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

Re: Controls Over Medicaid Fees and Rates
Report 2003-S-4

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 audited the Department of Health's (Department) policies and procedures for ensuring that the Medicaid Management Information System (MMIS) used only authorized and accurate fees and rates to pay Medicaid claims for the period January 1, 2001 through March 25, 2003.

A. Background

The 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 (CSC), uses the MMIS, a computerized payment and information reporting system, to process Medicaid claims and make payments to health care providers for services rendered to Medicaid recipients. In November 2002, CSC began using the eMedNY computer system to process Medicaid claims from pharmacies. For the period January 1, 2001 through March 25, 2003, Medicaid paid medical service providers approximately $68.5 billion.

Medicaid payments to health care providers are classified as "fee-based" or "rate-based." Fee-based payments, such as payments made to physicians and providers of durable medical equipment (e.g., wheelchairs), are paid according to a Department-approved fee schedule; rate-based payments, including those made to hospitals, clinics and nursing homes, are based on the provider's operating

expenses, as approved by the Department. Both the MMIS and the eMedNY computer systems store fee and rate payment information in Medicaid payment files, and refer to this information in paying providers' claims. However, this Medicaid payment file information is subject to change for a variety of reasons. For example, Medicaid fee amounts can be updated by regional pricing changes or by federally mandated changes; Medicaid rates may be updated due to changes in a provider's operating expenses. To make sure providers' claims are paid accurately, the Department must accurately update Medicaid payment file information with all approved fee and rate changes.

The Department authorizes its bureaus and other State agencies to calculate and update fee and rate information in Medicaid payment files. During this audit, we examined the functioning of four Department bureaus with responsibilities for updating this information for fees (two bureaus) and for rates (two bureaus). The Department revises fees and rates through a continuous process of confirming, documenting and processing changes by updating various computer systems. For example, when the Department approves a fee change for a provider of durable medical equipment, a Department reviewer first confirms that the change in fee is correct and approved, as noted on the Department's source documentation (i.e., a spreadsheet or file that captures each change, and the reason for the change). The change data is then transcribed onto a data entry form, which is used to create an electronic file. Department staff members use this file to update the Welfare Management System (WMS), a group of related systems that includes medical assistance eligibility and provider fee and rate information. On a weekly basis, the Department uses WMS to update Medicaid payment file information on eMedNY, and, in turn, in the MMIS.

When the Department revises Medicaid fees and rates, the MMIS automatically re-prices the provider's previously paid claims affected by the change and generates a payment adjustment based on the revised fee or rate. Thus, it is critical that the Medicaid payment file contains accurate information to avoid overpaying providers' past and future claims.

B. Audit Scope, Objectives and Methodology

We audited the Department's policies and procedures for controlling updates to Medicaid payment files from January 1, 2001 through March 25, 2003. The objective of our performance audit was to assess whether Department controls are adequate to ensure that only authorized and accurate fee and rate payment information is used to pay Medicaid claims. We did not review how fee and rate amounts are calculated.

To accomplish our audit objective, we interviewed Department and other State agency officials; reviewed applicable policies, procedures, and internal controls that pertain to Medicaid payment information; and compared Medicaid payment files to Department source records. In addition, we developed computer programs to extract the Medicaid history records for durable medical equipment (DME) fee codes and hospital and clinic rate codes from Medicaid payment files. We limited our review to include only those rate and fee codes set by the Department's bureaus. We used computer assisted audit techniques to identify the fee and rate updates that took place during our audit period and to calculate changes in fee and rate code amounts. We further limited our review to include all records with payment amount increases processed during our audit period. Thus, of the 1,527 DME fee updates recorded on Medicaid payment files during our audit period, we selected all 264 fee update records that showed fee amount increases during any part of our audit period. From a

population of 72,229 rate updates, we first excluded those rate codes (41,198 records) set by the Office of Mental Health for hospitals and clinics. From the remaining 31,031 rate updates, we ranked the percent of increase and sequentially selected a sample of 55 rate update records from the top 25 percent (7,758 records) of rate updates.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess the operations of the Department that are included in our audit scope. Further, these standards require that we understand the Department's internal control structure and compliance with those laws, rules and regulations that are relevant to the operations included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe that our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach when selecting activities to be audited. This approach focuses our audit efforts on those operations that we identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, finite audit resources are used to identify where and how improvements can be made. Thus, little effort is devoted to reviewing operations that may be relatively efficient or effective. As a result, our audit reports are prepared on an "exception basis." This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

C. Results of Audit

The Department is responsible for recording authorized and accurate fee and rate changes on Medicaid payment files to enable the MMIS and eMedNY systems to correctly pay Medicaid claims. However, our tests of selected fee and rate change transactions found that some fee changes, as listed in Medicaid payment files, were different from the fee changes indicated in the source documentation, or were not supported by source documentation at all. The discrepancies and lack of support for fee changes occurred because the Department has not assigned accountability for control of the Medicaid payment file updating processes, or developed written policies and procedures for staff to follow in processing the changes. Further, the Department does not always maintain adequate support for fee and rate changes, or reconcile changes in payment files to the related source documents. Unless the Department improves control over its process for updating fee and rate changes, there is a significant risk that MMIS and eMedNY could overpay or underpay health care provider claims because Medicaid payment file information is incorrect.

1. Controlling the Processing of Fee and Rate Changes

The Department is responsible for accurately paying Medicaid provider claims. To do this, it is imperative that the Department accurately record changes in the fee and rate payment codes contained in Medicaid payment files. For the Department to have reasonable assurance that it meets this goal, management must establish and maintain a comprehensive system of internal control over the update processes. This system should include written policies and procedures that guide staff in

performing processing tasks, and specifically assign accountability for correctly updating changes to the Medicaid payment files.

However, we found the Department does not have written policies and procedures for processing fee and rate changes. In fact, three of the four bureaus responsible to process the fee and rate code changes we examined have no written policies that explain their update process. Although one bureau does have written policies, its policies are limited to describing how to fill out the data entry form. Unless the Department provides all staff involved in processing fee and rate changes with formal policies and procedures for performing this function, Department managers have no assurance that staff understands how the update process should be done.

To make sure the Medicaid payment files are accurately updated, Department policies must also assign accountability for the results of the update process. Each of the bureaus involved in the updates we examined has responsibility for processing changes for certain types of fees or rates, from the initiation of the change (using a source document) to its accurate recording on the Medicaid payment file. However, the Department does not require each bureau to review and verify the accuracy of the entire change process, from beginning to end. In fact, some bureau managers assert that their responsibility for the accuracy of updates ends before the changes are recorded on Medicaid payment files - the critical last step in the update process. Therefore, management does not know whether fee and rate changes are processed correctly. To make sure health care providers receive accurate payments, the Department policies and procedures must assign accountability for the accuracy and integrity of updates.

In a prior audit (Report 97-S-45, issued October 14, 1998), we identified this lack of policies and procedures for change processing as a significant control weaknesses. Although Department officials indicated at that time that they would implement our recommendation to correct this weakness, they have not done so, and the problem remains unresolved. Thus, we reiterate the need for the Department to develop written policies and procedures to guide staff in doing the updates, and to assign accountability for their accuracy.

2. Documenting Changes and Verifying Their Accuracy

Fee and rate changes impact the amount of money Medicaid pays providers for delivering services. Therefore, it is essential that the Department maintain source documents to show the approved amount of the fee or rate change and the reason or authority (e.g., federal updates) for the change. Since processing updates involves multiple steps, maintaining source documentation also enables staff to verify that the fee or rate change, as listed on the source document, reconciles with the change that resulted in the Medicaid payment file. However, we found that the Department does not maintain source documentation for all the fee changes it processes. For example, when we tested a population of 264 fee update records recorded on Medicaid payment files during our audit period, we found 3 update records in which the fee amount in Medicaid payment files on MMIS, after updating, differed from the amount in the Department's source documentation. These discrepancies are shown in the following table.

Record	Source Document	MMIS	Difference
A	$13.65	$15.06	$1.41
B	$7.39	$10.29	$2.90
C	$1.69	$1.68	($.01)

When we questioned Department officials about these differences, they told us the MMIS amount was correct for records A and B. The MMIS amount was incorrect for record C. However, managers acknowledged that official source documentation was not prepared to support the new fee amounts. When the Department does not have source documents for changes to fee codes, it has no evidence that the Medicaid payment file fee amount, as changed, is accurate, and that the amount was reviewed and approved by management.

Similarly, we found that another 12 fee update records, involving deletions of certain fee codes to comply with new federal mandates, had no source documentation to explain what change was made, why it was made, or whether the change had management approval. Given the lack of controls over the Department's processing of fee and rate changes, there is a significant risk that an undocumented change could produce a Medicaid payment file fee that is higher than it should be. Such a change would result in Medicaid overpayments.

The Department should also routinely reconcile the changed fee or rate amount on the Medicaid payment file to the changed amount, as reviewed and approved by management, on the source document. Since reconciliation can both verify accuracy and identify errors, the Department could have detected the three discrepancies noted in the above table if it required regular reconciliation of the source document to the Medicaid payment file amount. However, at the time of our audit, none of the four bureaus did effective reconciliations: one bureau did no reconciliation at all; two bureaus reconciled data entry forms to internally generated data; and one bureau manually reconciled data entry forms to the WMS. Since this manual process does not compare the source document to the amount, as changed, on the Medicaid payment files, it does not provide assurance that all source documents were processed, or that source document data was entered correctly on the data entry form.

We reconciled a sample of 55 rate update records to appropriate source documentation to verify the authorization for and the accuracy of the changes made to the Medicaid payment file on the MMIS. Our test determined that all 55 rate changes were adequately supported. Notwithstanding the result of this test, we believe the control weaknesses identified in this audit, including the lack of a reliable reconciliation process, increase the potential for rate errors to occur and go undetected. For example, our prior audits have identified periodic rate updating errors, which caused significant increased Medicaid payments to providers. To minimize the risk of Medicaid overpayments, the Department needs to improve control over the update process by assigning accountability for its execution, developing processing policies and procedures, retaining adequate source documentation and reconciling source documentation to payment file changes.

Recommendations

1. *Establish policies and procedures that guide Department staff in correctly updating Medicaid payment files.*

2. *Develop and implement Department policies that assign accountability for the accurate updating of the Medicaid payment files.*

3. *Maintain complete source documentation for every fee and rate change performed.*

4. *Regularly reconcile source documentation to Medicaid payment file data to detect errors and to prevent potential Medicaid overpayment or underpayment.*

We provided draft copies of this report to Department officials for their review and comment. We considered their comments in preparing this report. Department officials generally agreed with the report's recommendations and identified actions planned to implement them. Also, Department officials disagreed that they did not maintain source documentation for all of the fee changes they process. A complete copy of the Department's response is included as Appendix A. We have included a State Comptroller's Note in Appendix A, to address the matter of disagreement contained in the Department's response.

Within 90 days after the 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 leaders of the Legislature and fiscal committees, advising what steps were taken to implement the recommendations contained herein, and where recommendations were not implemented, the reasons therefor.

Major contributors to the report include Ken Shulman, Bill Clynes, Don Paupini, Gail Gorski, Claudia Christodoulou, David Amedio and Nancy Varley. We wish to thank Department management and staff for the courtesies and cooperation extended to our auditors during the audit.

Very truly yours,

Kevin M. McClune
Audit Director

cc: Deirdre A. Taylor