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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

January 7, 1998

Mr. Brian Wing
Commissioner
Office of Temporary and Disability Assistance
40 North Pearl Street
Albany, NY 12243

Barbara A. DeBuono, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower
Empire State Plaza
Albany, NY 12237

Re: Report 97-F-33

Dear Mr. Wing and Dr. DeBuono:

Pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law, we reviewed the actions that had been taken by the Department of Social Services and the Department of Health as of July 22, 1997, to implement the recommendations included in our prior audit report 95-D-7. Our prior audit report, issued July 26, 1996, conveyed the results of our review of Medicaid payments for the 12-month period ended March 31, 1996.

Background

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 overpaid. The auditors analyze the reports generated by these programs and select claims for in-depth review.

During the period of our prior audit, the Department of Social Services 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. After

October 1, 1996, the Department of Health became responsible for administering the Medicaid program and MMIS. The Department of Social Services has been reorganized into Department of Family Assistance which includes the Office of Temporary and Disability Assistance and the Office of Children and Family Services.

Summary Conclusion

In our prior audit, we found that the Medicaid program overpaid providers up to $11,251,687. Of this amount, $2,252,919 had already been recovered from providers prior to issuance of the audit report. In summary, we recommended that the Departments of Social Services and Health pursue actual and potential overpayments totaling $8,998,768.

In our follow-up review, we found that Department of Social Services officials had effected the recovery of $3,558,302, had concluded that $2,893,983 of payments to providers were appropriate, were pursuing the recovery of $456,507 from providers, and had not initiated provider recovery on $1,034,085 of previously overpaid mental health claims. We also found that providers had effected the recovery of $200,995 by initiating recommended claims adjustments. With respect to payments valued at $854,896 for hospital stays that insurers had determined were not medically necessary, we found that the Department of Health's peer review contractor had made only limited progress in the recommended review of the related claims. Our follow-up review also noted that the Medicaid fiscal agent effected recovery from providers for about $25,000 of overpayments attributed to data entry errors.

Summary of Status of Prior Audit Recommendations

Overall, the Department of Social Services and the Department of Health have partially implemented all three of the prior audit recommendations.

Follow-up Observations

Recommendation 1

Recover the Medicaid overpayments totaling $6,099,934.

Recommendation 2

Follow up on the 1,557 claims valued at $2,924,761 which we identified as potentially overpaid.

Status - Partially Implemented

Agency Action - The Department of Social Services has effected the recovery of $3,558,302 from providers. For additional payments totaling $456,507, Department of Social Services officials informed us they were still pursuing provider recovery. For payments of $200,995, we noted that providers initiated the necessary Medicaid adjustment claims effectively resulting in the recoupment of overpayments. We previously reported that mental health services claims valued at $1,034,085 were overpaid by Medicaid for recipients with dual Medicaid and Medicare coverage. In these instances, Medicaid was responsible for paying the coinsurance amounts for which the recipient would have normally been liable to pay. We found that the Department of Social Services has not initiated recovery action on the related claims. For payments totaling $2,893,983, we found that, based on their review of provider documentation, the Department of Social Services determined the Medicaid payments in question were appropriate.

Auditors' Comments - The Department of Health needs to effect necessary recovery for outstanding overpayments totaling $1,490,592.

Recommendation 3

Work with Health and Health's peer review contractor to resolve the appropriateness of the 68 claims billed as inpatient care services.

Status - Partially Implemented

Agency Action - For 68 claims, we initially reported that Medicaid paid $854,896 for inpatient stays that insurers had denied because the insurers determined the stays were not medically necessary. The Department of Health's peer review contractor has determined that for three claims totaling $68,108, the inpatient hospital stays were in fact medically necessary. However, we found that for these claims, neither the Department of Health nor the Department of Social Services have requested the inpatient hospitals to appeal the insurer's previous denial decision. In the event the insurers reverse their decision, Medicaid should recover the payments valued at $68,108. For the remaining 65 claims, which pertain to psychiatric inpatient care, the Department of Health has determined that 48 claims totaling $494,971 related to Article 31 psychiatric hospitals. According to Department of Health officials, they are precluded from reviewing these facilities due to the lack of utilization review criteria. However, officials informed us they are working with the State Office of Mental Health to develop criteria that will enable them to conduct utilization reviews of Article 31 psychiatric facilities. For the remaining 17 claims totaling $291,817, the Medicaid peer review contractor has not reviewed the medical necessity of these claims. Department of Health officials informed us that they have requested the contractor to review the 17 claims.

Auditors' Comments - With respect to the claims valued at $68,108, the Department of Health needs to notify the providers to appeal the insurer's decision. For the 48 claims relating to psychiatric inpatient care, the Department of Health needs to continue working with the Office of Mental Health in the development of utilization review criteria of Article 31 facilities. The Department of Health needs to require its peer review contractor to timely review the remaining 17 claims.

Major contributors to this report were Douglas Coulombe and Susan DiFiore.

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 for the courtesies and cooperation extended to our auditors during this review.

Very truly yours,

Jerry Barber
Audit Director

cc: Patricia Woodworth