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May 30, 2001

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

Re: MMIS Claims Processing Activity
Report 2000-D-1

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 the accuracy of claims processed by the Medicaid Management Information System for the twelve months ended March 31, 2001.

A. Background

The Department of Health (Department or Health) 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. Health'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. During the twelve months ended March 31, 2001, the MMIS processed 181.8 million claims, including 76 million claims relating to retroactive adjustments. MMIS paid $26.7 billion to settle all the claims.

The Office of the State Comptroller (OSC) has on-site audit staff conducting continuous audits of MMIS. Each week, the auditors execute a series of computer programs to extract claims data from the newly adjudicated claims payment file. The 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.

This audit report is a summary of our examination of Medicaid payments for the 12-month period ended March 31, 2001. We reported details concerning exceptions and related causes to Health officials during the period of our review, so that recovery of overpayments could be initiated promptly.

B. Results of MMIS Claims Review

Based on available claims payment information, we determined that MMIS overpaid providers $36.9 million. In addition, we found another approximately $954,000 that may have been overpaid.

1. Actual Inpatient Hospital Overpayments

We determined that inpatient provider errors caused MMIS to overpay 3,340 claims valued at $36,851,373. Of this amount, $15,291,293 pertains to 1,759 claims that had already been recovered from providers prior to the completion of our field work on April 9, 2001. For the remaining $21,560,080, which pertains to 1,581 claims, the Department needs to make recoveries from providers. In accordance with regulations, providers are expected to take reasonable action to maximize third-party insurance resources and record such revenues on the Medicaid claim. In many of the overpaid claims, such revenues had not been obtained or the information on the claims was improperly recorded. The following paragraphs describe the error conditions we identified during our review and the amounts that need to be recovered.

?? MMIS overpaid 3,125 claims totaling $34,728,823 because other insurers had already paid the claim, or providers had not taken or could not demonstrate reasonable actions to first bill other insurers as required by Department regulations. In some instances, we found that providers did not comply with insurers' requirements for prior notification and billing within their time-limit rules.

?? MMIS overpaid 215 claims by $2,122,550 due to other miscellaneous provider billing errors. For example, MMIS pays a higher reimbursement rate for newborns with low birth weights. We noted that providers incorrectly entered the birth weight of newborns on the Medicaid claim forms, resulting in overpayments.

2. Actual Skilled Nursing Facility Overpayments

Regarding payments to skilled nursing facilities (SNF), we noted that MMIS overpaid 469 claims totaling $489,460. Of this amount, $306,174 pertains to 300 claims that had already been recovered from the SNF providers prior to the completion of our field work. For the remaining 169 claims totaling $183,286, the Department needs to make recoveries from the providers. In these SNF claims, the providers billed MMIS using their Medicaid per-diem rates; the claims should have been billed using the Medicare coinsurance rates, which are generally lower than Medicaid per-diem rates. We provided detailed information concerning these claims to the SNFs and requested that they submit adjustment claims to effect Medicaid recovery. In addition, we provided the Department with details of our findings for their follow-up with the providers.

3. Potential Overpayments to Inpatient Hospitals

We identified 58 claims totaling $954,169 that MMIS potentially overpaid. In these cases, we noted that insurers had determined that the recipients' inpatient hospital stay was not medically necessary. Therefore, we question the appropriateness of these MMIS payments. We referred the claims in question to the Department for review by the Department's peer review contractor.

C. Medicaid Rate Revisions

Health sets Medicaid rates for personal care services, which are the basis for payments to personal care providers. When Health revises Medicaid rates, the MMIS automatically re-prices the previously paid claims affected by the rate change and generates a payment based on the rate revision. It is critical that the rates calculated by Health are accurately recorded on the MMIS rate master file.

In this regard, in cooperation with Health staff, we prevented the overpayment of $734,096 to a personal care provider. We found that Health updated the provider's quarter hour rate at $14.02. However, we confirmed with Health's rate setters that the quarter-hour rate should have been $3.50. We also confirmed that the provider's rate was subsequently corrected.

D. Provider-Owed Balances

As part of routine MMIS claims processing, it is sometimes determined that providers owe money to Medicaid, either because previous claims were retroactively adjusted to a lower payment rate or because previous claims were incorrectly paid. In these cases, such adjustments result in provider-owed balances, which are normally collected from a provider's future billings. However, these balances may remain uncollected for a long period of time if the provider stops billing MMIS. Working in conjunction with Health's Division of Administration, we were able to effect the recoupment of $548,337 of provider-owed balances to the Medicaid program.

E. Third Party Insurance Updating

The Federal Social Security Act requires that Medicaid be the payor of last resort. The MMIS meets this requirement using the third-party insurance master file. The MMIS third-party insurance master file is updated based on local districts routinely updating the Welfare Management System (WMS), which tracks statewide recipient eligibility and third-party insurance information. As part of admission intake, hospitals routinely obtain third-party insurance information from recipients and bill the insurance carriers. In some instances, it is possible that recipients have insurance coverage and such information is not shown on the WMS. We reviewed the status of recipients' third-party insurance on the WMS as of March 31, 2001 to determine if insurance information was accurate. We verified insurance information using insurer explanation of benefits statements we obtained from providers as part of our audit of Medicaid payments for the two-years ended September 30, 2000. For 729 recipients where the WMS did not show recipient insurance coverage, we noted that health coverage existed at the time of hospitalization because an insurer had paid for the hospital stay. As a result, it is possible the recipients have active coverage and the likelihood exists

that MMIS will pay claims that should be paid by insurance carriers. We provided Department officials with the recipient and insurance details for their follow-up with local districts.

Recommendations

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

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.*

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

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.*

Major contributors to the report include Lee Eggleston, Douglas Coulombe, Nichole Barrett, Nancy Cecot, Claudia Christodoulou, Julianne DeRubertis, Karla Miller, Lisa Rooney, Leo Shaw, Amritesh Singh, Earl Vincent and Corinne Bruso.

We would appreciate receiving your response to the recommendations made in this report within 30 days, indicating any action planned or taken to implement the recommendations. We also wish to express our appreciation for the courtesies and cooperation extended to our auditors during their review.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Charles Conaway