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OFFICE OF THE STATE COMPTROLLER

April 4, 2014

Nirav R. Shah, M.D., M.P.H.  
Commissioner  
Department of Health  
Corning Tower  
Empire State Plaza  
Albany, NY 12237

Re: Medicaid Payments for Medicare Part A  
Beneficiaries  
Report 2013-F-16

Dear Dr. Shah:

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 have followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *Medicaid Payments for Medicare Part A Beneficiaries* (Report 2009-S-36).

**Background, Scope and Objective**

Many of the State's Medicaid recipients are also eligible for Medicare Part A, which provides supplementary medical insurance for inpatient care in hospitals, post-hospital nursing home care, hospice and home health services. If an individual is enrolled in both Medicaid and Medicare (commonly referred to as "dual-eligible"), Medicare is the primary payer and generally covers most of the eligible costs for health services. Medicaid, as a secondary payer, generally pays a small portion of the costs, such as coinsurance or deductibles.

About 780,000 Medicaid recipients are dually enrolled in Medicare Part A. At the time of the initial audit, Medicaid paid about \$1 billion annually for inpatient hospital services on behalf of dual-eligible recipients. The Department's Medicaid claims processing and payment system (eMedNY) has automated controls and edits that use eligibility information to ensure health care providers bill Medicare prior to submitting a claim to Medicaid. It is imperative that a Medicaid recipient's Medicare Part A insurance data be posted timely to the Department's eligibility

systems; otherwise, eMedNY will not identify the Part A coverage and Medicaid overpayments will likely occur.

We issued our initial audit report on September 20, 2010. Our objective was to determine if Medicaid made overpayments for recipients who were also enrolled in Medicare Part A. Our initial audit determined eMedNY did not always identify Medicaid recipients who were also covered by Medicare Part A. As a result, when eMedNY processed a claim for a dual-eligible person, it did not have the necessary information to ensure Medicare had already been appropriately billed. For the two years ended December 31, 2007, auditors identified \$14 million in potential Medicaid overpayments for claims pertaining to 2,564 dual-eligible individuals. We recommended that the Department improve their detection of Medicare Part A coverage for Medicaid recipients and prevent improper payments.

The objective of our follow-up was to assess the extent of implementation, as of February 5, 2014, of the four recommendations included in our initial audit report.

### **Summary Conclusions and Status of Audit Recommendations**

Officials made considerable progress in correcting the problems we identified in the initial audit report. This included the recovery of approximately \$22.6 million in Medicaid overpayments for services provided to recipients who were also covered by Medicare Part A. Of the initial report's four recommendations, three were implemented and one was not implemented.

### **Follow-Up Observations**

#### **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.*

Status - Implemented

Agency Action - The initial audit found 5,906 Medicaid recipients whose Medicare Part A coverage was not indicated on eMedNY. Since then, the recipients' Medicare coverage was properly updated to eMedNY. Specifically, the Department's Medicaid fiscal agent, Computer Sciences Corporation (CSC), coordinated with the federal Centers for Medicare and Medicaid Services (CMS) to update Medicaid recipients' Medicare coverage on eMedNY. CSC performs the updates through a series of computerized file matches with CMS Medicare coverage data. Since the initial audit, these matches are performed more frequently (weekly as opposed to monthly). This has resulted in more accurate and timely updates of Medicaid recipients' Medicare coverage to eMedNY.

#### **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.*

Status - Implemented

Agency Action - The Office of the Medicaid Inspector General (OMIG) investigates and recovers improper Medicaid payments on behalf of the Department. OMIG directed HMS, its third party insurance contractor, to review 320 questionable claim payments totaling \$1.5 million we had identified. HMS determined 31 claim payments were improper and recovered \$340,807 on these claims. HMS also formally assessed the level of risk of improper payment of the remaining questionable claims and concluded they were either appropriately paid or did not warrant further investigation.

### **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).*

Status - Not Implemented

Agency Action - Medicaid providers, including high volume providers such as hospitals, can check Medicaid recipients' Medicare Part A coverage through the CMS HIPAA Eligibility Transaction System (HETS). However, the Department has not instructed providers to verify eligibility through HETS. Accordingly, the Department should instruct Medicaid providers to check available systems, including HETS, for Medicare Part A coverage for Medicaid recipients likely to be eligible for Medicare.

### **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.*

Status - Implemented

Agency Action - During the course of our initial audit, HMS modified and improved how they select claims for their review. For instance, prior to our initial audit, HMS excluded claims with reported third party payment amounts. However, by including these claims in their reviews, HMS was able to identify and recover an additional \$22.3 million in inappropriate Medicaid claim payments.

Major contributors to this report were Paul Alois and Arnold Blanck.

We would appreciate your response to this report within 30 days, indicating any actions planned to address the unresolved issue discussed in this report. We thank the management and staff of the Department for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Andrea Inman  
Audit Manager

cc: Ms. Diane Christensen, Department of Health  
Mr. James Cox, Medicaid Inspector General