Office of the State Auditor

Department of Health Care Policy and Financing

Medicaid Claims Performance Audit November 2004

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This report contains the results of a performance audit of Medicaid claims processed by the Department of Health Care Policy and Financing. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct audits of all departments, institutions, and agencies of the state government. The State Auditor contracted with Clifton Gunderson LLP to conduct this performance audit in accordance with *Government Auditing Standards*. This report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

Clifton Gunderson LLP

Denver, Colorado
November 30, 2004

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Report Summary

Medicaid Claims
Performance Audit
November 2004

Authority, Purpose, and Scope

This report presents the results of our performance audit of Medicaid claims. The audit reviewed Medicaid claims processes and payments to determine whether the Department of Health Care Policy and Financing (the Department) and its fiscal agent process and pay such claims effectively. The audit was conducted on behalf of the Office of the State Auditor under the authority of Section 2-3-103, C.R.S., and in accordance with generally accepted government auditing standards. We collected data from the Department and its fiscal agent and analyzed claims data in four specific areas: 1) hospital outlier payments, 2) fee-for-service claims paid for HMO enrollees, 3) payments for service dates after a beneficiary's date of death, and 4) Medicaid rate changes. The audit did not include a review of the new Colorado Benefits Management System (CBMS).

Overview

Medicaid (Title XIX of the Federal Social Security Act) is a federal-state program that provides health care coverage to low income individuals and families. Medicaid benefits are available to various categories of clients, including low-income families with children; recipients of Supplemental Security Income (SSI) for the Aged, Blind and Disabled; individuals qualified for adoption assistance agreements or foster care maintenance payments under Title IV-E of the Social Security Act; qualified pregnant women; newborn children of Medicaid-eligible women; and certain low-income children and Medicare beneficiaries. By statute, the Colorado Department of Health Care Policy and Financing is the single state agency responsible for administration of the Medicaid program in Colorado.

Medicaid services are generally provided through one of two systems - managed care or non-managed care. In the managed care system, participants may be part of either the Primary Care Physician Program (PCPP) or a Health Maintenance Organization (HMO). Under the PCPP coverage option, the primary care provider serves as a medical case manager and is reimbursed for services through the Medicaid fee-for-service system, which provides a separate payment amount for each Medicaid claim. Under the HMO option, a designated organization is responsible for providing contractually agreed upon health care services to covered individuals. HMOs are reimbursed by Medicaid through a flat monthly rate per eligible participant (called a capitation payment) rather than for each service provided. In the non-managed care system, Medicaid clients obtain services from providers who agree to provide Medicaid-covered services and are paid on a fee-for-service basis.

The Department's Medicaid Management Information System (MMIS) is an automated claims-payment system that contains edits that determine whether claims should be paid,

denied, or placed into suspense. The Department and its fiscal agent, Affiliated Computer Services (ACS), manually review certain claims to determine whether they should be paid or denied. The Department is responsible for overseeing all fiscal agent activities.

Like other states, Colorado has experienced steady growth in both Medicaid spending and the number of Medicaid recipients. Between Fiscal Years 1999 and 2003, Colorado's Medicaid expenditures increased about 44 percent from about $1.8 billion to more than $2.6 billion while the number of recipients increased 42 percent from about 231,000 to about 329,000. Between Fiscal Years 2000 and 2003, the number of Medicaid clients enrolled in the HMO program increased more than 37 percent (from about 92,000 to about 127,000) and Medicaid payments to HMOs increased about 46 percent (from $245.4 million to about $357.6 million).

Summary of Audit Comments

Hospital Outlier Payments

The Medicaid Program reimburses hospitals for inpatient health care services using a base rate for each hospital. When the hospital files a claim for reimbursement with the Medicaid Program, the claim indicates the diagnosis and surgical procedure for the inpatient services provided. The Department uses this diagnosis and surgical procedure information to assign one of over 500 Diagnosis Related Grouping (DRG) codes, each with an associated weight reflecting the severity of the patient's condition. The DRG weight is multiplied by the hospital's base rate to determine the standard reimbursement for the inpatient stay. Each DRG includes an average length of stay for the patient's condition. In addition to the DRG reimbursement, outlier payments are made by the Medicaid Program to reimburse hospitals for exceptionally lengthy patient stays. Each DRG has a defined point after which the Medicaid Program provides an outlier payment for the remainder of the inpatient stay, excluding the day of discharge. We identified two areas in which the Department's oversight of outlier claims could be improved:

- **Incorrect Coding for Hospital Reimbursements.** One consideration in assigning a DRG is whether a patient's condition is considered to have complications—such as a post-operative infection. For DRGs "with complications," the time period that elapses before the hospital begins to receive an outlier payment is longer than for DRGs "without complications." Because of this difference, there is a potential financial incentive for hospitals to assign DRGs "without complications" to patients that have complications to receive outlier payments sooner. We reviewed 15 outlier claims from Fiscal Year 2003 that were assigned DRGs "without complications" and determined that for 6 of the 15 claims (40 percent), an incorrect DRG was assigned. For 5 of the claims, the "without complications" DRG was incorrectly assigned, meaning the patient did have complications and should have been assigned a DRG with complications. For 1 claim, a DRG for a more complex procedure was incorrectly assigned. As a result, these providers were overpaid by about 20 percent for the six claims, or a total of about $53,000. The Department and its utilization management contractor currently do not review outlier claims on a periodic basis to monitor trends or to identify outlier cases for further review. If the Department reviewed all of the 150 claims filed for DRGs "without

complications" in Fiscal Year 2003 and found the same rate of erroneous DRG assignments (40 percent) and the same rate of overpayments (20 percent) as we found for our 15-claim sample, we estimate the Department could identify about $200,000 for recovery. If the Department expanded its review to six years (the period for which providers are required to maintain medical records), it is likely that substantially more overpayments would be identified and recovered.

- **Trends in Hospital Outlier Claims.** We analyzed outlier claims paid in Fiscal Years 1999 through 2003 and identified trends that may be of concern to the Department. First, we found that only about 3 percent of DRGs accounted for 23 to 33 percent of the outlier claims and 34 to 44 percent of the outlier payments over the five year period. This may indicate that the DRGs assigned for these claims were incorrect, resulting in outlier payments being made sooner than they should be. Second, we found that about 10 percent of providers accounted for over 50 percent of the outlier claims and between 56 and 73 percent of outlier payments. This may mean that incorrect DRG codes were assigned, causing these hospitals to receive outlier payments that they were not entitled to receive. The Department does not routinely analyze trend information on outlier claims by provider, DRG, cost, or other factors to identify aberrant trends, including potentially abusive practices by providers.

Fee-for-Service Payments for HMO Enrollees

Each HMO contract specifies what services the HMO will provide to enrolled Medicaid clients under the monthly capitation payment. Certain services not included in the HMO contract are still covered by Medicaid and are billed by providers on a fee-for-service basis. Through analysis of Medicaid claims data, we determined there were over 535,000 claims paid through the fee-for-service system in Fiscal Year 2003 for clients enrolled in HMOs at the time of the service. Over 95 percent of these claims were paid appropriately through the fee-for-service system because they were for services not covered by the HMO contract. However, we did identify other claims that were incorrectly paid as fee-for-service, as follows:

- **Fee-for-Service Payments for HMO-Enrolled Clients.** We reviewed a sample of 40 claims worth about $1,100 and found that 9 claims totaling about $280 were for services that were covered under the HMO's contract and were incorrectly paid as fee-for-service. This represents an error rate of about 22 percent. Although the sample reviewed was not statistically valid, the rate of incorrect payments in the sample is sufficiently high to be of concern. Two of the claims were improperly paid by the fiscal agent. The other seven incorrect payments were automatically made by MMIS because information contained in the Department's claims payments and eligibility systems either at the time of service or at the time of payment was outdated and did not reflect HMO coverage.

- **Fee-for-Service Payments for HMO-Eligible Newborns.** For Fiscal Year 2003, the Department identified about $945,000 in fee-for-service payments for newborn services that should have been covered by HMOs. All HMO contracts require that covered services be furnished to newborns of enrolled members for up to 60 calendar days after birth. According to the Department, the process for obtaining Medicaid eligibility for

newborns and then processing them for HMO enrollment is frequently delayed. The Department reports that delays occur, in part, because counties do not always receive notification of birth and all the information required to initiate the Medicaid eligibility process in a timely way. The Department has not collected and evaluated data to determine where lags in the newborn enrollment process occur and whether certain counties experience more problems in this area than others. This information could be used to design processes to reduce the number and amount of newborn claims that are inappropriately paid as fee-for-service. In addition, the Department should evaluate the extent to which House Bill 04-1058, which allows certain providers to be designated to accept Medicaid applications and determine eligibility, increases the number of newborns enrolled in the Medicaid Program. On the basis of this evaluation, the Department should consider pursuing legislation to allow additional providers to be designated.

- **Frequency of Reconciliation of Capitation and Fee-for-Service Claims Payments.** The Department completes an annual computer-based match of claims payments with Medicaid eligibility and enrollment files to identify certain types of incorrect payments, including claims paid to HMOs that should have been paid through the fee-for-service system, and vice versa. This reconciliation is completed about a year after the end of each fiscal year. Because the process occurs so long after the payments are made, the Department must sometimes pursue recovery from HMOs that either no longer contract with the Department or are out of business. Although an HMO would still have a contractual obligation to reimburse the Department for previous years' overpayments, collection of these amounts could be more difficult once the Department and the HMO no longer have an ongoing business relationship. In addition, the Department loses the use of those improperly-paid funds for a significant amount of time and may lose interest on the funds.

Medicaid Claims After Date of Death

In Colorado, county social services departments are the primary contact point for families to report the death of a Medicaid recipient. When the county receives date of death information, it is entered into the Department's eligibility system and uploaded on a daily basis into MMIS. To determine the extent of payments for service dates after date of death, we compared Fiscal Year 2003 paid claims data with the Social Security Administration's Death Master File and the Colorado Department of Public Health and Environment's death data. We identified almost 19,000 claims totaling almost $2.1 million that were paid for service dates after date of death, of which 1,909 claims for approximately $882,000 (about 42 percent of the total $2.1 million) were paid to HMOs. The Department had already identified 853 of these claims and is proceeding with recovery of them. However, the Department did not identify the remaining 1,056 claims valued at $362,000. The Department does not conduct a periodic match of eligibility files and paid claims with date of death data from the Colorado Department of Public Health and Environment and/or the Social Security Administration to identify and pursue recovery of any claims paid for service dates after date of death.

Our recommendations and the Department's responses can be found in the Recommendation Locator of this report.

RECOMMENDATION LOCATOR
Agency Addressed: Department of Health Care Policy and Financing

Rec. No.	Page No.	Recommendation Summary	Agency Response	Implementation Date
1	15	Improve efforts to ensure that outlier claims are appropriate and accurate.	Agree	July 2006
2	18	Conduct a quarterly analysis of outlier trends to identify and research aberrant trends, including potentially abusive practices by providers. Use the analysis to help determine the focus of future reviews by the utilization management contractor.	Agree	April 2005
3	18	Consider implementing a concurrent authorization process for claims before they reach outlier status, particularly if aberrant or potentially abusive trends are identified during outlier trend analyses, as suggested in Recommendation No. 2.	Agree	July 2006
4	23	Improve the accuracy of claims payments by reinstating the Claims Processing Assessment System, periodically reviewing samples of fee-for-service payments made by the fiscal agent for claims suspended due to HMO enrollment, clarifying edit resolution text used by the fiscal agent, and modifying MMIS as needed.	Agree	January 2005
5	25	Collect data to determine where problems in the newborn enrollment process occur and additional processes to address those problems. As part of the next payment correction process, evaluate the extent to which CBMS reduces incorrect fee-for-service payments for newborns. After implementing HB 04-1058, evaluate the success of the designated sites in increasing newborn enrollment and consider pursuing statutory change to allow other providers to be designated.	Agree	July 2005
6	28	Improve the timeliness of payment recoveries by conducting the HMO payment correction process twice per year.	Agree	January 2005
7	31	Identify and pursue recovery of claims paid for service dates after date of death by using the claim-specific data provided through this audit and by periodically matching eligibility and paid claims data with death data from state and federal sources.	Agree	March 2005
8	34	Work with the fiscal agent to ensure that the quality control process for rate changes entered into MMIS includes all rate change parameters, including effective dates.	Agree	December 2004

Background and Description

The Medicaid Program

Medicaid (Title XIX of the Federal Social Security Act) is a federal-state program that provides health care coverage to low income individuals and families. Medicaid is an entitlement program, meaning that any state participating in the program must serve all eligible and enrolled individuals. Medicaid benefits are available to the following categories of persons:

- Low-income families with children
- Recipients of Supplemental Security Income (SSI) for the Aged, Blind and Disabled (including disabled children)
- Individuals qualified for adoption assistance agreements or foster care maintenance payments under Title IV-E of the Social Security Act
- Qualified pregnant women
- Newborn children of Medicaid-eligible women
- Various categories of low-income children
- Some low-income Medicare beneficiaries

Colorado Medicaid Program Administration

By statute, the Colorado Department of Health Care Policy and Financing (the Department) is the single state agency responsible for administration of the Medicaid program in Colorado. County departments of social services are responsible for determining an individual's eligibility for Medicaid. Individuals who are eligible for benefits under Medicaid may choose a provider from any institution, agency, or health professional, who has agreed to serve Medicaid recipients.

Medicaid services are generally provided through one of two systems−managed care or non-managed care−as described below.

Managed Care. Those within the managed care system participate in either the Primary Care Physician Program (PCPP) or are part of a Health Maintenance Organization (HMO). The services and payment mechanisms for these two programs are as follows:

Primary Care Physician Program (PCPP). Under this coverage option, individuals choose a primary care provider from a list of participating Medicaid service providers. When health care services are required, a PCPP-covered individual visits a primary care provider first, with the exception of medical emergencies. The role of the primary care provider is to serve as a medical case manager by coordinating and monitoring all Medicaid services. Reimbursement to PCPP providers is processed through the Medicaid fee-for-service system, which provides a separate payment amount for each Medicaid claim. As of August 2004, there were about 1,100 Primary Care Physician practices contracting with the Department.

Health Maintenance Organizations (HMO). An HMO is a health care plan in which a designated organization is responsible for providing comprehensive health care services to Medicaid-covered individuals. An HMO is reimbursed by Medicaid through a flat monthly rate per eligible participant (called a capitation payment) rather than for each service provided.

Each HMO maintains a risk-based contract to provide health care services to enrolled individuals. The term risk-based indicates that the HMO accepts the contractually set, fixed monthly capitation payment in return for providing all contractually covered services to Medicaid clients. A detailed summary of covered and non-covered services is included as an appendix to each HMO contract. An HMO is permitted to offer additional covered services in its contract, at its own expense, to differentiate itself from other HMOs, enhance its ability to enroll additional Medicaid clients, and control costs. One example of an additional product or service offered by an HMO is specialty eyeglasses for adults.

In Fiscal Year 2004, the Department contracted with two fully capitated HMOs to provide Medicaid services, one of which began contracting with the Department in May 2004.

Non-Managed Care. Medicaid clients may also obtain services from providers who are not in the managed care system. Medicaid pays these providers for the covered services they provide to eligible participants. Providers must submit a completed billing form, referred to as a Medicaid claim, in order to receive payment for covered Medicaid health services.

In addition, clients who are enrolled in an HMO may obtain non-managed care services that are not covered by their HMO's contract and have those services paid for as fee-for-service claims. These are referred to as wrap-around services. Examples of wrap-around services include:

- Certain auditory services for children, including hearing aids, auditory training, audiological assessment, and hearing evaluation
- Dental assessment, care, and treatment for children.
- Drug/alcohol treatment for pregnant women, including assessment and treatment.
- Private Duty Nursing (PDN), nursing services only.

In Fiscal Year 2004, about 16,600 non-managed care providers contracted with the Department to provide Medicaid services.

Payment and Eligibility Processing

One of the requirements of the federal Medicaid program is a Medicaid Management Information System (MMIS). The MMIS is an automated claims-payment system with an integrated group of procedures and computer processing operations (subsystems) designed to provide program controls, including a comprehensive tracking system for services provided

to Medicaid recipients, operations of claims processing, and management reporting for planning and control of Medicaid expenditures. The MMIS contains approximately 700 edits for processing claims according to Medicaid payment policies. As claims are processed through the MMIS, edits determine whether claims should be paid, denied, or placed into suspense.

In cases where an edit in the MMIS causes a claim to be suspended, the Department or its fiscal agent manually review the claim to determine the proper course of action. The Department currently contracts with Affiliated Computer Services (ACS) to serve as the State's fiscal agent for MMIS operations. ACS processes provider claims for Medicaid services and is responsible for ensuring that claims submitted by providers are processed timely and accurately through the MMIS according to State Medicaid policies. ACS is also responsible for provider enrollment and provider relations. The Department is responsible for overseeing all fiscal agent activities.

In September 2004 the Department began using the Colorado Benefits Management System (CBMS), a new automated system that maintains a wide variety of Medicaid data, including enrollment and eligibility information, in a single, unified, system. CBMS is an information technology system jointly developed by the Department of Human Services and the Department of Health Care Policy and Financing. CBMS is intended to accomplish a number of goals, including simplifying and expediting the eligibility determination process, allowing a single point of data entry for multiple programs, improving client access to public assistance and medical benefits by providing one-stop shopping, and improving accuracy and consistency in eligibility determinations statewide.

Medicaid Spending

Funding for the Medicaid program is shared between the federal and state governments and is based on a state's per capita income. If a state's per capita income is equal to or greater than the national average, the federal share is 50 percent. If a state's per capita income is lower, the federal share increases up to a maximum of 76.6 percent. Colorado's federal share (or match) is typically 50 percent. However, beginning in April 2003, all states received an additional 2.95 percent federal share, making Colorado's federal match rate 52.95 percent.

Like other states, Colorado has experienced steady growth in both Medicaid spending and in the number of Medicaid recipients. Between Fiscal Years 1999 and 2003, Colorado's Medicaid expenditures increased about 44 percent, from about $1.8 billion to more than $2.6 billion while the number of recipients increased 42 percent, from about 231,000 to about 329,000. According to Department of Health Care Policy and Financing personnel, a number of factors have contributed to the increases in Medicaid expenditures and recipients in Colorado. One factor is the economic downturn in recent years which has led to increased caseloads. Another factor is an increase in services paid through the fee-for-service system because many recipients who previously were enrolled in HMOs now receive services through PCPP or non-managed care programs, both of which are reimbursed on a fee-for-service basis.

HMO Spending and Enrollment

Since Fiscal Year 2000, the percent of eligible Medicaid clients enrolled in the HMO program has ranged between about 39 and 48 percent. The following table displays a four-year trend for HMO enrollment in Colorado.

Table 1. Department of Health Care Policy and Financing
Colorado HMO Enrollment and Payments
Fiscal Years 2000 Through 2003

Fiscal Year	HMO Average Annual Enrollment	Percent of Total Medicaid Clients	Medicaid Payments to HMOs (In Millions)	Average Cost/ HMO Enrollee
2000	92,500	39%	$245.4	$2,653
2001	120,400	45%	$312.5	$2,596
2002	136,000	48%	$323.5	$2,379
2003	127,100	39%	$357.6	$2,814

Source: Department of Health Care Policy and Financing, "Medicaid Managed Care and Mental Health Enrollment" annual reports and June 2004 Ad Hoc Report, "Total Payments to Managed Care Organizations."

As the table shows, the number of HMO clients increased significantly between Fiscal Years 2000 and 2002 but then dropped off in Fiscal Year 2003, due primarily to a change in Departmental policy. Specifically, prior to April 2003, the Department allowed 90 days for most newly eligible Medicaid clients to select and enroll in a managed care plan. Clients who did not select a managed care plan within this time period were automatically enrolled in a contract HMO. Exempt from this policy were residents in rural and other outlying areas that lacked a sufficient number of HMOs. These residents continued to be covered through the non-managed care program and have their services paid for through the Medicaid fee-for-service system. In late Fiscal Year 2003, the Department began allowing newly eligible Medicaid clients to choose whether to enroll in the HMO or to receive services through the PCPP or non-managed care programs. As a result, the number of clients enrolled in an HMO in Fiscal Year 2003 decreased.

Despite the decrease in HMO enrollment between Fiscal Years 2002 and 2003, overall Medicaid payments to HMOs increased during this period. The Department attributes this increase in payments to increased risk factors, indicating an increase in client severity of illness. The capitation rates paid to HMOs are calculated to include this severity of illness measure (also called a health status risk adjustment).

Audit Scope & Methodology

The purpose of this audit was to review Medicaid claims processes and payments to determine whether the Department, and its fiscal agent, process and pay such claims effectively. Four specific areas were targeted for review in this audit, including hospital outliers, fee-for-service claims paid for HMO enrollees, payments for service dates after a beneficiary's date of death, and Medicaid rate changes. We interviewed staff at the Department and worked with the Department's fiscal agent, ACS, to obtain Medicaid eligibility information and paid claims data. The audit did not include a review of the new Colorado Benefits Management System (CBMS).

Chapter 1

Hospital Outlier Payments

The primary methodology used by the Medicaid Program to reimburse hospitals for inpatient health care services is the Prospective Payment System. In this system, payment levels are set in advance of each year. Each hospital is assigned a base rate that is used to calculate the Medicaid reimbursement for an inpatient stay. When the hospital files a claim for reimbursement with the Medicaid Program, the claim indicates the diagnosis and surgical procedure for the inpatient services provided. The Department uses this diagnosis and surgical procedure information to assign one of over 500 Diagnosis Related Grouping (DRG) codes, each with an associated weight reflecting the acuity, or sickness level, of the patient's condition. The DRG weight is multiplied by the hospital's base rate to determine the standard reimbursement for the inpatient stay. A higher DRG weight generally signifies a greater amount of resources necessary to treat a patient and therefore a higher reimbursement rate. Each DRG includes an average length of stay for the patient's condition, and only one DRG is assigned to each patient for a hospital admission. The Department uses a combination of data provided by the Centers for Medicare and Medicaid Services (CMS) and state-specific information to establish reimbursement rates for Colorado Medicaid providers.

In addition to the DRG reimbursement for a hospital inpatient stay, outlier payments are made by the Medicaid Program to reimburse hospitals for exceptionally lengthy patient stays. The Colorado Medicaid Program uses a standardized formula to calculate outlier payments, which are made only after a defined "trim point" is reached. The trim point specifies the day of an inpatient hospital stay when the hospital will begin to receive an outlier payment. Hospital days beyond the trim point (excluding the day of discharge) are covered by the outlier payment.

The following table provides examples of the DRG and outlier payments that would be made to a hospital for selected conditions assuming a hospital base rate of $4,000.

Table 2. Department of Health Care Policy and Financing
Examples of DRG and Outlier Reimbursements Using a Hospital Base Rate of $4,000

[A] Condition/ Procedure	[B] Avg. Length of Stay for DRG	[C] Flat DRG Reimb. Amount	[D] Trim Point	[E] Daily Outlier Amount	[F] Days Paid Through Outlier Payment
Spinal Disorder or Injury	5.8 days	$4,112(1)	24 days	$567	Day 25 through day before discharge
Cardiac Device Replacement	3 days	$8,078(2)	11 days	$2,154	Day 12 through day before discharge
Fractures of the Hip and Pelvis	5 days	$3,908(3)	19 days	$625	Day 20 through day before discharge

Source: Department of Health Care Policy and Financing, "DRG Weight Table-Discharges 10/1/2003 and After."
Notes: Using a hospital base rate of $4,000:

1 This is the flat amount the Medicaid program would reimburse a hospital for a patient with a spinal disorder or injury who remains in the hospital from 1 to 24 days (until the trim point is reached). After 24 days, the hospital would receive a daily outlier payment as indicated in column E.

2 This is the flat amount the Medicaid program would reimburse a hospital for a patient undergoing a cardiac device replacement who remains in the hospital from 1 to 11 days (until the trim point is reached). After 11 days, the hospital would receive a daily outlier payment as indicated in column E.

3 This is the flat amount the Medicaid program would reimburse a hospital for a patient with a hip or pelvic fracture who remains in the hospital from 1 to 19 days (until the trim point is reached). After 19 days, the hospital would receive a daily outlier payment as indicated in column E.

As the table shows, using an assumed hospital base rate of $4,000, a hospital admitting a client for a spinal disorder or injury would initially be reimbursed $4,112 based on the assigned DRG code which has an associated average length of stay of 5.8 days. The trim point for this condition is 24 days so the hospital is eligible for an outlier payment only if the patient's inpatient hospital stay exceeds 24 days. If this patient was released from the hospital after an 80-day length of stay, an outlier payment for days 25 through 79 (since the day of discharge is not reimbursable by Medicaid), or 55 days, at a daily rate of $567 would be paid.

Under the DRG payment system, a hospital is reimbursed a calculated amount regardless of the patient's length of stay in the hospital, until the trim point is reached. As a result of the flat reimbursement amount provided through the DRG system, there is a financial incentive for a hospital to release patients as quickly as possible, particularly until the trim point is reached, at which time the hospital would begin receiving a daily outlier payment.

One way the Department monitors hospital payments is through reviews conducted by its utilization management contractor, which conducts sample reviews of health care claims submitted by acute care providers (those that offer short-term medical treatment for an illness or injury, of which hospitals are the most common type) on an annual basis. The purpose of the reviews is to evaluate whether: 1) the hospitalization was medically justified, 2) the client's treatment required inpatient admission, 3) the correct DRG was assigned, 4) the service is a benefit of the Medicaid program, 5) the care provided was of sufficient quality, and 6) the documentation supporting the claims was adequate. The Department uses information from its utilization management contractor to recover incorrect paid claims. According to the utilization management contractor's Fiscal Year 2003 report, incorrect claims payments totaled over $884,000, which the Department is pursuing for recovery. Additionally, estimated cost savings of over $2.2 million were identified as resulting from

the reviews of prior authorization requests (requests for advance authorization for certain services, as required by the Medicaid program) for Fiscal Year 2003.

We identified a number of areas in which the Department could ensure its oversight of hospital payments is directed to potentially high-risk claims, as discussed in this chapter.

Incorrect Hospital Claim Coding

One consideration in assigning a DRG is whether a patient is considered to have complications—such as a post-operative infection—associated with his or her condition. The DRG for a condition with complications will generally have a higher trim point than a DRG for the same condition without complications to account for the additional inpatient time the patient is expected to require to address the complications. Because of the differences in trim points, there is a potential financial incentive for hospitals to provide inaccurate diagnosis or procedure information on their claims, causing the Department to incorrectly assign DRGs without complications. As a result, the hospital would receive outlier payments for shorter hospital stays. The following table provides some examples of how trim points differ for a condition depending on whether there are complications associated with the diagnosis.

Table 3. Examples of DRG Codes and Trim Points For Conditions With and Without Complications

[A] Condition	Without Complications		With Complications		[F] Difference In When Outlier Payments Begin for Condition With and Without Complications (E – C)
	[B] Average Length of Stay	[C] Trim Point*	[D] Average Length of Stay	[E] Trim Point*	
Peripheral, Cranial and Other Nervous System Disorders	2.3 days	8 days	8.8 days	32 days	24 days
Peripheral Vascular Disorders	3.3 days	9 days	4.9 days	19 days	10 days
Connective Tissue Disorders	2.3 days	6 days	5.3 days	21 days	15 days
Spinal Procedures	4.1 days	23 days	10.2 days	56 days	33 days

Source: Department of Health Care Policy and Financing, "DRG Weight Table-Discharges 10/1/2003 and After."
* Day after which the daily outlier payment will begin.

As the table shows, for patients with DRGs that reflect complications, the hospital receives outlier payments after a much longer stay than for patients that did not have complications. Because outlier claims typically represent the highest cost and longest hospital stays, it is reasonable to expect that many outlier claims are for conditions that include complications.

To determine whether claims are being incorrectly coded to DRGs without complications, causing hospitals to receive outlier reimbursements earlier than they should, we judgmentally selected a sample of 15 outlier claims from Fiscal Year 2003 and asked the Department's utilization management contractor to review the claims for appropriate DRG coding and medical necessity.

The utilization management contractor determined that for 6 of the 15 claims (40 percent), an incorrect DRG was assigned. For 5 of the claims, the "without complications" DRG was incorrectly assigned, meaning the patient did have complications and should have been assigned a DRG with complications. For 1 claim, a DRG for a more complex procedure was

incorrectly assigned. As a result of the incorrect DRG coding, these providers were overpaid by about $53,000, as shown in the following table. The Department has initiated the recovery process for these funds by reprocessing the claims with the corrected DRG assignment.

Table 4. Department of Health Care Policy and Financing
Overpayments of Outlier Claims Due to Incorrect DRG Coding
Based on Sample Review for Fiscal Year 2003

	DRG Assigned		Reimbursement Amount		Diff. Between Original And Corrected Reimbursements	
Claim	**Original**	**Corrected**	**Original**	**Corrected**	**$**	**%**
1	8	532	$ 50,161	$ 17,740	$ 32,421	65%
2	151	150	21,704	20,488	1,216	6%
3	151	150	11,894	10,381	1,513	13%
4	371	370	76,104	68,610	7,494	10%
5	29	28	33,411	26,918	6,493	19%
6	373	372	67,857	63,547	4,310	6%
Total			**$261,131**	**$207,684**	**$ 53,447**	**20%**

Source: Results of utilization management contractor review of sample of outlier claims.

As the table shows, for these claims, the incorrect coding caused the Department to overpay by an average of about 20 percent for these six claims.

In Fiscal Year 2003, providers filed 855 outlier claims worth nearly $13 million in payments. Of these, 404 claims (47 percent) were for DRGs with or without complications and accounted for about $5.5 million (about 42 percent) of the total outlier payments. It is important to note that some DRGs, such as for a degenerative nervous system disorder, do not have a "with complications" component.

The Department and its utilization management contractor currently do not conduct reviews of outlier claims on a periodic basis to monitor trends or to identify outlier cases for further review. Because miscoding for DRGs can have a significant financial impact on total outlier payments, the Department should work with the utilization management contractor to have all outlier claims for DRGs "without complications" reviewed for all prior years for which records are available (Medicaid providers are required to maintain medical records for six years) to determine whether the correct DRGs were assigned in each case. The Department should reprocess incorrect DRG assignments and track recoveries to document the financial impact of this review. The Department should then use the findings from this process to make future assignments to its utilization management contractor for outlier claims reviews.

In Fiscal Year 2003, the Department had 150 paid outlier claims assigned to a "without complications" DRG totaling about $2.5 million. If the Department were to review all of these 150 claims and determine the same rate of erroneous DRG assignments (40 percent) and the same rate of overpayments (20 percent) as we found for our 15-claim sample, we estimate the Department could identify about $200,000 for recovery. If the Department expanded its review to include all other years for which providers are required to maintain medical records, it is likely that substantially more overpayments would be identified and recovered.

In addition, the Department should review its methodology for setting the trim point on DRGs to address potential miscoding on DRGs without complications. The Department maintains the authority to adjust trim points and DRG weights to ensure that Medicaid payments reasonably reflect the average cost of claims for each DRG. Where necessary, the Department should adjust trim points and DRG weights to reduce or eliminate potential financial incentives for providers to report incorrect information, leading to inaccurate DRG coding.

Recommendation No. 1:

The Department of Health Care Policy and Financing should improve efforts to ensure that outlier claims are appropriate and accurate by:

a. Working with the utilization management contractor to review all outlier claims for DRGs "without complications" for Fiscal Year 2004 and all prior years for which records are available. The Department should reprocess incorrect DRG assignments for recovery and track recoveries to determine the financial impact of miscoding.

b. Expanding future review assignments to include reviews of DRGs without complications.

c. Reviewing the methodology for setting the trim point on DRGs and adjusting trim points and DRG weights as needed to reduce or eliminate potential financial incentives for providers to report inaccurate diagnosis or surgical procedure information on their claims, leading to the assignment of incorrect DRGs.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: July 1, 2006. The Department will evaluate its contract with the Utilization Management Contractor to determine whether it can reallocate resources in order to quickly begin work on implementation of the recommendations. Additionally, the Department may pursue a budget amendment to request the additional dollars to comply with this recommendation. Funds, if appropriated, will be available July 1, 2006.

a. The Department agrees to work with the Utilization Management Contractor to review 10% of all outlier claims for DRGs "without complications" for Fiscal Year 2004 and prior years for which records are available. Recoveries will be pursued where appropriate and tracked in order to determine the financial impact of miscoding and the return on the reviews.

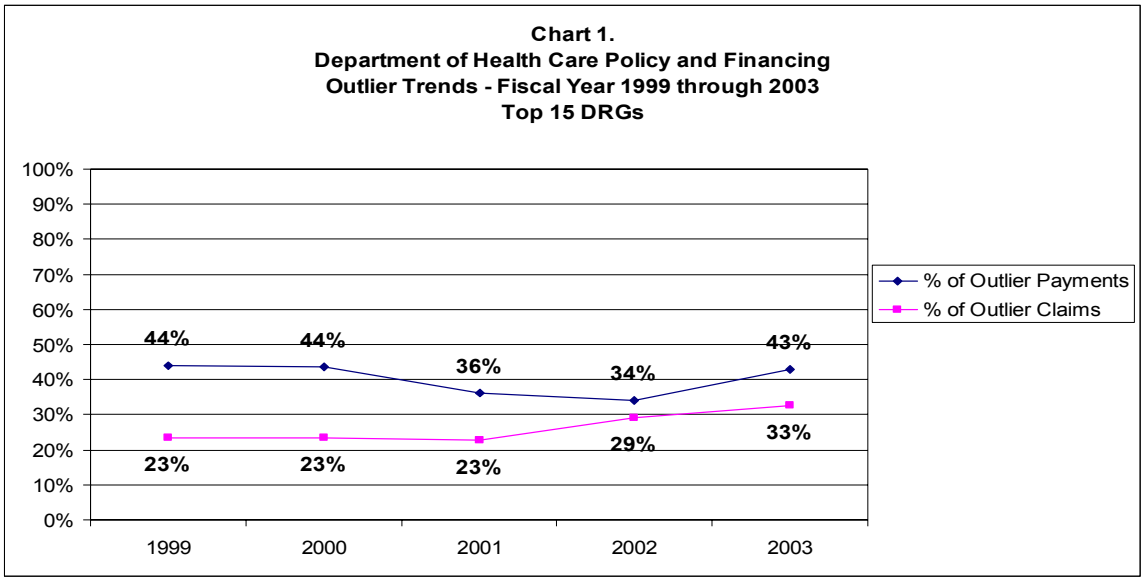
b. The Department agrees to include the review of DRGs "without complications" in future contracts with the Utilization Management Contractor.

c. The Department has already taken steps to implement the recommendation. The Board of Medical Services recently amended the Department's rules regarding

modification to the methodology for calculating trim points. The Department agrees to adjust trim points and DRG weights as needed to reduce or eliminate potential financial incentives for providers to assign incorrect diagnosis codes.

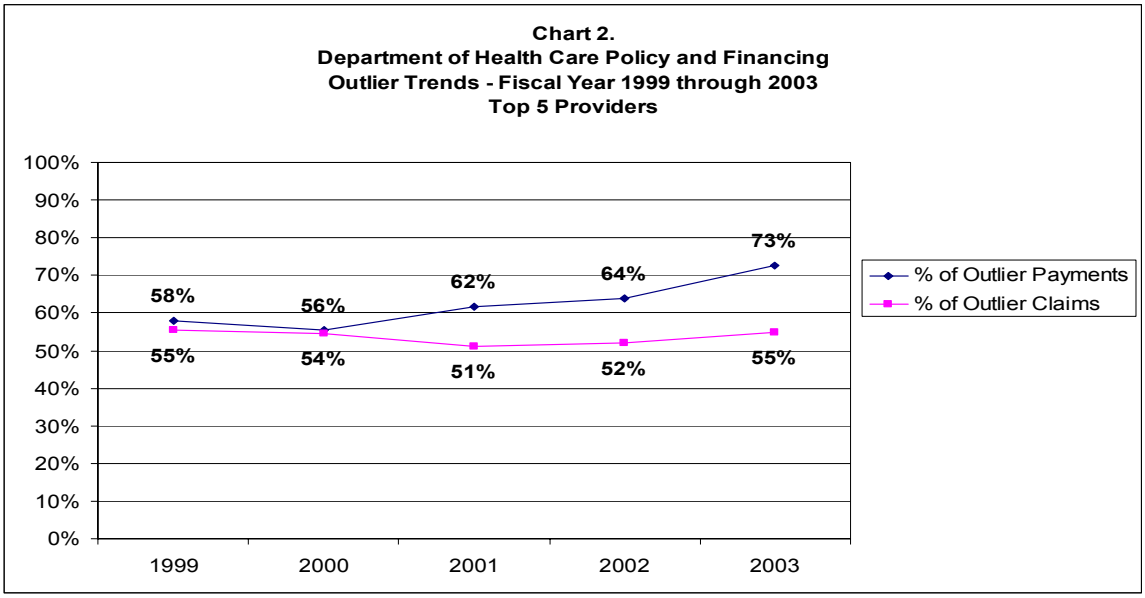
Outlier Trends

One way the Department could identify potentially high-risk claims is by analyzing data to identify trends in DRGs and providers that drive the majority of outlier claims and payments. We analyzed information on inpatient hospital outlier claims for Fiscal Years 1999 through 2003. The following two charts illustrate trends in outlier claims that may be of concern to the Department. Chart 1 indicates that only 15 DRGs (about 3 percent of the more than 500 DRGs) have accounted for 23 to 33 percent of the outlier claims and 34 to 44 percent of the outlier payments over the five year period. This may indicate that these 15 DRGs represent conditions that tend to require longer hospital stays. However, it may also indicate that the trim point for these DRGs is too low, resulting in outlier payments being made sooner than they should be.



Of the 15 claims we reviewed for proper DRG coding with respect to conditions with or without complications, 7 were for DRGs included in the Top 15 DRGs shown in the chart above. Of these 7 claims, 2 were assigned incorrect DRG codes as discussed previously. We also selected a sample of 5 outlier claims from among the highest cost cases for Fiscal Year 2003 (including Medicaid claims ranging from approximately $106,000 to $502,000 each) and asked the Department's utilization management contractor to review them for appropriateness. The purpose of the review was to determine whether hospitals were attempting to recover additional reimbursements for complex cases by keeping these patients in the hospital after the outlier period started. The utilization management contractor determined that the DRG coding and documentation was appropriate for these 5 claims.

Chart 2, below, shows that five hospitals (about 10 percent of the providers who submitted at least one outlier claim) accounted for over 50 percent of the outlier claims and between 56 and 73 percent of outlier payments in Fiscal Years 1999 through 2003. This may mean that these hospitals treat a higher number of complex and high-cost cases than other hospitals. However, it may also indicate that incorrect DRG codes were assigned, causing these hospitals to receive outlier payments that they were not entitled to receive.



These trend data alone do not indicate improper outlier activity or DRG assignment. However, the fact that a small number of DRGs and a small number of hospitals account for a relatively large percentage of outlier claims and payments may indicate risk areas where the Department should focus its medical review resources. Providers filed outlier claims worth about $13 million in Fiscal Year 2003. Identifying claims that have incorrect DRG coding that lead to hospitals receiving higher payments than they should, and identifying DRGs that drive a high proportion of outlier costs, could help the Department control outlier costs and ensure that all outlier claims are appropriate.

The Department should conduct a quarterly analysis of outlier trends by provider, DRG, cost, and other relevant criteria to identify and research any aberrant trends, including potentially abusive practices by providers. This analysis should be used to determine the extent to which outlier claims should be included in the reviews conducted by the utilization management contractor. Given the potential for inaccurate DRG coding in outlier cases, the Department should consider including outlier claims (particularly those coded to DRGs without complications) as part of a more risk-based process for selecting claims/providers for review.

Recommendation No. 2:

The Department of Health Care Policy and Financing should conduct a quarterly analysis of outlier trends by provider, by DRG, by cost, and other relevant criteria to identify and research any aberrant trends, including potentially abusive practices by providers. The

Department should use this analysis to help determine the focus of future reviews by the utilization management contractor.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: April 2005. The Department will conduct a quarterly analysis of outlier trends by provider, by DRG, by cost and other relevant criteria to identify and research any aberrant trends, including potentially abusive practices by providers. The Department will use this analysis to help determine the focus of future reviews by the Utilization Management Contractor. In order to assure completeness of claims data, the Department will conduct an analysis of the first quarter of Fiscal Year 2004-2005 in April of 2005.

Concurrent Authorization

A mechanism the Department could consider to help further control outlier costs is a concurrent authorization process. This process would be based on the Departments' prior authorization request (PAR), which is a document that providers are required to submit to request that the Medicaid program approve and pay for certain services. PARs must be completed for certain procedures, admissions, durable medical equipment (DME), non-emergency medical transportation, certain home health services, and physical and occupational therapy provided by independent therapists. PARs are submitted for review and approval by the Department's medical review contractor.

The Department currently does not require any type of authorization for claims before they reach outlier status. Although the current outlier payment system and the use of trim points serve as disincentives for hospitals to inappropriately keep patients until they reach outlier status, the Department could consider concurrent authorization for outliers to help ensure outlier claims are appropriate. To require concurrent authorization the Department would need to modify or expand the medical review contractor's review responsibilities and develop a review methodology that is specific to the outlier system.

Recommendation No. 3:

The Department of Health Care Policy and Financing should consider implementing a concurrent authorization process for claims before they reach outlier status, particularly if it identifies aberrant or potentially abusive trends during outlier trend analyses, as suggested in Recommendation No. 2.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: July 1, 2006. The Department agrees to work with the Utilization Management Contractor to develop and implement a concurrent authorization process for claims before they reach outlier status, if it identifies aberrant

or potentially abusive trends during outlier trend analyses conducted in recommendations 1 and 2. The Department will evaluate its contract with the Utilization Management Contractor to determine whether it can reallocate resources in order to quickly begin work on implementation of this recommendation. The Department may pursue a change request to request the additional dollars to comply with this recommendation if it identifies aberrant or potentially abusive trends during outlier trend analyses conducted in recommendations 1 and 2. Funds, if appropriated, will be available July 1, 2006.

Chapter 2

Fee-For-Service Payments for HMO Enrollees

As discussed previously, each HMO contract specifies what services the HMO will provide to enrolled Medicaid clients under the monthly capitation payment. The capitation payment covers all services received by an enrolled client from that HMO, as long as the service is included in the HMO's contract. Certain services not included in the HMO contract are still covered by Medicaid and are billed by providers on a fee-for-service basis. Through our analysis of Medicaid claims data provided by the Department's fiscal agent, ACS, we determined there were over 535,000 claims paid through the fee-for-service system in Fiscal Year 2003 for clients enrolled in HMOs at the time of the service.

We analyzed information provided by the Department to determine whether any of the claims paid as fee-for-service for HMO enrollees were for services covered by the HMO contract. We found that over 95 percent of these claims were for services, diagnoses, and procedures not covered by the HMO contract and were therefore paid appropriately through the fee-for-service system. However, we identified nearly 20,000 claims totaling $1.9 million that may have been inappropriately paid as fee-for-service. Because Medicaid eligibility and enrollment vary constantly (e.g., individuals become eligible for Medicaid or lose eligibility as their financial situation changes and can move among the HMO, PCPP, and non-managed care programs at certain times) each of these claims would need to be individually reviewed to determine if, in fact, it was covered under an HMO contract.

We selected a sample of 40 of these claims with payments totaling about $1,100 to determine if the fee-for-service payments were correct. We found that 9 claims totaling about $280 were covered under the HMO's contract and should not have been paid as fee-for-service. This represents an error rate of about 22 percent. Although the sample reviewed was not statistically valid, the rate of incorrect payments in the sample is sufficiently high to be of concern. Details of the incorrect payments are as follows:

- Two claims were improperly paid by the fiscal agent as fee-for-service claims. The first claim was for blood work done at an outpatient hospital. The HMO incorrectly denied the claim as a non-covered service and ACS then incorrectly processed the claim for payment as fee-for-service. The second claim was for a clinic visit for a pregnant Medicaid client. There was an input error on the claim form, indicating the incorrect HMO for this client. ACS incorrectly processed the claim for payment as fee-for-service instead of denying it and instructing the provider to bill the claim to the correct HMO. These two claims totaled about $140.

- Seven claims were automatically paid as fee-for-service claims because eligibility and enrollment information contained in the Department's claims payments and eligibility systems either at the time of service or at the time of payment was outdated and did not reflect HMO coverage. The amount of these claims totaled about $140. The Department had already identified 5 of these 7 claims through its payment correction

process (described below), but it still must spend considerable staff time and resources to identify and attempt recovery of these overpayments.

One of the challenges inherent in the Department's oversight of managed care is that Medicaid eligibility and HMO enrollment information frequently changes. A client's financial resources affect Medicaid eligibility; thus, a change in a client's financial situation can result in loss of eligibility. Additionally, during an annual open enrollment period, clients have the ability to switch between HMOs, and under certain circumstances, terminate their HMO coverage and move to a Primary Care Physician practice or the non-managed care program. These factors increase the likelihood that claims will be paid inappropriately since changes in eligibility and enrollment are not current in the system.

Review Processes for Paid Claims

To identify and recover fee-for-service claims that should have been covered by an HMO, the Department conducts an annual review of its HMO clients and claims. This payment correction process, which is described in more detail later in this chapter, compares information on claims automatically paid through the MMIS with client eligibility and enrollment data to identify claims that were paid incorrectly based on eligibility or enrollment data that was inaccurate at the time of payment. The comparison does not specifically include claims that were paid after being flagged by MMIS to be reviewed by the fiscal agent for approval.

Of the nine incorrect fee-for-service payments we found, the Department had already identified five for recovery through this annual process. Two claims, reflecting services for newborns, were not identified through the payment correction process because, at the time the payment correction process was completed, 18 to 20 months after the service dates, the eligibility and enrollment information in the Department's automated systems did not correctly identify these claims as covered by an HMO. Newborn claims are discussed in more detail later in this chapter. The other two claims, which were incorrectly authorized for payment through the fee-for-service system by ACS, were also not identified by the Department because the payment correction process does not specifically include claims suspended by MMIS and subsequently approved for payment by the fiscal agent. The Department could complete a periodic match of claims approved for payment by ACS with eligibility and enrollment data to identify incorrect payments made by the fiscal agent.

Prior to mid-2002, the Department administered a Medicaid quality control program−the Claims Processing Assessment System (CPAS)−to examine and evaluate the accuracy of claims processing and payments. In accordance with its contract with the Department, ACS ran the CPAS automated program based on parameters established by the Department. The CPAS function selected a sample of claims that Department staff reviewed to determine whether recipients were eligible for services and whether claims were paid timely and accurately. The purpose of the system was to identify and initiate corrective actions for any errors found through the sample review process. In addition to identifying errors in paid claims, this process provided the Department with an objective means of overseeing fiscal agent activities.

According to the Department, the CPAS program was discontinued in mid-2002 so that staff resources could be shifted to implement requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Department reports that when the CPAS program was operational, it required less than one full-time equivalent employee. Department staff also stated that the CPAS was an effective tool for identifying problematic claims payment issues.

The Department's payment correction process (described in detail later in the chapter) is useful for identifying claims payments for future recoveries. Unlike the CPAS program, however, the payment correction process does not identify process-related problems that need to be corrected, and it does not specifically identify claims that are suspended by MMIS but then approved for payment by ACS. The Department should reinstate the CPAS process and undertake additional review of claims that are suspended from payment by MMIS due to HMO enrollment and approved for payment as fee-for-service claims by ACS. These processes would improve the Department's ability to identify and recover incorrect payments, determine the causes of claims payment errors, and make changes to reduce errors in the future.

Recommendation No. 4:

The Department of Health Care Policy and Financing should improve the accuracy of claims payments by:

a. Reinstating its quality control process for Medicaid claims using the Claims Processing Assessment System (CPAS).

b. Periodically reviewing a sample of fee-for-service claims suspended from payment by MMIS due to HMO enrollment, which are then paid as fee-for-service claims by the fiscal agent. Based on the findings of these reviews, the Department should update and clarify edit resolution text to assist the fiscal agent in interpreting appropriate payment or denial actions for these claims.

c. Using these processes to identify and implement any necessary changes to MMIS, along with any process improvements and clarifications for manual reviews by the fiscal agent.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: January 2005. The Department is current with CPAS reviews.

a. HIPAA implementation was complete the fourth quarter of the last fiscal year, Fiscal Year 2003-2004, and it was always the Department's intent to reinstitute CPAS. The first data pull was made for the first quarter of Fiscal Year 2004-2005 and is now being analyzed by Department staff. This will continue on a quarterly basis.

b. Operations staff and systems staff will work with program staff to develop a recurring report in BOA, the Decision Support System, on fee for service claims paid for clients who are enrolled in HMOs. They can then analyze the reason for forcing the edit and if it was appropriate, then assess the process and clarify edit resolution where necessary to assure accuracy of claims payment and denials. This report will be revised, if necessary, by January 2005.

c. Agree as specified in A and B above.

Payments for Newborns

A provision in all HMO contracts requires that covered services be furnished to newborns of enrolled members for up to 60 calendar days from the date of birth. For a newborn to be entered into the eligibility system for proper processing of claims, the birth must first be reported to a county human services technician. This county employee is responsible for assigning a State ID and processing the newborn for Medicaid eligibility. Once Medicaid eligible, the newborn can be enrolled in an HMO. County technicians work directly with Medicaid clients to facilitate the eligibility and enrollment processes, subject to state statutes and Department policies. Once the infant is enrolled, the Department pays the HMO a monthly capitation payment.

For Fiscal Year 2003, the Department identified about $945,000 in fee-for-service payments for newborn services that should have been covered by HMOs. This represents about 20 percent of the $4.7 million in incorrect fee-for-service payments identified through the Department's payment correction process for Fiscal Year 2003. Thus, the Department is aware that fee-for-service payments for newborns that should have been enrolled in HMOs is a significant problem.

According to the Department, the process for obtaining Medicaid eligibility for newborns and processing them for HMO enrollment is frequently delayed. The Department reports that counties do not always receive notification of birth timely and that all the information required to initiate the Medicaid eligibility process is not always provided, delaying eligibility determination. When these delays occur, newborn services are paid as fee-for-service even if the child could have been enrolled in an HMO. The Department has worked with counties to encourage prompt reporting of newborns by families or providers and is developing other approaches to expedite the eligibility determination and HMO enrollment of newborns. For example, CBMS, the Department's new unified benefits management system, was designed to facilitate newborn reporting by providing county technicians with periodic system "flags" or notifications regarding the progress of pregnant mothers. These flags will allow county workers to track when a pregnant client is close to her delivery date and contact the client to obtain newborn information at the appropriate time.

In addition, the Department is considering the establishment of Medicaid application sites at large providers. These sites would simplify and expedite the process of applying for Medicaid eligibility and enrolling the newborn in a health plan. By allowing certain providers, such as hospitals, to accept Medicaid applications and determine eligibility on-site,

mothers would be able to apply for eligibility and enroll their newborns in a Medicaid program before they leave the hospital. House Bill 04-1058, enacted in 2004, allows the Department to designate specified entities, in addition to county social services departments, to accept medical assistance applications and determine Medicaid eligibility. However, the act also limits the number of designated entities to the following three: "the private service contractor that administers the children's basic health plan, Denver Health and Hospitals, and a hospital that is designated as a regional pediatric trauma center." After implementing the provisions of this act, the Department should evaluate the success of these designated sites in increasing the enrollment of newborns in the Medicaid Program. On the basis of its evaluation, the Department should consider whether a statutory change to expand its ability to designate other providers would further increase the number of newborns enrolled in the Medicaid Program.

The Department believes these efforts will help reduce the number and amount of claims for newborns that are inappropriately paid as fee-for-service. However, the Department does not currently track any data related to the elapsed time from a newborn's birth to the time the infant is determined to be Medicaid eligible and the time he or she is enrolled in an HMO. As a result, there are no data to assess where significant delays occur or whether certain counties experience more difficulty in enrolling newborns than others. This type of information is critical for the Department to design processes to address this issue.

Recommendation No. 5:

The Department of Health Care Policy and Financing should expand efforts to reduce the number and amount of newborn claims that are inappropriately paid as fee-for-service by:

a. Collecting data to determine where lags in the newborn enrollment process occur, whether certain counties experience more problems in this area than others, and what additional processes could be implemented to reduce inappropriate fee-for-service claims for newborns.

b. As part of its next payment correction process, evaluating the extent to which CBMS reduces the newborn portion of incorrect fee-for-service payments for HMO enrollees.

c. After implementing the provisions of HB 04-1058, evaluating the success of the designated sites in increasing newborn enrollment in Medicaid and considering the possibility of pursuing statutory change to expand its ability to designate other providers.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: July 2005.

a. The Department agrees to collect and evaluate data to evaluate where lags in the newborn enrollment process occur and whether certain counties experience more problems in this area than others. This information will be used to modify current efforts and/or design additional processes to reduce the number and amount of

newborn claims that are inappropriately paid as fee for service.

b. The Department, as part of its next payment correction process, agrees to evaluate the extent to which CBMS reduced the newborn portion of incorrect fee for-service payments for HMO enrollees.

c. The Department supports the expansion of its ability to designate other medical assistance sites.

HMO Payment Corrections

As mentioned previously, the Department completes an annual payment correction process to identify any overpayments made to contract HMOs. This process is a computer-based match of capitation and fee-for-service claims payments with Medicaid eligibility and enrollment files. Through this process, the Department identifies claims that were paid incorrectly, including claims paid to HMOs that should have been paid through the fee-for-service system, and vice versa. The process also identifies months for which an HMO should have received a capitation payment for a Medicaid client but, due to the timing of eligibility and enrollment data, did not receive this payment. Thus, results include a net calculation of amounts due to/from the Department for each HMO. The payment correction process is completed approximately one year after the end of each fiscal year.

For Fiscal Year 2003 the Department identified net HMO payment corrections of about $5.3 million. The following table provides detailed information on these corrections.

Table 5. Department of Health Care Policy and Financing
Fiscal Year 2003 HMO Payment Corrections

Payment Correction Type/Description	Amount Due From (To) HMOs
Fee-For-Service Payments for HMO Enrolled Clients	$4,748,985
Ineligible Clients (includes payments for service dates after a client's date of death)	1,851,406
Home and Community Based Services[1]	774,745
Third-Party Liability[2]	572,515
Fee-For-Service Payments for HMO Clients "Flipped" From the Plan[3]	328,796
Incorrect Rate Payment[4]	169,826
Unpaid Capitation Payments to HMOs	(51,003)
Unpaid Capitations to HMOs For Clients Incorrectly Listed as Disenrolled	(344,451)
Institutional[5]	(2,714,489)
Total	**$5,336,330**

Source: Department of Health Care Policy and Financing, "Payment Correction for Plans (FY 2003)", June 7, 2004.
Notes:
1 HMOs receive a higher capitation rate for clients receiving home and community based services
2 HMOs receive a separate rate for clients who have insurance coverage.
3 Clients who are enrolled in an HMO and are erroneously disenrolled for a period of up to three months but are then re-enrolled by the fourth month are referred to as "flippers". This occurs as a result of occasional eligibility system problems.
4 Capitation payments to HMOs vary based on characteristics such as eligibility type, county of residence, and age, among others.
5 HMOs receive a higher capitation rate for clients requiring nursing home or other institutional care.

The net amount due from HMOs, as identified by the payment correction process, varies from year to year, but the total amount for the past four years totals about $36 million. The table below summarizes payment correction amounts for Fiscal Years 2000 through 2003.

Table 6. Department of Health Care Policy and Financing
HMO Payment Corrections – Net Amount Due From HMOs
Fiscal Years 2000 through 2003

	FY 2000	FY 2001	FY 2002	FY 2003	Total
Payment Correction Amount	$9,736,000	$14,231,000	$6,774,000	$5,336,000	$36,077,000

Source: Department of Health Care Policy and Financing, Rates Section, "Payment Correction for Plans (FY99-FY02) and (FY03)."

Once the HMO payment correction process is completed, the Department sends a demand letter to each HMO indicating the results of this reconciliation and the amount due from the HMO. Depending upon the circumstances in each case, the Department can: 1) request a check from the HMO for the repayment; 2) recover the funds through a full or partial offset against current payments to the HMO; or 3) negotiate a settlement with the HMO that reflects a combination of claims payments, payment correction repayments, and other relevant issues.

Payment offsets and negotiated settlements frequently involve claims across multiple fiscal years. For example, the Department may reduce capitation payments to an HMO in Fiscal Year 2005 for incorrect payments made in 2003 and a settlement agreement may include amounts the Department owes an HMO to settle a legal issue from one year and amounts the HMO owes the Department from overpayments in another year. The Department's accounting system accounts for the net activity of all payments and recoveries, but does not discretely report the detail of individual recoveries. According to the Department, it is very difficult to track individual recoveries, particularly in the case of settlements, because so many factors are considered in agreeing to a negotiated settlement.

A shortcoming of the Department's process is that payment corrections are calculated more than one year after the close of the fiscal year. As a result, the Department may find it difficult to recover payments owed by HMOs that may either no longer contract with the Department or no longer be in business. Though an HMO would still have a contractual obligation to reimburse the Department for previous years' overpayments, collection of these amounts could be more difficult once the Department and the HMO no longer have an ongoing business relationship. In addition, because the payment correction process occurs so long after the incorrect payments were made, the Department loses the use of those improperly-paid funds for a significant amount of time and may lose interest on the funds. As Table 5, above, shows, the Department lost the use of over $5 million from at least June 30, 2003 (the end of Fiscal Year 2003) and June 2004 (when the payment correction process for Fiscal Year 2003 was completed). In some cases, funds may be tied up for much longer, for those incorrect payments that occurred early in Fiscal Year 2003, such as in July 2002, and were not identified through the payment correction process until June 2004.

To make the payment correction process as accurate and timely as possible, the Department needs to allow time for eligibility and enrollment information to be updated and to allow

claims to be processed through the system. Pursuant to Medicaid policy, providers have up to 120 days after the service date to submit a claim for payment. Therefore, the Department could complete its payment correction process twice a year for claims for service provided at least six months earlier. This frequency would allow sufficient time for claims to be submitted and for eligibility and enrollment updates to be reflected in the system while allowing the Department to identify incorrect payments and begin recoveries sooner. More frequent payment correction would also reduce the risks associated with attempting recoveries from HMOs that are no longer under contract with the Department or are no longer in business.

Recommendation No. 6:

The Department of Health Care Policy and Financing should improve the timeliness of payment recoveries by conducting the HMO payment correction process twice per year.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: January 2005. The Department will begin conducting the HMO payment correction process twice per year.

Chapter 3

Medicaid Claims After Date of Death

In Colorado, county technicians within each county's social services department are the primary contact point for families to report the death of a Medicaid recipient. When the county technician receives date of death information, it is entered into the Colorado Benefits Management System (CBMS), which maintains eligibility records for Medicaid clients. Prior to the implementation of CBMS, client eligibility information was maintained in the Client Oriented Information Network (COIN). County technicians update specific screens in CBMS to indicate a final eligibility date for a Medicaid client who has died, along with a reason code indicating that eligibility is terminated due to the death of the client. On a daily basis, Medicaid eligibility information from CBMS is uploaded into the MMIS. The MMIS contains specific programming language, in the form of system edits, to deny any Medicaid claims submitted for service dates after death.

Through its payment correction process, the Department identified over $1.8 million in payments to HMOs for ineligible clients for Fiscal Year 2003, including those who were ineligible due to death. This amount accounted for nearly 35 percent of all the overpayments identified by the Department. Currently, the Department's payment correction process does not distinguish between clients who are ineligible due to death from those ineligible due to other reasons.

Comparison of Claims with Date of Death Information

To determine the extent of payments made for service dates after date of death, we obtained Fiscal Year 2003 paid claims data from the Department's fiscal agent along with the Fiscal Year 2003 Medicaid client eligibility file. In Fiscal Year 2003, the Department paid over 20.6 million claims for $2.2 billion and the Medicaid client eligibility file included over 2.2 million client records. To identify claims that may have been paid for service dates after date of death, we compared the 20.6 million claims with death data from two sources, as follows:

- **Social Security Administration (SSA) Death Master File**. The Death Master File (DMF) from the Social Security Administration (SSA) contains over 65 million records of reported deaths. The SSA receives direct reports of deaths from relatives and friends of the deceased and from funeral homes. The SSA also obtains data by crosschecking its own files with information from other federal and state agencies, including vital records offices. The DMF we used contains death data from approximately 1935 through March 2004. For purposes of this analysis, we used records with dates of death from 1990 through 2003. This file contains various information on each decedent, including: social security number, name, date of birth, date of death, and ZIP code of last residence.

- **Colorado Department of Public Health and Environment (CDPHE) Death Data.** When a Colorado resident dies, either the physician or the coroner fills out the cause of death portion of the death certificate. This certificate is then forwarded to the funeral home, or other funeral-related establishment. The funeral industry is required to complete the demographic information on the death certificate and forward it to the local vital statistics office. There is a vital statistics office in each of Colorado's 64 counties, typically within the county's health department. The vital statistics office is required by statute to forward the death certificate to CDPHE. The Office of Vital Statistics in CDPHE provided a death data file covering the period 2001 through 2003. This file includes the following information on each decedent, if available: social security number, name, date of birth, date of death, gender, and a code indicating the county where the death occurred.

Based on our analysis, we identified almost 19,000 claims totaling almost $2.1 million paid for service dates after date of death in Fiscal Year 2003, as shown in the table below.

Table 7. Department of Health Care Policy and Financing
Results of Fiscal Year 2003 Data Analysis
Paid Claims for Services after Date of Death

Date of Death Source	Number of Clients	Number of Claims	Paid Amount
Medicaid Clients With Same Date of Death in Both SSA and CDPHE Data	4,530	10,208	$878,598
Medicaid Clients With Different Date of Death in SSA and CDPHE Data	254	1,675	$186,479
Medicaid Clients With Date of Death in SSA Data But Not CDPHE Data	433	5,563	$835,156
Medicaid Clients with Date of Death in CDPHE Data But Not SSA Data	238	1,528	$187,487
Total	**5,455**	**18,974**	**$2,087,720**

Source: Clifton Gunderson analysis using SSA Death Master File, CDPHE death data file, and Health Care Policy and Financing Fiscal Year 2003 Medicaid claims data.

It is important to note that the amount of claims paid for service dates after date of death as shown in the table could be over- or under-stated for a number of reasons. First, the basis for our data match is the client's social security number. It is possible that the social security number in the Department's eligibility information is incorrect. For example, a Medicaid client may have the social security number of his or her spouse or other family member listed as the client's social security number in the eligibility file. If the spouse dies, yet the living spouse remains Medicaid eligible, our analysis would show claims for the living client as paid incorrectly after date of death when they would actually be legitimate Medicaid claims. Second, the SSA and CDPHE obtain death data from different sources and each data set could be missing information.

After we analyzed claims displayed in Table 7, above, we determined that 1,909 claims for approximately $882,000 (about 42 percent of the total $2,087,720 we identified) were paid to HMOs for services after a client's date of death. The Department had already identified 853 of these claims through its payment correction process. These claims total about $520,000 and the Department is proceeding with recovery. However, the Department did not identify the remaining 1,056 claims valued at $362,000. We provided the Department with

information on these claims and it is reviewing them to determine what actions it will take to recover improper payments and address incorrect client information in the eligibility system or MMIS.

State Date of Death Studies

In early 2003 the Department had a study conducted by a contractor to identify incorrect payments made for services after a Medicaid beneficiary's date of death. The contractor reviewed dates of service in Calendar Years 1999 through 2001. The contractor used MMIS client records and state vital statistics files to identify claims that were paid for services provided after a client's date of death. On the basis of this review, the Department processed 225 claims for recovery of about $156,000. The Department does not routinely compare Medicaid client data with date of death information to identify incorrect payments. The Department indicates it is not planning any additional date of death projects.

Payment for Medicaid services after date of death is a continuing concern for many states. To assess how states currently address this issue, we conducted a national survey of State Medicaid Directors, State Auditors, and State Medicaid Fraud Control Units. In total, 40 states responded to our survey. The survey responses indicated that 28 states have conducted reviews to identify payments after death and reduce the frequency of such payments. About three-quarters of the reviews used state vital statistics data and the remaining one-quarter used SSA data. On the basis of their reviews, the solution most frequently recommended to reduce the number of payments after date of death was to improve processes for the accurate and timely recording of date of death information into the payment system and to conduct periodic matches of eligibility data with vital records and/or the SSA Death Master File, updating Medicaid recipient master files accordingly. After completing its review of the claims we identified as incorrectly paid due to date of death, the Department should consider periodically conducting a match of paid claims with date of death information from CDPHE and the SSA.

Beginning in February 2004, the Department changed the timing of monthly capitation payments to HMOs. Prior to this date, HMO capitation payments were made before the beginning of the month. Since eligibility changes frequently take place on the last day of the month, payments made to HMOs prior to the end of the month could be incorrect. Now that the Department pays HMOs at the beginning of the month, eligibility files should be more accurate and the number of payments made after date of death should decline. The change in the timing of HMO payments should also reduce the amount of staff time and Departmental resources required to identify and recover incorrect payments in the future.

Recommendation No. 7:

The Department of Health Care Policy and Financing should take steps to reduce the amount of paid claims for clients after death by:

a. Using the claim-specific data provided through this audit to identify and recover any payments made for services provided after date of death.

b. Periodically conducting a data match of eligibility files and paid claims with date of death data from the Colorado Department of Public Health and Environment and/or the Social Security Administration to identify and pursue recovery of any claims paid for service dates after date of death.

c. Updating client eligibility files as indicated on the basis of parts "a" and "b" of this recommendation.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: March 2005.

a. The Department agrees to use the claim-specific data provided through this audit to identify and recover any payments made for services provided after date of death.

b. The Department will periodically conduct a data match of eligibility files and paid claims with date of death data from the Colorado Department of Public Health and Environment and/or the Social Security Administration to identify and pursue recovery of any claims paid for service dates after date of death.

c. The Department will ensure that client eligibility files are updated as indicated.

Chapter 4

Medicaid Rate Changes

The Department maintains authority to change reimbursement rates paid to Medicaid providers. Rate changes can result from provisions in the State budget, the level of Medicaid funding, and from other Medicaid policy decisions. The Department contracts with an outside firm to assist in calculating provider rates. This contractor audits and compiles information from Medicare and Medicaid cost reports filed by providers. Federal regulations require cost reports documenting provider-specific activity for the year, including revenues, expenditures, and service-related statistical information, to be filed annually. The Department uses data from the cost reports to calculate reimbursement rates, which are then provided to the Department's fiscal agent, ACS. ACS is responsible for updating and conducting a quality control review of MMIS rate tables to ensure that rate information is input correctly.

The Department indicates that both hospitals and Federally Qualified Health Centers (FQHCs) had Medicaid rate changes during Fiscal Year 2004. FQHCs are health centers approved by the federal government as programs to provide low cost health care services. They can include community health centers, tribal health clinics, migrant health services, and health centers for the homeless.

Rate changes may be entered into the MMIS prior to the effective date of change or retroactively. When a rate change is made retroactively, the MMIS has the capacity to "mass adjust" prior claims and pay them at the correct level. Operationally within MMIS, the mass adjustment includes the following three steps: 1) the initial claim payment; 2) a negative claim payment to offset this original amount; and 3) a claim payment at the proper reimbursement rate.

Hospital Rates

As mentioned previously, inpatient hospital care is reimbursed through the Prospective Payment System in which payment levels are set in advance of each year. Each hospital has a base rate that is used along with the Diagnosis Related Grouping (DRG) code assigned to each inpatient stay to calculate the Medicaid reimbursement for that patient.

According to information provided by the Department, 75 hospitals had rate changes in Fiscal Year 2004. Of these hospitals, 31 had rate decreases while 44 had rate increases. Fiscal Year 2004 hospital rate changes were entered into MMIS in August 2003 with an effective date of September 1, 2003. We tested a sample of 177 service dates for the 31 hospitals with rate decreases to determine whether claims reflected the correct payment rates. All tested claims reflected the appropriate hospital base rates, with no exceptions noted.

Federally Qualified Health Center (FQHC) Rates

FQHCs can be freestanding or affiliated with a hospital. Freestanding FQHCs are reimbursed through an all-inclusive encounter rate for each patient visit. Hospital-affiliated FQHCs are reimbursed at 100 percent of reasonable cost as reported on the Medicare cost report, subject to Department guidelines for audit and verification of the reported data. This report is used to determine a provider's allowable costs, based upon Medicare reimbursement rules and regulations. Allowable costs serve as the basis for determining a provider's reimbursement rate.

The Department provided us with a list of 20 freestanding FQHCs with rate decreases effective for dates of service beginning July 1, 2003. There were no FQHCs with rate increases in Fiscal Year 2004. According to the Department, this rate change was initiated by the Legislature in June 2003, which required a $2.8 million decrease in payments to FQHCs. The Department developed the methodology to achieve the required payment reduction, and calculated the rate decreases necessary for implementation. The Department completed the methodology and rate determinations in early October and on October 9, 2003, forwarded the new rates to ACS for input into the MMIS rate tables. Because the effective date for the rates was retroactive to July 1, 2003, this process required a "mass adjustment" in MMIS, so that any claims with service dates on or after the effective date but before the new rate was effective in the system were reprocessed.

We reviewed a sample of 93 claims for the 20 FQHCs to determine whether the claims reflected the correct payment rates. We identified one exception for a claim paid at $128.72 for a service date of July 1, 2003. The correct rate for this claim was $125.49. The Department worked with ACS to research this issue and determined that when the mass adjustment was entered, the effective date was keyed as 7/10/03 instead of 7/01/03. In addition to the sample claim, the Department determined that only one other claim was paid during this period at the incorrect rate of $128.72. This claim had a service date of July 8, 2003.

According to ACS, internal quality control processes require staff to check rate change transmittals twice−once after the rate is updated and once after the mass adjustment criteria has been entered. For this transmittal, each provider number required a mass adjustment, so each individual provider was checked through the quality control process. However, the keying error for this provider was not identified during this process.

Recommendation No. 8:

The Department of Health Care Policy and Financing should work with the fiscal agent to ensure that its quality control process for rate changes includes a review of all rate change parameters that are input into MMIS, including the effective dates of rate changes.

Department of Health Care Policy and Financing Response:

Agree. Implementation Date: Immediate review of all transmittals. Review of policy and procedure in December 2004.

Given the criticality of accurate rate updates, the Department currently monitors rate change updates when notified that the transmittal requesting the change has been closed. Transmittals are not finalized by the fiscal agent until they have gone through their internal quality control checks. Operation staff will review all policy and processes utilized by claims and quality control staff at the fiscal agent to monitor the accuracy of their data input and mass adjustments, and make changes where appropriate. Both entities will continue to monitor each rate change and mass adjustment 100%.

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