider before the prior audit report was issued. For the remaining $8.8 million of overpayments, the Department initiated recovery efforts in September 2003.

### Recommendation 2

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

Status – Partially Implemented

Agency Action – According to Department officials, when providers submit a check to correct inappropriate claims, the Medicaid payment file cannot always be adjusted accordingly. In many instances, the amount repaid by the provider is a negotiated amount and cannot be tied to any specific claim. Officials added that there would not be any changes made to the Medicaid payment file in the legacy MMIS system, but discussions regarding payment file adjustments in the eMedNY system are ongoing.

### Recommendation 3

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

Status – Implemented

Agency Action –Department officials provided us with a copy of the report they developed for the local social services districts that identifies dual eligibles enrolled in managed care and instructs districts to pursue disenrollment of the dual eligibles from the Medicaid system. This report was initiated in June 2003. In July 2003, the Department implemented an edit to prevent dual eligibles from enrolling in managed care.

### Recommendation 4

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

Status – Implemented

Agency Action –Department officials provided us with a list of 107 dual eligible recipients who were enrolled in managed care. All 107 recipients were disenrolled from managed care as of July 1, 2002.

Major contributors to this report were Ken Shulman, Bill Clynes, Don Paupini and Carol O'Connor.

We would appreciate your response to this report in 30 days, indicating any actions planned or taken to address any unresolved matters discussed in this report. We also thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during the review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Deidre A. Taylor