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
Empire State Plaza
Albany, NY 12237

Re: Report 99-F-6

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 taken by the Department of Health as of June 8, 1999, to implement the recommendations included in our prior report titled *MMIS Claims Processing Activity* (Report 96-D-8). Our prior report, which was issued on August 20, 1997, conveyed the results of our review of Medicaid payments for the State fiscal year ended March 31, 1997.

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.

At the beginning of our prior review period, the Department of Social Services administered New York's Medicaid program, and used the MMIS to process Medicaid claims and make payments to health care providers for services rendered to recipients. After October 1, 1996, the Department of Health became responsible for administering the Medicaid program and MMIS.

Summary Conclusion

In our prior report, we found that the Medicaid program overpaid providers $16.6 million. We also found an additional $1.6 million that may have been overpaid. We recommended that the Departments of Social Services and Health pursue actual and potential overpayments totaling $18.2 million. We also determined that two Health and Hospitals Corporation (HHC) facilities were billing Medicare and Medicaid at the same time and remitting their Medicare Part B revenues quarterly to the State. In addition, we determined that Health was not initiating recovery of the Medicaid overpayments in a timely fashion.

In our follow-up review, we found that Department of Health officials had recovered $9,584,876 in previously identified overpayments, had concluded that $5,516,260 in potential provider overpayments were appropriate, and were pursuing recovery of $3,147,334 from providers. Of the $3,147,334 Health was still pursuing, $1,267,067 was for claims referred to Health's peer review contractor for hospital stays that insurers had determined were not medically necessary. We found that the peer review contractor has made no actual recoveries of Medicaid overpayments based on their review. In addition, final determination on some of the claims were not made until nearly two years after they were referred. Regarding the two HHC facilities which were billing Medicare and Medicaid simultaneously and remitting their Medicare revenues quarterly, we found that this billing situation has remained unchanged. Further, we found that Health officials have not taken sufficient actions to recover Medicaid overpayments previously reported.

Summary of Status of Prior Report Recommendations

Of the five recommendations contained in our prior report, the Department of Health has partially implemented three recommendations and not implemented two recommendations.

Follow-up Observations

Recommendation 1

Recover the Medicaid overpayments totaling $16,615,542.

Recommendation 2

Follow up on the 74 claims we identified as potential errors, and as appropriate, recover the overpayments of $1,632,928.

Status - Partially Implemented (Recommendations 1 and 2)

Agency Action - The Department of Health has recovered $9,584,876 from providers. For payments totaling $5,516,260, Health officials determined that the payments in question were appropriate. For payments totaling $3,147,334, Health officials are still pursuing recovery.

Auditors' Comments - The Department of Health needs to take appropriate steps to recover from providers remaining outstanding overpayments totaling $3,147,334.

Recommendation 3

Refer the 53 claims totaling $1,267,067 to the Medicaid peer review contractor to resolve the appropriateness of these claims billed to Medicaid as inpatient care services.

Status - Partially Implemented

Agency Action - Health's peer review contractor, Island Peer Review Organization (IPRO), has determined that for 13 claims totaling $302,211, 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 $302,211, providing that providers do not appeal IPRO's determination. For 13 claims totaling $440,113, IPRO determined that acute care was required for the period in question and it appears the original insurer should have paid the claims. However, Health has not requested the inpatient hospitals to appeal the insurers' previous denial decision. In the event the insurers reverse their decision, Medicaid could recover these payments ($440,113). In addition, IPRO determined that 11 claims totaling $199,817 were not within IPRO's jurisdiction because they involved Article 31 hospitals licensed by the State Office of Mental Health. As such, Health has no jurisdiction over these facilities. For three claims totaling $110,404, no information was provided by IPRO. While these claims were provided to Health by OSC for IPRO review, Health could not provide us with the IPRO disposition of these claims. For another three claims totaling $33,391, IPRO had previously reviewed the claims and determined that Medicaid recovery was appropriate. Although, these claims represented overpayments, IPRO has not submitted the necessary adjustment claims to effect recovery. For the remaining 10 claims totaling $181,131, IPRO was awaiting additional information or clarification from either the hospitals or Health.

Auditors' Comments - With respect to the 13 Medicaid claims totaling $302,211 that were denied by IPRO, Health needs to ensure that Medicaid recovery is made. For the 13 claims totaling $440,113 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 11 claims totaling $199,817 of Article 31 facilities not within Health's jurisdiction, Health should refer such claims to the New York State Office of Mental Health for review. For three claims totaling $110,404 for which neither Health nor IPRO could provide us with the results of their review, we again referred the claims to Health for review and Health needs to determine IPRO's action on these claims. Regarding another three claims totaling $33,391 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 10 remaining claims totaling $181,131, Health needs to assist IPRO with the additional information it needs to determine whether the hospital stays were medically necessary. Although we submitted detailed information to Health prior to issuance of Report 96-D-8 on August 20, 1997, we note that for 35 claims, IPRO did not notify providers of its decision until April 14, 1999, or nearly two years since the issuance of our report. Health needs to more closely monitor IPRO's review and the recovery of related Medicaid payments.

Recommendation 4

Require the two HHC facilities to bill third-party resources first and reflect such revenues on the Medicaid claim.

Status - Not Implemented

Agency Action - We determined that the two HHC facilities are still billing Medicare and Medicaid simultaneously and remitting their Medicare Part B revenues quarterly to the Department of Health, rather than recording such revenues as an offset on their Medicaid claims.

Recommendation 5

Initiate recovery of Medicaid overpayments at least twice a year.

Status - Not Implemented

Agency Action - Health officials have not taken steps to initiate recovery of overpayments to providers at least twice annually.

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