NEW YORK STATE
OFFICE OF THE STATE COMPTROLLER

H. Carl McCall
STATE COMPTROLLER

DEPARTMENT OF HEALTH

MEDICAID ACCOUNTS RECEIVABLE

99-S-34

DIVISION OF MANAGEMENT AUDIT AND
STATE FINANCIAL SERVICES

H. Carl McCall
STATE COMPTROLLER

Report 99-S-34

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Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Dear Dr. Novello:

The following is our report on the Department of Health's practices related to the monitoring of Medicaid accounts receivable.

This 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. Major contributors to this report are listed in Appendix A.

Office of the State Comptroller
Division of Management Audit
and State Financial Services

May 16, 2001

Executive Summary

Department of Health
Medicaid Accounts Receivable

Scope of Audit

The Department of Health (Health) administers New York State's Medicaid program, which provides 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 and pay most of the claims submitted by providers who render services to eligible Medicaid recipients.

Health receives payments and recoups funds from providers that Medicaid has overpaid, as identified through audits or when negative retroactive rate adjustments are made for rate-based providers. The Audit Units forward overpayment information to the Medicaid Financial Management Unit (Finance), which is responsible for establishing and maintaining accounts receivable records on the MMIS Provider Accounting Master File (Master File). The Audit Units and Finance each maintain independent databases with overpayment information in support of the Master File. Collectively, this overpayment information is referred to as Medicaid accounts receivable.

Our audit addressed the following question about Health's monitoring of Medicaid accounts receivable as of December 31, 1999:

- Does Health have adequate controls in place to maintain, monitor, collect and report on accounts receivable?

Audit Observations and Conclusions

As of December 31, 1999, the value of accounts receivable maintained on MMIS totaled $89.7 billion. Most of these receivables, $88.8 billion or 99 percent, were artificial receivables, necessitated by system limitations. The remaining accounts receivable were classified as non-Medicaid accounts receivable ($791.5 million) and Medicaid accounts receivable ($116.5 million).

We found that Health's controls to maintain, monitor, collect and report on the Medicaid accounts receivable are not effective to ensure that all Medicaid accounts receivable transactions have been properly recorded and are collected timely. Although updated provider accounts receivable information is shared between Health's units, no regularly scheduled verifications or reconciliations are performed between the Master File and the supporting databases to ensure accurate updating and file integrity. We compared the Master File to each supporting database and determined there were significant differences. For example, the Medicaid accounts receivable on the database maintained by one of Health's Audit Units totaled $25,312,900, while the

Master File receivables for this Unit totaled $199,001,400. As a result, we believe that the Master File and the Audit Units' databases may contain inaccurate data or are missing data. The Audit Units were unaware of these discrepancies, which could adversely affect Medicaid accounts receivable collection activities. (See pp. 5-7)

Our audit also found that Health does not have a routine process to age the Medicaid accounts receivable to identify the length of time that they are outstanding. Our analysis determined that approximately $16 million of accounts receivable was outstanding for more than one year. We also found that nearly $4 million of accounts receivable was more than six years old. Consequently, if court action were initiated in the collection process for these accounts receivable, the six year statute of limitations would apply, and they would become unrecoverable. In addition, when providers infrequently bill Medicaid or become inactive, Health does not have an established collections process to ensure that outstanding accounts receivable are recovered in a timely manner. (See pp. 7-8)

Medicaid providers often become affiliated with other Medicaid providers by establishing a group practice or through a change in ownership. At Health's option, overpayments may be recovered by withholding all or part of a provider's and their affiliate's payments. However, we found that Health does not have a process to regularly identify or initiate the collection of overpayments from affiliated group practices or new owners. As a result, we identified 18 providers with outstanding accounts receivable totaling almost $2 million on the Master File that were enrolled in at least one group provider practice. We also identified 20 providers, with outstanding accounts receivable totaling over $101 million, where a change in ownership was identified on the Master File. These outstanding accounts receivable are at increased risk of not being collected in a timely fashion. (See p. 8)

Our report contains seven recommendations to improve controls over Medicaid accounts receivable.

Comments of Officials

Department of Health officials generally agreed with our recommendations. A complete copy of the Department of Health's response is included as Appendix B.

Contents

Introduction

Background

The New York State Medical Assistance Program (Medicaid) is a Federally aided, State-operated and administered program that provides medical benefits for certain low-income persons in need of health and medical care. Subject to broad Federal guidelines, states determine the benefits covered, program eligibility, rates of payment to providers and methods of administering the program. In New York, the Federal, State and local governments jointly fund the Medicaid program.

The Department of Health (Health) contracts with a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and pay providers for services rendered to eligible Medicaid recipients. The payments are made through the Medicaid Management Information System (MMIS), a computerized claims processing, payment and information reporting system.

As of December 31, 1999, we determined that the value of accounts receivable maintained on MMIS was approximately $89.7 billion. However, these accounts receivable originate from several different State agencies and for different reasons. The major classifications of accounts receivable are "Medicaid accounts receivable," representing about $116.5 million; "non-Medicaid accounts receivable," representing more than $791.5 million and "artificial accounts receivable," representing about $88.8 billion.

Most Medicaid accounts receivable are created when:

- overpaid providers are identified through audits conducted by Health's Bureau of Compliance and Audit, the Rate Audit Unit and the Third Party Audit Unit, collectively referred to as Audit Units, as well as external contractors and the Office of the State Comptroller;

- negative retroactive rate adjustments are processed against rate-based Medicaid providers.

Non-Medicaid accounts receivable most often arise through requests by the:

- Office of Mental Retardation and Developmental Disabilities or the Office of Mental Health to withhold payments from Medicaid providers in regard to mortgage financing activities for intermediate care facility sites or operational start-up fees and tax assessments;

- Office of the Attorney General to withhold payments in regard to suspected or proven cases of provider fraud and abuse.

Artificial accounts receivable are used, due to system limitations, as a mechanism to prevent MMIS from making certain payments to the State for State funded operations, such as psychiatric centers.

Health receives payments and recoups funds from providers that Medicaid has overpaid. For providers who are unwilling or otherwise cannot remit the entire overpaid amount, Health may establish a scheduled repayment plan. The repayment plan offers two alternatives. Providers may remit checks to Health on a periodic basis or elect to have Health create an automated MMIS recoupment. Such a recoupment would enable offsets from future Medicaid payments until the overpayment is reimbursed to the State. If the provider defaults on a repayment agreement, the provider's case is referred to the Office of the Attorney General for collection. Currently, the statute of limitations, or the period of time during which the State has to collect identified overpayments owed to the State, is six years. To ensure collectibility of overpayments within MMIS, it is Health's policy not to write off accounts receivable, regardless of the length of time outstanding. This policy allows for automatic recoupment, should an inactive provider resume submitting claims to MMIS.

The Audit Units each establish and maintain independent databases with accounts receivable information. The Audit Units regularly forward this information to the Medicaid Financial Management Unit (Finance), which is responsible for establishing and maintaining accounts receivable records on the MMIS Provider Accounting Master File (Master File) and Finance's own database. When establishing the accounts receivable, Finance adds a recoupment code to each record that serves to identify the Audit Unit responsible for the receivable. As repayments are made, Finance forwards updated information on a monthly basis to the responsible Audit Unit, so the unit may update its database.

Audit Scope, Objective and Methodology

We audited Health's policies and procedures for maintaining, monitoring, collecting and reporting Medicaid accounts receivable in MMIS as of December 31, 1999. The objective of this performance audit was to determine if Health has adequate controls in place to maintain, monitor, collect and report on Medicaid accounts receivable.

To accomplish our audit objective, we interviewed Health officials; analyzed selected Health accounting system data files; and reviewed the policies and procedures of the Audit Units and Finance. Our audit did not include an examination of the individual databases to substantiate the validity of individual providers' accounts receivable as established on the Master File as of December 31, 1999.

Health's Third Party Audit Unit monitors three contractors, Public Consulting Group, Health Maintenance Service, and the Center for Medicare Advocacy, which perform recovery of Medicaid overpayments relating to recipient third party insurance issues for Health. Due to the outsourcing of this function, the Third Party Audit Unit establishes only a minimal number of accounts receivable annually, and we deemed those not to be material. Therefore, we excluded review of the supporting accounts receivable data for the Third Party Audit Unit from our audit. We also did not examine the records of the contractors since these accounts receivable are not recorded on MMIS.

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.

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 Officials to Audit

Draft copies of this report were provided to Health officials for their review and comments. Their comments were considered in preparing this report and are included as Appendix B.

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.

Medicaid Accounts Receivable

Health should ensure that appropriate controls are in place to regularly report and reconcile the Medicaid accounts receivable maintained on the Master File and the related databases that are used by the Audit Units and Finance. Our audit found that Health does not have sufficient processes in place to report on and reconcile the Master File to the supporting databases. In addition, Health does not routinely age the Medicaid accounts receivable. In order to maximize collection efforts, Health should regularly assess the collectibility of accounts receivable through an aging process. We also found that Health does not regularly recover overpayments from affiliated providers. Without these processes in place, Health's management has reduced assurance that all Medicaid accounts receivable transactions have been properly recorded and that collections of accounts receivable have been maximized.

Accounts Receivable Reconciliation

To ensure data integrity, transactions that are processed in an automated system such as accounts receivable should be subject to a variety of controls to check for accuracy, completeness and validity. In addition, processes should be in place to regularly report on the accounts receivable and reconcile payment transactions between the Master File and supporting databases. We found that Health has not established any process to regularly reconcile the Master File to the Audit Units' databases. Without a periodic reconciliation process, Health cannot ensure the accuracy and file integrity of accounts receivable information. To identify the impact, we independently verified the balance of the Master File as of December 31, 1999. Finance and the Audit Units provided their selected databases to us for our review, with accounts receivable records that they deemed to be outstanding as of December 31, 1999. Using this information, we identified approximately $116.5 million in Medicaid accounts receivable represented by 1,176 records.

While we were able to reconcile the Master File to the Finance database, we were unable to reconcile the total value of each Audit Units' database to the information on the Master File. As a result, we believe that the Master File and the Audit Units' databases may contain inaccurate data or are missing data. The following identifies the results of our independent verification between the accounts receivable information on the Bureau of Compliance and Audit's database and the Master File:

Database or File Reconciled	Total Dollar Value Identified	Records Identified in Reconciliation
Bureau of Compliance and Audit Accounts Receivable Database	**$ 25,312,900**	**207**
Bureau of Compliance and Audit Accounts Receivable on Master File	**$199,001,400**	**33**

When we compared the accounts receivable on the Bureau of Compliance and Audit database to supporting records on the Master File, we found that the database totaled $25,312,900, while the total on the Master File for this Bureau's records totaled $199,001,400, representing a difference of ($173,688,500). We also found that only 33 records on the Master File matched to the 207 accounts receivable records maintained on the Bureau of Compliance and Audit database.

We noted similar discrepancies when we attempted to reconcile the Rate Audit Unit's database to the accounts receivable on the Master File, as follows:

File or Database Reconciled	Total Dollar Value Identified	Records Identified in Reconciliation
Rate Audit Unit Accounts Receivable Database	**$ 65,188,165**	**3,303**
Rate Audit Unit Accounts Receivable on Master File	**$ 14,314,340**	**1,828**

When we compared the accounts receivable on the Rate Audit Unit database to supporting records on the Master File, we found that the database totaled $65,188,165, while the total on the Master File for the Rate Audit Unit's records totaled $14,314,340, representing a difference of $50,873,825. We also found that only 1,828 records on the Master File matched to the 3,303 accounts receivable records maintained on the Rate Audit Unit database.

The Audit Units were unaware of these discrepancies, which could adversely affect accounts receivable collection activities. As a result of our findings, Health officials began to reconcile the differences.

Health has contracted with Computer Science Corporation to develop and operate a replacement Medicaid system called eMedNY. This system has

design provisions to replace the processing methods currently utilized by Health for establishing, maintaining, collecting and reporting accounts receivable. It is imperative, however, that a data cleansing process be performed to ensure completeness and accuracy of data transferred to the new processing system before it becomes operational.

Accounts Receivable Aging and Collections

Reports should be produced to assist management in taking appropriate actions for collection of overpayments. To avoid the loss of outstanding accounts receivable, Health should regularly assess the collectibility of accounts receivable through an aging process. Our audit found that Health does not have a routine reporting process to identify the length of time that Medicaid accounts receivable are outstanding. Accounts receivable which remain outstanding for a long period of time are at a higher risk of not being collected.

We used computer assisted auditing techniques to age Medicaid accounts receivable records maintained on the Master File (see Exhibit A). Our analysis determined that approximately $16 million of accounts receivable, represented by 149 records, was outstanding for more than one year. Many of these accounts receivable are not recouped through the automated recoupment process because the providers are not billing Medicaid on a regular basis. We also found that the Master File had nearly $4 million of accounts receivable that were more than six years old. Consequently, if court action were initiated in the collection process for these accounts receivable, the six year statute of limitations would apply, and they would become unrecoverable.

In addition, we found that Health's automated recoupment process functions effectively for providers who regularly bill Medicaid. However, when providers infrequently bill Medicaid or become inactive, Health does not have an established collections process in place to ensure that outstanding accounts receivable are recovered in a timely manner. For example, the Rate Audit Unit performs only a cursory review of Finance reports that identify accounts receivable payment transactions for the current period. Health does not have procedures in place to routinely identify providers on the Rate Audit Unit database that have stopped payment of agreed repayment plans or have become inactive. Having such procedures would facilitate Health's collection efforts for outstanding accounts receivable.

We also found that accounts receivable recoveries would be improved if Health established a regular collection process for providers who are inactive or bill infrequently. We found that Health is not maximizing its collection efforts to increase recoveries of overpayments for inactive or

infrequent billing providers. For example, Health does not routinely send (i.e. annual or semi-annual) collection letters for outstanding accounts receivable on the Master File. While Health officials told us that Finance sent collection letters to providers with outstanding accounts receivable balances in February 2000, these officials also noted that this type of collection effort had not been initiated in several years.

Recovering Overpayments from Affiliated Providers

Medicaid providers often become affiliated with other Medicaid providers by establishing a group practice or through a change in ownership. When this occurs, Health issues a new MMIS provider identification number to the group or new owner for billing purposes. Health maintains information regarding these affiliations on MMIS. Payments for Medicaid services performed by providers with group affiliations may be made to either the individual provider or to the affiliated group practice. However, if the provider stops billing Medicaid, recoveries will not be made through the automated recoupment process and additional collection efforts would be required, such as determining whether affiliated providers or new owners are active and receiving payments.

According to Part 518 of Health's Code, Rules and Regulations, at Health's option, overpayments may be recovered by withholding all or part of a provider's and their affiliate's payments. However, we found that Health does not have a process to regularly identify or initiate the collection of overpayments from affiliated group practices or new owners. Health does not use available MMIS information to regularly check the status of affiliated providers to facilitate recovery of outstanding accounts receivable. In addition, Health does not have a procedure to ensure that when provider ownership changes, the responsibility for overpayment liabilities related to current and future recoupments is considered.

As a result, we identified 18 providers with outstanding accounts receivable totaling almost $2 million on the Master File, that were enrolled in at least one group provider practice. We also identified 20 providers, with outstanding accounts receivable totaling over $101 million, where a change in ownership was identified on the Master File. However, in these cases, Health did not determine if recovery could be made against these providers.

Recommendations

1. Implement a reconciliation process to ensure the accuracy, completeness and validity of accounts receivable data maintained on the Master File and the Audit Units' databases.

   (In response to our draft audit report, Health officials disagreed that there is a need to reconcile accounts receivable activity from the Audit Units to the Provider Master File. However, we believe that a reconciliation process comparing the Provider Master File to the Audit Unit Units' databases would enhance Health's process for accounting for these monies. While it is possible that some of the differences identified in our analysis may be attributed to timing of file updates, a reconciliation process would help to ensure the accuracy and file integrity of the accounts receivable.)

2. Perform a data cleansing of the accounts receivable data before migration to the new Medicaid system.

3. Establish a process to perform a detailed aging of the Master File on a regular basis.

4. Establish a process to timely identify and collect receivables from inactive or infrequent billing providers.

5. Implement a procedure to regularly check the status of each provider with a recoupment balance to determine if they are affiliated with other group providers, and as necessary, initiate recoupments against the affiliated providers.

6. Implement a procedure to ensure that when provider ownership changes, the responsibility for overpayment liabilities related to current and future recoupments is considered.

7. Evaluate the status of the 18 providers with group provider affiliations and the 20 providers identified as being under new ownership to determine if recovery of outstanding accounts receivable may be initiated.

Recommendations (Cont'd.)

(In response to our draft audit report, Health officials indicated that when staff evaluated the status of these providers, they identified a smaller number of providers that may actually be affected. However, it should be noted that MMIS files identified all of these providers as having a group affiliation or a change of ownership. Health should correct the MMIS records of those providers with inaccurate information regarding group affiliation or new owners.)

MEDICAID MANAGEMENT INFORMATION SYSTEM PROVIDER ACCOUNTING MASTER FILE MEDICAID ACCOUNTS RECEIVABLE AGING REPORT AS OF DECEMBER 31, 1999				
	Number of Total A/R Records	Percent of Total A/R Records	Total Outstanding Amount	Percent of Total A/R Amount
Less than 6 months	954	81.1%	$88,844,150	76.3%
6 months - 1 year	73	6.2%	$11,572,736	9.9%
1 - 2 years	61	5.2%	$6,727,869	5.8%
2 - 3 years	23	2.0%	$2,899,828	2.5%
3 - 4 years	14	1.2%	$2,159,871	1.9%
4 - 5 years	12	12.0%	$264,705	.2%
5 - 6 years	6	0.5%	$29,506	0.0%
Greater than 6 years	33	2.8%	$3,954,421	3.4%
Total	1,176	100.0%	$116,453,086	100.0%

Exhibit A

Major Contributors to This Report

Kevin McClune
Lee Eggleston
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Appendix A

STATE OF NEW YORK
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Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

April 18, 2001

Kevin M. McClune
Audit Director
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Albany, New York 12236

Dear Mr. McClune:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's revised draft audit report 99-S-34, entitled "Medicaid Accounts Receivable".

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Department of Health
Comments on the
Office of the State Comptroller's
Revised Draft Audit Report
99-S-34 Entitled
"Medicaid Accounts Receivable"

The following are the Department of Health's (DOH) comments in response to the Office of the State Comptroller's (OSC) Revised Draft Audit Report 99-S-34 entitled "Medicaid Accounts Receivable".

Recommendation #1:

Implement a reconciliation process to ensure the accuracy, completeness and validity of accounts receivable data maintained on the Master File and the Audit Units' databases.

Response #1:

The MFM unit reconciles its accounts receivable database to the Master File on a weekly basis. In addition, MFM reports on a regular basis to the Bureau of Compliance and Audit (BCA) and the Rate Audit Unit (RAU) concerning accounts receivable activity initiated by their offices.

The Department does not agree that there is a need to reconcile accounts receivable activity from the BCA and RAU to the Master File. Receivables from both sources are submitted to the MFM for collection, and are routinely reconciled to the MFM data. MFM data is then reconciled to the Master File accomplishing the same objective. Implementing a process for the BCA and RAU to reconcile their receivables to the Master File would duplicate actions already taken by the MFM.

Recommendation #2:

Perform a data cleansing of the accounts receivable data before migration to the new Medicaid system.

Response #2:

All current accounts receivable data will be cleansed prior to transfer to eMedNY. In addition, since the new eMedNY system will not require the establishment of artificially high accounts receivables to ensure that no funds are released to providers regardless of the value of claims submitted by the providers, all accounts receivable amounts subsequently entered in eMedNY will be valid debts.

Recommendation #3:

Establish a process to perform a detailed aging of the Master File on a regular basis.

Response #3:

The collectability of the Medicaid accounts receivables will be reviewed on a regular basis. However, it should be noted that the Department occasionally enters into agreements with providers that allow for extended collection periods. A receivable that has aged several years is not necessarily at risk for collection.

Recommendation #4:

Establish a process to timely identify and collect receivables from inactive or infrequent billing providers.

Response #4:

The MFM unit has recently strengthened collection procedures by sending an additional collection letter to providers who become inactive on MMIS. The MFM unit also refers debts to the Department's Division of Legal Affairs for additional collection action, as appropriate.

Recommendation #5:

Implement a procedure to regularly check the status of each provider with a recoupment balance to determine if they are affiliated with other group

providers, and as necessary, initiate recoupments against the affiliated providers.

Response #5:

In some instances it may become necessary to recover debts from affiliated providers. If the provider stops submitting claims through MMIS and it appears that the debt may otherwise go uncollected, a transfer of the debt to an active, affiliated provider should be made. However, if the original provider continues to actively submit claims there is no compelling reason to transfer the debt to an affiliated provider, even if it would slightly reduce the overall collection time. Since the Department assesses interest on Medicaid receivables, there is no cost to the State for extending the collection period for active providers. The MFM unit will attempt to review the debts of inactive or infrequently billing providers on a regular basis and assign the debts to active, affiliated providers based on common federal tax ID numbers

Recommendation #6:

Implement a procedure to ensure that when provider ownership changes, the responsibility for overpayment liabilities related to current and future recoupments is considered.

Response #6:

If a new owner assumes the liabilities of the previous owner and maintains the same provider identification number, there is no impediment to the continued collection of the debt. However, if a new provider identification number is issued for the new owner, either the DOH unit that issued the new operating certificate or the unit that enrolled the provider in MMIS will notify the MFM unit when a change in ownership has occurred, thereby allowing for the proper transfer of the receivable.

Recommendation #7:

Evaluate the status of the 41 providers with group provider affiliations and the 20 providers identified as being under new ownership to determine if recovery of outstanding accounts receivable may be initiated.

Response #7:

In the audit findings OSC "identified 41 providers with outstanding accounts receivable totaling almost $11.6 million on the Master File that were enrolled in at least one group provider practice." However, upon review of this information, the Department found only three Medicaid receivables totaling approximately $431,000 where providers were actually enrolled in a valid, active group practice. All three of these receivables resulted from audits. Since rate based providers such as hospitals and nursing homes cannot have valid group identification numbers, none of those incorrectly assigned numbers should have been included in the OSC total. OSC also "identified 20 providers with outstanding accounts receivable totaling over $101 million, where a change of ownership was identified on the Master File." However, considering only Medicaid receivables, these numbers should more appropriately be 16 providers and $1.4 million outstanding. Despite the OSC numbers, the Department will continue to review the providers identified by OSC as either group affiliated or under new ownership to determine if any of those accounts receivable can be reassigned.