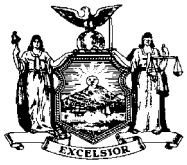
H. CARL MCCALL
STATE COMPTROLLER



A.E. SMITH STATE OFFICE BUILDING
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

July 6, 1999

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

Re: Report 99-F-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 reviewed the actions that had been taken by the Department of Health (Health) as of June 8, 1999, to implement the recommendations included in our prior report, *MMIS Claims Processing Activities* (Report 97-D-5). Our prior report, which was issued on June 24, 1998, conveyed the results of our review of Medicaid payments for the State fiscal year ended March 31, 1998.

Background

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. The program is authorized by Title XIX of the Social Security Act. Subject to broad Federal guidelines, each state determines how the Medicaid program will be administered, including the benefits covered, the rules for eligibility, and the rates of payments to providers. Health administers the Medicaid program in New York State. Health contracts with a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and make payments to providers. The fiscal agent processes claims and pays providers for services rendered to eligible Medicaid recipients through the Medicaid Management Information System (MMIS), a computerized payment and information reporting system.

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

During the period of our prior review, Health administered New York's Medicaid program, and used the Medicaid Management Information System (MMIS) to process Medicaid claims and make payments to health care providers for services rendered to recipients.

Summary Conclusion

In our prior review, we found that the Medicaid program overpaid providers up to $34.2 million. Of this amount, approximately $8.8 million has been recovered from providers. In summary, we recommended that Health pursue actual and potential overpayments totaling approximately $25.4 million.

In our follow-up review, we found that Department of Health officials had recovered $3,389,077 in previously identified overpayments, had concluded that $5,062,595 of payments to providers were appropriate, and had yet to recover $16,989,621 from providers. Of the $16,989,621, Health had not initiated recovery efforts from providers for $11,998,039. Health was pursuing $3,207,250 of the $16,989,621 with their peer review contractor for hospital stays that insurers had determined were not medically necessary. We found the peer review contractor has made no actual recoveries of Medicaid overpayment based on their efforts. In addition, final determination by the peer review contractor on some of the claims was not made until nearly one year after they were referred.

Summary of Status of Prior Report Recommendations

The Department of Health has partially implemented the three recommendations contained in our prior report.

Follow-up Observations

Recommendation 1

Recover the Medicaid overpayments totaling $21,834,206.

Recommendation 2

Follow up on the 159 claims we identified as potential errors, and as appropriate, recover the overpayments of $3,607,087 respectively.

Status - Partially Implemented (Recommendations 1 and 2)

Agency Action - Health has recovered $3,389,077 from providers. For payments totaling $5,062,595, Health determined that the payments in question were appropriate. Health has not recovered the remaining overpayments totaling $16,989,621. As mentioned previously in this report, we conduct ongoing reviews of Medicaid payments and, based on our review, we report the details to Health officials semiannually so that they can recover overpayments from providers in a timely fashion. On May 23, 1998, we reported to Health on $11,998,039 of overpayments to inpatient hospitals and recommended recovery. Given that it has been more than one year since we issued the preliminary report, we believe Health officials should have initiated recovery efforts. Officials informed us they have limited staffing resources dedicated to Medicaid collection efforts and this is preventing timely recoveries. However, considering the materiality of overpayments, we believe provider recovery should take place more timely.

.

Auditors' Comments - Health needs to take steps to recover outstanding overpayments totaling $16,989,621 and initiate future recovery efforts in a more timely fashion.

Recommendation 3

Work with Health and Health's peer review agent to resolve the appropriateness of the 131 claims billed as inpatient care services.

Status - Partially Implemented

Agency Action - Health's peer review contractor, Island Peer Review Organization (IPRO), determined that for 28 claims totaling $889,998, acute care was not warranted and providers were notified of the decision. It is expected that Medicaid recovery will be made for the full amount of the $889,998 providing the providers do not appeal IPRO's determination. Additionally, IPRO determined that for seven claims totaling $118,312, the hospital had initiated adjustments resulting in Medicaid recovery. For 30 claims totaling $659,014 IPRO determined that acute care was required for the period in question and it appears the original insurer should have paid for the claims. However, Health has not requested the inpatient hospitals to appeal the insurer's previous denial. In the event the insurers reverse their decision, Medicaid could recover these payments ($659,014). In addition, IPRO determined that 16 claims totaling $415,392 were not within IPRO's jurisdiction because they are Article 31 hospitals licensed by the State Office of Mental Health. As such, Health has no jurisdiction over these facilities. For another five claims totaling $106,672, IPRO had previously reviewed the claims and determined that Medicaid recovery was appropriate. Although these claims represented overpayments, IPRO had not submitted the necessary adjustment claims to effect recovery. For the remaining 45 claims totaling $1,017,862, IPRO was awaiting additional information or clarification from either the hospitals or Health.

As mentioned previously, we sent the claims in question to Health for referral to IPRO as part of our semiannually preliminary report on May 28, 1998. However, we note that IPRO's determination of medical necessity and resulting provider denials were not sent to Health until nearly one year from the date the claims were sent for referral. Given the materiality of potential overpayments, we believe IPRO should review the claims more timely.

Auditors' Comments - With respect to the 28 claims denied by IPRO, Health needs to ensure that Medicaid recovery is made. For the 30 claims totaling $659,014 where IPRO determined that acute care was required, IPRO needs to turn these over to Health's Office of Medicaid Management - Division of Provider Relations for referral to inpatient hospitals so the hospitals can appeal the insurance companies' decision of payment denial. For the 16 claims totaling $415,392 of Article 31 facilities not within its jurisdiction, Health should refer such claims to the New York State Office of Mental Health for their review. With respect to the five claims previously reviewed by IPRO, but not adjusted on MMIS, Health needs to obtain documentation from IPRO whether such adjustments resulted in Medicaid recovery. For the remaining 45 claims totaling $1,017,862, Health needs to assist IPRO with the additional information it needs to determine whether the hospital stays were medically necessary. In summary, Health needs to more closely monitor IPRO's review and the recovery of related Medicaid payments.

Major contributors to this report were Lee Eggleston, Doug Hunter, Doug Coulombe and Carol O'Connor.

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

Very truly yours,

Kevin M. McClune
Audit Director

cc: Mr. Charles Conaway