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STATE COMPTROLLER



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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

August 29, 2002

Michael A. Stocker, M.D.
President and Chief Executive Officer
Empire Blue Cross Blue Shield
3 Huntington Quadrangle
Melville, NY 11747

Re: New York State Health Insurance Program
Coordination of Medicare Coverage
Report 2002-S-8

Dear Dr. Stocker:

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 audited hospitalization claims processed for the New York State Health Insurance Program's Empire Plan (Plan). The scope of our financial-related/compliance audit included medical claims of Plan members for the year ended December 31, 2001.

A. Background

The New York State Health Insurance Program (Program) provides hospital services, surgical services and other medical and drug coverage to more than 790,000 active and retired State employees and their dependents. It also provides coverage for more than 376,000 active and retired employees of participating local government units and school districts, and dependents of such employees.

The Plan is the Program's primary health benefits plan, providing services to almost 1 million individuals in the Program at an annual cost of more than \$2.5 billion. The Department of Civil Service (Department) contracts with Empire Blue Cross Blue Shield (Empire Blue Cross) to administer the hospitalization portion of the Plan. During the calendar year ended December 31, 2001, Empire Blue Cross approved about 816,000 claims totaling more than \$706 million and charged the State about \$35 million for administrative and other related expenses.

Medicare is a federal health insurance program created in 1965 to provide medical coverage for people aged 65 or older. In 1973, Congress passed legislation to extend Medicare coverage to those who are disabled or suffer from chronic renal failure. For eligible persons, Medicare hospital

insurance (Part A) is premium-free, and pays most costs of inpatient hospital care and medically necessary care in a skilled nursing facility, hospice or home health care setting. Medicare medical insurance (Part B), which helps pay for doctor and outpatient hospital services and other products and services not covered by Part A, requires eligible persons to enroll and pay monthly premiums. Medicare requires individuals and providers of care to submit claims for payment timely (within 15 to 27 months, depending on the date of service).

When Plan members, including covered spouses and dependents, become eligible for Medicare coverage, Medicare becomes the primary payer of their medical expenses. By identifying Medicare-eligible Plan members and coordinating payment of their claims with Medicare, the Plan can reduce its expenditures. The Department is primarily responsible for maintaining the Plan's enrollment system, including updating this system to reflect current Medicare eligibility information. Insurance carriers also have a role in the coordination of claims with Medicare (i.e., by maintaining edits to flag potential Medicare-eligible claims and by obtaining Medicare eligibility data and sharing it with the Department). Therefore, the Department and its carriers need to work together to provide reasonable assurance that Medicare reimbursable claims are properly processed.

B. Audit Scope, Objective and Methodology

We audited the Plan's Medicare-related claims for the year ended December 31, 2001. The primary objective of our audit was to determine whether the Plan identifies Medicare eligibility when it processes medical claims for Medicare-eligible Plan enrollees and their spouses and dependents.

Our audit survey showed that neither the Department nor the Plan's insurance carriers tracked Medicare eligibility information on a comprehensive basis. Therefore, we focused our audit on Plan members who were eligible for Medicare during the year ended December 31, 2001, according to Medicare eligibility data for Plan members that we obtained from the federal Centers for Medicare and Medicaid Services (CMS). We compared this information with Empire Blue Cross claims data to identify claims that were not properly coordinated with Medicare. As in our previous audits of Plan Medicare coordination issues, we identified related matters that the Department, in its capacity as administrator of the Plan and the enrollment system, needs to address to improve the Plan's coordination with Medicare. We informed the Department of these matters under separate cover in a letter dated October 25, 2001.

We did our audit according to generally accepted government auditing standards. Such standards require that we plan and do our audit to adequately assess those Department and Empire Blue Cross operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department and Empire Blue Cross and that we review these entities' compliance with the laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses on those operations that we identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. Thus, we devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit reports on an exception basis. This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

C. Results of Audit

Because of weaknesses in the Plan's system for identifying Medicare eligibility, we estimate that, during the audit period, Empire Blue Cross paid claims totaling more than \$1.4 million which should have been paid by Medicare.

We provided preliminary reports of our audit findings to Empire Blue Cross officials and considered their comments in preparing this report. Empire Blue Cross officials agree with our findings and informed us that they have recovered \$630,035 of the \$1,471,987 we identified, and are actively pursuing the remaining claims.

Inaccuracies in Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so their claims can be coordinated with Medicare, thereby significantly reducing costs chargeable to the Plan. We compared data from CMS to claims information obtained from Empire Blue Cross and identified a population of 2,709 Empire Blue Cross claims for which Medicare was potentially the primary insurer. From this population, we selected a statistical sample of claims and reviewed these claims with Empire Blue Cross officials. Based on the results of this review, we estimated the dollar amount of claims that were Medicare's responsibility during our audit period. To the extent Medicare was the primary insurer, these claims should have been submitted to Medicare.

Since, in some instances, information that may affect the Medicare eligibility of a claim (e.g., employment status, certain medical conditions including end-stage renal disease, etc.) was either inaccurate or unavailable on the records provided by Empire Blue Cross, we had to investigate each sampled claim to determine the extent of Medicare's responsibility. Empire Blue Cross officials provided us with additional information required to assess these claims. Based on our review, we determined, with 95 percent confidence, that Empire Blue Cross paid (as the primary insurer) between \$1,275,470 and \$1,668,504 in claims (with a midpoint of \$1,471,987) that were appropriately the responsibility of Medicare.

Thus, Empire Blue Cross, rather than Medicare, paid these claims because neither the Department nor Empire Blue Cross tracked Medicare eligibility information on a comprehensive basis during the audit period. Empire Blue Cross officials informed us that they are finalizing a contract with CMS to access Medicare eligibility data and they plan to seek the Department's approval for reimbursement of the administrative costs involved with acquiring and utilizing this data. We encourage Empire Blue Cross officials to continue to develop procedures to ensure that all Medicare-eligible claims are processed appropriately. The use of Medicare data obtained from CMS

could provide the basis for such procedures. We also encourage Empire Blue Cross officials to continue to work with the Department and other Plan carriers to establish a coordinated and comprehensive approach.

Recommendations

1. *Review the population of questionable claims from which we estimated that \$1,471,987 was overpaid. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.*
2. *Continue working with the Department to develop a comprehensive system of procedures and internal controls to improve the processing of Medicare-eligible claims. Address areas such as:*
 - *pursuing federal Medicare eligibility data so the Plan's enrollment system reflects accurate Medicare information; and*
 - *updating the Plan's enrollment system with the Medicare eligibility information identified in this audit.*

Major contributors to this report were Ronald Pisani, Dennis Buckley and Douglas Abbott.

We would appreciate receiving your response to the recommendations made in this report within 90 days, indicating any action planned or taken to implement them.

We wish to express our appreciation to the management and staff of Empire Blue Cross for the courtesies and cooperation extended to our auditors during this audit.

Yours truly,

Kevin M. McClune
Audit Director

cc: George Sinnott, Department of Civil Service
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