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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

May 10, 2004

Mr. Frank J. Branchini
President and Chief Executive Officer
Group Health Incorporated
441 9th Avenue
New York, NY 10001

Re: New York State Health Insurance Program
Coordination of Medicare Coverage
Report 2003-S-13

Dear Mr. Branchini:

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 mental health and substance abuse claims processed for the New York State Health Insurance Program's Empire Plan (Plan). The scope of our performance audit included claims of Plan members for the year ended December 31, 2002.

A. Background

The New York State Health Insurance Program (Program) provides hospital and surgical services and other medical and drug coverage to more than 796,000 active and retired State employees and their dependents. It also provides coverage for more than 392,000 active or 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 about 1 million individuals at an annual cost of more than $2.9 billion. The Department of Civil Service (Department) contracts with Group Health Incorporated (GHI) to administer the mental health and substance abuse portion of the Plan. During the year ended December 31, 2002, GHI approved almost 521,000 charges totaling more than $61 million and charged the State over $14.4 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, is optional and 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). GHI processes certain claims that should be coordinated with Part A, and other claims that should be coordinated with Part B. Therefore, our audit included GHI's coordination with Parts A and B.

Generally, Medicare is the primary payer of medical expenses for retired enrollees, as well as their spouses and their dependents. Therefore, the Plan requires all of its Medicare-eligible members to enroll in both parts of Medicare. If Plan members eligible for primary Medicare coverage do not enroll in Medicare, the members are responsible for the full cost of medical services that Medicare would have covered. Thus, 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 processed properly.

B. Audit Scope, Objective, and Methodology

We audited the Plan's Medicare-related claims for the year ended December 31, 2002. The primary objective of our audit was to determine whether the Plan identifies Medicare eligibility when it processes 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 on a comprehensive basis. Therefore, we focused our audit on Plan members who were eligible for Medicare during the audit period, according to Medicare eligibility data from the Federal Centers for Medicare and Medicaid Services (CMS). We compared this information with GHI claims data to identify claims that were not properly coordinated with Medicare. As in our previous audits of the Plan's coordination with Medicare, 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 in a separate 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 GHI operations included in our audit scope. Further, these standards require that we understand the internal control systems of the Department and GHI 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Results of Audit

Because of weaknesses in the Plan's system for identifying Medicare eligibility, we estimate that GHI erroneously paid $293,799 as the primary insurer. These payments should have been coordinated, instead, with Medicare.

We provided preliminary reports of our audit findings to GHI officials and considered their comments in preparing this report. GHI officials agreed with our findings and informed us that they are reviewing them. The officials said they will apply the appropriate recovery procedures and remit recoveries to the Plan.

1. Inaccuracies in Medicare Eligibility Status

All Medicare-eligible Plan members should be identified so that payment of their claims can be coordinated with Medicare, thereby reducing costs chargeable to the Plan. However, when we compared Medicare eligibility data for Plan members to information in GHI claims, we identified 2,714 claims that had not been coordinated with Medicare. In some instances, information necessary to determine the Medicare eligibility of these Plan members (e.g., employment status, remaining level of Medicare benefits) was unavailable on the records provided by GHI.

To develop an estimate of the number of claims that were Medicare's responsibility, we statistically sampled claims and reviewed them with GHI officials. Based on this review, we determined, with 95 percent confidence, that GHI paid as the primary insurer between $282,566 and $305,033 in claims (with a midpoint of $293,799) that should have been coordinated with Medicare. Details of the sample from which we made this determination are presented below.

a. Claims for Members Enrolled in the Medicare Program

Our sample included 163 claims totaling $127,679. From that sample, we determined that 142 claims totaling $124,334 were appropriately the responsibility of Medicare. GHI paid these claims instead of Medicare, because neither the Department nor the Plan's carriers had tracked Medicare entitlement data on a comprehensive basis during the audit period. GHI officials informed us that they are negotiating an agreement with CMS to obtain Medicare-eligibility data.

We encourage the Department and GHI to continue working together to develop procedures for ensuring that all Medicare-eligible claims are processed appropriately. The use of Medicare data obtained from CMS could provide the basis for such procedures.

b. Claims for Members Not Enrolled in Medicare Part B

The Plan requires all Plan members eligible for primary Medicare coverage to enroll in both Medicare Part A and Medicare Part B. Plan members who are eligible for primary Medicare coverage but do not enroll in Medicare are responsible for the full cost of medical services that Medicare would have covered. We determined that 20 of the 163 sampled claims, totaling $3,270, were paid for Plan members who were eligible for primary Medicare coverage but had failed to enroll in Medicare Part B. Department officials informed us that it might not be appropriate to attempt to recover costs for some of these claims. Therefore, GHI officials should work with the Department (the primary administrator of the Plan's enrollment system) to recover overpaid claims, where appropriate, to ensure that Plan members enroll in Part B. Officials should also ensure that the enrollment system is updated accordingly.

2. Cost Recovery Procedures

In our prior audit of GHI's Coordination of Medicare Coverage (Report 2001-S-17, issued on February 28, 2002), we estimated, with 95 percent confidence, that GHI had paid charges totaling between $314,972 and $344,105 (with a midpoint of $329,539) that should have been coordinated with Medicare. During our follow-up review of that audit (Report 2003-F-27, issued on February 25, 2004), GHI officials reported that they had recovered $11,007.

During our follow-up review we determined that GHI's low rate of recovery was due, in part, to their cost recovery procedures. For example, GHI officials informed us that at the time of our prior audit, they did not rely on the Medicare eligibility information identified in our audit. Instead, the officials said that they first confirmed Medicare eligibility with Plan members before initiating recovery efforts for members who positively confirmed that they were eligible. During our follow-up review, we informed GHI that such procedures were not necessary because we had provided them with the actual dates of Medicare eligibility. GHI officials, thus, stated they will, in the future, rely on the Medicare eligibility information identified in our audits, and no longer perform the member confirmations. We appreciate GHI officials' prompt attention to this matter.

GHI officials also informed us that they do not offset identified overpayments against future participating provider payments, as the Plan's other carriers do. GHI officials attributed this policy to their "sensitive provider network" (providers would have limited recourse to seek recovery from Medicare given their timely filing criteria) and a lack of specific offset language in their provider agreements. To improve the efficiency of GHI's cost recovery process, we encourage GHI officials to consider revising provider agreements to specify offset procedures.

Recommendations

1. *Review the population of questionable claims from which we estimate that $293,799 was overpaid. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.*

2. *Work with the Department to pursue recovery of claims, where appropriate, for those claims attributed to members eligible for, but not enrolled in, Medicare Part B.*

3. *Work 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 that the Plan's enrollment system reflects accurate Medicare information.*

    - *Enrolling in Part B the Medicare-eligible members identified in our audit.*

    - *Updating the Plan's enrollment system with the Medicare-eligibility information identified in our audit.*

4. *Improve procedures for maximizing the recovery of overpayments identified in our audits. In the case of participating providers, consider offsetting against future claim payments.*

Major contributors to this report were Ronald Pisani, David Fleming, and Maria Harasimowicz.

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 GHI for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Frank J. Houston
Audit Director

cc: George Sinnott, Department of Civil Service
Robert Barnes, Division of the Budget
John Baackes, Group Health Incorporated
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