ALAN G. HEVESI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

April 29, 2005

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 2004-F-38

Dear Dr. Novello:

According 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 followed up on the actions taken by officials of the Department of Health (Department) to implement the recommendations contained in our audit report, *MMIS Claims Processing Activity* (Report 2002-D-3).

Background, Scope and Objective

The Department administers the State's Medical Assistance program (Medicaid), which was established in accordance with Title XIX of the federal Social Security Act to provide medical assistance to 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 has on-site staff conducting continuous audits of MMIS. Each week, on-site staff members execute a series of computer programs to extract claims data from the adjudicated claims payment file. The computer programs were designed to extract those claims most likely to have been overpaid. Staff members analyze the reports generated by these programs and select claims for in-depth review.

Our initial audit report, issued on August 19, 2003, examined the accuracy of claims processed by the MMIS. Specifically, we identified about $60 million in actual or potential savings to the Medicaid program. Of this amount, about $39.6 million was returned to the Medicaid program and we recommended that Department staff investigate and recover the remaining $20.4 million in overpayments. The objective of our follow-up, which we did

according to Generally Accepted Government Auditing Standards, was to assess the extent of implementation as of January 10, 2005 of the five recommendations included in our initial report.

Summary Conclusions and Status of Audit Recommendations

We found that Department officials have made progress in recovering the overpayments we identified. However, additional improvements are needed. Of the five audit recommendations, two recommendations have been implemented and three recommendations have been partially implemented.

Follow-up Observations

Recommendation 1

Recover Medicaid overpayments of $16.9 million relating to 1,135 inpatient hospital claims.

Status - Partially Implemented

Agency Action - Department officials sent the claims to its collections contractor, Public Consulting Group (PCG), for follow-up with providers. PCG recovered $6.1 million of overpaid claims from providers and determined an additional $44,281 in claims were addressed in prior audits. Based on their review of provider submitted documents, PCG determined claims totaling $6.9 million were appropriate. PCG identified the remaining $3.9 million in claims as invalid claims that should be recouped. However, responsible Department officials did not pursue recovery of these claims. Officials stated to us that these claims required a more intensive review and they decided not to use their resources to pursue recovery of these specific claims.

Recommendation 2

In conjunction with the Department's quality improvement organization, assess the appropriateness of the 90 inpatient hospital claims totaling $2.6 million pertaining to medical necessity and, as appropriate, recover any overpayments.

Status - Implemented

Agency Action - Based on reports provided to us by the Department, the Department's quality improvement organization, the Island Peer Review Organization (IPRO), reviewed 71 of the inpatient hospital claims to determine the medical necessity of the services provided. Based on IPRO's analysis, overpayments for seven claims totaling $202,459 were recovered. IPRO officials determined the remaining 64 claims they reviewed, totaling $2.0 million, were medically necessary. The remaining 19 claims, totaling $363,439 were for services provided to individuals under the jurisdiction of the Office of Mental Health. OMH officials reviewed these claims and found these claims to be medically necessary.

Recommendation 3

Recover Medicaid overpayments totaling $105,327 relating to skilled nursing facility claims.

Status - Partially Implemented

Agency Action - Based on reports provided by PCG, the Department along with PCG reviewed the skilled nursing facility claims. This analysis found that claims totaling $7,412 were claims that were addressed in prior audits. PCG determined claims totaling $8,083 were appropriate and as such Department officials will not pursue recovery. For the remaining $89,832 in claims, PCG identified these as invalid claims that should be recouped. Department officials stated to us that PCG will attempt to recover the $89,832 in a payment integrity project that was being developed at the time of our follow-up.

Recommendation 4

Initiate recovery action against the seven providers with outstanding accounts receivable balances totaling $817,663.

Status - Implemented

Agency Action - Based on reports provided by the Department, the Department recovered the outstanding accounts receivable balances totaling $557,205 for five of the seven providers. The outstanding accounts receivable balances totaling $260,458 for the remaining two providers were referred to the Attorney General's Office for recovery.

Recommendation 5

In conjunction with the local districts, evaluate whether the 326 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 requested local district officials determine if any of the recipients had third-party insurance and update the appropriate MMIS reference files accordingly. Department officials provided documentation which shows local districts researched the 326 recipients' third-party coverage with the following results:

- 22 recipients were found to have active third-party insurance and the WMS third-party insurance files have been updated accordingly,
- 52 recipients were found not to have third-party insurance, and
- the third-party insurance status had not yet been determined for 252 recipients.

Major contributors to this report were Ken Shulman, Ed Durocher and Holly Winters.

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

Yours truly,

David R. Hancox
Audit Director

cc: Robert Barnes, DOB