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August 20, 1997

Barbara Ann DeBuono, M.D., M.P.H.
Commissioner
Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12234

Mr. Brian Wing
Commissioner
Department of Social Services
16th Floor
40 North Pearl Street
Albany, NY 12243

Re: MMIS Claims Processing Activity
Report 96-D-8

Dear Commissioners DeBuono and Wing:

Pursuant to the State Comptroller's authority as set forth in Section 1, Article V of the State Constitution and Section 8, Article 2 of the State Finance Law, we have reviewed the accuracy of claims processed by the Medicaid Management Information System (MMIS) for the twelve months ended March 31, 1997.

A. Background

On October 1, 1996, responsibility for administering New York State's Medicaid Program was transferred from the Department of Social Services to the Department of Health. The Medicaid Management Information System (MMIS) continues as the statewide centralized medical assistance and payment system. During the twelve months ended March 31, 1997, MMIS processed 160.7 million claims, totaling $23.8 billion, including 54.9 million claims relating to retroactive adjustments. The Department of Health contracts with a fiscal agent, Computer Sciences Corporation, to operate the MMIS. The Department of Health and the Division of the Budget are also involved in certain aspects of MMIS, including the setting of medical assistance policy and promulgating rates paid to MMIS-enrolled providers.

The Office of the State Comptroller (OSC) has on-site staff conducting continuous audits of MMIS. Each week, OSC's on-site staff execute a series of computer programs to extract claims data from the newly adjudicated claims payment file. OSC auditors designed the programs to extract those claims most likely to have been overpaid. The auditors analyze the reports generated by these programs and select claims for in-depth review on a judgmental basis.

This report is a summary of our weekly examinations of Medicaid payments for the 12-month period ended March 31, 1997. We reported details concerning exceptions and related causes to the Departments of Health and Social Services on an ongoing basis 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 $16.6 million. In addition, we found approximately $1.6 million that may have been overpaid.

1. Actual Overpayments

We determined that provider errors caused MMIS to overpay 1,061 claims valued at $16,615,542. Providers are expected to bill third-party insurance companies before billing Medicaid. In addition, providers must enter accurate information on the Medicaid claim. Most of the overpayments were made because third-party insurance was not taken into account or forms were incorrectly completed by providers. The following paragraphs describe the error conditions identified during our examination and the amounts which were overpaid.

- MMIS overpaid 891 claims valued at $15,089,386 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 regulations.

- MMIS overpaid $970,804 for 57 claims that had been rejected by insurance companies because they had not been billed within the companies' requirement of time-limit or inpatient notification rules.

- MMIS overpaid 10 claims totaling $307,097 because incorrectly - low birth weights had been reported on the Medicaid claims. MMIS pays a higher reimbursement for newborns with low birth weights.

- MMIS overpaid 103 claims by $248,255 due to other miscellaneous computational or provider billing errors.

2. Potential Overpayments

We also identified 74 claims totaling $1,632,928 that MMIS potentially overpaid. The following paragraphs describe the conditions we identified during our examination.

- For 53 claims valued at $1,267,067, 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 of Health for review by their peer review contractor.

- We found 21 claims for which MMIS paid $365,861 even though insurance companies may have been liable for these payments. In certain of these instances, providers may not have used the correct policy number when billing the insurance companies or providers may have been unaware that the recipients had third-party insurance. We provided recipients' insurance policy numbers to the provider allowing the provider to rebill the insurance company.

C. Provider Owed Balances

We worked in conjunction with the Department of Health's Division of Administration, to recoup $671,148 owed to the Medicaid Program by providers. As part of routine MMIS claims processing, it is sometimes determined that providers owe money to Medicaid because claims were retroactively adjusted to a lower payment rate or otherwise incorrectly paid. In these cases, such adjustments result in provider owed balances. Owed balances are normally collected from subsequent provider billings. Sometimes, owed balances may remain uncollected for a long period of time if the provider stops billing MMIS. However, cooperative efforts of the Department of Health and OSC auditors have resulted in expediting recovery of such owed amounts.

For example, in one case, a community free-standing clinic owed the Medicaid Program $189,153 resulting from previously adjusted claims. The clinic provider was not a frequent biller. However, we identified a skilled nursing facility provider who was affiliated with the clinic provider and informed Department of Health officials. They effected the recoupment by transferring the debt to the affiliated skilled nursing provider. MMIS will recover the owed balance from the nursing facility provider's future Medicaid payments.

D. Adjustment Claims for Two HHC Facilities

Providers are required to bill third-party insurers, including Medicare, before billing Medicaid. During our review, it came to our attention that two New York City Health and Hospital Corporation (HHC) facilities do not bill Medicare Part B (Medicare) for inpatient ancillary services before billing Medicaid. (Medicare is a Federal health insurance program for the elderly and eligible disabled recipients.) It appears the HHC facilities bill Medicaid and Medicare at the same time and do not adjust their MMIS claim to reflect the Medicare revenues.

HHC officials informed us that the two facilities had an agreement with the Department of Social Services to remit their Medicare Part B revenues quarterly. According to Department of Social Services officials, the two HHC facilities were allowed to remit their revenues directly to the State because they lacked the technology to properly adjust their claims. For the quarter ended September 30, 1996, HHC remitted $808,251 in Medicare revenues to the Department of Health. To assure payment history accuracy, the Department of Health needs to require that the two facilities realize their third-party revenues first and then reflect such revenues on their Medicaid claim.

E. Recovery of OSC Overpayments

As mentioned previously in this report, OSC auditors conduct ongoing reviews of Medicaid payments. When we identify overpayments, we report the details to the Departments of Health and Social Services so that recoupment from the providers can take place. As part of this examination, we issued four preliminary audit reports to the two departments for the State fiscal year ended March 31, 1997. Three of these four preliminary reports, issued during the 1996 calendar year, identified more than $8.7 million in overpayments. In our follow-up with the Department of Social Services on April 30, 1997, we found that Social Services had not initiated provider recovery for these overpayments. Social Services officials told us they would initiate Medicaid overpayment recovery once they received our fourth preliminary audit report. (We issued the fourth preliminary report on May 22, 1997.)

Department of Social Services officials pointed out they have limited resources for collection efforts and based on previous discussions with OSC staff, they believed it was more cost-effective for them to do one annual provider recovery. However, considering other factors, such as the materiality of overpayments, providers' inquiries, the State's fiscal condition, and recent OSC streamlining of reporting overpayments for collection purposes, we believe provider recovery should take place at least twice a year.

Recommendations

1. *Recover the Medicaid overpayments totaling $16,615,542.*

2. *Follow up on the 74 claims we identified as potential errors, and as appropriate, recover the overpayments of $1,632,928.*

3. *Refer the 53 claims totaling $1,267,067 to the Medicaid peer review contractor to resolve the appropriateness of these claims billed to Medicaid as inpatient care services.*

4. *Require the two HHC facilities to bill third-party resources first and reflect such revenues on the Medicaid claim.*

5. *Initiate recovery of Medicaid overpayments at least twice a year.*

Major contributors to the report were Lee Eggleston, Doug Hunter, Doug Coulombe, Earl Vincent, Victoria Woods, Nancy Cecot, Blanche Vellano, Mike Muth, Larry Julien and Amritesh Singh.

We would appreciate receiving your written response to 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,

Jerry Barber
Audit Director

cc: Patricia Woodworth