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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

February 8, 2002

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

Re: Report 2001-F-47

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 have reviewed the actions taken by the Department of Health (Health) as of January 2, 2002, to implement the recommendations contained in our audit report, *MMIS Claims Processing Activity* (Report 98-D-5). Our report, which was issued on June 7, 1999, reviewed Medicaid payments to providers during the State fiscal year ended March 31, 1999.

Background

Health administers the State's Medical Assistance program (Medicaid), which was established 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.

The Office of the State Comptroller (OSC) has on-site staff conducting continuous audits of MMIS. Each week, on-site auditors execute a series of computer programs to extract claims data from the newly adjudicated claims payment file. The computer programs were designed to extract those claims most likely to have been overpaid. Auditors analyze the reports generated by these programs and select claims for in-depth review.

Summary Conclusions

In our prior report, we found that the Medicaid program overpaid providers about $32.9 million. Of this amount, OSC staff recovered about $7.1 million from providers and recommended that Health staff investigate and recover the remaining $25.8 million of potential overpayments.

In our follow-up review, we found that Health officials have recovered $14.1 million from providers and determined that $10.2 million in claims were appropriate. While officials were actively pursuing the recovery of an additional $1.3 million of overpaid claims at the time of our follow-up review, they had yet to initiate collection activities for $229,000 in overpayments. We also found that Health officials developed a payment policy for dually eligible recipients and instructed the Medicaid fiscal agent and the inpatient hospitals on the appropriate billing procedure. Further, Health officials had not acted in a timely manner to obtain the timely recovery of Medicaid overpayments.

Summary of Status of Prior Report Recommendations

Of the five prior report recommendations, Health officials have implemented one recommendation, partially implemented two recommendations and have not implemented two recommendations.

Follow-up Observations

Recommendation 1

Recover Medicaid overpayments totaling $23,578,579 associated with 1,576 inpatient hospital claims.

Status - Partially Implemented

Agency Action - We determined that Health officials have collected $13.9 million and were actively pursuing the recovery of an additional $592,000 from providers at the time of our follow-up review. Based on their review of provider documentation, officials determined that claims totaling about $9.1 million were appropriate.

Recommendation 2

Recover Medicaid overpayments totaling $151,976 associated with 2,494 HMO claims.

Status - Not Implemented

Agency Action - Health officials have not initiated collection activities for these claims.

Recommendation 3

Work with the Medicaid peer review agent to resolve the appropriateness of the 82 claims we identified as potential errors, and as appropriate, recover the overpayments of $2,039,295.

Status - Partially Implemented

Agency Action - Health's peer review agent reviewed the inpatient hospital claims and found:

Appropriate medically necessary services	$1,103,600
Awaiting hospital documentation or unable to adjust	679,700
Outside of their jurisdiction – OMH licensed hospital	77,500
Reviewing claims documentation	20,700
Recovered Overpayments	157,800
	$2,039,300

For claims the peer review agent determined were medically necessary, Health officials will not pursue recovery of these Medicaid payments. For claims where the peer review agent was unable to adjust the claim or the services were outside the peer review agent's jurisdiction, Health officials are reviewing the status of these claims.

Recommendation 4

Develop a Medicaid payment policy and instruct the Medicaid fiscal agent and inpatient hospitals regarding the appropriateness of billing Medicaid when a recipient is dually covered by an insurer and the insurer makes a full contractual payment.

Status - Implemented

Agency Action - Health officials developed a Medicaid payment policy and used the Department's web page to instruct the Medicaid fiscal agent and inpatient hospitals on the appropriate billing procedures.

Recommendation 5

Take appropriate and necessary steps to effect the timely recovery of Medicaid overpayments.

Status - Not Implemented

Agency Action - We found that potentially overpaid claims, which we sent to Health officials in May 1998, were not sent to providers to initiate collection activities until January 2000.

Major contributors to this report were Ken Shulman, Bill Clynes and Carol O'Connor.

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

Very truly yours,

Kevin M. McClune
Audit Director

cc: Deirdre A. Taylor