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STATE OF NEW YORK
OFFICE OF THE STATE COMPTROLLER

June 7, 1999

Mr. Dennis Whalen
Executive Deputy Commissioner
Department of Health
Tower Bldg., Room 1408
Empire State Plaza
Albany, NY 12237

Re: MMIS Claims Processing Activity
Report 98-D-5

Dear Mr. Whalen:

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 for the twelve months ended March 31, 1999.

A. Background

The Department of Health (Health) 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. Health's fiscal agent, Computer Sciences Corporation, uses the Medicaid Management Information System (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 twelve months ended March 31, 1999, MMIS processed 163.5 million claims, including 75 million claims relating to retroactive adjustments. MMIS paid $24.7 billion to settle all the claims.

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 that are most likely to have been overpaid. The auditors analyze the reports generated by these computer 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, 1999. We reported details concerning exceptions and related causes to

Health officials on a semi-annual 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 $30.8 million during the year ended March 31, 1999. In addition, we found another approximately $2 million in claims that may have been overpaid.

1. Actual Inpatient Hospital Overpayments

We determined that inpatient hospital provider errors caused MMIS to overpay 2,163 claims valued at $30.7 million. Of this amount, $7,092,236 pertains to 587 claims that had already been recovered from providers prior to the completion of our audit field work on May 25, 1999. For the remaining $23,578,579 (1,576 claims), the Department 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 we identified, 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 audits and the amounts which need to be recovered.

- We identified that MMIS overpaid 2,145 claims valued at $30,421,569. We reached this conclusion because, 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 Department 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 18 claims by $249,246 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 incorrect birth weight information on the Medicaid claims, resulting in overpayment. Also, in some claims, the providers had not billed the insurers within the required time frames.

2. Actual Health Maintenance Organization Overpayments

Regarding managed care billings, we noted that one health maintenance organization (HMO) was overpaid $151,976 (2,494 claims). In this case, Medicaid paid a higher paying rate code for health care services intended for recipients age zero to five months. Our analysis shows that in the claims in question, the recipients were in fact older than five months. In addition, our analysis of the amount entered by the HMO on the claim form showed the amount

that Medicaid should have paid. We provided detail information to the HMO concerning these claims and requested they submit adjusted claims to effect Medicaid recovery.

3. Potential Overpayments to Inpatient Hospitals

We identified 82 claims totaling $2,039,295 that MMIS potentially overpaid. In these claims, we noted that 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.

B. Offsetting Third-Party Insurance Payments

Under the New York Health Care Reform Act (HCRA) of 1996, hospitals and private insurers were allowed to negotiate their own payment rates. As a result, beginning January 1, 1997, New York ceased regulating the hospital reimbursement rates that insurers were required to pay inpatient hospitals. In some claims where recipients are dually covered by both Medicaid and private insurers, the rate deregulation has resulted in hospitals getting paid less by insurers when compared to Medicaid rates. As a result, some hospitals are billing Medicaid for the difference between the higher Medicaid rate and the amount paid by the insurer. However, we question whether Medicaid should be making such residual payments, since insurers and hospitals have agreed to set payment rates and such rates are considered full payment for services rendered. In addition, some hospitals informed us it is against their policy to bill other sources (i.e., patient or Medicaid) to obtain a residual payment even though Medicaid policy is silent in this instance.

According to Health officials, the State does not have a policy, which addresses the appropriateness of hospitals seeking additional payment from Medicaid under HCRA. However, at the close of our audit, officials informed us they were addressing the issue and would develop a policy effectively instructing the Medicaid fiscal agent and inpatient hospitals that insurer contractual payments would be considered full payment, with the exception of insurer coinsurance or deductibles, which Medicaid will pay. For example, some insurers have policy coverage limits or some insurers require a deductible amount that is payable by the recipient.

C. Provider-Owed Balances

Working in conjunction with Health's Division of Administration, we were able to effect the recoupment of $494,215 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 has resulted in expediting recovery of such amounts.

D. Recovery of OSC Overpayments

Based on our ongoing audits of Medicaid payments and identification of overpayments, we report the details to Health semiannually so that timely recoupment from providers can take place. As part of this examination, we issued two preliminary audit reports to Health for the State fiscal year ended March 31, 1999. We issued the first preliminary report on December 18, 1998, which reported overpayments up to $17.1 million. The second report was issued on May 13, 1999 and that report included overpayments totaling $15.7 million. In our follow-up with Health officials on May 25, 1999, we found that Health had not initiated provider recovery for these overpayments from the first preliminary report. Given the time that has elapsed since we issued the first report, we believe Health officials should have initiated recovery efforts. Health officials informed us that they have limited staff resources dedicated to Medicaid collection efforts, which is preventing recoveries from taking place in a timely fashion. However, given the materiality of overpayments, inquiries made by providers, and OSC streamlining procedures that facilitate Health's collection efforts, we believe provider recovery should take place soon after we send overpayment documentation to Health's collection staff.

Recommendations

1. Recover Medicaid overpayments totaling $23,578,579 associated with 1,576 inpatient hospital claims.

2. Recover Medicaid overpayments totaling $151,976 associated with 2,494 HMO claims.

3. Work with the Medicaid peer review agent to resolve the appropriateness of the 82 claims we identified as potential errors, and as appropriate, recover the overpayments of $2,039,295.

4. Develop a Medicaid payment policy and instruct the Medicaid fiscal agent and inpatient hospitals regarding the appropriateness of billing Medicaid when a recipient is dually covered by an insurer and the insurer makes a full contractual payment.

5. Take appropriate and necessary steps to effect the timely recovery of Medicaid overpayments.

Major contributors to the report include Lee Eggleston, Doug Hunter, Doug Coulombe, John Cervera, Nancy Cecot, Leo Shaw, Robert Elliott, Julie DeRubertis, Amritesh Singh, Tina Santiago, Andrea Salamy and Earl Vincent.

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: Charles Conaway