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November 29, 2005

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 2005-F-20

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 followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Medicaid Claims Paid for Medicare Part A Eligible Recipients - 2002* (Report 2003-S-59).

Background, Scope and Objective

The Department 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. The Department'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.

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. 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 day 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 all of the recipient's Medicare benefits have been exhausted. 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 Medicare coverage is available, the provider must bill Medicare even if the recipient denies having such 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 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 Medicare should have paid. The Department contracted with Public Consulting Group, Inc. to identify and recover incorrectly paid Medicaid claims in 2002.

Our initial audit report, which was issued on August 16, 2004, examined the Department's compliance with its regulations for the payment of Medicaid claims made to inpatient hospitals for Medicare recipients for the period January 1, 2002 through December 31, 2002. Our report identified Medicaid may have overpaid providers more than $20.5 million. The objective of our follow-up, which was conducted in accordance with generally accepted government auditing standards, was to assess the extent of implementation as of October 17, 2005 of the recommendation included in our initial report.

Summary Conclusions and Status of Audit Recommendation

We found that Department officials partially implemented the recommendation contained in our initial audit report. Officials have taken steps to address overpaid claims for Medicaid recipients who are also Medicare eligible.

Follow-up Observations

Recommendation

Investigate and recoup the overpayments identified in this report.

Status - Partially Implemented

Agency Action - According to Department officials, they provided the claims totaling $15,751,658 identified in the recommendation to their collections contractor, Public Consulting Group, Inc. (PCG). Using a methodology similar to what our audit employed, PCG has independently identified Medicaid overpayments during the same time period. Department officials believe that it would not be worth the effort to uniquely identify the recovery activities related to the overpayments identified in our initial audit. Department officials stated that as part of its Medicaid Match and Recovery project, PCG has recovered

$28,264,600 which includes additional claims, not related to our initial review, for Medicaid recipients who are also Medicare eligible.

Major contributors to this report were Bill Clynes, Erika Akers, Don Collins, and Jennifer Van Tassel.

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

Very truly yours,

Steven E. Sossei
Audit Director

cc: Robert Barnes, Division of the Budget