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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

September 8, 1999

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

Re: Medicaid Recipients Enrolled In Medicare HMO Risk Plans
Report 98-S-5

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 Department of Health's controls for ensuring the appropriateness of Medicaid payments made for recipients who are enrolled in both Medicaid and Medicare HMO risk plans for the period January 1, 1996 through December 31, 1997.

A. Background

The New York State Department of Health (Health) 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. Health'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 rendered to eligible Medicaid recipients. In New York, the Federal, State and local governments jointly fund the Medicaid program.

Medicare is a Federally funded insurance program primarily for people who are over age 65 or disabled. Most of the State's aged Medicaid recipients are also covered by Medicare. Dual eligible recipients are those recipients who are enrolled in both Medicaid and Medicare. Medicare

beneficiaries have the option to enroll in a Medicare HMO risk plan (Medicare plan). Medicare plans generally require that enrollees receive all of their care through the Medicare plan. Medicare pays the Medicare plans through a monthly capitation premium for each recipient enrolled in the particular plan. If a Medicaid provider determines that a dual eligible recipient is also enrolled in a Medicare plan, then the Medicaid provider should refer the recipient to a provider that participates in the recipient's Medicare plan. However, referral to the Medicare plan is not necessary in the following instances: in cases of emergency; when the Medicaid provider is also part of the recipient's Medicare plan; or when the recipient has obtained a referral from the Medicare plan to see a provider outside the plan.

By law, Medicaid is always the payer of last resort. In New York State, it is the responsibility of the Medicaid provider to determine whether a recipient's Medicare benefits provide coverage for the service being billed. Medicaid recipients are required to present a benefit identification card when obtaining medical services. Providers use the recipient's benefit identification card to access Health's Electronic Medicaid Eligibility Verification System (EMEVS), which is an electronic verification system used to verify the recipient's Medicaid eligibility and to obtain information regarding other insurance coverage, such as a Medicare plan, the recipient may have. Medicare plans do not necessarily cover all medical services or equipment required by a recipient. Therefore, when Medicaid recipients have dual eligibility, there are instances where it is appropriate for Medicaid to be billed for certain services and equipment.

B. Audit Scope, Objectives and Methodology

We audited Health's controls for ensuring the appropriateness of Medicaid payments made for recipients who are enrolled in both Medicaid and Medicare plans for the period January 1, 1996 through December 31, 1997. The objectives of our economy and efficiency audit were to determine whether Medicaid payments for recipients also enrolled in Medicare plans were appropriate and to evaluate the process that Health uses to ensure Medicaid is the payer of last resort.

To accomplish our audit objectives, we interviewed Health officials, and 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 inpatient, clinic, physician, and durable medical equipment (DME) claims paid for Medicaid recipients while they were enrolled in Medicare plans. To determine dual eligible recipients, we provided the social security numbers of the recipients eligible for Medicaid at the time of our audit to the fiscal intermediary that processes Medicare claims for the Social Security Administration. The fiscal intermediary compared the social security numbers to its Medicare files to identify potential dual eligible recipients. We then determined those recipients who were enrolled in Medicare plans. We matched those recipients enrolled in the Medicare plans to the Medicaid payment files in order to determine paid claims for clinic, physician, DME and inpatient services provided to these recipients. Based on this match we identified 12,660 claims for services rendered to 1,248 Medicaid recipients who were also enrolled in Medicare plans. We determined

that 886 providers were paid $1.5 million for these claims. We judgmentally selected any physician, DME, or inpatient provider who had over $1,000 in Medicaid claims and any clinic provider who had over $2,000 in claims. Based upon our past experience of auditing these types of claims and our knowledge of Medicare, we set these dollar limits to focus our audit on the higher-paid providers for each type of claim. Using this criteria we selected 87 providers who were paid $1.1 million for 6,770 claims for rendering services to 166 Medicaid recipients. The claims we analyzed related to the services performed by the sampled providers during the period January 1, 1996 through December 31, 1997.

For these claims we requested the providers to furnish proof that Medicare plans were billed where appropriate. Further, for the 166 recipients who received services from the 87 providers in our sample population, we determined whether their Medicare plan coverage had been recorded on the EMEVS and the MMIS third party file. The MMIS third party file is used during Medicaid claims processing to ensure that a Medicaid recipient's other insurance is maximized before any Medicaid payments are made.

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 Health that are included in our audit scope. Further, these standards require that we understand Health's internal control structure and 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.

C. Results of Audit

We found that Health does not have the controls necessary to ensure that Medicaid payments made for recipients who are also enrolled in Medicare plans are appropriate. We identified 87 providers who were paid $1.1 million by Medicaid for services rendered to 166 recipients who were enrolled in Medicare plans. We followed up with these providers to determine whether Medicare had been properly billed before the providers billed Medicaid. However, we found that the process that Health requires providers to use to ensure Medicaid is the payer of last resort is not adequate, resulting in a risk that inappropriate Medicaid payments were made. Since the Medicaid providers did not refer the recipients to a Medicare plan participating provider, we did not have the necessary information to determine to what extent the $1.1 million of Medicaid payments may have been inappropriate.

Medicaid providers need an accurate, effective system for identifying recipients who are enrolled in Medicare plans. Health instructs providers to use EMEVS for identifying a recipient's Medicaid eligibility and other insurance coverages. However, we found that EMEVS does not

accurately reflect recipients' Medicare plan coverage. From our sample of 87 providers who billed Medicaid $1.1 million on behalf of 166 recipients with dual insurance eligibility, we found that Health did not identify and record on EMEVS the Medicare plan coverage for most of the recipients sampled. Only 4 of the 166 recipients sampled (2 percent) had their Medicare plan coverage on EMEVS. We also found that only 10 of the 166 recipients sampled (6 percent) had their Medicare plan coverage on the MMIS third party file. When Health does not ensure such information is recorded on EMEVS and MMIS, the Medicaid providers and Health cannot ensure that Medicaid is the payer of last resort. Also, without this information on EMEVS, providers cannot direct recipients to a participating provider in their Medicare plan or request a referral from the recipient's Medicare plan.

We surveyed each of the 87 providers to determine the appropriateness of the Medicaid payments for the claims in our sample. We found that a majority of the providers did not bill Medicare. Since the Medicaid providers did not refer the recipients to their Medicare plan participating provider, we cannot determine what the appropriate Medicaid payment should have been. Medicaid is responsible only for those services not covered by the Medicare plan. Without documentation from the recipient's Medicare plan stating what the plan covers and pays, we were unable to determine what Medicaid should have paid. It is therefore important for providers to refer Medicaid recipients to the appropriate provider within the recipients' Medicare plan.

In addition, Health's policy is to not enroll dual-eligible recipients into Medicaid managed care plans. However, we found that 21 of the 166 recipients in Medicare plans were also enrolled in Medicaid managed care plans. As a result, Medicaid paid a total of $73,860 in monthly capitation payments on behalf of these recipients for the two year period ended December 31, 1997. These capitation payments occurred because Health was not aware that these recipients were enrolled in a Medicare plan. In one of our prior audits (Report 96-S-67, issued on April 4, 1997), we questioned whether dual-eligible recipients already enrolled in Medicare plans should be enrolled in Medicaid managed care plans and the appropriateness of the capitation payments made by Medicaid for these recipients. While Health has taken steps to address this issue, there is still a need to obtain accurate Medicare information for Medicaid recipients with dual eligibility. Health can obtain such information from the Medicare fiscal intermediary or the Federal Health Care Financing Administration.

Recommendations

1. *Perform periodic file matches with either the Federal Health Care Financing Administration or the Medicare fiscal intermediary to identify recipients who are enrolled in Medicare plans, and update the recipients' coverage to both the EMEVS and the MMIS third party file to prevent inappropriate Medicaid payments.*

2. *Instruct providers to refer Medicaid recipients enrolled in Medicare plans to a participating provider of that plan, when appropriate.*

3. Ensure that dual eligible recipients are not simultaneously enrolled in Medicaid and Medicare managed care programs.

We provided a draft copy of this report to Department of Health officials for their review and comments. Their comments were considered in preparing this report and are included as Appendix A. Department of Health officials agree with our recommendations and stated that actions have been or will be taken to implement them.

Within 90 days after 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 leaders 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 this report were Lee Eggleston, Don Paupini, Terry Smith, Larry Julien and Paul Bachman.

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

Very truly yours,

Kevin M. McClune
Audit Director

cc: Mr. Charles Conaway

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.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

August 17, 1999

Kevin M. McClune
Audit Director
Office of the State Comptroller
Alfred E. Smith State Office Building
Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's draft audit report 98-S-5 on "Medicaid Recipients Enrolled in Medicare HMO Risk Plans".

Thank you for the opportunity to comment.

Very truly yours,

Dennis P. Whalen
Executive Deputy Commissioner

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report
98-S-5 Entitled
"Medicaid Recipients Enrolled in
Medicare HMO Risk Plans"

The following are the Department of Health's (DOH) comments in response to Draft Audit Report 98-S-5 entitled "Medicaid Recipients Enrolled in Medicare HMO Risk Plans".

Recommendation #1: Perform periodic file matches with either the Federal Health Care Financing Administration or the Medicare fiscal intermediary to identify recipients who are enrolled in Medicare plans, and update the recipients' coverage to both the EMEVS and the MMIS third party file to prevent inappropriate Medicaid payments.

Response #1: The Department has just recently begun receiving monthly files of New York Medicare beneficiaries enrolled in Medicare risk plans. Analyses of the files are being performed, and the information will be added to the WMS and passed on to update EMEVS and MMIS, once it is verified. This will alert providers to the fact that recipients have other coverage, and will enable the Department to ensure that Medicaid is the payer of last resort.

Recommendation #2: Instruct providers to refer Medicaid recipients enrolled in Medicare plans to a participating provider of that plan, when appropriate.

Response #2: A Medicaid Update article will be prepared and issued to all providers.

Recommendation #3: Ensure that dual recipients are not simultaneously enrolled in Medicaid and Medicare managed care programs.

Response #3: This issue was addressed in a prior OSC audit, 96-S-67. DOH policy prohibits the enrollment of recipients with both Medicare and Medicaid coverage (i.e., dual eligible recipients) into Medicaid managed care plans until such time as appropriate rates and coordination of benefit policies are developed. EMEVS data is used to identify recipients with Medicare coverage. The use of monthly Medicare data updates by EMEVS should result in more complete identification of such recipients.

The availability of the third party coverage information should assist local social services districts in determining the status of the recipients' third party coverage as they enroll recipients into managed care programs.