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June 24, 1998

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

Re: MMIS Claims Processing Activity
Report 97-D-5

Dear Commissioner DeBuono:

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 for the twelve months ended March 31, 1998.

A. Background

The Medicaid Management Information System (MMIS) is a statewide centralized medical assistance information and payment system. The Department of Health (Health) is responsible for administering the State's Medicaid program, which provides medical assistance to needy people. During the twelve months ended March 31, 1998, MMIS processed 155.7 million claims, including 137.5 million claims relating to retroactive adjustments. MMIS paid $23.8 billion to settle all the claims. Health contracts with a fiscal agent, Computer Sciences Corporation, to process Medicaid claims and make payments to providers of medical services. In addition, Health and the Division of the Budget are responsible for setting 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.

This report is a summary of our examination of Medicaid payments for the 12 month period ended March 31, 1998. We reported details concerning exceptions and related causes to Health during the examination period 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 $30.6 million. In addition, we found approximately $3.6 million that may have been overpaid.

1. Actual Overpayments

We determined that provider errors caused MMIS to overpay 2,095 claims valued at $30,571,724. Of this amount, $8,737,518 pertains to 553 claims that had already been recovered from providers prior to the completion of our audit field work on May 28, 1998. For the remaining $21,834,206 (1,542 claims), Health still 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, such revenues had not been attained or the information on the claims was improperly recorded. The following paragraphs describe the error conditions identified during our examination and the amounts which need to be recovered.

- We identified that MMIS overpaid 1,407 claims valued at $21,252,032. 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 Health's regulations. In some instances, we found that providers did not comply with insurer's requirements of prior notification and billing within their time-limit rules.

- MMIS overpaid 35 claims by $512,095 due to other miscellaneous provider billing errors. For example, MMIS pays a higher reimbursement for newborns with low birth weights. We noted that providers improperly entered the birth weight of the newborn on the Medicaid claim, resulting in overpayments. In other instances, insurance companies rejected hospitals' claims because providers had not billed within the companies' time-limit rules.

- With respect to 100 nursing home claims, Medicaid overpaid providers $70,079. Our review showed these claims should have been paid at the Medicare coinsurance rate, which is lower than the daily Medicaid per-diem rate.

2. Potential Overpayments

We identified 159 claims totaling $3,607,087 that MMIS potentially overpaid. The following paragraphs describe the conditions we identified during our examination.

- For 131 claims valued at $3,207,250, 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 Health for review by their peer review contractor.

- We found 28 claims for which MMIS paid $399,837 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.

3. Provider Owed Balances

Working in conjunction with Health's Division of Administration, we were able to effect the recoupment of $1,568,390 owed to the Medicaid program. 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 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. Sometimes, these balances may remain uncollected for a long period of time if the provider stops billing MMIS. However, the cooperative efforts of Health and OSC auditors have resulted in expediting recovery of such balances.

For example, in one case, we identified a downstate health maintenance organization (HMO) provider with an outstanding balance of $455,197. The downstate HMO had ceased providing health care to Medicaid recipients. Since the HMO was affiliated with a second HMO in Western New York, we asked Health to recover the owed amount from the affiliate HMO. The amount owed was caused by a lowering of the Medicaid rates, which generated the outstanding balance against the downstate HMO. Our discussion with Health officials revealed they had lowered the Western New York HMO's rates; however, the lower rates were inadvertently applied to the downstate HMO. Since the downstate HMO was no longer providing health care services to Medicaid recipients, it is uncertain that the State's Medicaid program would have recovered the funds. Working with Health officials, they corrected the Western New York HMO's rates and subsequently, MMIS processed a negative payment adjustment of $647,015. According to Health officials, the payment adjustment against the Western New York HMO was greater than the payment adjustment to the downstate HMO because of a higher caseload at the Western New York HMO. As a result of our involvement, the Medicaid program will recover the balance from the provider's future payments.

Recommendations

1. *Recover the Medicaid overpayments totaling $21,834,206.*

2. *Follow up on the 159 claims we identified as potential errors, and as appropriate, recover the overpayments of $3,607,087.*

3. *Work with Health and Health's peer review agent to resolve the appropriateness of the 131 claims billed as inpatient care services.*

Major contributors to the report include Lee Eggleston, Doug Hunter, Doug Coulombe, Earl Vincent, Nancy Cecot, Mike Muth, Leo Shaw, Robert Elliott, Larry Julien, Julie DeRubertis, and Amritesh Singh.

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: Robert L King