ALAN G. HEVESI
COMPTROLLER

110 STATE STREET
ALBANY, NEW YORK 12236

STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

August 16, 2004

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 2003-S-60

Dear Dr. Novello:

According 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 accuracy of selected claims processed by the Medicaid Management Information System (MMIS) for the year ended March 31, 2004.

A. Background

The Department of Health (Department) administers the State's Medical Assistance program (Medicaid), established under 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 year ended March 31, 2004, MMIS paid 223.9 million claims, including 73.7 million claims relating to retroactive rate adjustments, totaling $36.4 billion.

B. Audit Scope, Objectives and Methodology

We audited the Department's MMIS claims processing activity relating to the payment of selected Medicaid claims for the year ended March 31, 2004. The objectives of our financial audit were to determine whether: 1) Medicaid payments were supported with claims paid using accurate fee and rate payment information; 2) medical providers properly billed and reported insurance payments on Medicaid claims; and 3) the Department properly monitored Medicaid accounts receivable balances.

To accomplish our audit objectives, the Office of the State Comptroller has on-site staff conducting continuous audits of MMIS. Each week, on-site staff members run a series of computer programs to extract primarily inpatient hospital and skilled nursing facility (SNF) claims data from the claims payment file. We designed the programs to extract the claims most likely to have been overpaid, based upon previous trends. We analyzed the reports generated by these programs and selected claims for further review. In addition, we reviewed provider payments to ensure they were properly prepared and the checks were released to valid Medicaid enrolled providers. We also reviewed the Department's calculation of the federal, State and local government funding sources and ensured such funding sources were in place prior to the weekly release of Medicaid payments. Additionally, we interviewed Department officials, reviewed applicable sections of federal and State laws and regulations, and examined relevant Department payment policies and procedures. We also requested and reviewed other information from Medicaid providers substantiating their claims to MMIS.

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 within 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.

In addition to being the State Auditor, the Comptroller performs certain other constitutionally and statutorily mandated duties as the chief fiscal officer of New York State, several of which are performed by the Division of State Services. These include operating the State's accounting system; preparing the State's financial statements; and approving State contracts, refunds, and other payments. In addition, the Comptroller appoints members to certain boards, commissions and public authorities, some of who have minority voting rights. These duties may be considered management functions for purposes of evaluating organizational independence under Generally Accepted Government Auditing Standards. In our opinion, these management functions do not affect our ability to conduct independent audits of program performance.

C. Internal Control and Compliance Summary

Our evaluation of the internal control structure of the MMIS identified several control weaknesses relating to providers' billing and reporting of third-party insurance revenues, revision to Medicaid rates, uncollected Medicaid accounts and updating MMIS with recipient third-party insurance. As a result of these weaknesses, we found an increased risk that some Medicaid payments were inappropriate. These matters are presented throughout this report.

D. Results of Review

For the year ended March 31, 2004, we identified about $41.9 million in actual and potential savings to the Medicaid program. The $41.9 million comprises $32.5 million of actual or potentially

overpaid claims, an $8.6 million payment rate error, and $789,219 of recovery of provider-owed balances. About $27.2 million of the $41.9 million has already been returned to the Medicaid program; the remaining $14.7 million requires further investigation and recovery by the Department.

1. Claims Review

Based on available claims payment information, we identified $32.5 million of actual and potentially overpaid claims. This amount comprises $18.1 million of claims for which recoveries have already been made and $14.4 million of claims where further recovery action is needed. Of the $14.4 million, $1.6 million relates to claims that are potentially overpaid and require further investigation by the Department.

Inpatient Hospital Claims

We determined that provider errors caused MMIS to overpay 2,797 inpatient claims valued at $30.1 million. Of this amount, $17.6 million pertains to 1,941 claims that were already recovered from providers prior to the completion of our fieldwork. The Department needs to recover the remaining $12.5 million, which represents 856 claims, from providers.

According to regulations, providers are expected to take reasonable action to maximize third-party insurance resources and record such revenues on the Medicaid claim. In prior audits (Reports 93-S-14 and 94-S-72), issued on August 5, 1993 and April 14, 1995, we found that medical providers were not always billing and reporting payments from private insurance carriers. We recommended the Department take actions to enforce its billing requirements. While the Department provides ongoing instructions such as provider manuals or update newsletters, some providers are still not meeting the Department's regulations, policy and billing procedures.

In many of the overpaid claims, we found such revenues had not been obtained, or the information on the claims was incorrectly recorded. The following paragraphs describe the errors we found during our audit and the amounts that need to be recovered.

- We identified that MMIS overpaid 2,738 claims valued at $29.1 million. In these instances, we found that either 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 59 claims by $965,898 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 108 claims totaling $1.6 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 Medicaid quality improvement organization or for referral to the Office of Mental Health.

Skilled Nursing Facility Claims

For recipients who have both Medicare and Medicaid eligibility, Medicaid reimbursement policy requires that Medicaid pay for Medicare or private insurance coinsurance payments. Medicare pays the first 20 days in full of a recipients' stay in a nursing home. Between days 21 and 100, Medicaid pays the Medicare coinsurance ($105 per day in 2003).

We found that MMIS overpaid 624 claims totaling $744,278 to SNFs. Of this amount, $492,124 pertains to 442 claims that were recovered from the SNF providers prior to the completion of our fieldwork. The Department needs to recover the remaining $252,154, which represents 182 claims, from the providers. In these SNF claims, the providers billed MMIS using their daily Medicaid rates, rather than the Medicare coinsurance rates. Medicare coinsurance rates are generally lower than Medicaid daily rates. We provided detailed information concerning these claims to the SNFs and requested they submit adjustment claims to correct their Medicaid billings. In addition, we provided the Department with details of these claims for follow-up with the providers.

Practitioner Claims

Providers are to follow instructions when billing Medicaid. Providers are responsible for ensuring the claim form is completed accurately. For example, providers are required to enter Medicare approved and payment amounts when recipients are dually covered under the federal Medicare program on the Medicaid claim. The MMIS uses this information to determine the Medicaid payment.

When we reviewed physician billings, we found MMIS overpaid $32,622, representing three claims, to three physicians. For these claims, we note the providers' claim form included an error relating to Medicare approved payment amounts, causing the overpayment. We provided the detailed information concerning these claims to the Department and the practitioners. The Department's fiscal agent submitted the necessary MMIS adjustments that resulted in full repayment.

2. Medicaid Rate Revisions

Payments to SNF providers are based on daily rates approved by the Department's Bureau of Long Term Care Reimbursement. When the Department revises Medicaid rates, the MMIS claims processing system 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 the rates calculated by the Department are accurately recorded on the MMIS rate master file.

In a prior audit (Report 2003-S-4) issued November 18, 2003, we found the Department did not always update fee and rates changes accurately. As a result, we found there was a significant risk that Medicaid claims could be overpaid or underpaid because incorrect fees and rates were used in calculating the payments. We recommended the Department develop written policies and

procedures to guide staff in doing updates and to assign accountability to help ensure the updates are accurate.

Working with the Department's staff, we prevented the overpayment of $8.6 million to a SNF. We found that the Department updated the provider's two daily rates at $499.16 and $494.19, when the rates should have remained at $233.81 and $231.98, as we confirmed with the Department's rate setters. We also confirmed the provider's rate was subsequently restored to the correct rate preventing further Medicaid overpayment.

3. Provider-Owed Balances

As part of routine MMIS claims processing, we determined that providers sometimes owed money to the Medicaid program, either because previously submitted claims were retroactively adjusted to a lower payment rate or because previous claims were incorrectly paid. In these cases, such adjustments resulted in provider-owed balances, which are normally collected from a provider's future billings. However, some accounts remained uncollected for extended periods of time since the providers were not actively providing services to Medicaid recipients.

In a prior audit (Report 99-S-34), we found the Department did not have a process to regularly identify or initiate the collection of overpayments from affiliated group practices or new owners. We recommended the Department use available MMIS information to regularly check the status of affiliated providers to facilitate recovery of outstanding accounts receivable or initiate recoupments against the affiliated providers.

Working with the Department's staff, we were able to recover $439,744 of provider-owed balances to the Medicaid program. In addition, we identified nine providers with outstanding accounts receivable balances totaling $349,475 that we referred to the Department for recovery action. In most cases, the Department has agreed to transfer the owed balances to affiliated providers.

4. 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, updated by both the Department and local social services districts when they update the State's Welfare Management System (WMS). The WMS 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. The Department and local social services districts are not always made aware if a recipient has third-party insurance coverage. In some instances, it is possible that recipients have insurance coverage, and such information is not shown on the WMS.

In a prior audit (Report 95-S-18), we recommended improvements to the Department's procedures used to identify Medicaid recipients with third-party health insurance. We identified Medicaid recipients with third-party insurance whose coverage was not identified by the State and as a result, the insurance companies were not paying their share of the cost of medical services.

In conjunction with our audit of Medicaid payments, we reviewed the status of recipients' third-party insurance on the WMS as of March 31, 2004 to determine if insurance information was accurate. 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 203 recipients, the WMS did not identify 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 follow-up with local districts.

Recommendations

1. *Recover Medicaid overpayments of $12.5 million relating to 856 inpatient hospital claims.*

2. *In conjunction with the Department's quality improvement organization and the Office of Mental Health, assess the appropriateness of the 108 inpatient hospital claims totaling $1.6 million pertaining to medical necessity and, as appropriate, recover any overpayments.*

3. *Recover Medicaid overpayments totaling $252,154 relating to 182 SNF claims.*

4. *Initiate recovery action against the nine providers with outstanding accounts receivable balances totaling $349,475.*

5. *In conjunction with the local districts, determine whether the 203 recipients have active third-party insurance and update the WMS third-party insurance files to reflect active insurance status.*

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 agree with our recommendations and will take appropriate steps to recover the Medicaid overpayments. However, Department officials responded some claims we provided them are either duplicative of their efforts, unrecoverable because providers are "time barred" from seeking insurance payments, or lack enough information to warrant recovery. Department officials respond they will recover claims they determine are inappropriate. For recommendation five, Department officials responded they are aware of this situation and already provide local districts with this information. A complete copy of the Department's response is included as Appendix A. Appendix B contains State Comptroller's Notes, which address matters where we disagree with the Department's response.

Major contributors to the report include Ken Shulman, Bill Clynes, Douglas Coulombe, Earl Vincent, Ottavio Nicotina, Carrie Zusy, Leo Shaw, Nancy Cecot and Heather Pratt.

We also wish to express our appreciation for the courtesies and cooperation extended to our auditors during their audit.

Yours truly,

David R. Hancox
Director
State Audit Bureau

cc: Robert Barnes

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

July 14, 2004

David R. Hancox
Audit Director
Office of the State Comptroller
110 State Street
Albany, New York 12236

Dear Mr. Hancox:

Enclosed are the Department of Health's comments on the Office of the State Comptroller's (OSC) draft audit report 2003-S-60 entitled "MMIS Claims Processing Activity (replaces 2003-D-1)."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

Appendix A

cc: Mr. Howe
Ms. Kuhmerker
Mr. Lawrence
Mr. Meister
Ms. Pettinato
Mr. Reed
Mr. Seward
Mr. Stenson
Mr. Van Slyke

Department of Health
Comments on the
Office of the State Comptroller's
Draft Audit Report 2003-S-60
Entitled "MMIS Claims Processing Activity"

The following are the Department of Health's (DOH) comments concerning the recommendations contained in the Office of the State Comptroller's (OSC) draft audit report 2003-S-60 entitled "MMIS Claims Processing Activity (replaces 2003-D-1)."

Recommendation #1

Recover Medicaid overpayments of $12.5 million relating to 856 inpatient hospital claims.

Response #1

As a result of an initial review, we have determined that a number of the claims are either duplicative of our efforts, unrecoverable or lacking enough information to warrant recovery. Regarding time barred claims, the Office of Medicaid Management has informed OSC in the past that claims that subsequently become time barred before the audit is processed for collection, will not be pursued since a provider is unable to receive payment from a third party insurer for these claims. Claims ultimately determined to be inappropriate Medicaid overpayments will be recovered.

* Note 1

Recommendation #2

In conjunction with the Department's quality improvement organization and the Office of Mental Health, assess the appropriateness of the 108 inpatient hospital claims totaling $1.6 million pertaining to medical necessity and, as appropriate, recover any overpayments.

Response #2

The 108 claims have been referred to IPRO for review and recovery as appropriate.

Recommendation #3

Recover Medicaid overpayments totaling $252,154 relating to 182 SNF claims.

Response #3

The Office of Medicaid Management is in the process of reviewing the OSC workpapers to assess the overpayments and will recover where appropriate.

* See State Comptroller's Notes, page 12

Recommendation #4

Initiate recovery action against the nine providers with outstanding accounts receivable balances totaling $349,475.

Response #4

The Department will transfer the debts to affiliated providers for recovery for all except Bishop J. G. Sherman Episcopal because of a current bankruptcy proceeding.

Recommendation #5

In conjunction with the local districts, determine whether the 203 recipients have active third-party insurance and update the WMS third-party insurance files to reflect active insurance status.

Response #5

The Department is aware of this circumstance and routinely shares this type of finding with the local districts. This finding duplicates information included in the "Potential Coverage Report" which is sent to the local districts monthly.

* *Note 2*

* See State Comptroller's Notes, page 12

State Comptroller's Notes

1. The Department responded some claims we provided them are either duplicative of their efforts, unrecoverable because providers are "time barred" from seeking insurance payments, or lack enough information to warrant recovery. We acknowledge the Department's ongoing efforts in identifying overpaid claims. However, for the claims the Department officials responded were duplicative, they did not provide any documentation the claims that we referred duplicated their work.

   Additionally, the Department's efforts are not completely identifying all at-risk Medicaid payments. Of the $32 million in overpaid claims we identified, over $18 million in overpayments were returned by the providers based upon our follow up. With respect to the remaining $14.4 million, we continue to maintain the Department officials need to pursue this balance from providers.

   Regarding "time barred" claims, Department regulations require that providers first submit their bills to all other medical insurances before billing Medicaid. We found the providers did not demonstrate other insurers were billed, and their claims were denied, before billing Medicaid. The Department allows providers to retain Medicaid overpayments if the providers can no longer bill another insurance company. For claims that Department officials say lack information, the providers did not respond to our audit requests for additional information. As such, the Department should consider additional action.

2. The Department responded it is already aware of recipients with third party insurance coverage that are not updated to MMIS files. Further, they state our recommendation duplicates what they already referred to the local districts for follow up. However, we advised Department officials on March 31, 2004 of 203 recipients with insurance that was not updated on MMIS. However, as of July 1, 2004, only three of these recipients' files had been updated with third party insurance. If the Department sent information to the local districts as they responded, there must be a communication problem between the Department and local districts.