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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 22, 2000

Antonia C. Novello, 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 - 1998 Report 99-D-3

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 reviewed Medicaid claims processing activity for Medicaid recipients who were also eligible for Medicare Part A benefits during the 1998 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

The New York State Department of Health (Health) 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. Health'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 rendered 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. Medicare, which is federally funded, covers inpatient hospital expenses for eligible beneficiaries during a 90-day 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 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 after the recipient has exhausted all Medicare benefits. 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 available 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 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 that 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 that Medicare should have paid. Health maintains a Benefit Recovery System (BRS) to identify incorrectly paid Medicaid claims where Medicare eligibility began prior to the date the Medicare eligibility information was added to the Medicaid files.

B. Methodology

To determine the recipients who were dual eligible, we provided the social security numbers of the 5,331,579 recipients eligible for Medicaid at the time of our review, to Empire Medicare Services (Empire), the fiscal intermediary in New York State that processes Medicare claims for the Social Security Administration. Empire compared these social security numbers to their Medicare files and identified 771,383 potential dual eligible recipients. Out of the 771,383 recipients, we identified 323,664 recipients who were dual eligible during the 1998 calendar year.

From the 323,664 recipients, we selected 3,511 recipients and attempted to compare their 1998 Medicaid claims to their Medicare claims. Our selection of these recipients was based on various audit risk criteria for claiming activity that we determined, from prior audit experience, showed a high risk for Medicaid overpayment. We noted that 10 of the 3,511 recipients did not have Medicaid claims during our review period and, therefore, we excluded them from our review. For 2,491 recipients who had Medicare claims, Empire provided us with Medicare claim information. To accomplish our review for these recipients, we compared their Medicaid and Medicare claims to determine whether the Medicaid payment was appropriate.

Of the remaining 1,010 recipients, we requested providers to verify Medicare eligibility and send us a copy of the EOMB as proof that Medicare was billed for 961 recipients. We did not request such verification for the remaining 49 recipients because we determined that they were at low risk for having overpayments.

C. Results of Review

We reviewed Medicaid and Medicare calendar year 1998 claims for the selected recipients and found that Medicaid may have overpaid providers as much as $14.9 million. This amount comprises $8.5 million for recipients who had billings for both Medicare and Medicaid, but where Medicare reimbursement was not maximized, and $6.4 million for recipients who had potential Medicare eligibility but no Medicare billings.

1. Claims for Recipients with Both Medicare and Medicaid Payments

For 2,491 recipients, Medicaid paid about $71.6 million to providers. Using computer assisted audit techniques, we evaluated the appropriateness of Medicaid payments for these recipients. We analyzed about 46,000 Medicare and 11,000 Medicaid claims and found that for 715 of these recipients, Medicaid overpaid $8.5 million to providers. The reasons for the provider overpayments are as follows:

Provider Did Not Bill Medicare but Billed Medicaid for the Entire Claim Period	$5,443,230
Provider Billed Both Medicare and Medicaid for the Full Amount During the Same Claim Period	1,978,817
Medicare Information Recorded on the Medicaid Claims Was Not Accurate	448,700
Provider Did Not Bill for Available LTR Days	404,091
Provider Billed Medicaid Although There Was Evidence of Another Third Party Resource (e.g. Medicare HMO, private insurance, etc.)	241,886
Total Overpayments	$8,516,724

2. Claims for Recipients with Potential Medicare Eligibility, but No Medicare Billings

For 961 recipients, Medicaid paid $18.1 million to providers. We contacted the providers for these recipients and requested a copy of the Medicare EOMB to ascertain that they had maximized Medicare before billing Medicaid. We found that for 440 recipients, Medicaid overpaid the providers $6.4 million because Medicare coverage was available but never billed. Of the $6.4 million, providers agreed to refund Medicaid $2.3 million. For the other $4 million, providers are waiting for a Medicare determination regarding their billing. Once Medicare makes a determination on these claims, the Medicaid claims will be adjusted accordingly.

Recommendation

Investigate and recoup the overpayments cited in this report.

Major contributors to this report were Lee Eggleston, Robert Wolf, Sharon Whitmore, Victoria Woods, Robert Elliott and Larry Julien.

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: Mr. Charles Conaway