State of New York
Office of the State Comptroller
Division of Management Audit

DEPARTMENT OF HEALTH AND DEPARTMENT OF SOCIAL SERVICES

MEDICAID PAYMENTS FOR MEDICARE BENEFICIARIES

REPORT 95-S-91

H. Carl McCall

Comptroller

State of New York
Office of the State Comptroller

Division of Management Audit

Report 95-S-91

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Mr. Brian Wing
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Dear Dr. DeBuono and Mr. Wing:

The following is our audit report on the practices of the Department of Health and the Department of Social Services relating to controls over Medicaid payments for Medicare beneficiaries.

This audit was performed pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit

May 21, 1997

Executive Summary

Department Of Health and Department Of Social Services Medicaid Payments For Medicare Beneficiaries

Scope of Audit

Many of New York State's aged or disabled Medicaid recipients are also covered by Medicare. Medicare covers all inpatient hospital expenses, for eligible beneficiaries, during a 90-day benefit period, with the exception of a deductible and a coinsurance amount. After the 90-day benefit period, up to 60 additional days of Medicare coverage may also be available to a Medicaid recipient. These additional days, called lifetime reserve (LTR) days, may be used only once in a lifetime, and would cover all expenses except for a coinsurance amount. When a Medicaid recipient also has Medicare coverage, Medicaid pays Medicare deductibles, coinsurances and remaining expenses only after all Medicare benefits have been exhausted. By law, Medicaid is always the payer of last resort.

During our audit period, the Department of Social Services (Social Services) administered Medicaid through its fiscal agent. The fiscal agent processes Medicaid claims and pays providers for services rendered to eligible Medicaid recipients through the Medicaid Management Information System (MMIS). After October 1, 1996, the Department of Health (Health) became responsible for administering Medicaid through the fiscal agent.

Our audit addressed the following question regarding Social Services' and Health's controls over inpatient hospital payments for recipients who were eligible for both Medicaid and Medicare for the calendar year 1994.

- **!** Are controls sufficient to ensure that Medicare benefits are exhausted before Medicaid makes a payment?

Audit Observations and Conclusions

Based on our audit, we conclude that sufficient controls are not in place to ensure that a recipient's Medicare benefits are exhausted before Medicaid makes a payment.

We found that some Medicaid providers directly bill Medicaid and fail to bill Medicare, even though Medicare coverage is available. This practice causes substantial Medicaid overpayments. We also found that some providers are billing both Medicare and Medicaid for the same services, without informing Medicaid that a Medicare payment was received. Our sample of 1,313 recipients' records showed that, in these categories, Medicaid overpaid more than $3.8 million for Medicaid services provided in 1994. Based on our random sample, we project that total overpayments in 1994 for these two types of errors amounted to $8.2 million. We recommend that Social Services and Health investigate and recoup the overpayments cited in our report and determine why providers failed to return duplicate payments. (see pp. 5-6)

We surveyed seven large states to learn the methodology each uses to prohibit duplicate payments where dual coverage is present. We found that six of the seven states use, at least to some degree, an automated crossover billing system to ensure that Medicare coverage was properly utilized. Under this type of billing system, providers are required to submit applicable claims directly to Medicare before billing Medicaid. In these instances, Medicare pays the Medicare portion and directly forwards the remaining balance of the claim to Medicaid. This allows Medicaid to pay based on remaining charges and ensures that Medicaid is the payer of last resort. Based on the significant overpayments we identified in this audit, we believe that Social Services should investigate the feasibility of implementing a mandatory statewide crossover system. (see pp. 6-7)

MMIS maintains a recipient eligibility file which is intended to identify whether recipients have Medicare coverage before paying a Medicaid claim. If the file indicates that Medicare coverage is available but the recipient's Medicaid claim shows no coverage, the claim will not be paid. We found that this file is not updated on a timely basis, and in some instances, the file was not updated to reflect the recipient's Medicare coverage. As a result of our findings in this and other audits, we have initiated a separate audit of Social Services' file matching and updating process. (see pp. 7-8)

Our audit showed that Social Services and Health have no method to track Medicaid recipients' use of LTR days. Since Social Services and Health cannot track LTR days, they have no way to accurately determine when LTR days are available to be used and therefore cannot enforce their policy to require use of LTR days prior to making Medicaid payments. We determined that if LTR days were properly utilized, Medicaid could have saved approximately $4.2 million for recipients who subsequently died before using their LTR days. We noted that substantial additional savings could be achieved since deceased recipients represented only 10 percent of the total population having both Medicare and Medicaid claims. We recommend that Social Services and Health investigate the possibility of developing a system to track LTR day balances. We also recommend that Social Services immediately educate providers regarding the use of LTR days. (see pp. 8-10)

Comments of Officials

Health and Social Services officials agree with the recommendations contained in our report. Health officials stated that they are currently evaluating the feasibility of implementing a crossover billing system, and are developing an RFP for a new MMIS. Collectively, these actions would address the Medicaid overpayment problems identified in this report.

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Introduction

Background

The Department of Social Services (Social Services) administers New York 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. In New York, the Federal, State and local governments jointly fund the Medicaid program. Social Services contracts with a fiscal agent to process Medicaid claims and make payments to service providers. The fiscal agent processes Medicaid claims and pays providers for services rendered to eligible Medicaid recipients through the Medicaid Management Information System (MMIS).[1]

Medicare also provides medical assistance to many aged and/or disabled Medicaid recipients. Medicare hospital insurance benefits (Part A) help pay for medically necessary inpatient care in a general hospital. Medicare pays for these benefits based on benefit periods. A benefit period begins the first day the recipient receives a Medicare-covered service in a qualified hospital. The benefit period ends when the recipient has been out of a hospital or other facility that primarily provides skilled nursing or rehabilitation services for 60 days in a row. If the recipient enters a hospital again after 60 days, a new benefit period begins. With each new benefit period, Medicare renews Part A hospital and skilled nursing facility benefits.

If a recipient is hospitalized, Medicare will pay for all covered hospital services during the first 60 days of a benefit period, except a deductible. The Medicare Part A deductible in 1994 (the period covered by our audit) was $696 per benefit period. If the recipient was hospitalized for more than 60 days in a benefit period in 1994, Medicare paid all covered hospital services, except for a coinsurance of $174 each day over 60 days for up to 30 additional days. Under Medicare Part A, the recipient has a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve (LTR) days could be used if the recipient is in the hospital for more than 90 days in a benefit period. When a LTR day is used, Medicare Part A pays for all covered services except for an LTR coinsurance. In 1994, the LTR coinsurance was $348 a day. LTR days cannot be replaced once they are used. When providers bill for recipients who have both Medicare and Medicaid coverage (dual coverage), they must first utilize Medicare coverage before billing Medicaid. When Medicare coverage is exhausted, Medicaid will begin to pay for all costs, as shown in the following table.

Hospital Benefits for Recipients

[1] During our audit period, Social Services administered Medicaid and MMIS through its fiscal agent, Computer Sciences Corporation. After October 1, 1996, the Department of Health became responsible for administering Medicaid and MMIS, also through the fiscal agent.

With Dual Coverage

Benefit	Medicare Pays	Medicaid Pays
First 60 days	All but $696	$696
61st to 90th day	All but $174 a day	$174 a day
91st to 150th day	All but $348 a day	$348 a day
Beyond 150 days	Nothing	All costs

Medicare produces a notice of utilization for each claim processed. The notice of utilization shows the amount Medicare paid for the claim or whether Medicare denied the claim and reasons for denial.

Audit Scope, Objective and Methodology

We audited Social Services' and Health's practices for processing Medicaid claims for recipients who were eligible for Medicare Part A coverage during the 1994 calendar year. The objective of our program audit was to assess whether Social Services and Health ensured Medicare Part A benefits were used before allowing a Medicaid payment to be made. This is the first in a series of audits by the Office of the State Comptroller relating to Medicare Part A.

To accomplish our objective, we interviewed officials from Social Services and Health, reviewed applicable Medicaid and Medicare policies, procedures, rules, regulations and internal controls that pertain to claims processing. We developed computer programs to extract, analyze and evaluate claims paid for inpatient hospital stays during our audit period.

To determine whether Medicaid made appropriate payments for inpatient hospital services, we compared recipients' Medicare Part A claims to claims paid by Medicaid for 1994 inpatient hospital services for the same recipients. We made this determination through use of a computer file match that consisted of comparing the Medicaid fiscal agents' claims payment files to Medicare's claims payment files located at one of Medicare's fiscal intermediaries (companies that process and pay Medicare claims on behalf of the Federal government), Empire Medicare Services. Our audit reviewed Medicaid claims for each recipient to determine whether Medicaid properly paid in instances where Medicare coverage was also available. With the cooperation and assistance provided to us by the Federal Department of Health and Human Services, Health Care Finance Administration, we were able to obtain additional data showing inpatient hospital admissions not included in the records provided to us by Empire Medicare Services.

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 the operations of Social Services and Health that are included in our audit scope. Further, these standards require that we

understand the agencies' internal control structures and compliance with those laws, rules and regulations that are relevant to those agency 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, judgements 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 our audit efforts on those operations that have been identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little audit effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of Health and Social Services Officials to Audit

Draft copies of this report were provided to Health and Social Services officials for their review and comment. Their comments have been considered in preparing this report, and are included as Appendix B and C, respectively.

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

Claims Processing When Medicare Part A Coverage Is Available

In New York State, it is the responsibility of the Medicaid provider to determine whether the recipients' Medicare eligibility provides coverage for the service being billed. If the recipient's Medicaid identification card indicates Medicare coverage, the provider must bill Medicare even if the recipient denies having Medicare coverage. Upon being billed, Medicare sends providers documentation indicating what services are paid by Medicare. Using this information, the provider may bill Medicaid for the amount that Medicare did not cover. By law, Medicaid is always the payer of last resort. If the provider knows that the recipient does not have Medicare coverage, or if the provider submitted a claim to Medicare and Medicare denied it, the provider may bill Medicaid directly. If the recipient has Medicare coverage and the provider fails to first bill Medicare, Medicaid could overpay the amount that Medicare should have paid.

Through a computer match between Medicaid and Medicare files, we selected a random sample of 1,313 recipients who were shown to have both Medicare and Medicaid claims for 1994. We reviewed their Medicaid and Medicare claims to determine whether Medicare benefits were exhausted before Medicaid payments were made. Our review of these 1,313 recipients' claims showed that providers incorrectly billed Medicaid, resulting in overpayments of more than $3.8 million. Our audit showed that providers failed to bill Medicare before billing Medicaid. This resulted in Medicaid paying the bill for the entire hospital stay when Medicare should have contributed to the payment. We also found that, in several instances, providers billed both Medicare and Medicaid for the same services, which resulted in duplicate payments. Based on our random sample, we project that total overpayments in 1994 for these two types of errors amounted to $8.2 million.

Social Services and Health officials need to implement controls that will ensure that Medicare is fully utilized. We noted that other states have systems and safeguards in place to help ensure that Medicare coverage is fully utilized. We believe that Social Services and Health should investigate the feasibility of implementing similar systems and safeguards. We further noted that, while Social Services and Health did have a system in place to help ensure utilization of Medicare, the system was not operating as intended thereby allowing Medicaid overpayments to occur. The existing system needs to be strengthened pending development of more comprehensive systems and safeguards used by other states. We also noted an additional area where Social Services and Health could further maximize use of available Medicare coverage by fully utilizing available Medicare LTR days.

Providers Failed to Bill Medicare Before Billing Medicaid

Our review of 1,313 recipients' Medicaid and Medicare claims showed that for 6.5 percent of the recipients (86 recipients), providers billed Medicaid for services when they should have first billed Medicare. This resulted in a Medicaid overpayment. Medicaid was unaware of Medicare coverage for these claims and paid the provider the entire Medicaid allowable amount. Because providers failed to first bill Medicare for the claims, Medicaid overpaid more than $2.8 million. For example, in one instance, a recipient was an inpatient in a hospital from December 17, 1993 through March 8, 1994. The provider failed to bill Medicare and instead billed Medicaid. As a result, the provider was overpaid $164,433 by Medicaid. We provided Social Services officials with our findings so they could immediately recoup the overpayments.

Providers Received Duplicate Payments From Medicaid and Medicare

For 3.5 percent of the 1,313 recipients (46 recipients), providers billed both Medicaid and Medicare for the same services. In each of these instances providers failed to inform Medicaid that Medicare made a payment. Providers should have billed Medicaid for only the Medicare deductible, coinsurance and/or the LTR coinsurance. Because of these duplicate payments, Medicaid overpaid providers $984,591. We noted that in one case, Medicaid paid $69,015 for a claim when a payment should not have been made. We provided Social Services officials with our findings so they could immediately recoup overpayments.

We noted during our audit that Social Services had recognized overpayments of $487,400 from the same recipients' claims we selected in our sample. However, Social Services officials did not take the appropriate steps to recoup the overpayments.

Medicaid Pays for Claims Without Proof that Medicare Coverage Is Exhausted

Before paying a claim that potentially involves dual coverage, Medicaid should require proof that no Medicare eligibility exists, or that the provider has exhausted Medicare benefits. This requirement would ensure that Medicaid is the payer of last resort.

We surveyed seven large states to learn the methodology they use to prohibit duplicate payments where dual coverage is present (See Exhibit A for details by state). We found that six of the seven states we surveyed use, at least to some degree, an automated crossover billing system to ensure that Medicare coverage was properly utilized. Under this type of billing system, providers are required to submit applicable claims directly to the Medicare intermediary before billing Medicaid. In these instances, the intermediary deducts and pays the Medicare portion and directly forwards the remaining balance of the claim to Medicaid. This allows Medicaid to pay based on remaining charges and ensures that Medicaid is the payer of last resort.

In June 1985, New York State had a voluntary statewide crossover system available for inpatient hospital providers to bill both Medicare and Medicaid on the same claim form for recipients who have dual coverage. The system ensured Medicaid was billed only for its portion of the claim. However, in September 1989, Social Services halted the system. In its report "NYS Medicare/Medicaid Crossover System" Social Services concluded that it would not be cost effective to institute a crossover project unless utilization is mandatory.

Based on the significant overpayments we identified in this audit, we believe that Social Services should investigate the feasibility of implementing a mandatory statewide crossover system. A system such as this would reduce the opportunity for overpayments due to the failure of providers to properly utilize Medicare.

As also noted in Exhibit A, if claims are directly billed to Medicaid, many of the states require, at least, some type of proof that Medicare reviewed a claim before making a payment. At the very least, we believe Social Services and Health should require some type of proof that Medicare was fully utilized before paying a claim directly billed to them by a provider.

MMIS Does Not Update Its Recipient Eligibility File on a Timely Basis

When providers submit claims to MMIS for processing, claims undergo certain validity checks called "edits." One such MMIS edit is designed to determine whether the recipient has Medicare coverage (Medicare eligibility edit). MMIS periodically obtains Medicare eligibility information from various Medicare sources. This information is updated to the MMIS recipient eligibility file. When providers submit claims to MMIS for reimbursement, an MMIS edit checks the recipient eligibility file to determine whether the recipient has Medicare coverage. If the file indicates that such coverage is available but the claim shows no coverage, the claim will fail the edit and will not be paid. However, if the recipient eligibility file shows no Medicare coverage, the edit will allow the claim to continue to process and possibly be paid.

We found that the MMIS edit failed to deny payment for recipients who we determined had Medicare coverage. To determine why Medicaid made payments for recipients who were eligible for Medicare, we selected 44 paid Medicaid claims and followed the processing methodology used by MMIS. In 32 (73 percent) of these instances, we found that the recipients' Medicare coverage was not updated to the recipient eligibility file until after the claim was processed. In 11 (25 percent) instances, we noted that Medicare coverage was never updated to the recipient eligibility file. In one instance, the recipient's eligibility was updated to the file, but the Medicare eligibility date was incorrect. Officials informed us during our audit that they have a system in place to recognize Medicaid claims that are paid before Medicare eligibility is updated to the recipient eligibility file. While this system recognized

overpayments of $487,400 (as noted earlier in the report), Social Services did not take action to recoup the overpayments.

As a result of our findings in this and other audits, we have initiated a review of Social Services' file matching and updating process. Because of the additional work we plan to perform in this area, we will not make a recommendation in this report concerning updates to the recipient eligibility file pending the completion of additional work.

Social Services and Health Do Not Track Lifetime Reserve Days Resulting in Medicaid Overpayments

Medicare rules state that a patient can elect not to use LTR days while in a hospital or within 90 days after being discharged. However, as a condition of receiving Medicaid, New York State requires that dual eligible recipients always utilize LTR days when these days are available. If a recipient elects not to use the LTR days, then the recipient would be responsible to pay for the hospital services. The Medicaid Provider Manual (Section 2.2.9.5), which is sent to all inpatient hospital providers states, "If a Medicaid/Medicare recipient chooses not to use his or her LTR days, the recipient is then completely responsible for payment of these days."

Our audit showed that Social Services and Health have no method to track Medicaid recipients' use of LTR days. Since Social Services and Health cannot track LTR days, they have no way to accurately determine when LTR days are available to be used. For example, we found that Medicaid paid $28,392 for a hospital claim where the provider did not bill for remaining LTR days. We calculated, for this example, that if Social Services and Health required LTR days to be used, Medicaid would have paid only $5,916, thus saving $22,476.

To determine the impact of this lack of controls, we reviewed 703 Medicaid claims and the associated Medicare claims for 32 deceased recipients contained in our audit sample of 1,313. (We judgmentally selected these recipients' claims for review because we knew the recipients were deceased and thus could not use LTR days in the future). Our review showed that, for these 703 claims, a total of 1,711 LTR days remained unused. A review of their claim records showed that providers could have utilized 87 (5.1 percent) of these LTR days. However, we found that none of these 87 LTR days was used. We determined that, because providers failed to bill Medicare for these 87 LTR days and Medicaid never identified these as available LTR days, Medicaid overpaid approximately $92,939, an average overpayment of $1,068 for each unused LTR day.

Using computer assisted audit techniques, we determined from Medicaid files that, during our 1994 audit period, there were 17,154 dual eligible recipients who had 932,294 unused LTR days remaining. From this population, we determined that 1,701 of these recipients were deceased. These deceased recipients had 76,524 unused LTR days remaining that could never again be

utilized. If 3,887 (5.1 percent) of these LTR days were utilized by recipients at an average savings of $1,068 per LTR day, Medicaid could have saved approximately $4.2 million in 1994. Since the deceased population we reviewed represented only a small portion (approximately 10 percent) of the total crossover population that had Medicare and Medicaid claims, we conclude that substantial additional Medicaid savings could be realized if Medicaid tracked LTR day balances and required that LTR days be exhausted before a Medicaid payment is made.

Recommendations

1. Investigate and recoup overpayments cited in this report. Request explanations from providers showing why they failed to immediately return duplicate payments.

   (Health and Social Services officials agreed with this recommendation. Social Services officials indicated that they have begun recovery efforts for the overpayments identified in the report. Neither Health nor Social Services officials directly responded to the portion of our recommendation that they request explanations from providers showing why the providers failed to immediately return duplicate payments.)

2. Investigate the feasibility of implementing a mandatory statewide crossover system. Additionally, for any claim directly billed to Medicaid by a provider, require some type of proof that Medicare was fully utilized before paying such a claim.

   (Health officials agree that implementation of a crossover billing system has merit and stated they are engaged in discussions with Empire Medicare Services of Syracuse, the primary Medicare intermediary for New York State, to evaluate the feasibility of implementing such a system. Health officials did not respond directly to the portion of our recommendation that, for any claim directly billed to Medicaid, they require proof from providers that Medicare was fully utilized before paying the claim.)

3. Investigate the possibility of developing a system that tracks LTR day balances to ensure that these benefits are exhausted before a Medicaid payment is made.

   (Health officials stated that implementation of a crossover billing system is expected to assist in the identification of Life Time Reserve (LTR) days, by enabling a careful tracking and reporting of LTR availability. Social Services officials stated their belief that LTR days are not always utilized where appropriate and indicated they will work with the Health Department to determine whether or not a viable tracking system can be implemented.)

Recommendations (Continued)

4. Immediately take action to educate providers regarding the proper use of LTR days.

   (Health officials stated they will work with the Department of Social Services to develop a Medicaid Update article addressing the use of LTR days by dually eligibles. Further, Health officials stated they will clarify the distinction between optional and mandatory use of LTR days, and the interaction between the billing responsibilities of providers and the potential liability of recipients.)

Systems Used By Other States To Process Crossover Claims

State	Use of Automated Crossover Billing
Massachusetts	Partial use of an automated crossover billing system is in place. Massachusetts is planning to set up a full automated crossover billing system for all Part A claims. For those known to have Medicare coverage, the state requires documentation from Medicare before making Medicaid payments.
Florida	Partial use of an automated crossover billing system is in place for many Medicare intermediaries. Florida plans to set up the system with additional intermediaries. Medicaid will not pay a claim for a dual eligible recipient unless the provider submits it through Medicare. Providers may submit void or adjustment claims to Medicaid only when accompanied by documentation from Medicare.
New Jersey	Medicaid providers have the option of billing through the Medicare intermediary or directly billing Medicaid. Claims for acute hospital services (except repetitive services such as psychiatric or rehabilitative) must have documentation from Medicare or they will be rejected.
Michigan	An automated crossover billing system is not used.
Ohio	Full use of an automated crossover billing system is in place. Under this system, if a Medicaid recipient has Medicare coverage, the provider must bill Medicare first. If providers directly bill Medicaid, the Medicaid system will reject the claim.
California	Full use of an automated crossover billing system is in place. California instructs providers to obtain insurance information at the time of admittance to a hospital. If a Medicaid recipient has Medicare coverage, the provider must first bill Medicare. California will pay a Medicaid claim if the provider can show proof that Medicare did not cover the hospital stay.
Texas	Partial use of an automated crossover billing system is in place. Texas plans to set up the system with additional intermediaries. Texas requires documentation from Medicare if the provider bills directly to Medicaid.

Major Contributors to This Report

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March 14, 1997

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Re: OSC Draft Rpt: DOH-DSS Medicaid Payments for Medicare Beneficiaries 95-S-91 (97-002)

Dear Mr. McClune:

The following is our response to the recommendations in the report that are the responsibility of the Department of Social Services.

Recommendation: Investigate and recoup overpayments cited in this report. Request explanations from providers showing why they failed to immediately return duplicate payments.

Response: We have already begun our recovery efforts of the overpayments identified in the report. In investigating the reasons for these overpayments, we identified a number of conditions that allow MMIS to authorize payment for those claims that should have been paid by Medicare. The use of "zero fills" by providers which overrides existing system edits is a primary cause. In order to identify providers which may be abusing the system to easily obtain quicker reimbursement through Medicaid, we are requesting that periodic reports be generated that identify "zero fill" claims where third party liability is indicated.

Recommendation: Investigate the possibility of developing a system that tracks Life Time Reserve (LTR) day balances to ensure that these benefits are exhausted before a Medicaid payment is made.

Response: The Department recognizes that LTR days are not always utilized where appropriate and we will work with the Department of Health to determine whether or not a viable tracking system can be implemented.

Thank you for sharing this report with us and we trust our comments are responsive to the issues raised.

Sincerely,

David P. Avenius