ALAN G. HEVESI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

August 13, 2004

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

Re: Report 2004-F-15

Dear Dr. Novello:

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 followed up on actions taken by the officials of the Department of Health (Department) to implement the recommendation contained in our report, *Medicaid Claims Paid for Medicare Part A Eligible Recipients – 2001* (Report 2002-D-1).

Background, Scope and Objective

The Department administers the State's Medical Assistance program (Medicaid), which was established to provide medical assistance to needy people. The Department's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System, 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.

Most of New York's aged or disabled Medicaid recipients are also covered by Medicare, which is federally funded. One component of Medicare is Medicare Part A, which covers inpatient hospital expenses, except for deductibles and coinsurance, for eligible beneficiaries during a 90-day benefit period. 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, the Medicaid provider is responsible for determining whether the recipient's Medicare benefits allow coverage for the services being provided. The provider must first bill Medicare. The provider may bill Medicaid for the deductible and coinsurance amount and any expenses for time periods not covered by Medicare. If the recipient has Medicare coverage and the

provider fails to bill Medicare first, Medicaid could overpay claims by the amount Medicare should have paid.

Our initial audit, which was issued on April 25, 2003, identified instances where Medicaid paid providers inappropriately for Medicaid recipients who have Medicare coverage. Our report recommended the Department investigate and recoup about $20.9 million of potential overpayments. The objective of our follow-up, which we did according to Generally Accepted Government Auditing Standards, was to assess the extent of implementation as of June 8, 2004 of our recommendation included in our initial report.

Summary Conclusion and Status of Audit Recommendation

We found Department officials have initiated recovery efforts and are still waiting to recover about $6.4 million. Department officials have partially implemented the recommendation contained in the prior report.

Follow-up Observations

Recommendation

Investigate and recoup the overpayments identified in this report.

Status - Partially implemented

Agency Action - According to Department officials, they have recovered $7.2 million of the $20.9 million of potential overpayments identified in our initial audit report and are awaiting recovery of an additional $6.4 million from providers. Official stated their collection contractor determined $7.3 million of the reported overpayments are valid Medicaid payments. We requested that Department officials provide documentation supporting the validity of these payments. Officials could only provide us with an analysis for $3.6 million of the $7.3 million. We reviewed the data provided and do not agree with the Department's determination for $2.4 million of the Medicaid payments:

- The Department classified $1.3 million as non-covered services and not recoverable. We maintain these payments are recoverable since our audit methodology only selected those payments that are fully reimbursable by Medicare. Department officials did not provide documentation to support their determination of such overpayments as valid Medicaid payments.
- The Department's collection contractor classified $795,344 as not recoverable since Medicare rejected the provider's claims because the provider failed to file the claims on time. In the initial audit, we notified the providers in time for them to meet the required Medicare billing timeframes. We believe the Department's determination that these Medicaid payments are valid, contradicts its Medicaid payment regulations.

- The Department classified $262,627 as valid Medicaid payments even though the providers had already adjusted the claims and thereby returned the overpayment to Medicaid.
- The Department classified $30,562 as valid, even though the providers were unable to locate documentation supporting the claimed medical service.
- The Department classified $55,453 to be valid because these claims needed to be reviewed by an independent peer review organization or were being reviewed by the Department's collection contractor.

Major contributors to this report were Ken Shulman, Bill Clynes, Don Paupini and Ottavio Nicotina.

We would appreciate your response to this report within 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 this process.

Yours truly,

David R. Hancox
Director
State Audit Bureau

cc: Robert Barnes