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

June 9, 1998

Barbara A. DeBuono, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Claims Paid for Medicare Part A Eligible Recipients - 1996
Report 97-D-20

Dear Dr. DeBuono:

Pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law, we reviewed Medicaid claims processing activity for Medicaid recipients who were eligible for Medicare Part A coverage during the 1996 calendar year (dual eligible recipients). The purpose of this review was to identify instances where Medicaid inappropriately paid providers for dual eligible recipients.

## A. Background

Since October 1, 1996, the Department of Health (Health) has administered New York State's Medical Assistance Program (Medicaid). This program was established in accordance with Title XIX of the Federal Social Security Act to provide medical assistance to needy people. Prior to October 1, 1996, the Department of Social Services had this responsibility. In New York, the Federal, State and local governments jointly fund the Medicaid program. Health contracts with a fiscal agent to process Medicaid claims and to make payments to providers for services rendered to Medicaid-eligible recipients through the Medicaid Management Information System (MMIS).

Most of New York State's aged or disabled Medicaid recipients are also covered by Medicare. Medicare, which is Federally funded, covers all inpatient hospital expenses for eligible beneficiaries during a 90-day benefit period, except for deductible and coinsurance amounts. If a recipient needs more than 90 days of inpatient care during a benefit period, Medicare will allow up to an additional 60 "lifetime reserve" (LTR) days of coverage. LTR days can be used only once in the recipient's lifetime. For each LTR day the recipient uses, Medicare will pay all covered services except a daily LTR coinsurance amount. When a Medicaid recipient also has Medicare coverage, Medicaid pays for Medicare deductibles, coinsurance and remaining expenses only after the recipient exhausted all Medicare benefits. By law, Medicaid is always the payor of last resort.

In New York State, it is the responsibility of the Medicaid provider to verify if a recipient's Medicare benefits provide coverage for the service being billed. If the recipient's Medicaid identification card indicates Medicare coverage, the provider must bill Medicare even if the recipient denies having Medicare coverage. Upon being billed, Medicare sends providers an Explanation of Medical Benefits (EOMB) indicating the services paid, if any, less any deductibles. Using this information, the provider may bill Medicaid for the deductibles or any service periods not covered by Medicare. If the provider knows that the recipient does not have Medicare coverage, or if the provider submitted a claim to Medicare and Medicare denied it, the provider may bill Medicaid directly. If the recipient has Medicare coverage and the provider fails to first bill Medicare, Medicaid could overpay its liability by the amount that Medicare should have paid.

To determine if Medicaid properly paid hospital claims for recipients with Medicare coverage, we compared the recipients' 1996 Medicare Part A claims to their Medicaid claims. We selected two judgmental samples of recipients' claims based on risk patterns that show a high potential for overpayment, such as claims submitted by hospitals which had high error rates in our prior audits. To determine if Medicare coverage for these recipients was available, we requested the Medicare fiscal intermediary to provide us with the recipient's inpatient hospital claim data for 1994, 1995 and 1996. In similar past reviews, we determined that the Medicare three year data is needed to identify the available 1996 Medicare benefits. We also obtained additional claiming data for these recipients from the U.S. Department of Health and Human Services, Health Care Financing Administration, to supplement the data received from the Medicare fiscal intermediary. To accomplish our review, we reviewed each recipient's Medicaid and Medicare claims to determine whether Medicaid payments were appropriate.

## B. Results of Review

We reviewed the Medicaid and Medicare claims for 3,373 dual eligible recipients, and identified that Medicaid potentially overpaid providers about $15.2 million for the 1996 calendar year. This amount included about $4.9 million for recipients who lacked Medicare eligibility on Medicaid third party insurance files and $10.3 million for recipients whose Medicare eligibility was recorded. We understand that to reduce such erroneous Medicaid payments in the future,

Health has initiated a project to require providers to submit their claims for dual eligible recipients to the Medicare fiscal intermediary, which will then process the Medicare payment and, if appropriate, submit the claims to Medicaid for payment. Health officials plan to have the project operational by October 1998.

### 1. Recipients Who Lacked Medicare Eligibility on Medicaid Reference Files

Medicaid providers used the State's Welfare Management System (WMS) to help determine if a Medicaid recipient has Medicare or other third party insurance coverage. In a prior audit report Accuracy of Medicare Information for Medicaid Recipients (96-S-91), we identified over 41,000 recipients whose Medicare coverage was not identified or correctly reflected on WMS. Based on our experience, we selected 202 of these recipients, who were likely to have been inappropriately billed to Medicaid. For these recipients, Medicaid paid $6.1 million to providers. We contacted the providers and requested a copy of the Medicare EOMB, to ascertain that they had maximized Medicare before billing Medicaid. For 173 recipients, MMIS had overpaid the providers about $4.9 million or 80 percent of the Medicaid payment. As a result of our review, the providers have begun adjusting or voiding their Medicaid claims and properly billing Medicare.

### 2. Recipients With Medicare Eligibility Recorded on Medicaid Reference Files

From a population of 564,162 recipients that reflected Medicare coverage on the Medicaid reference files, we selected 3,171 recipients with Medicaid payments of about $97 million. Using computer assisted audit techniques, we evaluated the appropriateness of Medicaid payments for these recipients. We analyzed about 40,600 Medicare and 26,200 Medicaid claims and found that for 816 of these recipients, Medicaid overpaid nearly $10.3 million to hospital providers. The reasons for the providers' overpayments were as follows:

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|---|---|---|
| 1. | Provider did not submit claims to Medicare | $ 7,300,000 |
| 2. | Medicare payment information recorded on Medicaid claims and the actual Medicare claims did not agree | 2,700,000 |
| 3. | Provider failed to bill for available LTR days | 240,000 |
| 4. | Claims not billed in chronological order | 45,000 |
| | Total Overpayment | $10,285,000 |

### Recommendation

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

Major contributors to this report were Lee Eggleston, William Clynes, Dominick DiFiore, Sharon Whitmore, Victoria Woods and Nancy Cecot.

We would appreciate receiving your response to the recommendation made in this report within 30 days indicating any action planned or taken to implement the recommendation. 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: Robert L. King