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October 21, 2003

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

Re: Report 2003-F-30

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 actions taken by the Department of Health (Department) as of October 10, 2003, to implement the recommendations contained in our report, *MMIS Claims Processing Activity* (Report 2000-D-1). Our report, which was issued on May 30, 2001, reviewed the accuracy of claims processed by the Medicaid Management Information System for the twelve months ended March 31, 2001.

Background

The Department administers the State's Medical Assistance program (Medicaid), which was established to provide medical assistance for needy people. The Department'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 $38.3 million. Of this amount, OSC staff recovered about $15.6 million from providers and recommended that the Department investigate and recover the remaining $22.7 million of potential overpayments.

In our follow-up review, we found that Department officials had recovered $4.6 million in previously identified overpayments, had concluded that $1.9 million in potential provider overpayments were appropriate and were pursuing recovery of $14.7 million from providers. Providers also adjusted claims valued at $1.2 million resulting in the recovery of the overpayment. For an additional $317,391 relating to inpatient hospital stays requiring medical necessity review by other state agencies, we found that the Department had referred the claims to the agencies for review. We also found Department officials instructed local social services districts (local districts) to review the third party insurance coverage information for some recipients with insurance coverage and to update the Welfare Management System third-party insurance files as necessary.

Summary of Status of Prior Audit Recommendations

Of the four prior report recommendations, Department officials have implemented one recommendation and partially implemented three recommendations.

Follow-up Observations

Recommendation 1

Recover Medicaid overpayments totaling $21,560,080 relating to 1,581 inpatient hospital claims.

Status – Partially Implemented

Agency Action – Based on reports provided by the Department, we determined Department officials had sent the claims to a collections contractor for follow-up with providers. The contractor recovered $4.3 million of overpaid claims from providers and was actively pursuing the recovery of an additional $14.6 million from providers at the time of our follow-up review. Based on their review of provider submitted documents, the contractor determined that claims totaling $1.4 million were appropriate. For the remaining $1.2 million, the Department determined the providers had submitted the necessary adjustment claims resulting in recovery of the overpayments.

Recommendation 2

In conjunction with the Department's peer review agent, assess the appropriateness of the 58 inpatient hospital claims totaling $954,169 relating to medical necessity and, as appropriate, recover any overpayments.

Status – Partially Implemented

Agency Action – Based on reports provided by the Department, the Department's peer review agent reviewed the inpatient hospital claims and found:

Recovered Overpayments	$188,598
Medically Necessary Services	418,061
Claims referred to OMH or OASAS	317,392
Not Medically Necessary Services	30,118

As shown above, based on the peer review agent's analysis, overpayments totaling $188,598 were recovered. Department officials will not pursue recovery of $418,061 in claims that the peer review agent determined were medically necessary. The Department referred claims totaling $317,392 to either the Office of Mental Health or the Office of Alcoholism and Substance Abuse Services for review. The Department still needs to pursue recovery of claims totaling $30,118, based on the peer review agent's determination that the services were not medically necessary.

Recommendation 3

Recover Medicaid overpayments totaling $183,286 relating to 169 skilled nursing facility claims.

Status – Implemented

Agency Action – Based on reports provided by the Department, the Department, through its collections contractor recovered $148,562 and, for an additional $34,724 in claims, the contractor determined the Medicaid payments were appropriate.

Recommendation 4

In conjunction with the local districts, evaluate whether the 729 recipients have active third-party insurance and update the WMS third-party insurance files to reflect active insurance status.

Status – Partially Implemented

Agency Action – Department officials provided local district officials with a listing of recipients, within their county, whose third-party insurance coverage was potentially not updated to the WMS third-party insurance files. Department officials requested that the local districts determine if any of the recipients had third-party insurance coverage. However, Department officials could not provide us with details concerning what actions, if any, the local districts had taken to update the information to the third-party insurance files.

Major contributors to this report were Ken Shulman, Bill Clynes, Doug Coulombe and Leo Shaw.

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

Very truly yours,

Kevin M. McClune
Audit Director

cc: Deirdre A. Taylor