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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

July 22, 2004

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

Re: Nursing Home Claims Paid for Medicare Eligible Recipients
Report 2003-S-32

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 audited the applicable controls at the Department of Health (Department) for ensuring that Medicaid appropriately paid nursing home claims on behalf of recipients who have both Medicare and Medicaid coverage. Our audit covered the three-year period ended December 31, 2002.

A. Background

The 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.

Annually, Medicaid spends more than $5 billion for skilled nursing home services provided to Medicaid recipients. Many Medicaid recipients are also eligible for Medicare Part A, which covers hospitalization and a limited amount of skilled nursing home services after hospitalization. Medicare, which is 100 percent federally funded, covers skilled nursing home care expenses for eligible recipients up to 100 days following a hospitalization of at least three days. Medicare covers the initial 20 days in full. The remaining 80 days are covered, less a daily co-insurance, which the recipient is responsible for paying. When the recipient has both Medicare and Medicaid coverage,

Medicaid is responsible for paying the recipient's co-insurance costs. In New York, it is the responsibility of the skilled nursing home provider to determine whether the recipient's Medicare benefits allow coverage for the services being provided.

Medicare covers nursing home services as a continuation of an individual's hospital stay. Therefore, Medicare will cover only those recipients who are hospitalized prior to being admitted to the nursing home, and only if the care received is related to the hospital stay. In addition, Medicare covers only skilled care, which Medicare defines as care required for improving an individual's medical condition, or preventing the condition from getting worse. Skilled care is typically provided by registered and practical nurses or therapists. If all of these criteria are met, Medicare typically pays for the recipient's nursing home care up to 100 days. By law, Medicaid is the payer of last resort. Therefore, nursing home providers should bill Medicare first, and then bill Medicaid for any amount that Medicare does not cover. However, nursing home officials may decide that billing Medicare is unnecessary because they know the recipient does not meet all of Medicare's criteria.

B. Audit Scope, Objective and Methodology

We audited the Department's policies and procedures relating to the payment of nursing home claims for the three-year period January 1, 2000 through December 31, 2002. The objective of this performance audit was to determine whether the Department established adequate controls to ensure that Medicaid appropriately paid nursing home providers on behalf of recipients who were eligible for both Medicaid and Medicare coverage.

To accomplish our audit objective, we interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined relevant Department payment policies and procedures. In addition, we evaluated Medicare claims information provided by the federal Centers for Medicare and Medicaid Services (CMS). Using computer-assisted audit techniques, we compared this information to paid Medicaid nursing home claims for the three-year period in order to identify potential duplicate billings. We also evaluated Medicaid nursing home payments for the 15-month period October 1, 2001 through December 31, 2002 for those Medicaid recipients who also had Medicare coverage, but whose services were not appropriately billed to Medicare. Medicare has a statute of limitations, which requires nursing home officials to submit claims within stipulated timeframes in order to be considered for payment. Therefore, we chose to evaluate claims paid during the last 15 months of our audit period, since nursing homes can still obtain payment from Medicare for services they provided during this period. For both of these tests, we excluded payments made to nursing homes that operate outside of New York State.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of the Department that are within our audit scope. Further, these standards require that we understand the Department's internal control structure and its compliance with those 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 who 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 Review

The Department is responsible for maintaining the MMIS to enable accurate payment of Medicaid claims submitted by health care providers, such as nursing homes. MMIS contains numerous edits and controls that help to ensure the accuracy of Medicaid claims. Some of these controls are designed to ensure proper payments when a recipient has both Medicare and Medicaid coverage. However, MMIS does not have any controls in place that would detect when a provider has received payment from both Medicaid and Medicare for the same patient's nursing home costs. In addition, MMIS cannot identify all the Medicaid recipients whose nursing home costs, although eligible for payment by Medicare, were billed instead to Medicaid. Since MMIS does not receive a file of Medicare paid claims, the only way to detect these types of inappropriate payments would be through an audit after the Medicaid claims have been paid. As a result of these weaknesses, we determined that nursing home providers were overpaid at least $7.0 million.

1. Claims for Recipients with Both Medicare and Medicaid Payments

With the information obtained from CMS, we compared nursing home claims paid by Medicare to nursing home claims paid by Medicaid. Using computer-assisted audit techniques, we identified all cases where the nursing home provider received both a Medicare and Medicaid payment for the same nursing home service. We identified potential duplicate billings, totaling approximately $8.6 million that were submitted by 631 nursing homes. To confirm the validity of our observations, we judgmentally selected 341 of the 631 providers and requested these providers to review the questionable Medicaid claims to determine whether they were actually inappropriate duplicate payments. We selected these providers because they exceeded a $5,000 threshold that we set for follow up on questionable claims. They accounted for approximately $8.0 million (93 percent) of the total questionable claims. As of February 19, 2004, we received responses from 268 providers that had billed for $6.7 million of our $8.0 million sample. Several of the providers submitted documentation to justify why some of their billings were appropriate. These explanations accounted for about $600,000 of the $6.7 million in claims submitted by the 268 responding nursing homes. However, the nursing home providers acknowledged that $6.1 million of the claims we questioned were duplicate payments. Providers reported that many of them have already begun to adjust their Medicaid claims for these overpayments. Because the Department does not have procedures in place to detect duplicate payments of this nature, Medicaid paid at least $6.1 million in

inappropriate Medicaid payments. Further, we believe that the same rate of error will be found in the claims of those providers who did not respond to our request for information, as well as in the claim payments to providers we did not include in our sample. We provided the Department with all the results from our sample including the details on the 73 providers that did not respond to our audit inquiry.

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

Using computer-assisted audit techniques, we identified all cases where the provider received a Medicaid payment for nursing home services, but no Medicare payment, even though the recipient met two of the three Medicare eligibility criteria (Medicare Part A coverage and a qualifying hospital stay). MMIS did not have adequate information to determine whether the recipient met Medicare's requirement of skilled care. Therefore, we judgmentally selected the top 100 nursing home providers based on dollar amount of the claims in question. We requested that providers review these claims and inform us of their reasons for not billing Medicare. As of February 19, 2004, we received responses from 81 of the 100 providers. The majority of the providers' responses indicated the recipient did not meet Medicare's level of skilled care. However, we identified approximately $900,000 in inappropriate Medicaid payments for services that should have been billed to Medicare. For those claims where Medicare should have been billed, several of the responses received indicate that the providers did not bill Medicare because they were unaware of the recipient's Medicare eligibility or of the qualifying inpatient stay. We provided the Department with all the results from our sample including the details on the 19 providers that did not respond to our audit inquiry.

Recommendations

1. *Investigate and recoup the overpayments identified in this report. Follow up with the 92 providers that did not respond to our audit inquiry and recoup any additional overpayments that may be determined to be owed. In addition, make certain that all provider-initiated adjustments are made appropriately.*

2. *Routinely audit Medicaid claims to ensure Medicaid is the payer of last resort when the recipient also has Medicare coverage. Take appropriate actions when overpayments are identified.*

We provided draft copies of this report to Department officials for their review and comment. We considered their comments in preparing this report. Department officials agreed with our recommendations and plan to begin routine audits of the type discussed in recommendation number 2 within the next year. A complete copy of the Department's response is included as Appendix A.

Within 90 days after the final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller and the leader of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Major contributors to the report were Ken Shulman, Bill Clynes, Ed Durocher, Paul Alois, Claudia Christodoulou, Julie DeRubertis, Robert Elliott and Marticia Madory.

We wish to thank the management and staff of the Department of Health for the courtesies and cooperation extended to our auditors during this audit.

Very truly yours,

Steven E. Sossei
Audit Director

cc: Robert Barnes, DOB

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 11, 2004

Steven E. Sossei
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2003-S-32) entitled "Nursing Home Claims Paid for Medicare Eligible Recipients."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

cc: Mr. Howe
Ms. Kuhmerker
Ms. Pettinato
Mr. Reed
Mr. Seward
Mr. Van Slyke

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2003-S-32
Entitled "Nursing Home Claims Paid for
Medicare Eligible Recipients"

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report (2003-S-32) entitled "Nursing Home Claims Paid for Medicare Eligible Recipients."

Recommendation #1

Investigate and recoup the overpayments identified in this report. Follow up with the 92 providers that did not respond to our audit inquiry and recoup any additional overpayments that may be determined to be owed. In addition, make certain that all provider-initiated adjustments are made appropriately.

Response #1

The Department's Office of Medicaid Management (OMM) will review OSC's work papers and initiate recovery where appropriate.

Recommendation #2

Routinely audit Medicaid claims to ensure Medicaid is the payer of last resort when the recipient also has Medicare coverage. Take appropriate actions when overpayments are identified.

Response #2

OMM expects to initiate this type of audit work within the next year under our Medicaid Match and Recovery contract.