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April 25, 2003

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Medicaid Claims Paid for Medicare Part A Eligible Recipients – 2001
Report 2002-D-1

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 (dual eligible recipients) during the fifteen-month period ended December 31, 2001. The purpose of this review was to identify instances where Medicaid paid providers inappropriately for dual eligible recipients.

A. Background

The New York State Department of Health (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 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 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 maintains a Benefit Recovery System to identify incorrectly paid Medicaid claims, where Medicare eligibility began prior to the date the Medicaid eligibility information was added to the Medicaid files.

B. Methodology

To determine which recipients were dual eligible, we used Medicare eligibility information from the federal Centers for Medicare and Medicaid Services. We compared this information to Medicaid eligibility files and identified 466,749 recipients who were dual eligible during the fifteen-month audit period ended December 31, 2001. Using audit risk criteria developed from prior audits, we selected 4,516 recipients from this dual eligible group and compared their Medicaid claims to their Medicare claims for the fifteen-month audit period. We obtained the Medicare claims for these recipients from Empire Medicare Services (Empire), the fiscal intermediary in New York State that processes Medicare claims for the federal Centers for Medicare and Medicaid Services.

The Department paid providers almost $120.7 million in Medicaid reimbursements on behalf of these 4,516 recipients during the fifteen-month audit period. Our audit consisted of reviewing these recipients' Medicare and Medicaid claims histories to determine whether hospital providers had fully utilized these recipients' Medicare benefits before billing Medicaid. From Empire, we obtained Medicare claims for 3,365 of the 4,516 recipients, and we compared these recipients' Medicaid claims to the Medicare claims to determine whether the Medicaid payments were appropriate. Empire did not report any Medicare claims for the remaining 1,151 recipients. Consequently, we requested providers to verify Medicare eligibility for these recipients by submitting to us a copy of the EOMB as proof that Medicare had been billed.

C. Results of Review

We determined that Medicaid had overpaid providers more than $20.9 million. This amount includes almost $11.6 million for recipients who had billings for both Medicare and Medicaid even though the Medicare reimbursement had not been maximized, as well as over $9.3 million for recipients who were eligible for Medicare but had no Medicare billings.

1. Claims for Recipients with Both Medicare and Medicaid Payments

Using computer-assisted audit techniques, we analyzed 42,753 Medicare and 13,520 Medicaid claims. We found Medicaid overpaid providers almost $11.6 million on behalf of 1,015 recipients. The overpayments were made for the following reasons:

Reasons	Overpayments
Provider did not bill Medicare; instead, billed Medicaid for the entire claim period	$7,749,522
Provider billed both Medicare and Medicaid for the full amount during the same claim period	2,018,081
Provider did not correctly code the Medicare claim or did not submit necessary documentation to Medicare	1,170,225
Provider did not bill for available LTR days	263,781
Medicare information recorded on the Medicaid claims was not accurate	243,798
Provider billed Medicaid for services provided to recipients who were listed as deceased on the Medicare records	110,059
Provider billed Medicaid, despite evidence of another third-party resource (e.g., Medicare HMO, private insurance, etc.)	38,150
Total Overpayments	$11,593,616

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

We contacted the providers and requested a copy of each Medicare EOMB to verify that the providers maximized Medicare before billing Medicaid. For 622 recipients, we found that Medicaid overpaid the providers more than $9.3 million because Medicare coverage was available but was never billed. Of the $9.3 million, providers agreed to refund $3 million to the Medicaid program. For the remaining $6.3 million, providers were awaiting a Medicare determination regarding their billing at the conclusion of our audit. Once Medicare makes a determination on these claims, the Medicaid claims will be adjusted accordingly.

Recommendation

Investigate and recoup the overpayments identified in this report.

Major contributors to this report were Ken Shulman, Bill Clynes, Sheila Emminger, Dominick DiFiore, Leo Shaw, Robert Elliott, Tina Santiago, Casey O'Connor, Carrie Zusy and Karla Funk.

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: Dierdre A. Taylor