Alan G. Hevesi
COMPTROLLER

OFFICE OF THE
NEW YORK STATE COMPTROLLER
DIVISION OF STATE SERVICES

DEPARTMENT OF HEALTH

MEDICAID CLAIMS PROCESSING ACTIVITY

Report 2004-S-29

AUDIT OBJECTIVES

Our audit objectives were to determine whether Medicaid providers had reported third party insurance payments appropriately, whether the Department of Health (Department) had accurately updated the Medicaid system to reflect provider rate revisions, and whether the Department had properly monitored the accounts receivable balances of Medicaid providers.

AUDIT RESULTS – SUMMARY

For the year ended March 31, 2005, we identified overpayments totaling more than $34 million, of which $19.1 million was actually returned to the Department. The Department should investigate the remaining overpayments we identified, valued at $15.2 million, and make recovery where appropriate.

Our report contains four recommendations to improve controls over verifying the accuracy of provider reported third party insurance and to investigate and recover claim overpayments. Officials generally agreed with our recommendations and have taken steps to implement changes.

This report, dated October 31, 2005, is available on our website at: http://www.osc.state.ny.us. Add or update your mailing list address by contacting us at: (518) 474-3271 or
Office of the State Comptroller
Division of State Services
State Audit Bureau
110 State Street, 11th Floor
Albany, NY 12236

BACKGROUND

The Department administers the State's Medical Assistance program (Medicaid), which was established under Title XIX of the Federal Social Security Act to provide medical assistance to needy people. In New York, the Federal, State, and local governments jointly fund the Medicaid program. During the year that ended on March 31, 2005, the Department processed 232 million Medicaid claims valued at $38.6 billion.

AUDIT FINDINGS AND RECOMMENDATIONS

Inpatient Hospital Claims Review

According to Federal law and State regulations, if a Medicaid recipient has health insurance from a third-party insurer (e.g., private insurance company) the Medicaid provider must bill the third-party insurer before billing Medicaid. The provider then indicates on the Medicaid claim the amount of the payment received from the third-party insurer. The Medicaid system uses this indicated amount to reduce the Medicaid payment. We identified $18.4 million in overpayments that providers had actually returned to the Department as a result of our audit, as well as more than $14.9 million in overpayments that the Department should investigate and recover where appropriate. These claims were overpaid because the Medicaid system did not verify the accuracy of the third-party insurance payment indicated by the Medicaid provider. There is currently no control within the Medicaid system to verify the accuracy of the third-party insurance payment indicated by the Medicaid provider.

In response to our draft report, Department officials stated verifying the accuracy of provider reported third party insurance payments can only be done as a post payment review activity. The Department has a process in place to review and recover Medicaid overpayments when third party insurance should have paid the claim.

Recommendations

1. The Department should instruct providers of the requirement to bill and report third-party resources prior to billing Medicaid.

2. Investigate and recover the remaining $14.9 million in inpatient claim overpayments.

Nursing Home Claims Review

When a Medicaid recipient, who is also qualified to receive Medicare benefits is an inpatient of a skilled nursing facility, Medicaid reimbursement policy requires Medicaid to pay the recipient's Medicare coinsurance. We found Medicaid had overpaid 321 nursing home claims totaling $373,154 because the nursing homes billed Medicaid using the daily Medicaid rate, not the lower Medicare coinsurance rate. We provided the nursing homes with detailed information concerning these claims, and asked them to correct their Medicaid billings by submitting adjustment claims. As a result of our audit, overpayments totaling $248,947 were returned to the Department. The Department still needs to recover the remaining claims valued at $124,207.

Recommendation

3. Investigate and recover the $124,207 Medicaid overpayments relating to nursing home claims.

Medicaid Rate Revisions

Payments to certain Medicaid providers are based on daily or hourly rates approved by the Department. When the Department revises Medicaid rates, the Medicaid claims-processing system automatically re-prices the provider's previously paid claims that were affected by the rate change and generates a payment adjustment based on the revised rate. It is critical that the rates calculated by the Department be updated accurately to the Medicaid rate master file.

We identified three inappropriately updated provider rates that generated overpayments totaling $455,394. As a result of our audit, the Department corrected these rates and recovered the overpayments.

Provider Accounts Receivable

Some Medicaid providers owe money to the Medicaid program, either because previously submitted claims had been adjusted retroactively to a lower payment rate or because previous claims had been paid incorrectly. In these cases, such adjustments result in the establishment of accounts receivable balances for the provider. These balances are normally collected from a provider's future Medicaid billings.

We identified seven providers with accounts receivable balances totaling $137,111, which the Department had not collected because the providers were not actively billing for Medicaid services. We referred these balances, some of which had been outstanding since September 2003, to the Department for recovery action. In all cases, the Department has agreed to accelerate the recoveries by transferring the owed balances to affiliated providers.

Recommendation

4. Accelerate recoveries by referring overdue accounts receivable totaling $137,111 to affiliated providers.

AUDIT SCOPE AND METHODOLOGY

We did our audit according to generally accepted government auditing standards. We audited the accuracy of selected Medicaid claims processed by the Department for the year that ended on March 31, 2005. To accomplish our audit objectives, we extracted claims from the Medicaid payment file and compared that data with documentation we received from Medicaid providers. We also interviewed Department officials, reviewed applicable sections of Federal and State laws and regulations, and examined relevant Department payment policies and procedures.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions, and public authorities, some of whom have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under generally accepted government auditing standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

AUTHORITY

The audit was performed according to the State Comptroller's authority under Article V, Section 1, of the State Constitution; and Article II, Section 8, of the State Finance Law.

REPORTING REQUIREMENTS

We provided a draft copy of the matters contained in this report to Department officials for their review and comment. Certain matters and a recommendation presented in the draft report were changed based on the Department's response. Department officials generally agreed with our recommendations and indicated actions planned or taken to implement them. Complete copies of the Department's responses are included as Appendices A and B. Appendix C contains State Comptroller's notes which address the changes to the final report based on the Department's response.

Within 90 days after final release of this report, as required by Section 170 of the Executive Law, the Commissioner of the Department of Health shall report to the Governor, the State Comptroller, and the leaders of the Legislature and fiscal committees, advising of the steps that were taken to implement the recommendations it contained, and/or the reasons certain recommendations were not implemented.

CONTRIBUTORS TO THE REPORT

Major contributors to this report include Sheila Emminger, Warren Fitzgerald, Earl Vincent, Larry Julien, Carrie Zusy, Leo Shaw, Nancy Cecot, Wendy Matson, Heather Pratt and Marticia Madory.

APPENDIX A – AUDITEE RESPONSE

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

September 9, 2005

David R. Hancox
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. Hancox:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report (2004-S-29) entitled "MMIS Claims Processing Activity."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Mr. Griffin
Mr. Howe
Ms. Kuhmerker
Mr. Meister
Mr. Reed
Mr. Seward
Mr. Van Slyke
Mr. Wing

Department of Health
Comments on the
Office of State Comptroller's
Draft Audit Report 2004-S-29 Entitled
"MMIS Claims Processing Activity"

The following are the Department of Health's (DOH) comments in response to the Office of State Comptroller's (OSC) Draft Audit Report (2004-S-29) entitled "MMIS Claims Processing Activity."

Recommendation #1:

Develop a control that can verify the accuracy of provider reported third party insurance payments that are made prior to the Medicaid claims payment. In the interim, the Department should once again instruct providers of the requirement to bill and report third-party resources prior to billing Medicaid.

Response #1:

* Note 1

The verification of the accuracy of provider reported third party insurance payments can only be done as a post payment review activity. The Department has a process in place to review and recover third party insurance and has recovered Medicaid overpayments in this time period. Department staff has requested a meeting with OSC to discuss the specifics of the protocol used for this review. At this meeting DOH would also like to discuss the basis for the recommendation to again instruct providers of the requirement to utilize third party insurance. It is the opinion of the Office of Medicaid Management (OMM) that claims denied during eMedNY claims processing and its post-payment recovery projects provide a more pointed reminder of the need to utilize available insurance.

* Note 2

Recommendation #2:

Investigate and recover the remaining $14.9 million in inpatient claim overpayments.

Response #2:

* Note 3

The Department's initial review showed that 33% of the $9.8 million originally reported had been a duplication of claims recovered by the Department's third party contractor. After a meeting with OSC staff, DOH will determine the cost benefit of pursuing the remaining potential overpayments identified by the audit and recover overpayments where appropriate.

* See State Comptroller's Notes, page 10

Recommendation #3:

Investigate and recover the $124,207 Medicaid overpayments relating to nursing home claims.

Response #3:

The Department has been working with the third party contractor in developing and testing a payment integrity project that will include inpatient claims of recipients in a skilled nursing facility for the period reported by OSC. Within the next two weeks, the contractor will send a mail-out to selected providers with information to correct payments.

Recommendation #4:

Accelerate recoveries by referring overdue accounts receivable totaling $137,111 to affiliated providers.

Response #4:

All debts from the seven providers in question were reassigned to affiliated providers for collection.

APPENDIX B – AUDITEE RESPONSE

STATE OF NEW YORK
DEPARTMENT OF HEALTH

RIVERVIEW CENTER 150 BROADWAY, 4TH FLOOR ALBANY, NEW YORK 12204-2719

Antonia C. Novello, M.D., M.P.H., Dr. P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

September 23, 2005

Warren Fitzgerald
Office of the State Comptroller
110 State Street
Albany N.Y. 12236

Re: 2004-S-29

Dear Mr. Fitzgerald:

This is to confirm our discussion and clarify OMM's response to Recommendation #2.

OMM's current third party post payment recovery efforts include activities similar to those of this audit. Subsequent to the controllers' identification, we also identified approximately 33% of the same claims in our inpatient reviews.

For the remaining amount, we are in the process of developing an inpatient payment integrity review that will include audit criteria similar to that used by OSC staff for this review. At our request, OSC staff has shared their claims selection criteria.

Sincerely,

Joseph J. Flora, Deputy Director
Bureau of revenue Initiatives &
Fraud Detection System
Office of Medicaid Management

APPENDIX C – STATE COMPTROLLER'S NOTES

1. Certain matters and the recommendation presented in the draft report were changed based on the Department's response.

2. We encourage the Department to supplement its results and work pro-actively to remind providers Medicaid is the payer of last resort. For example, the Department's monthly publication, *Medicaid Update,* could include a reminder of the requirements to bill and report third party resources before billing Medicaid.

3. The Department subsequently clarified its response to the recommendation - see Appendix B. As explained in Appendix B, the Department's audit criteria can identify 33 percent of the claims OSC identified. The Department is working to enhance its audit criteria to include more OSC identified issues.