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July 11, 2000

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 2000-F-8

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 the Department of Health as of June 21, 2000, to implement the recommendations contained in our audit report, *Medicaid Payments for Medicare Beneficiaries* (Report 95-S-91). Our report, which was issued on May 21, 1997, assessed whether Medicare Part A benefits were used before Medicaid claims were paid during calender year 1994. The audit report identified potential Medicaid overpayments where Medicare coverage was not maximized.

Prior to October 1, 1996, the Department of Social Services was responsible for administering the Medicaid program through its fiscal agent, Computer Sciences Corporation. After October 1, 1996, the Department of Health became responsible for administering Medicaid through the fiscal agent. Hence, our follow-up review focused on actions taken by the Department of Health to implement our recommendations.

Background

The Medicaid program provides medical assistance to needy people. Medicaid claims are processed and paid by the Medicaid Management Information System (MMIS), a computerized payment and information reporting system. The New York State Department of Health (Health) is responsible for administering the Medicaid program and the MMIS.

According to Federal law and State regulations, if a Medicaid recipient has health insurance from Medicare or other third-party resources, the medical service provider must bill Medicare and all third-party resources before billing the MMIS. By law, Medicaid is always the payer of last resort. MMIS has built-in computer controls to deny payment to providers for recipients with Medicare coverage unless the claim indicates the Medicare program has been billed for its share of the costs.

Medicare is a Federally funded program for the aged or disabled that covers inpatient hospital expenses for eligible beneficiaries. Medicare pays for 90 days of hospital services during a benefit period, except for deductibles 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 a recipient's lifetime. For each LTR day a recipient uses, Medicare will pay all covered services except a daily LTR coinsurance amount. When a Medicaid recipient also has Medicare coverage (dual eligible recipient), Medicaid pays for the Medicare deductible, coinsurance and the remaining portion of a hospital stay after the recipient has exhausted all Medicare benefits.

Summary Conclusions

In our prior audit, we found that Health did not have adequate controls to ensure that Medicare coverage had been fully utilized prior to allowing Medicaid payments to be made. We found that providers were directly billing Medicaid even though Medicare coverage was available. We also found that some providers were billing both Medicare and Medicaid for the same services, without informing Medicaid of the Medicare payment. The audit identified a number of areas where Health could improve its procedures for processing Medicaid claims for recipients with Medicare coverage.

In our follow-up review, we found that Health officials have made significant progress in recovering the overpayments we identified in our audit. As of March 27, 2000, Health officials had recovered approximately $2.8 million of the $3.8 million in overpayments identified in our report, had concluded that $228,000 was correctly billed based on providers' explanations, and were pursuing recovery of $798,000 in potential overpayments. However, Health officials had made little progress in implementing the recommendations to reduce the MMIS processing exposures. While Health officials initiated a project to explore the feasibility of a crossover system that would mandate providers bill Medicare before they bill Medicaid, Health officials were unable to determine the project results or why this project was never completed.

Summary of Status of Prior Audit Recommendations

Of the four prior audit recommendations, Health officials implemented one recommendation, partially implemented two recommendations, and have not implemented one recommendation.

Follow-up Observations

Recommendation 1

Investigate and recover overpayments cited in this report. Request explanations from providers showing why they failed to immediately return duplicate payments.

Status - Partially Implemented

Agency Action - Of the $3.8 million in potential overpayments we identified, Health officials have recovered approximately $2.8 million and have concluded that $228,000 was correctly billed, based on explanations given by health care providers. Additionally, Health officials were pursuing the recovery of approximately $798,000 in potential overpayments. However, Health officials did not request an explanation from providers showing why they failed to immediately return duplicate payments. Health officials stated their belief that this would be of limited benefit in that the comments received might not be credible.

Recommendation 2

Investigate the feasibility of implementing a mandatory statewide crossover system. Additionally, for any claim directly billed to Medicaid by a provider, require some type of proof that Medicare was fully utilized before paying such a claim.

Status - Partially Implemented

Agency Action - Health officials initiated a project to review the feasibility of establishing a mandatory statewide crossover system. However the project was not completed and a system was not developed. According to Health officials, staff turnover and changes in office responsibilities led to the project's demise. According to Health officials, they anticipate that these issues will be addressed as part of eMedNY, which will replace the existing MMIS system.

Recommendation 3

Investigate the possibility of developing a system that tracks LTR day balances to ensure that these benefits are exhausted before a Medicaid payment is made.

Status - Not Implemented

Agency Action - Health officials stated that the anticipated crossover system, addressed in Recommendation 2, would track the use of the Life Time Reserve days. However, this system was not developed. According to Health officials, they anticipate that this issue will be addressed as part of eMedNY, which will replace the existing MMIS system.

Recommendation 4

Immediately take action to educate providers regarding the proper use of LTR days.

Status - Implemented

Agency Action - Health officials updated the provider manual to educate providers that a recipient with Medicare and Medicaid coverage must utilize all of their LTR days; if a recipient chooses not to use their LTR days, then the recipient is completely responsible for payment of those days. Health officials also placed a notice in the August 1997 Medicaid Update to educate providers on the proper use of LTR days for crossover recipients.

Major contributors to this report were Lee Eggleston, William Clynes and Dominick DiFiore.

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 review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Charles Conaway