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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

May 24, 2002

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 2001-D-3

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, 2002.

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, 2002, the MMIS processed 192.8 million claims, including 55 million claims relating to retroactive rate adjustments. MMIS paid $29 billion to settle all the claims.

The Office of the State Comptroller (OSC) 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 newly adjudicated claims payment file. We designed the programs to extract the claims most likely to have been overpaid. We analyze the reports generated by these programs and select claims for in-depth review.

This report is a summary of our review of Medicaid payments for the 12-month period ended March 31, 2002. We reported details concerning exceptions and related causes to Health 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 $29.1 million. In addition, we identified another approximately $1.1 million of claims that may have been overpaid.

1. Actual Inpatient Hospital Overpayments

We determined that inpatient provider errors caused MMIS to overpay 2,922 claims valued at $28,361,000. Of this amount, $12,062,000 pertains to 1,685 claims that were already recovered from providers prior to the completion of our field work on April 12, 2002. For the remaining $16,299,000, which represents 1,237 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, we found such revenues had not been attained 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.

- We identified that MMIS overpaid 2,849 claims valued at $26,852,000. In these instances, we found that 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 other instances, we found that providers did not comply with insurers' requirements of prior notification and billing within their time-limit rules.

- MMIS overpaid 73 claims by $1,509,000 due to other miscellaneous provider billing errors. For example, MMIS pays a higher reimbursement 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 found that MMIS overpaid 501 claims totaling $726,302. Of this amount, $459,769 pertains to 369 claims that had already been recovered from the SNF providers prior to the completion of our fieldwork. For the remaining $266,533, which represents 132 claims, the Department needs to make recoveries from the providers. In these SNF claims, the providers billed MMIS using their per-diem rates when the claims should have reflected billing for Medicare coinsurance rates. Medicare coinsurance rates 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 audit for their follow-up with the providers.

3. Potential Overpayments to Inpatient Hospitals

We identified 54 claims totaling $1,142,000 that MMIS potentially overpaid. In these claims, we noted that insurers determined 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

Payments to SNFs are based on daily rates set by Health. When Health revises Medicaid rates, the MMIS automatically re-prices the provider's previously paid claims affected by the rate change and generates a payment adjustment based on the revised rate. 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 $119,690 to a SNF. We found that Health updated the provider's daily per diem rates at $368.04 and $364.36 depending on the type of service provided. However, we confirmed with Health's rate setters that the two daily rates should have been $145.00 and $143.53, respectively. We also confirmed that the provider's rate was subsequently restored to the correct rate. Health's staff corrected the rates on the rate master file and recovered the Medicaid overpayment.

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. Working in conjunction with Health's Division of Administration, we were able to recover $500,156 of provider-owed balances to the Medicaid program.

E. Third-Party Insurance Updating

The Federal Social Security Act requires that Medicaid be the payer 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' updating of 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, 2002 to determine if insurance information was updated. We compared insurance information using insurer explanation of benefits statements we obtained from providers as part of our review of Medicaid payments for year ended September 30, 2001. For 149 recipients, the WMS did not show existing recipient insurance coverage, which was evidenced by the fact that an insurer paid for a 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 third-

party insurers. We provided Department officials with the recipient and insurance details for their follow-up with local districts.

Recommendations

1. Recover Medicaid overpayments relating to 1,237 inpatient hospital claims referenced in the report.

2. In conjunction with the Department's peer review agent, assess the appropriateness of the 54 inpatient hospital claims pertaining to medical necessity and, as appropriate, recover any overpayments

3. Recover Medicaid overpayments relating to 132 skilled nursing facility claims.

4. Health in conjunction with the local districts should evaluate whether the 149 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 Ken Shulman, Bill Clynes, Douglas Coulombe, Earl Vincent, Nichole Carter, Nancy Cecot, Karla Funk, Lisa Rooney, Amritesh Singh and Blanche Vellano.

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: Deirdre A Taylor