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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

March 21, 2005

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 2004-S-28

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 by Group Health Incorporated (GHI) 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, 2003.

A. Background

The New York State Health Insurance Program (Program) provides hospital and surgical services and other medical and drug coverage to about 791,000 active and retired State employees and their dependents. It also provides coverage for about 396,000 other individuals who are either active or retired employees of participating local government units and school districts or dependents of such employees.

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 on a timely basis (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 both 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, they 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 of Civil Service (Department) is primarily responsible for maintaining the Plan's enrollment system, including updates intended to reflect current Medicare eligibility information. Insurance carriers also play a role in the coordination of claims with Medicare (i.e., by maintaining edits that will 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

The 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.

We determined our audit population by comparing data from the Federal Centers for Medicare and Medicaid Services (CMS) with claims information obtained from GHI. Since some information that could affect the Medicare eligibility of a claim (e.g., employment status, etc.) was either inaccurate or unavailable on the records provided by GHI, we used statistical sampling techniques to determine the extent of Medicare's responsibility. GHI officials provided us with additional information that facilitated our review of the statistically-sampled claims. Based on the results of this review, we estimated the dollar amount of claims that were Medicare's responsibility during our audit period.

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

The Department, in its capacity as custodian of the Plan's enrollment file, has not established a system to obtain Medicare enrollment information from CMS. Although GHI coordinated over five million dollars in claims with Medicare, the lack of current Medicare enrollment data caused GHI to erroneously pay $269,345 as the primary insurer. These payments should have been coordinated, instead, with Medicare.

We provided GHI officials with preliminary reports of our audit findings and considered their comments in preparing this report. The officials agreed with our findings. The officials also said they will apply the appropriate cost 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 with information in GHI claims, we identified 2,280 claims that did not appear to have been coordinated with Medicare. In some instances, information necessary for determining 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 $263,914 and $274,777 in claims (with a midpoint of $269,345) that should have been coordinated with Medicare.

a. Claims for Members Enrolled in the Medicare Program

Our sample included 206 claims, with a total value of $169,504 that had been paid by GHI. We determined Medicare should have been held responsible for 146 of these claims, totaling $159,910. GHI had erroneously paid the claims primarily because the Department had not tracked Medicare entitlement data on a comprehensive basis during the audit period. GHI officials informed us they are negotiating an agreement with CMS that will enable them to obtain Medicare-eligibility data.

We encourage the Department and GHI to continue working together to develop procedures for ensuring 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 Medicare would have covered. Of the 206 sampled claims, 44 totaling $3,047 were for services covered by Medicare Part B, and were paid on behalf of Plan members who were eligible for primary Medicare coverage but had failed to enroll in Medicare Part B. Department officials informed us it might not be appropriate to attempt to recover costs for some of these claims. However, we believe significant future savings are achievable once these members are enrolled. Therefore, GHI officials should work with the Department (the primary administrator of the Plan's enrollment system) to ensure that these members enroll in Part B, to recover overpaid claims, where appropriate and cost effective, and to ensure the enrollment system is updated accordingly.

2. Cost Recovery Procedures

In response to our preliminary findings report, GHI informed us their recovery procedures do not consider claims with payment amounts of less than $100. Our population includes 2,280 claims totaling $283,957. Because of its $100 per claim threshold, GHI will pursue recovery for just 131 of the claims, totaling $170,062. The other 2,149 claims, totaling $113,895, are at less than $100.

Medicare will not accept claims from third parties. Therefore, GHI must contact providers and request that they resubmit their claims to Medicare. Instead of sending individual cost recovery letters to the providers for each overpaid claim, GHI should total all overpaid claims incurred by each provider before applying the $100 cost-recovery threshold. This process would enable GHI to minimize related administrative costs by pursuing cost recovery for more claims while sending fewer cost recovery letters to the providers. For example, if GHI officials had grouped overpaid claims by provider before they applied the $100 threshold, they would have pursued recovery for 2,184 claims totaling $280,927.

Recommendations

1. *Review the population of questionable claims from which we estimate overpayments of $269,345. Recover costs for Medicare-eligible claims from the appropriate parties and remit the recoveries to the Plan.*

2. *Ensure that Medicare-eligible members enroll in Medicare Part B. Work with the Department to pursue cost recovery, where appropriate, for claims attributed to such members who are not enrolled in Medicare Part B.*

3. *Work with the Department and the other Plan carriers to develop a Plan-wide system of procedures and internal controls to improve the processing of Medicare-eligible claims. Key in this process are the acquisition and updating of Federal Medicare eligibility data.*

4. *Revise cost recovery procedures to accumulate overpaid claims incurred by each provider before assessing the cost-effectiveness of pursuing recovery.*

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.

Yours truly,

David R. Hancox
Director
State Audit Bureau

cc: Daniel Wall, Department of Civil Service
Robert Barnes, Division of the Budget
Patricia Kennah, Group Health Incorporated