OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF STATE GOVERNMENT ACCOUNTABILITY

New York State Department of Health

Medicaid Payments for Medicare Part A Beneficiaries

Report 2009-S-36

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of State Government Accountability

September 20, 2010

Richard F. Daines, M.D.
Commissioner
Department of Health
Corning Tower Building
Empire State Plaza
Albany, New York 12237

Dear Dr. Daines:

The Office of the State Comptroller is committed to helping State agencies, public authorities and local government agencies manage government resources efficiently and effectively and, by so doing, providing accountability for tax dollars spent to support government operations. The Comptroller oversees the fiscal affairs of State agencies, public authorities and local government agencies, as well as their compliance with relevant statutes and their observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving operations. Audits can also identify strategies for reducing costs and strengthening controls that are intended to safeguard assets.

Following is a report of our audit of the Department of Health entitled *Medicaid Payments for Medicaid Part A Beneficiaries*. This audit was performed pursuant to the State Comptroller's authority under Article V, Section 1 of the State Constitution and Article II, Section 8 of the State Finance Law.

This audit's results and recommendations are resources for you to use in effectively managing your operations and in meeting the expectations of taxpayers. If you have any questions about this report, please feel free to contact us.

Respectfully submitted,

Office of the State Comptroller
Division of State Government Accountability

EXECUTIVE SUMMARY

Audit Objective

Our objective was to determine if Medicaid made overpayments for recipients who were also eligible for Medicare Part A health insurance.

Audit Results - Summary

Medicaid is the payer of last resort, according to federal law and State regulations. This means that if a Medicaid recipient is also covered by Medicare (dual eligible) the medical service provider must first bill Medicare before billing Medicaid. However, we found that the Department of Health's (Department) Medicaid claims and payment processing system (eMedNY) did not always identify Medicaid recipients who were also covered by Medicare Part A (hospital coverage). Therefore, when eMedNY processed a claim for a dual eligible person, it did not always have the information to ensure Medicare had already been appropriately billed. As a result, Medicaid was overpaying for claims pertaining to dual eligible persons. For the two years ended December 31, 2007, we identified $14 million in potential Medicaid overpayments for claims pertaining to 2,564 dual eligible individuals.

Most people become eligible for Medicare Part A health insurance when they reach 65 years of age. Medicare Part A usually pays a majority of a recipient's hospital costs, and Medicaid pays certain lesser amounts not covered by Medicare. The eMedNY system has computer edits which check claims for Medicare Part A coverage and ensure providers bill Medicare prior to billing Medicaid. In general, amounts paid by Medicare reduce the amounts Medicaid pays. However, if recipients' Medicare coverage is not posted to eMedNY, the edits cannot prevent Medicaid overpayments.

Using Medicare Part A eligibility information obtained from the federal Centers for Medicare and Medicaid Services (CMS), we assessed the completeness of Medicare data posted to eMedNY as of December 31, 2007. We determined that, as of May 2010, eMedNY did not include Medicare coverage data for 5,906 Medicaid recipients who had been eligible for Medicare Part A prior to December 31, 2007.

We further determined that Medicaid processed 3,188 claims (totaling about $20 million) for inpatient hospital services provided to 2,564 dual eligible recipients during the period January 1, 2006 through December 31, 2007 for which Medicare Part A was never billed.

We reviewed a judgmental sample of 110 of these claims (totaling about $2.3 million) for inpatient services provided during our audit period to these individuals with Medicare A

coverage. Based on our review, we determined that Medicaid overpaid 67 (61 percent) of the sampled claims by nearly $1.6 million (about 70 percent of the $2.3 million paid) because Medicare Part A was not billed for services provided to recipients who had such coverage. Medicare coverage had not been posted to eMedNY by the time the recipients of these services were hospitalized.

For example, Medicaid paid nearly $41,000 for a ten-day hospital stay (in February, 2006) for a 68 year-old patient covered by Medicare Part A and Medicaid. However, because the recipient's Medicare Part A coverage was not updated to eMedNY until December 3, 2007, eMedNY overpaid the claim by nearly $40,000. Based on the CMS data, we determined the recipient became eligible for Medicare Part A health insurance on October 1, 2005 (four months prior to admission).

Similar to the 110 claims we reviewed, the 3,078 claims we did not review were also for common inpatient hospital admissions. Thus, we concluded that the 3,078 claims had similar risks of overpayment as did the 110 claims. If nearly 70 percent of the total Medicaid paid for all 3,188 claims was improper, then the overpayments would have approached $14 million ($20 million times 70 percent). In some cases, a recipient's Medicare Part A eligibility was not posted to eMedNY until several years after their hospital stay.

CMS makes information pertaining to a recipient's Medicare eligibility available online - if a health care provider chooses to use it to determine a recipient's Medicare coverage. However, providers sometimes do not access such information (or access it properly). Rather, they rely extensively on the data maintained by eMedNY to identify a recipient's Medicare enrollment. We concluded that the Department should instruct Medicaid providers to check with CMS for Medicare insurance, when eMedNY has no indicator of such coverage, particularly for patients who are 65 or more years old.

The Department also employs a contractor to verify the accuracy of Medicaid claims paid on behalf of recipients eligible for Medicare Part A health insurance through post-payment reviews. However, there were limitations in the contractor's review. We noted that the contractor did not pursue 53 of the 67 improperly paid Medicare-related claims that we identified because the claims included payments from other sources (such as Medicare Part B) and thus were considered less likely to return a Medicare payback. In other cases, the contractor incorrectly determined that the services were not a Medicare eligible service, and therefore did not investigate the matter.

Our report contains four recommendations to the Department to improve their detection of Medicare Part A coverage for Medicaid recipients and prevent improper payments. In response to our draft audit report, Department officials indicated that certain steps are planned or have been taken which address our report's recommendations.

This report, dated September 20, 2010, is available on our website at:
http://www.osc.state.ny.us.
Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Government Accountability
110 State Street, 11th Floor
Albany, NY 12236

Introduction

Background

Medicaid and Medicare are two public programs which provide medical and health-related services to specific groups of people in the United States. Both programs were created in 1965 under the Social Security Act and are managed by the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. Accordingly, CMS possesses computerized health care data for over 74 million Americans.

Medicare covers most people 65 years of age and older, certain people with disabilities, and some people with permanent kidney failure. Medicare is administered and funded solely by the Federal Government. Medicaid is a means-tested health and medical services program for certain individuals and families. Medicaid is administered jointly through the Federal, State and local governments. Medicaid covers low-income and financially needy people, including many of those also covered by Medicare. Although primary oversight of Medicaid program is handled at the Federal level, states establish their own Medicaid eligibility standards. In New York, costs for Medicaid are shared by the Federal Government, the State, and New York City or the counties outside of New York City. More than 670,000 New York State residents are "dual eligibles" because they are covered by both Medicare and Medicaid.

The Medicare program has several coverage categories or "parts." Medicare Part A provides coverage for hospitalization, post-hospital nursing home care, home health care, and hospice. Most people become eligible for Medicare Part A health insurance when they reach 65 years of age. Medicare Part B insurance covers the costs for doctors, laboratory fees, and certain outpatient medical services. If an individual is enrolled in both Medicare and Medicaid, Medicare is the primary payer, generally covering most of the eligible costs for health services. The Medicaid program is the "payer of last resort" and generally pays a small portion of costs, such as co-insurance or deductibles.

To obtain Medicaid benefits, individuals must first apply for them through their local social services districts. New York has 58 local districts representing a county in all areas of the State except in New York City. The five boroughs of New York City comprise one local district overseen by the New York City Human Resources Administration. Local districts also determine if individuals who apply for Medicaid are eligible for Medicare and, as such, should update State Medicaid data bases accordingly.

The Department of Health (Department) administers New York's Medicaid program, which provides medical assistance to nearly 5 million individuals and annually pays over $46 billion to Medicaid providers. Many of the State's Medicaid recipients are also eligible for Medicare Part A health insurance. Each week, the Department's Medicaid management information and claims processing system, eMedNY, uses various automated controls and edits to detect inappropriate claims and prevent payment. For example, eMedNY has edits which use a Medicaid recipient's eligibility information to check claims for recipients with Medicare Part A health insurance. These controls help ensure health care providers billed Medicare prior to submitting a claim to Medicaid. Therefore, it is imperative that a Medicaid recipient's Medicare Part A insurance data be posted timely to the Department's eligibility databases; otherwise, eMedNY's edit checks will not identify the Part A coverage and Medicaid overpayments will likely occur.

Medicaid pays about $1 billion annually for inpatient hospital services on behalf of recipients who are also eligible for Medicare.

Audit Scope and Methodology

Our objective was to determine if Medicaid made overpayments for recipients who were also eligible for Medicare Part A health insurance coverage. Our audit was limited to claims covered by Medicare Part A health insurance for hospital inpatient services. Our audit period was from January 1, 2006 through May 31, 2010.

To accomplish our objectives, we interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined the Department's relevant policies and procedures. We also obtained Medicare Part A health insurance information from the federal Center for Medicare and Medicaid Services (CMS) and identified Medicaid recipients who had Medicare Part A coverage during our audit period.

In addition, we selected a judgmental sample of 110 Medicaid claims paid by eMedNY between January 1, 2006 and December 31, 2007. We selected these claims because they were billed by four hospitals that received the largest amount of payments from Medicaid for inpatient hospital stays for recipients who, according to information obtained from CMS, had Medicare Part A health insurance coverage. In addition, we analyzed pertinent eMedNY claims payment data for the period January 1, 2008 through May 31, 2010. We also visited four hospitals that were among the largest Medicaid providers, reviewed pertinent records, and interviewed hospital administrators.

We conducted our performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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. 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 (some of whom have minority voting rights) to certain boards, commissions, and public authorities. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these functions do not affect our ability to conduct independent audits of program performance.

Authority

The audit was performed 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.

Reporting Requirements

We provided a draft copy of this report to Department officials for their review and formal comment. We considered the Department's comments in preparing this report and have included them in their entirety at the end of it. In their response, Department officials indicated that certain steps are planned or have been taken which address our report's recommendations. Our rejoinders to the Department's response are included in our State Comptroller's Comments.

Within 90 days of the final release of this report, as required by Section 170 of the Executive Law, the Commissioner 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.

Contributors to the Report

Major contributors to this report include Warren Fitzgerald, Dan Towle, Emily Wood, Lauren Bizzarro, Steven Sossei, and Brian Mason.

Audit Findings and Recommendations

Improper Hospital Payments

According to Federal law and State regulations, if a Medicaid recipient is eligible for Medicare, medical service providers must bill Medicare prior to billing Medicaid. Further, Department regulations require Medicaid providers to take the reasonable measures necessary to assure that claims are not submitted to Medicaid until they are submitted to other available payment sources, such as Medicare Part A. As a result, when serving Medicaid recipients who are 65 or older it is reasonable to expect providers to check for the Medicare eligibility. Also, eMedNY has computer edits which check claims for patients with Medicare Part A coverage. These edits help ensure that providers have billed Medicare prior to submitting a claim to Medicaid. During claims processing, eMedNY uses the amount paid by Medicare to reduce the amount Medicaid owes the provider. However, if recipients' Medicare Part A coverage is not updated to eMedNY, the edit checks will not occur, and significant Medicaid overpayments will likely result.

Using Medicare Part A eligibility information obtained from CMS, we assessed the completeness of the Medicare eligibility data posted to eMedNY as of December 31, 2007. We determined that, as of May 2010, eMedNY did not include Medicare Part A coverage data for 5,906 Medicaid recipients who were deemed eligible for Medicare Part A by CMS for some point between January 1, 2006 and December 31, 2007.

We further determined that Medicaid processed 3,188 claims (totaling about $20 million) for inpatient hospital services provided to 2,564 dual eligible recipients during the period January 1, 2006 through December 31, 2007 for which Medicare Part A was never billed.

From four hospitals that were among the largest Medicaid providers, we reviewed a judgmental sample of 110 of the larger claims (totaling about $2.3 million) for inpatient services provided during our audit period. We found only 43 of these claims were paid correctly. In most of these instances, eMedNY paid the coinsurance amounts owed by individuals who were also covered by a Medicare HMO, which paid most of the patients' hospitalization costs. In certain other instances, Medicare denied claims because the recipient had reached the maximum amount of benefit payments (i.e., the patient's benefits were exhausted) making Medicaid responsible for paying the claim.

Based on our review, we determined that Medicaid overpaid the remaining 67 sampled claims (61 percent) by nearly $1.6 million (about

70 percent) because Medicare Part A was not billed for services provided to recipients who had such coverage. In each instance, Medicare coverage had not been posted to eMedNY by time the recipients were hospitalized. As a result, instead of paying the deductibles owed by the patients (which were capped at $952 in 2006 and $992 in 2007), Medicaid paid nearly all of the amounts that should otherwise have been paid by Medicare.

The following are two examples of significant Medicaid overpayments that occurred because Medicare Part A was not billed:

- Medicaid paid $73,000 for a claim covering a 68 year-old recipient's six-day hospital stay in July 2007. We determined the recipient's Medicare Part A coverage was not posted to eMedNY until December 2007, about six months after the recipient was admitted. Consequently, when the hospital did not bill Medicare, eMedNY did not identify the error and overpaid the claim by nearly $72,000 ($73,000 less the deductible of $992); and

- Medicaid paid nearly $41,000 for a ten-day hospital stay in February, 2006 for a 68 year-old patient covered by Medicare Part A and Medicaid. Because the Medicaid recipient's Medicare Part A coverage was not updated to eMedNY until December 3, 2007 (nearly 22 months after the admission), eMedNY overpaid the claim by nearly $40,000 ($41,000 less the deductible of $952). Based on the CMS data, we determined the recipient became eligible for Medicare Part A health insurance on October 1, 2005 (four months prior to admission). As a result of our review, this provider returned nearly $150,000 to Medicaid for the improper Medicare-related claims we identified.

The remaining 3,078 claim payments we did not review in detail were also for common inpatient hospital admissions and they were otherwise similar to the 110 payments sampled. Thus, we concluded that the 3,078 claims had similar risks of overpayment as did the 110 claims reviewed. If nearly 70 percent of the total Medicaid paid for all 3,188 claims was improper, then the overpayments would have approached $14 million ($20 million times 70 percent). In some cases, a recipient's Medicare Part A eligibility was not posted to eMedNY until several years after their hospital stay. Consequently, the Medicaid overpayments pertaining to any one recipient could have been very large.

We also reviewed the Medicaid activity for the period January 1, 2008 through May 31, 2010 for the 5,906 recipients, whose Medicare Part A enrollment had not been posted to eMedNY as of December 31, 2007, We identified that 812 of the 5,906 recipients had received Medicaid-funded services during that period and their Medicare Part A coverage

was still not posted to eMedNY. From January 1, 2008 through May 31, 2010, eMedNY processed and paid over 51,000 claims costing nearly $16 million for services provided to these recipients. This included $1.5 million for 320 inpatient hospital claims for 191 recipients who had Medicare Part A coverage. It is likely that the Medicaid payments for these claims could have been significantly reduced, if they were also billed to Medicare first.

There are several reasons that cause Medicaid to have overpaid these hospital claims. One principle cause is that the individual's Medicare A coverage was not recorded on eMedNY, and thus, eMedNY did not process the claim as a dual eligible claim. Instead, eMedNY processed the claims as a Medicaid only claim, thereby avoiding certain edits. The failure to have updated information on Medicare Part A coverage can be caused in turn by such things as the failure of the local social service district staff to properly update their systems, which in turn updates eMedNY. It may also be caused by an individual failing to notify the provider or local office that they have Medicare Part A coverage.

Providers also contribute to the problem by not adequately searching for Medicare eligibility information before submitting claims to Medicaid. In our discussion with providers we noted that some providers will look only on the eMedNY system to determine if a Medicaid client is also Medicare eligible. CMS has information that pertains to a recipient's Medicare eligibility available online but some providers have chosen not to use this information. Consequently, we concluded that the Department should instruct Medicaid providers to check with CMS for Medicare insurance, when eMedNY has no indicator of such coverage, particularly for patients who are 65 or more years old and/or are disabled.

In addition, the Department employs a contractor (Health Management Systems or HMS) to verify through post-payment reviews, the accuracy of Medicaid claims paid on behalf of recipients eligible for Medicare Part A health insurance. Through its reviews, HMS identifies apparent Medicaid overpayments resulting from providers' failure to bill Medicare. HMS then works with the Department and providers to recover the improper payments. The recoveries resulting from HMS' efforts have been significant in recent years.

However, there were some limitations in HMS' reviews of Medicaid recipients' Medicare eligibility. We noted that HMS did not pursue 53 of the 67 improperly paid Medicare-related claims detailed previously in this report. Most of the claims were not reviewed because they included payments from other sources (such as Medicare Part B) or because the services were considered ineligible for Medicare reimbursement.

Medicare Part B often pays a doctor directly for services performed in a hospital, when the doctor is not on the hospital's staff. For 24 of the 53 claims, we determined that HMS did not check for Medicare Part A coverage because the provider recorded a Medicare Part B (or private) insurance payment on the claim to Medicaid. State officials believe these claims have a lower risk of a provider failing to bill Medicare Part A than claims which have no Medicare Part B and/or private coverage indicated. Because HMS' reviews focus on a broad range of high risk Medicaid claims, resources were not allocated to claims of comparatively lesser risk, such as those indicating Medicare Part B or private coverage. Nonetheless, as a result of our review, the Department has taken steps to require HMS to now include similar claims in their post-payment reviews for Medicare Part A coverage.

HMS also did not pursue more than 20 other claims we identified because officials believed that the services provided were ineligible for Medicare Part A coverage. However, these determinations appear incorrect. In fact, for certain claims, administrators at hospitals we visited acknowledged that the services in question were eligible for Medicaid Part A coverage. As a result, hospital officials subsequently adjusted some of these claims and returned overpayments including the aforementioned $150,000.

Recommendations

1. Follow up on the Medicaid recipients we identified whose Medicare Part A coverage is not indicated on eMedNY and ensure their coverage is properly updated to eMedNY.

2. For the questionable claim payments made after January 1, 2008 that we identified, investigate and recover any overpayments made for services provided to the recipients eligible for Medicare Part A.

3. Instruct Medicaid providers to check with the Centers for Medicare and Medicaid Services for Medicare Part A coverage for Medicaid recipients likely to be eligible for Medicare (the aged and disabled).

4. Assess the effectiveness of the vendor's policies and processes to identify Medicaid recipients who also have Medicare Part A coverage. Recommend improvements to the process as warranted.

Agency Comments

STATE OF NEW YORK
DEPARTMENT OF HEALTH
Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

James W. Clyne, Jr.
Executive Deputy Commissioner

September 14, 2010

Steven E. Sossei, CPA
Audit Director
Office of the State Comptroller
Division of State Government Accountability
110 State Street – 11th Floor
Albany, New York 12236

Dear Mr. Sossei:

Enclosed are the New York State Department of Health's comments on the Office of the State Comptroller's draft audit report 2009-S-36 on "Medicaid Payments for Medicare Part A Beneficiaries."

Thank you for the opportunity to comment.

Sincerely,

James W. Clyne, Jr.
Executive Deputy Commissioner

Enclosure

cc: James Sheehan
Robert W. Reed
Donna Frescatore
Diane Christensen
Stephen Abbott
Dennis Wendell
Ron Farrell
Mary Elwell
Irene Myron
Lynn Oliver

Department of Health
Comments on the Office of the State Comptroller's Draft Audit Report 2009-S-36 on Medicaid Payments for Medicare Part A Beneficiaries

The following are the Department of Health's (Department) comments in response to the Office of the State Comptroller's (OSC) draft audit report 2009-S-36 on "Medicaid Payments for Medicare Part A Beneficiaries."

Recommendation #1:

Follow up on the Medicaid recipients we identified whose Medicare Part A coverage is not indicated on eMedNY and ensure their coverage is properly updated to eMedNY.

Response #1:

OSC's description of the Department's computer matches does not reflect current practice. Contrary to the two examples cited in the report, due to recent initiatives, updates to eMedNY to reflect Medicare coverage are performed routinely, promptly and are available when the provider swipes the recipient's Medicaid card.

* Comment 1

Each month, the Department sends a file of dual-eligible recipients for CMS' determination of Medicare coverage. As CMS' response file provides the most accurate Medicare Part A and Part B coverage data, the Department initiated a project in February 2010 and a second project in August 2010 to use this file to update existing Medicare coverage information in eMedNY. As a result, Medicare information is now more timely and accurate. To further improve timeliness, the Department has initiated work on the possibility of sending and receiving the file weekly.

Recommendation #2:

For the questionable claim payments made after January 1, 2008 that we identified, investigate and recover any overpayments made for services provided to the recipients eligible for Medicare Part A.

Response #2:

The Office of the Medicaid Inspector General (OMIG) has requested access to the ResDac data utilized by OSC to verify the questionable claim payments identified by OSC and will pursue appropriate recoveries.

Recommendation #3:

Instruct Medicaid providers to check with the Centers for Medicare and Medicaid Services for Medicare Part A coverage for Medicaid recipients likely to be eligible for Medicare (the aged and disabled).

* See State Comptroller's Comments, page 21.

Response #3:

The Department will evaluate the need for healthcare facilities to verify Medicare coverage. This will be done in consideration of the eMedNY claim processing improvements described in Response #1 above.

* Comment 2

Recommendation #4:

Assess the effectiveness of the vendor's policies and processes to identify Medicaid recipients who also have Medicare Part A coverage. Recommend improvements to the process as warranted.

Response #4:

The third party vendor contractor is under continuous oversight and evaluation for improvement by the OMIG. The OSC findings are based on the use of a source file that neither the OMIG nor the vendor currently have access to. The OMIG is in the process of applying for access and will perform a similar match when obtained.

* See State Comptroller's Comments, page 21.

State Comptroller's Comments

1. Our report accurately details Department and OMIG practices as they existed as of May 31, 2010. Further, our computer matches of Medicaid and CMS data were performed prior to the Department's recent initiatives, including the use of CMS response files to update Medicare coverage data on eMedNY. Thus, the Department's initiatives were in response to our audit observations, and they should help address the deficiencies we identified during the audit. We commend the Department for taking action. Moreover, our conclusion that eMedNY lacked pertinent Medicare information for 5,906 Medicaid recipients who had Medicare Part A coverage, prior to December 31, 2007, remains valid. Consequently, we maintain that the Department should conduct the follow-ups necessary to ensure the Medicare coverage of these recipients is properly reflected on eMedNY.

2. We acknowledge that the file matches with CMS data (through projects that began in 2010) will help the Department to update eMedNY with Medicare data that is more timely and accurate. Nonetheless, there is still risk that Medicare data for some Medicaid recipients is not updated timely, which could lead to significant Medicaid overpayments (nearly $72,000 for one recipient alone, as noted in our report). Consequently, we maintain that the Department should instruct providers to check for Medicare coverage for recipients likely to be eligible for Medicare Part A benefits.