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August 19, 2003

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 2002-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 (MMIS) for the 12 months ended March 31, 2003.

A. Background

The Department of Health (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 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 12 months ended March 31, 2003, the MMIS processed 210.8 million claims, including 86.7 million claims relating to retroactive rate adjustments. MMIS paid $33.4 billion to settle these claims.

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. 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, 2003. We reported details concerning exceptions and related causes to the Department during the period of our review, so that recovery of overpayments could be initiated promptly.

B. Results of Review

For the 12-month period ended March 31, 2003, we identified about $60 million in actual or potential savings to the Medicaid program. The $60 million comprises $32.4 million of actual or potentially overpaid claims, a $24.6 million payment rate error and $3 million of provider-owed balances. About $39.6 million of the $60 million has already been returned to the Medicaid program; the remaining $20.4 million requires further investigation and recovery by the Department.

1. Claims Review

Based on available claims payment information, we identified $32.4 million of actual and potentially overpaid claims. This amount comprises $12.8 million of claims for which recoveries have already been made and $19.6 million of claims that were potentially overpaid and must be reviewed by the Department.

Inpatient Hospital Claims

We determined that provider errors caused MMIS to overpay 2,828 inpatient claims valued at $29.5 million. Of this amount, $12.6 million pertains to 1,693 claims that were already recovered from providers prior to the completion of our review. For the remaining $16.9 million, which represents 1,135 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 incorrectly 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 2,774 claims valued at $28.5 million. In these instances, we found that other insurers had already paid the claim, or providers had not taken or could not demonstrate reasonable attempts 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 54 claims by $1.0 million due to other miscellaneous provider billing errors. For example, MMIS pays a higher reimbursement for newborns with low birth weights. We noted that providers entered the incorrect birth weight of newborns on the Medicaid claim forms, resulting in overpayments.

In addition, we identified 90 claims totaling $2.6 million 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 Medicaid payments. We

referred the claims in question to the Department for review by the Department's quality improvement organization.

Skilled Nursing Facility Claims

We found that MMIS overpaid 288 claims totaling $321,377 from skilled nursing facilities (SNF). Of this amount, $216,050 pertains to 185 claims that were recovered from the SNF providers prior to the completion of our review. For the remaining $105,327, which represents 103 claims, the Department needs to recover this amount 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 correct their Medicaid billings. In addition, we provided Department officials with details of these claims for their follow-up with the providers.

Managed Care Organization Claims

Regarding managed care billings, we noted that MMIS overpaid $34,812 (representing 404 claims) to one Managed Care Organization (MCO). For this MCO, Medicaid paid a higher paying rate code for health care services intended for recipients age zero to five months. Our analysis showed that, in the claims in question, the recipients were older than five months. We provided the detailed information concerning these claims to the MCO, and they have submitted the necessary MMIS adjustments, resulting in full payment recovery as of the close of our review.

2. Medicaid Rate Revisions

Payments to outpatient clinics are based on daily rates approved by the Department. When the Department 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 the Department are accurately recorded on the MMIS rate master file.

In this regard, in cooperation with Department staff, we prevented the overpayment of $24.6 million to an outpatient clinic. We found that the Department updated the provider's per-visit rate at $5,000, when the rate should have remained at $122.99, as we confirmed with the Department's rate setters. We also confirmed that the provider's rate was subsequently restored to the correct rate. The Department's staff corrected the rates on the rate master file and prevented the Medicaid overpayment.

3. Provider-Owed Balances

As part of routine MMIS claims processing, it is sometimes determined that providers owe money to the Medicaid program, 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 the Department's Division of Administration, we were able to

recover $2,229,141 of provider-owed balances to the Medicaid program. In addition, we identified seven providers with outstanding accounts receivable balances totaling $817,663. We have referred these seven accounts to the Department for recovery action.

4. 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 social services 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 10, 2003 to determine if insurance information was reflected. We compared the available insurance information on WMS with insurer explanation of benefits statements we obtained from providers as part of our review of Medicaid payments for the year ended March 31, 2003. For 326 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 of $16.9 million relating to 1,135 inpatient hospital claims.*

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.*

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

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

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.*

Major contributors to the report include Ken Shulman, Bill Clynes, Douglas Coulombe, Earl Vincent, Ottavio Nicotina, Nichole Carter, Carrie Zusy, Blanche Vellano and Elizabeth Wright.

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