DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

June 16, 2010

Report Number: A-03-08-00208

Julie Hudman, Ph.D.
Director
Department of Health Care Finance
825 North Capitol Street NE, Suite 500
Washington, DC 20001

Dear Dr. Hudman:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicaid Management Information System Prepayment Edit in the District of Columbia.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to call me, or contact Robert Baiocco, Audit Manager, at (215) 861-4486 or through email at Robert.Baiocco@oig.hhs.gov. Please refer to report number A-03-08-00208 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Consortium Administrator
Consortium for Medicaid and Children's Health Operations
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, IL 60601

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID MANAGEMENT INFORMATION SYSTEM PREPAYMENT EDIT IN THE DISTRICT OF COLUMBIA

Daniel R. Levinson
Inspector General

June 2010
A-03-08-00208

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In the District of Columbia (the District), the Department of Health Care Finance (the State agency) administers the Medicaid program.

Section 1903(r) of the Social Security Act (the Act) requires all States with Medicaid programs to have CMS-approved mechanized claims processing and information retrieval systems. Pursuant to *The State Medicaid Manual*, CMS Pub. No. 45, CMS requires States to maintain a Medicaid Management Information System (MMIS). The purpose of the MMIS is to enable States to efficiently process claims, control program expenditures, monitor service utilization, and stay informed of program trends. Since 2001, the State agency has contracted with Affiliated Computer Systems, Inc. (ACS), to manage and maintain its MMIS.

Federal regulations (42 CFR § 447.45(f)(1)(iii)) require States to conduct prepayment claims review to " ... verify that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed." Accordingly, States' MMIS includes claims processing edits to identify claims with possible errors. The District's MMIS edit 103 identifies possible conflicts and flags the claim for one of three dispositions: pay the claim, suspend the claim for further review, or deny the claim. During the period of our audit, flagged claims were automatically paid.

Between January 1, 2005, and December 31, 2007, MMIS edit 103 identified 99,424 claims totaling $71 million that represented claims already paid and potential conflicts. We based our review on 32,295 of the claims grouped into 7,646 matches totaling $68.6 million ($48 million Federal share).

OBJECTIVE

Our objective was to determine whether the State agency's MMIS edit 103 properly prevented overpayments for conflicts.

SUMMMARY OF FINDINGS

The State agency's MMIS edit 103 did not properly prevent overpayments for conflicts. We reviewed a sample of 116 matches with possible conflicts. The State agency correctly paid all of the claims in 56 matches but made unallowable payments in 60 matches (Appendix C).

As a result, we estimate that the State agency made overpayments of at least $742,856 ($520,000 Federal share) for matches with conflicts. These overpayments occurred because the State agency did not review the claims flagged by MMIS edit 103 to determine which claims in the matches were allowable. Instead, the MMIS was set to automatically pay the flagged claims and neither ACS nor the State agency performed a follow up review to determine whether the flagged claims were allowable. In February 2008, the State agency took corrective action by instructing ACS to deny all claims flagged by MMIS edit 103.

RECOMMENDATION

We recommend that the State agency refund to the Federal Government $520,000 for payments to providers with conflicting claims identified by MMIS edit 103.

STATE AGECNY COMMENTS

In its written comments on our draft report, the State agency concurred with our recommendation. The State Agency's comments are included in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

The Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In the District of Columbia (the District), the Department of Health Care Finance (State agency) administers the Medicaid program.

The District's Federal medical assistance percentage (FMAP) is 70 percent. The Department of Health & Human Services (HHS) advances funds equal to the Federal share of the estimated cost of the program on a quarterly basis. CMS may require adjustment of the grant award for the Federal share of firmly established overpayments to providers. Improper payments to providers are not medical assistance under the State plan within the meaning of sections 1903(a)(1) and 1905(a) of the Act. Therefore, Federal funding in such payments constitutes an overpayment which must be adjusted under section 1903(d)(2)(A). Accordingly, after reviewing the State's form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, the Secretary may adjust future payments to reflect any overpayment or underpayment that the State made in prior quarters.

Medicaid Management Information System

Section 1903(r) of the Act requires all States with Medicaid programs to have a CMS-approved mechanized claims processing and information retrieval system, called a Medicaid Management Information System (MMIS), as defined in Federal regulations (45 CFR § 95.605). The *State Medicaid Manual*, CMS Pub. No. 45, requires States to maintain an MMIS to efficiently process claims, control program expenditures, monitor service utilization, and stay informed of program trends. The State agency contracts with Affiliated Computer Systems, Inc. (ACS), to manage and maintain the District's MMIS.

Prepayment Review and Edits

Federal regulations (42 CFR § 447.45(f)(1)(iii)) require that States conduct prepayment claims review to verify " ... that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed." Accordingly, States' MMIS include claims processing edits to identify claims with possible errors. The State agency's MMIS edit 103 identifies claims with possible conflicts and flags them for one of three general dispositions: pay the claim, suspend the claim for further review, or deny the claim. During the period of our audit, claims flagged under MMIS edit 103 were automatically paid.

Prior Audit

In September 2008 we issued a report that reviewed claims paid to a non-emergency transportation (NET) provider in the District.[1] We identified claims that the MMIS had flagged under edit 103 because they conflicted with claims paid to another provider for the same services and for the same beneficiary on the same service dates. In all instances, the State agency paid the flagged claims without any further review.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the State agency's MMIS edit 103 properly prevented overpayments for conflicts.

Scope

Our audit period covered January 1, 2005, through December 31, 2007. We based our review on 32,295 claims grouped into 7,646 "matches" totaling $68,576,999 ($48,003,899 Federal share).[2] A match included the flagged claim and any other paid claim which MMIS edit 103 identified as a possible conflict.

We also determined that claims questioned in our prior audit, and the corresponding matching claims, appeared in the sampling population for this audit. We therefore reduced our estimated results by $8,894 ($6,225 Federal share), which represents the total value of those questioned and matching claims.

During our audit, we did not review the overall internal control structure of the District or the Medicaid program. Rather, we limited our internal control review to the controls related to the objective of our audit.

We conducted fieldwork at the State agency's offices and visited 16 providers in the District.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance, including the State plan and relevant Departmental Appeals Board decisions;

[1] *Review of Non-Emergency Transportation Services Provided by Epps Transportation Services, Inc., From January 1, 2004, Through December 31, 2006* (A-03-07-00204).

[2] Some matches included more than one flagged claim.

- held discussions with State agency and ACS officials to obtain an understanding of MMIS edit 103 evaluation criteria and disposition options;

- obtained from ACS a database that included all claims flagged by MMIS edit 103 during our audit period and the related claims with potential conflicts;

- identified 99,424 claims that related to MMIS edit 103: 49,437 flagged claims and 49,987 previously paid claims that the MMIS identified as possible conflicts;

- eliminated 67,129 medical doctor claims because they represented 68 percent of the claims but only 3 percent of the total amount claimed;

- grouped the remaining 32,295 flagged and related claims into 7,646 matches based on the MMIS edit 103 criteria. Each match included at least one flagged claim and a related paid claim;

- selected a stratified random sample of 116 matches for review;

- reviewed State agency and provider documents to determine whether the State agency resolved conflicts pursuant to Federal and District requirements; and

- estimated the dollar impact of the unallowable Federal reimbursement claimed in the total population of 7,646 matches.

Appendix A contains the details of our sample design and methodology, and Appendix B contains our sample results and estimates.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

The State agency's MMIS edit 103 did not properly prevent overpayments for conflicts. We reviewed a sample of 116 matches with possible conflicts. The State agency correctly paid all of the claims in 56 matches but made unallowable payments in 60 matches (Appendix C).

As a result, we estimate that the State agency made overpayments of at least $742,856 ($520,000 Federal share) for matches with conflicts.[3] These overpayments occurred because the State agency did not review the claims flagged by MMIS edit 103 to determine which claims in the matches were allowable. Instead, the MMIS was set to automatically pay the flagged claims and neither ACS nor the State performed a follow up review to determine whether the flagged claims

[3] We reduced the lower limit based on our estimate, $751,750, by $8,894 that we questioned in a previous report.

were allowable. In February 2008, the State agency took corrective action by instructing ACS to deny all claims flagged by MMIS edit 103.

FEDERAL AND DISTRICT REQUIREMENTS

Improper payments to providers are not medical assistance under the State plan within the meaning of sections 1903(a)(1) and 1905(a) of the Act. Federal regulations (42 CFR § 447.45(f)) require that the State must conduct prepayment claims review to verify " ... that the claim does not duplicate or conflict with one reviewed previously or currently being reviewed." Accordingly, the States' MMIS must include claims processing edits to identify suspect claims.

The Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, contains general cost principles for determining whether costs incurred by State and local governments are allowable as charges to Federal grants. The circular, Att. A(C), requires that, to be allowable, costs must be adequately documented and authorized or not prohibited under State or local laws or regulations. Costs must also benefit the program. Consistent with OMB Circular A-87, section 2497.1 of CMS's *State Medicaid Manual* states that "Federal financial participation (FFP) is available only for allowable actual expenditures" and "[e]xpenditures are allowable only to the extent that, when a claim is filed, you have adequate supporting documentation in readily reviewable form to assure that all Federal requirements have been met."

Claims must also comply with the Medicaid State plan, which establishes allowable services pursuant to Section 1905(a) of the Act. The District's State plan limits personal care services to 8 hours per day, unless the provider requests and receives prior authorization to exceed these limits.[4] Att. 4.19C of the State plan allows a nursing facility or intermediate care facility for the mentally retarded to claim a maximum of 18 days per year to hold the bed for a beneficiary who is also claimed for those days by an acute care hospital.

OVERPAYMENTS FOR CONFLICTS

The State agency's MMIS edit 103 identified and flagged claims matched for conflicting services for the same beneficiary on the same dates of service. We determined that 60 matches we sampled included overpayments to providers as follows.

- For 24 matches, 23 providers did not support their claims with sufficient documentation as required by the Manual. In many cases the providers were no longer in business and we could not contact them. Some providers could not locate supporting documentation.

- For 21 matches, 12 providers admitted that they had rendered no service and were therefore not eligible for payment pursuant to section 1905(a) of the Act. In 12 of the matches the State agency paid unrelated providers; however, in 9 matches the State agency made payments under two different provider numbers owned by the same

[4] Supplement 1 to Attachment 3.1-A, 24.F.1, page 29, as implemented in the District of Columbia Municipal Regulations (29 DCMR § 5009.2).

company. Only one service was rendered and therefore only one of the payments was allowable.

- For five matches, eight providers claimed non-emergency transportation services for beneficiaries who either received the corresponding Medicaid covered service at their residences or received no corresponding Medicaid covered service at all. These costs did not benefit the program and were not allowable for a Federal share.

- For four matches, two providers each billed 8 hours per day (16 total hours per day) for personal care services for the same patient on the same day without the prior authorization that the State plan requires.

- For four matches, three institutional facilities claimed days that exceeded State plan limits to reserve beds for resident beneficiaries who received inpatient services at acute care hospitals.

- For two matches, both the discharging and the admitting institutional facilities claimed a resident day when a beneficiary transferred from one to another, although the State plan allows only the admitting facility to claim the resident day.

Based on our sample results, we estimated that the State agency improperly claimed at least $520,000 (Federal share) for payments it made that were not allowable because they were for matches with conflicting claims (Appendix B).

NO FOLLOW-UP REVIEW

The MMIS automatically paid claims flagged for conflicts and then posted them on a "Claims Exception Report" because the disposition code for MMIS edit 103 was set to "pay but report." However, neither the State agency nor ACS subsequently reviewed for disposition the claims on the report. Officials from the State agency told us that it did not perform a follow up review of the flagged claims. Representatives from ACS explained that their claims resolution staff would only perform a follow up review if the disposition code for the edit was set to suspend payment for the claims.

We looked back to 2002, when the State agency contracted with ACS to administer the State MMIS, and determined that the disposition code for MMIS edit 103 was set to "deny" flagged claims as of April 2002. Disposition changed to "suspend" in July 2002, and in July 2004 it was set to "pay but report," where it remained until February 2008. Neither the State agency nor its fiscal agent could provide a reason why the disposition code changed to "pay but report."

CORRECTIVE ACTION TAKEN

On February 14, 2008, the State agency instructed ACS to change the disposition code for MMIS edit 103 to "deny." The MMIS now automatically denies and returns all provider claims flagged as potential conflicts under MMIS edit 103. We believe that this change should prevent future overpayments.

RECOMMENDATION

We recommend that the State agency refund to the Federal Government $520,000 for payments to providers with conflicting claims identified by MMIS edit 103.

STATE AGENCY COMMENTS

In its written comments on our draft report, the State agency concurred with our recommendation. The State agency's comments are included in their entirety as Appendix D.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of provider claims matched for conflicts for Medicaid services from January 1, 2005, through December 31, 2007, and claimed by the Department of Health Care Finance (the State agency).

SAMPLING FRAME

The sampling frame consisted of 7,646 matches totaling $68,576,999. The matches were developed by comparing two claims database files, "Excepted" and "Related," extracted from the State's Medicaid Management Information System (MMIS).[1]

SAMPLE UNIT

The sample unit was a match comprising one excepted claim and one or more related claims.

SAMPLE DESIGN

We used a stratified random sample to evaluate the matches. The strata were determined by the following criteria:

- stratum 1: matches with total paid amount less than $1,000
- stratum 2: matches with total paid amount between $1,000 and $200,000
- stratum 3: matches with total paid amount greater than $200,000

SAMPLE SIZE

We selected a sample of 116 matches divided into 3 strata as follows:

	Range	Total Matches	Total Dollars	Sampled Matches	Sampled Dollars
Stratum 1	< $1,000	4,470	$944,427	50	$9,380
Stratum 2	$1,000 - $200,0000	3,160	62,919,560	50	757,865
Stratum 3	>$200,000	16	4,713,012	16	4,713,012
TOTALS		**7,646**	**$68,576,999**	**116**	**$5,480,257**

[1] Excepted claims were flagged under MMIS edit 103 as possible conflicts. Related claims are the original submitted claims compared to the conflicting claims.

SOURCE OF RANDOM NUMBERS

We used an approved Office of Inspector General, Office of Audit Services, statistical software package to generate the random numbers for selecting the matches.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in stratum 1 from 1 to 4,470. After generating 50 random numbers, we selected the corresponding items for stratum 1. We consecutively numbered the sample units in stratum 2 from 1 to 3,160. After generating 50 random numbers, we selected the corresponding items from stratum 2. We selected all of the 16 matches in stratum 3. A list of 116 matches was then created.

ESTIMATION METHODOLGY

We used Office of Inspector General, Office of Audit Services, statistical software to estimate the amount of overpayments.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Sample Size	Value of Sample	Matches With Errors	Value of Unallowable Costs
1	50	$9,380	41	$3,885
2	50	757,865	18	10,404
3	16	4,713,012	1	183
Total	**116**	**$5,480,257**	**60**	**$14,472**

Estimates of Unallowable Costs
(*Limits Calculated for a 2-sided 90-Percent Confidence Interval)*

Point estimate	$1,005,027
Lower limit	$751,750
Upper limit	$1,258,305

APPENDIX C: 60 SAMPLE MATCHES WITH ERRORS

	Deficiency
1	Documentation not adequate
2	Service not provided
3	No associated medical service or no transportation required
4	Personal care services exceeded 8 hours per day without prior authorization
5	Exceeded 18 day limit for billing reserved bed days
6	Counted discharge day as resident day

Sample Number	Number of Errors	Provider Type	1	2	3	4	5	6	Match Total	Total Errors	Total Allowable
2	1	Laboratory		X					$10.60	$5.30	$5.30
3	2	Laboratory		X					10.60	5.30	5.30
4	3	Laboratory		X					14.00	7.00	7.00
5	4	Podiatrist		X					17.90	8.95	8.95
9	5	Podiatrist	X						27.88	19.37	8.51
10	6	Child Hospital		X					30.00	15.00	15.00
11	7	Podiatrist		X					36.26	18.13	18.13
12	8	Podiatrist		X					43.34	21.67	21.67
13	9	NET	X						55.00	27.50	27.50
14	10	NET			X				55.00	55.00	0.00
15	11	HCBS Waiver	X						63.00	63.00	0.00
16	12	HCBS Waiver	X						63.00	63.00	0.00
17	13	NET	X						66.00	33.00	33.00
18	14	NET	X						66.00	33.00	33.00
19	15	NET	X						66.00	33.00	33.00
20	16	NET			X				66.00	66.00	0.00
21	17	NET			X				66.00	66.00	0.00
22	18	NET			X				66.00	66.00	0.00
23	19	NET	X						71.50	35.75	35.75
24	20	NET	X						82.50	41.25	41.25
25	21	NET	X						82.50	41.25	41.25
27	22	Physician D.O.		X					102.24	39.18	63.06
28	23	NET	X						114.75	50.25	64.50
29	24	HHA	X						130.00	65.00	65.00
30	25	NET	X						132.00	99.00	33.00
31	26	NET	X						146.50	77.75	68.75
32	27	NET			X				154.50	154.50	0.00
33	28	NET	X						163.28	81.66	81.62
34	29	Day Treatment		X					192.50	92.81	99.69
35	30	NET	X						196.35	97.50	98.85
36	31	Ambulance	X						216.86	108.43	108.43
37	32	HCBS Waiver		X					261.12	130.56	130.56

Sample Number	Number of Errors	Provider Type	1	2	3	4	5	6	Match Total	Total Errors	Total Allowable
38	33	NET	X						$264.00	$132.00	$132.00
39	34	NET		X					264.00	132.00	132.00
40	35	Clinic	X						265.10	132.55	132.55
41	36	HHA		X					324.48	162.24	162.24
42	37	HCBS Waiver	X						358.08	249.92	108.16
44	38	NET	X						396.00	198.00	198.00
45	39	NET	X						396.00	198.00	198.00
48	40	HHA		X					783.04	522.24	260.80
49	41	Day Treatment	X						874.50	437.25	437.25
52	42	HCBS Waiver		X					1,200.00	600.00	600.00
53	43	Day Treatment		X					1,200.00	600.00	600.00
54	44	HHA				X			1,304.80	652.80	652.00
55	45	HHA				X			1,304.80	652.00	652.80
56	46	HHA				X			1,304.80	652.00	652.80
57	47	HHA				X			1,304.80	652.00	652.80
58	48	HHA		X					1,305.60	652.80	652.80
59	49	HHA		X					1,305.60	652.80	652.80
60	50	HHA		X					1,305.60	652.80	652.80
61	51	Day Treatment		X					1,342.00	488.00	854.00
62	52	Day Treatment		X					1,342.00	366.00	976.00
63	53	Day Treatment		X					1,708.00	732.00	976.00
64	54	Day Treatment	X						2,623.50	1,311.75	1,311.75
67	55	NF					X		4,510.02	610.02	3,900.00
68	56	NF						X	5,500.96	192.61	5,308.35
69	57	ICF/MR						X	8,864.73	251.64	8,613.09
70	58	NF					X		9,318.42	341.00	8,977.42
77	59	NF					X		12,698.72	343.22	12,355.50
109	60	NF					X		268,972.56	183.16	268,789.40
		TOTALS	**24**	**21**	**5**	**4**	**4**	**2**	**$335,211.29**	**$14,471.91**	**$320,739.38**

GLOSSARY

ICF/MR	Service provided in an intermediate care facility for the mentally retarded
HCBS Waiver	Nursing home level care provided in a home or community-based setting
HHA	Service provided by a home health agency
NET	Non-emergency transportation service
NF	Skilled nursing facility service

APPENDIX D: STATE AGENCY COMMENTS

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Director

May 24, 2010

Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Dear Mr. Virbitsky:

Thank you for the opportunity to provide comments on your draft report, "Review of Medicaid Management Information System Prepayment Edit in the District of Columbia," (A-03-08-00208).

Your report reviewed the District's use of claims processing edit 103, which identifies claims that may have potential conflicts with other claims. During the study time period—January 1, 2005 though December 31, 2007—your audit identified a sample of claims which were used to estimate a total of $520,000 (Federal share) in payments that you determined to be not allowable because conflicts on the claims were not reviewed prior to payment. You recommended that we repay to the Federal government your estimated amount of $520,000.

As your report indicates, the District's claims processing contractor did not have the 103 edit turned on during the study time period. As your report also notes, this edit was turned back on during February 2008, and claims that are flagged by the edit are now denied. This action prevents future overpayments from being made on claims that are flagged by the 103 edit.

We concur with your recommendation, and will repay the Federal government the $520,000, per your calculations.

Sincerely,

Julie Hudman, Ph.D.
Director

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