# REPORT OF

# THE

# STATE AUDITOR

## Medicaid Management Information System
## Department of Health Care Policy and Financing

**Performance Audit**
**May 2001**

# LEGISLATIVE AUDIT COMMITTEE
# 2001 MEMBERS

***Representative Fran Coleman***
**Chairman**

***Senator Jack Taylor***
**Vice-Chairman**

***Senator Norma Anderson***
***Representative Glenn Scott***
***Senator Stephanie Takis***
***Senator Ron Tupa***
***Representative Val Vigil***
***Representative Tambor Williams***

## Office of the State Auditor Staff

***J. David Barba***
**State Auditor**

***Joanne Hill***
**Deputy State Auditor**

***Sally W. Symanski***
***Cindy P. Drake***
***Illana Poley***
**Legislative Auditors**

**STATE OF COLORADO**

J. DAVID BARBA, CPA
State Auditor

**OFFICE OF THE STATE AUDITOR**
(303) 866-2051
FAX(303)866-2060

Legislative Services Building
200 East 14th Avenue
Denver, Colorado 80203-2211

May 21, 2001

Members of the Legislative Audit Committee:

This report contains the results of our performance audit of the Medicaid Management Information System. 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 state government. The report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing.

# TABLE OF CONTENTS

**STATE OF COLORADO**
**OFFICE OF THE STATE AUDITOR** **REPORT SUMMARY**
**J. DAVID BARBA, CPA**
**State Auditor**

# Medicaid Management Information System
# Department of Health Care Policy and Financing
# Performance Audit
# May 2001

## Authority, Purpose, and Scope

This audit of the Medicaid Management Information System (MMIS) was conducted under the authority of Section 2-3-103, C.R.S., which authorizes the Office of the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. The audit was performed in accordance with generally accepted auditing standards. The purpose of the audit was to review the Department of Health Care Policy and Financing's (HCPF) controls over claims processing through MMIS for the Colorado Medicaid program. We reviewed documentation, analyzed data, and interviewed personnel at the Department and at the State's fiscal agent for the program, Consultec, LLC. Audit work was performed between September 2000 and May 2001. As part of our audit, Buck Consultants performed a technical review on aspects of MMIS operations. Results of Buck Consultants' work have been incorporated into this report as noted in the text.

We would like to express our appreciation for the assistance and cooperation extended by management and staff at the Department of Health Care Policy and Financing and at Consultec, LLC.

## Overview

The Medicaid program was enacted by the federal government in 1965 to provide health care to qualifying low-income individuals. In Fiscal Year 2000 the Colorado Medicaid program had expenditures of over $1.7 billion for health care services and served an average monthly enrollment of approximately 273,700 recipients. The Medicaid program is an entitlement, which means that any state participating in the program must serve all individuals who are eligible and enrolled. The program is funded by about 50 percent state general funds and 50 percent federal matching funds. Medicaid is the largest federal program administered by the State.

The Department of Health Care Policy and Financing is the agency designated by the State to administer the Medicaid program. The Medical Services Board, appointed by the Governor, establishes state Medicaid rules and regulations. The Department of Human Services determines an individual's eligibility for Medicaid through the county departments of social services and administers mental health and developmental disabilities programs, which receive Medicaid funds.

As part of its Medicaid plan each state is required by federal regulations to have an automated claims processing and information retrieval system, referred to as the Medicaid Management Information

System (MMIS). In 1996, HCPF contracted with Consultec to design, develop, and install a new MMIS for the State, and in December 1998, Medicaid claims processing was converted to the new system. The cost of the system was about $25.2 million. In October 1999 the federal Health Care Financing Administration certified MMIS, thus enabling the State to receive the enhanced federal matching rate (90 percent for design, development, and implementation; 75 percent for operations) both retroactively to conversion and prospectively. Currently the Colorado MMIS processes over one million claims on behalf of Medicaid recipients each month.

Since December 1998, Consultec has also served as the State's fiscal agent for the Medicaid program. Consultec is responsible for overseeing claims processing and ensuring payments are appropriate. In Fiscal Year 2000 the fiscal agent received about $11.5 million to perform these services.

Out of the over one million claims submitted by providers and processed through MMIS each month, approximately 95 percent are electronic and 5 percent are paper. This does not include the monthly capitation payments to managed care organizations, including HMOs. Paper claims are manually keyed into MMIS, at which point they are processed in the same manner as electronic claims.

As claims are processed through MMIS, they are "reviewed" by a complex series of approximately 700 system edits designed to ensure payments are accurate and allowable under the Medicaid program, based on the type of claim and service and other factors. The edits "flag" claims as they are processed to be either paid, denied, or placed into suspense; these settings are referred to as "edit dispositions." The fiscal agent's claim technicians manually resolve suspended claims by using on-line "edit resolution text," which outlines the appropriate action to take for the particular claim. Once edits are resolved, the claim is placed back into the processing queue. Each Friday, provider payment records, based on claims approved for payment, are uploaded from MMIS into the State's financial system. Payments are issued to providers by warrants or electronic fund transfers.

## Department Oversight of Claims Processing

The key performance measures for claims processing are timeliness and accuracy. "Accuracy" in this context refers to whether paid claims are accurately calculated and are allowable under state Medicaid policy. Our audit found that while HCPF has numerous processes in place for overseeing the fiscal agent's activities and claims processing, the Department lacks adequate, systematic methods for monitoring the basic performance benchmarks of both accuracy and timeliness. Further, our analysis indicates the need to improve the accuracy of claims processing and to ensure timeliness requirements are met.

**Accuracy**. The Department reports that its most recent claims audit (October 2000) showed a financial error rate of less than 1 percent; this is within the industry standard for financial error rates in an automated claims processing environment. The financial error rate is the absolute value of payment errors in the sample divided by the dollars paid for all claims in the sample.

As part of our audit, Buck Consultants tested a random sample of 150 suspended claims to evaluate the quality and efficiency of claims processing. The auditors found that 26 claims (17.3 percent) had some type of error that occurred because of a mistake made during processing. While there is no industry standard for a tolerable error rate on suspended claims, there is general agreement that an error rate of 17.3 percent is unacceptably high. Buck Consultants noted that suspended claims have already been subject to the fiscal agent's data entry quality assurance procedures, which should have identified and corrected the great majority of the errors identified. Quality assurance procedures should be improved to increase processing efficiency by correcting these errors earlier, rather than allowing data entry errors to cause claims to suspend. At that point manual intervention is required to correct the problem and processing is delayed. Additionally, more effective quality assurance procedures would address the risk of data entry errors going undetected when the errors do not cause the claim to suspend.

We noted the following concerns with the Department's mechanisms for monitoring accuracy.

*Claims audits performed by HCPF staff.*

- The Department has not established specific measurable goals for accuracy of payment, either for the fiscal agent or for the Department itself.

- The Department has not ensured that claims audits are completed on a routine basis. Only three audits on samples of paid claims have been performed since the installation of the new MMIS on December 1, 1998. These audits should be performed at least quarterly.

- The Department has not reported financial error rates that reflect all errors identified in the claims audits. The reported rates reflect only errors attributable to the fiscal agent. The overall financial error rate reflecting errors attributable to both the Department and the fiscal agent should be calculated. This overall rate would reflect the extent to which payments are accurate and in accordance with Medicaid policy. For example, the March 2000 claims audit reported a financial error rate of 4 percent for the fiscal agent. However, the rate reflecting all errors, regardless of source, would have been 10.4 percent. The industry standard in an automated claims processing environment for the financial error rate is 1 percent or less.

- The Department has not formally communicated the results of claims audits to the fiscal agent and to HCPF staff and ensured that corrective action plans are developed and implemented.

*Fiscal agent quality assurance (QA) procedures.* The errors identified by Buck Consultants were either due to mistakes made in data entry of paper claims or problems with the edit resolution function. These results indicate weaknesses in the fiscal agent's QA procedures over both the data entry and edit resolution functions. In addition, the fiscal agent does not perform audits on samples of paid claims. Buck Consultants reports that in a commercial automated claims processing environment, standards require that 3 percent of the volume of processed claims be audited.

*Review of edits and edit resolution text.* The Department and fiscal agent staff have reviewed fewer than 200 of the 700 edits in MMIS, along with the related edit dispositions and resolution text. The Department reports that some problems have resulted because the resolution text does not always appropriately match the edits in the new MMIS. Additionally, inappropriate edit dispositions have in some instances contributed to inaccurate payments and high volumes of suspended claims.

**Timeliness**. The Department has not required the fiscal agent to provide reports on timeliness measures established in the contract. The contract requires that 100 percent of electronic claims be processed to the point of approval or denial in the next daily cycle after receipt; 90 percent of paper claims must be processed within 15 calendar days of receipt. The fiscal agent reports "average" processing times from entry to approval or denial. Averages are not a satisfactory measure, because they may obscure instances in which some claims take an unacceptably long time to process. As a result, the Department is unable to determine if the contract requirements are being met.

For suspended claims, the contract requires that 100 percent be processed within 25 calendar days of receipt. Buck Consultants found that for its sample of suspended claims, only 56.6 percent met processing requirements. In a separate analysis, we found that out of the nearly 25,400 claims in suspense on February 28, 2001, almost 23 percent (over 5,700 claims) had been in MMIS for over 25 calendar days. Over 900 claims had been in suspense for over six months.

## Medicaid Providers

Medicaid providers include a broad range of professions and facilities. Under state and federal requirements, a Medicaid provider must have a valid license or certificate, as applicable, to furnish the goods or services charged to the program. HCPF is responsible for ensuring this requirement is met. The Department of Regulatory Agencies (DORA) and the Department of Public Health and Environment are responsible for issuing licenses and certifications and otherwise regulating the various types of providers as a whole in the State. The fiscal agent reports that about 16,600 providers have submitted claims under Medicaid during the current fiscal year.

We compared information from DORA on licensed professionals in the State for three of the major professions (physicians, pharmacists, and dentists) with the provider database maintained on MMIS. Out of a sample of 131 providers, we found that 65, or just under half, currently had valid licenses; the remaining 66 did not. Because of the manner in which we chose our sample, these results are not indicative that a similar percentage of all MMIS providers lack licenses. However, these results do confirm that there are unlicensed providers in the MMIS database. Out of the 66 unlicensed providers, we found 7 that had received almost 580 payments totaling about $2540. These seven providers all either had inactive licenses or had allowed their licenses to lapse.

The Office of the State Auditor has previously issued recommendations to HCPF directed at, among other things, the need to (1) verify licensing and other provider credentials and (2) perform periodic reenrollments of providers. The Department has made some progress in addressing these areas.

- **Reenrollment of providers**. The Department has begun a three-year phased reenrollment of the 1,700 Primary Care Physicians in the Medicaid program. The Department has not yet developed a plan for reenrolling other providers or a policy on frequency of reenrollment.

- **Deactivation of nonparticipating providers**. Recently the Department worked with the fiscal agent to identify providers that have not submitted claims in three years, and as a result, over 6,000 providers were placed on "inactive" status. The Department has not established a policy on how often deactivations will occur or what benchmark will be used in the future.

- **Data match project**. The Department has several staff working on matching licensing information from DORA with providers on MMIS. The process is highly manual because the two databases are not compatible, and the match is not yet completed. HCPF plans to electronically perform this match with data from DORA, but no time frame has been established for implementation and no policy has been established for how often the match would be performed. Many professional licenses must be renewed every two years.

In addition, we found that, with the exception of the Board of Medicaid Examiners at DORA, the Department has not established protocols with the state agencies that regulate providers to receive information on providers that have had their licenses revoked or suspended.

We also found that the Department should work with providers to enforce Medicaid rules requiring providers to submit electronic, rather than paper, claims. In addition, the Department should propose rules to the Medical Services Board requiring payment to providers by electronic fund transfers (EFTs). At present, the Department makes approximately 53 percent of all provider payments under Medicaid by state warrant and only 47 percent by EFT.

The Department agreed with all 14 recommendations in the report. A summary of our recommendations and the Department's responses can be found in the Recommendation Locator.

## RECOMMENDATION LOCATOR

**All recommendations are addressed to the Department of Health Care Policy and Financing.**

| Rec. No. | Page No. | Recommendation Summary | Agency Response | Implementation Date |
|---|---|---|---|---|
| 1 | 33 | Ensure claims processed through MMIS are accurate and allowable under the Medicaid program by (a) establishing appropriate performance measures for claims processing, (b) conducting regular claims audits on at least a quarterly basis, (c) reporting all errors and problems identified in the claims audit, and (d) ensuring corrective action plans are developed and implemented in a timely manner. | Agree | a. June 2001<br>b. September 2001<br>c. September 2001<br>d. September 2001 and Ongoing |
| 2 | 37 | Require that the fiscal agent (a) expand quality assurance procedures for testing the accuracy of data entry on paper claims, (b) conduct regular audits of paid claims on a defined percentage of processed claims, and (c) increase oversight of edit resolution claim technicians and reassess production requirements to ensure suspended claims are appropriately resolved. The Department should monitor results to ensure satisfactory results are obtained. | Agree | a. September 2001<br>b. September 2001<br>c. August 2001 |
| 3 | 39 | Establish the review of MMIS edits, edit dispositions, and edit resolution text as a high priority, and work with the fiscal agent to complete this project as soon as possible. | Agree | August 2001 |
| 4 | 45 | Ensure that timeliness of processing requirements are met for claims processed through MMIS by the fiscal agent. | Agree | September 2001 |
| 5 | 47 | Require that the fiscal agent furnish adequate monthly reports on contractual performance expectations. The Department should monitor compliance with requirements and take corrective action as appropriate. | Agree | September 2001 |

## RECOMMENDATION LOCATOR

**All recommendations are addressed to the Department of Health Care Policy and Financing.**

| Rec. No. | Page No. | Recommendation Summary | Agency Response | Implementation Date |
|---|---|---|---|---|
| 6 | 50 | Ensure that the State receives all programming hours stipulated in the contract and that system change requests for MMIS are addressed in a timely manner. | Agree | Ongoing |
| 7 | 53 | Establish a formal policy on requests to the fiscal agent for changes to the MMIS reference table data. | Agree | October 2001 |
| 8 | 62 | Develop and implement adequate controls over the provider database in MMIS by establishing formal policies, procedures, and time frames for (a) routine reenrollment of Medicaid providers, (b) deactivation of providers who have not submitted claims to the Medicaid program for specified lengths of time, and (c) periodic data matches on provider credential information with other state agencies that regulate Medicaid providers. | Agree | August 2001 |
| 9 | 63 | Establish routine communication on disciplinary actions taken by other state agencies that regulate Medicaid providers. | Agree | August 2001 |
| 10 | 64 | Implement edits in MMIS to review laboratory claims for compliance with CLIA requirements in accordance with state Medicaid policy. | Agree | June 2001 |
| 11 | 66 | Work with Medicaid providers and implement electronic claims filing for the Medicaid program as required under state regulations. | Agree | April 2002 |
| 12 | 68 | Propose rules to the Medical Services Board to require electronic payments to providers under the Medicaid program. | Agree | December 2001 |

## RECOMMENDATION LOCATOR

**All recommendations are addressed to the Department of Health Care Policy and Financing.**

| Rec. No. | Page No. | Recommendation Summary | Agency Response | Implementation Date |
|---|---|---|---|---|
| 13 | 70 | Work with the fiscal agent to minimize the cost of processing resubmitted claims by establishing and implementing guidelines for denying claims due to incomplete information and form submission. | Agree | April 2002 |
| 14 | 71 | Work with the fiscal agent to establish specific criteria for claims processing staff to use in identifying claims that should be referred to provider relations for follow-up with specific providers. | Agree | December 2001 |

# Description

## Introduction

The Medicaid program was enacted under the federal Social Security Act (Title XIX) in 1965 to provide health care to low-income individuals meeting certain qualifications. The program is separate and distinct from the federal Medicare program, which funds health services to individuals 65 years of age and older. In Fiscal Year 2000 the Colorado Medicaid program had expenditures of over $1.7 billion for health care services, exclusive of administrative costs and Medicaid funds expended to support the State's Indigent Care Program. During Fiscal Year 2000 the Medicaid program served an average monthly enrollment of approximately 273,700 recipients.

The Medicaid program is an entitlement under federal law. This means that any state participating in the program must serve all individuals who are eligible and enrolled. The program is funded by about 50 percent state general funds and 50 percent federal matching funds. The Medicaid program is the largest federal program administered by the State in terms of federal dollars expended. In terms of state general funds, the Medicaid program's growth in health care service expenditures has exceeded the statutory 6 percent limit annually since Fiscal Year 1992. Thus, the program has a considerable impact on the entire state budget.

The Medicaid program expends more for health care services than any single private sector insurance company operating in the State. The Department reports that the Medicaid program accounts for about 14 percent of all Colorado health care costs.

## Colorado Medicaid Program

Each state designs its own Medicaid program and submits its plan to the federal Health Care Financing Administration (HCFA). HCFA must approve the plan in order for the state to receive federal matching funds. In Colorado the Department of Health Care Policy and Financing (HCPF) is the agency designated by the State to submit the state plan and to oversee and administer the state Medicaid program. The program serves individuals in 12 different eligibility groups on the basis of the individual's income, age, disability,

citizenship status, and other factors (e.g., some pregnant women qualify for Medicaid benefits). Both acute and long-term care services are available to recipients; however, the specific services an individual may access are based on the person's eligibility category. For example, routine preventive dental care benefits are available to children in the Medicaid program, but these services are not available to adults.

Below is a summary of Medicaid service expenditures by major category for recent years. Medicaid administrative costs are not included.

**Table 1: Summary of Medicaid Health Care Service Expenditures[1] by Major Category**

Fiscal Years 1996 - 2000

*(All Funding Sources; Amounts in Millions)*

| Category | Fiscal Year | | | | |
|---|---|---|---|---|---|
| | **1996** | **1997** | **1998** | **1999** | **2000** |
| Nursing Facilities | $297.7 | $325.0 | $329.8 | $346.0 | $357.6 |
| Managed Care Capitation Payments | $174.3 | $236.3 | $236.9 | $305.5 | $356.6 |
| Home and Community Based Services | $159.1 | $177.8 | $202.6 | $262.5 | $288.3 |
| Inpatient Hospital | $229.8 | $200.7 | $199.1 | $215.6 | $210.1 |
| Prescription Drugs | $65.9 | $76.0 | $85.1 | $98.0 | $111.3 |
| Physician Services | $70.5 | $67.6 | $65.5 | $69.6 | $73.8 |
| Home Health Services | $17.4 | $36.2 | $48.2 | $61.1 | $66.0 |
| Outpatient Hospital Services | $50.0 | $45.4 | $50.0 | $46.0 | $60.0 |
| Clinic Services | $49.1 | $65.0 | $64.7 | $50.1 | $60.0 |
| Supplemental Medicare Insurance Premiums | $23.0 | $23.1 | $23.4 | $24.2 | $25.1 |
| Development Disabilities | $26.2 | $24.3 | $22.2 | $21.2 | $20.8 |
| Dental Services | $6.2 | $7.1 | $7.2 | $13.4 | $18.4 |
| Federally Qualified Health Centers | $11.6 | $9.1 | $10.7 | $10.5 | $9.7 |
| Laboratory Services | $7.7 | $6.9 | $6.2 | $6.9 | $8.0 |
| Mental Health Services | $10.3 | $7.0 | $6.9 | $1.8 | $3.7 |
| Other Services | $51.8 | $47.7 | $50.4 | $62.9 | $71.4 |
| **Total, Medicaid Health Care Services** | **$1,250.** | **$1,355.** | **$1,408.** | **$1,595.** | **$1,740.** |
| *Medicaid Funds Expended for Colorado Indigent Care Program* | *$144.1* | *$136.3* | *$146.7* | *$195.1* | *$140.6* |
| **Total, All Medicaid-Funded Services** | **$1,394.** | **$1,491.** | **$1,555.** | **$1,790.** | **$1,881.** |

**Source:** Office of the State Auditor analysis of agency data.

[1]Expenditures are from quarterly HCFA 64 reports submitted by the Department of Health Care Policy and Financing (HCPF) to the federal government. These reports are prepared on the cash basis of accounting and show amounts*paid* during the period. Expenditures reflect Medicaid services funded through HCPF and through the Department of Human Services (DHS). DHS administers the mental health and developmental disabilities programs. The table is compiled on the basis of the state fiscal year. Medicaid administrative expenditures are not included.

# Payment of Medicaid Services

The Colorado Medicaid program has an average monthly enrollment of well over a quarter of a million recipients. These individuals lack financial resources and may be elderly, physically or mentally disabled, and/or mentally ill. Currently over one million claims are processed on behalf of these recipients each month. The following table illustrates the average caseload of individuals in the Colorado Medicaid program, the number of claims processed, and the average number of claims processed for each individual each month over a four-year period.

**Table 2: Summary of Medicaid Caseloads and Claims**
Fiscal Years 1998 - 2001

| Fiscal Year | Average Monthly Caseload | Claims Processed[1] | Avg. Claims per Individual per Month |
|---|---|---|---|
| 1998 | 259,776 | 8,984,759 | 2.88 |
| 1999 | 259,031 | 11,319,207 | 3.64 |
| 2000 | 273,724 | 12,559,420 | 3.82 |
| 2001[2] | 288,612 | 12,919,866 | 3.73 |

**Source:** Office of the State Auditor analysis of agency data.
[1]Includes both paid and denied claims. Monthly capitation payments made to managed care organizations, including HMOs, are not counted as "claims."
[2]Fiscal Year 2001 caseloads are appropriated amounts; claims data is the Department's estimate for Fiscal Year 2001.

Ensuring that each payment for Medicaid services is accurate and allowable under laws and regulations is a complex and critical function of every state's Medicaid program. In addition to the accuracy of the payment calculation, factors that must be assessed for each payment include:

- Is the individual eligible for and enrolled in the Medicaid program?
- Do the services qualify under Medicaid program rules for the individual?
- Is the provider of the services an eligible and enrolled provider in the Medicaid program?

In order to handle the large volume of transactions in the Medicaid program, each state is required to have an automated claims processing and information retrieval system as part of its federally approved Medicaid plan. Under federal

regulations this system is referred to as the Medicaid Management Information System (MMIS). Each state's MMIS must undergo a review and approval process by the Health Care Financing Administration in order for the state to receive an enhanced rate of federal matching funds for its MMIS. As of 1972 the federal government has made available enhanced matching funds for an approved MMIS of 90 percent for design, development, and installation, and 75 percent for ongoing operations. This is considerably higher than the approximately 50 percent federal matching rate available for Medicaid expenditures for other administrative costs and for benefits to recipients.

Under federal regulations states are allowed to contract with an entity to perform the role of fiscal agent for their Medicaid program. The Medicaid fiscal agent is responsible for overseeing the claims processing operations of MMIS and ensuring payments are appropriate. In Colorado, HCPF contracts with Consultec, LLC, a subsidiary of Affiliated Computer Services, Inc., to fulfill the role of fiscal agent. Nationally, 35 states contract with another entity to perform all fiscal agent functions. Of these, seven states in addition to Colorado have contracted with Consultec to perform this service.

# Administrative Structure of Medicaid Program

While HCPF is the state agency responsible for administering the Colorado Medicaid program, including overseeing the fiscal agent, other entities have key roles in the program. In particular, the Medical Services Board, appointed by the Governor, establishes state rules and regulations for the program. The Department of Human Services (DHS) is responsible for determining an individual's eligibility for Medicaid services through the county departments of social services. DHS also administers mental health and developmental disabilities programs that receive Medicaid funds. Medicaid services overseen by DHS also are paid through the fiscal agent and MMIS.

The table below shows expenditures for Medicaid administration, including a breakdown for the cost of processing claims and operating MMIS, since Fiscal Year 1996. This table does not reflect the $25.2 million the State expended for the implementation of a new MMIS that became operational on December 1, 1998.

**Table 3: Medicaid Administrative and Health Care Service Expenditures[1]**
Fiscal Years 1996 - 2000
*(All Funding Sources; Amounts in Millions)*

| Expenditures | Fiscal Year | | | | |
|---|---|---|---|---|---|
| | **1996** | **1997** | **1998** | **1999** | **2000** |
| **Administration[2]** (exclusive of MMIS operations) | $48.2 | $41.6 | $52.3 | $62.6 | $60.5 |
| **MMIS Operational Costs[3]** | $10.1 | $10.0 | $9.7 | $10.8 | $12.7 |
| **Total Admin. Expenditures[4]** | $58.3 | $51.6 | $62.0 | $73.4 | $73.2 |
| **Medicaid Health Care Service Expenditures[2]** | $1,250.6 | $1,355.2 | $1,408.9 | $1,595.3 | $1,740.8 |
| **Total Medicaid Expenditures** | **$1,308.9** | **$1,406.8** | **$1,470.9** | **$1,668.7** | **$1,814.0** |
| **Total Admin. as a % of Total Medicaid Expenditures[4]** | 4.5% | 3.7% | 4.2% | 4.4% | 4.0% |

**Source:** Office of the State Auditor analysis of agency data.
[1]Medicaid funds for Disproportionate Share and Graduate Medical Education are used to support the Colorado Indigent Care Program; these funds are excluded from this table.
[2]Expenditures are from quarterly HCFA 64 reports submitted by the Department of Health Care Policy and Financing (HCPF) to the federal government. These reports are prepared on the cash basis of accounting and show amounts *paid* during the period. Administration includes indirect costs.
[3]Includes approximately $1.2 million in addition to payments of $11.5 million to fiscal agent for Fiscal Year 2000. Amounts are from the state financial system, which reports information on an accrual basis. Amounts do not include costs for design, development, and implementation of the new MMIS, which totaled approximately $25.2 million.
[4]Administrative expenditures for federal reporting purposes, as shown here, include some expenditures classified as "program" expenditures by the Department for state budgeting and reporting purposes. These include, among others, expenditures for the Single Entry Point program, county pass through and administration, and administration at the Department of Human Services for mental health and developmental disabilities programs. In Fiscal Year 2000 the total amount of federal "administrative" expenditures classified as "program" expenditures by HCPF was $35.2 million. Under this treatment, administrative expenditures were about 2.1% ($38 million) of total Medicaid expenditures.

# Implementation and Operation of the New MMIS

In September 1994, HCPF began the procurement process to rebid the contract for fiscal agent services for the Colorado Medicaid program. In addition,

because the then-existing MMIS was about 20 years old, the Department was seeking a contractor to develop and install a new MMIS. In August 1996 the Department signed a contract with Consultec to develop and implement the new MMIS and to serve as the State's fiscal agent after installation of the system. The projected implementation date for the new MMIS was July 1, 1998. The contract provided that Consultec would serve as the fiscal agent for three years, with an option to renew the contract for five succeeding one-year periods upon the agreement of both the State and Consultec.

According to the contract, the cost for the implementation phase of the new MMIS was to be about $25.2 million. For the operations phase, the base cost for Consultec to serve as the fiscal agent was placed at about $9.1 million for the first year and increased to a little over $9.8 million by the third year. These costs did not reflect certain costs that were to be passed through directly to the State. Additionally, pricing for the operations phase was based on a maximum claims volume of eight million claims per year. For claims in excess of this threshold, the State would reimburse Consultec at 40 percent of the bid price per claim (bid price per claim was about $1.18 for Fiscal Year 2000).

The new MMIS took over two years to develop. After a test period of several months, during which the new system was run parallel with the prior system for two months, the new MMIS was implemented on December 1, 1998, or five months later than originally scheduled. In addition to the contracted costs of $25.2 million, HCPF expended about $2 million for various enhancements to the system and provisions for additional training for HCPF staff. In October 1999 the State received certification from the federal Health Care Financing Administration. This approval allowed the State to receive the enhanced federal matching rate for implementation costs (90 percent) and operational costs (75 percent). These enhanced rates applied both retroactively to the conversion and prospectively.

## Initial Impact on Claims Processing

The rebidding of the contract and implementation of the new MMIS was a large and critical undertaking for the Department that required significant staff resources over a period of more than four years. In terms of the conversion itself, from the general perspective of operations the conversion appears to have had an impact on activity for the first several months. A review of the months before and after implementation indicates that the number of claims processed was 15 percent less (about 120,000 claims) than the prior six-month's average volume in the first month after implementation. In the second month, volume

was still down about 5 percent. However, these numbers may not fully reflect the impact of the conversion because information is not available on how much of the volume was attributable to claims resubmitted and reprocessed, or how many claims were held in suspense (i.e., accepted into MMIS but not processed) for periods in excess of a month.

Of the 15 major categories of claims, some of those particularly adversely affected by the implementation include inpatient and outpatient claims, Home Health and Home and Community Based Services claims, transportation claims, and medical supply claims. By the third month after the conversion the number of claims processed overall had increased substantially. In the subsequent months volume appears to reasonably approximate expected levels. In terms of the timeliness of payments, we were unable to obtain information that would allow us to assess the impact of the conversion. Limitations on information available about timeliness of claims processing and claims held in suspense are discussed in Chapter 1.

To determine Medicaid providers' level of satisfaction with the performance of the fiscal agent, the Department conducted a survey using a sample of providers in the summer of 2000, or about 18 months after implementation. Results indicated that providers rate the fiscal agent's performance somewhat above average (about 5.3 to 7.1) across various aspects of service on a scale of 1 to 10 (10 high).

## MMIS Operations Costs

In terms of what the State has actually expended for the operations phase of MMIS, for Fiscal Year 2000, which was the first full fiscal year of operations under the new contract, costs were slightly over $11.5 million. The table below summarizes contract expenditures specifically incurred by the State for Fiscal Year 2000, as well as the amounts requested by the Department for contract operations for Fiscal Year 2001 and 2002. As the table shows, for Fiscal Year 2000 the State expended almost $2.3 million in pass-through costs and claims overage costs. The claims overage costs resulted because the actual number of claims processed was about 12.6 million, or about 4.6 million greater than the 8 million claims threshold upon which the contractual fixed price was based. The Department had anticipated during the initial contracting process that the threshold would be significantly exceeded. The 12.6 million in actual claims for Fiscal Year 2000 was about 1 million greater than the estimate of 11.6 million claims prepared by the Department in 1996. Overall, the average cost per claim, including pass-through costs and the claims overage charge, was about $.92 for Fiscal Year 2000.

**Table 4: MMIS Contract Costs for Operations**
Fiscal Years 2000 - 2002

| Type of Costs | Fiscal Year 2000 Actual Expenditures | Fiscal Year 2001 Approp. With Supplemental Request | Fiscal Year 2002 Budget Request Amendment |
|---|---|---|---|
| Fixed contractual costs | $9,279,184 | $9,875,638 | $10,004,021 |
| Pass-through costs[1] | $345,549 | $357,194 | $357,442 |
| Claims overage costs[2] | $1,903,407 | $2,420,574 | $2,603,008 |
| Total contract costs | $11,528,140 | $12,653,406 | $12,964,471 |
| Encounter claims | – | $19,011 | $4,263,893 |
| Total contract with encounter claims | $11,528,140 | $12,672,417 | $17,228,364 |

**Source:** Office of the State Auditor analysis of agency data.
[1]Pass-through costs include postage incurred by the fiscal agent for provider mailings and the fiscal agent's cost of maintaining an electronic provider bulletin board.
[2]Cost of processing claims in excess of the 8,000,000 claims per year upon which the fixed contract costs were based. In Fiscal Year 2000, actual claims were 12,559,420, or 4,559,420 over the base amount. The State anticipated claims would significantly exceed the 8,000,000 base amount for claims.

In addition to regular operations costs, for Fiscal Years 2001 and 2002 the table reflects costs related to encounter claims. Encounter claims, which are presently not processed through MMIS, will in the future be submitted by managed care organizations to report information about the specific services provided to Medicaid patients. Unlike other claims, encounter claims do not require payment. Rather, the purpose of encounter claims is to track service utilization under managed care organizations, including HMOs, thus providing accountability to the State for these services. Additionally, encounter claims will allow the Department to have access to more comprehensive data to use in setting rates for contracts with managed care organizations.

The $19,011 shown in the table for Fiscal Year 2001 is for start-up costs the Department is incurring for putting the encounter claims procedures and systems into place. This involves working with managed care organizations to submit encounter claims and with the fiscal agent to enable MMIS to process the claims. HCPF intends to have managed care organizations begin submitting encounter claims for processing in Fiscal Year 2002.

## Contract Renegotiations With the Fiscal Agent

Since the summer of 2000 the Department has been engaged in renegotiations with Consultec regarding the MMIS contract. The last year of the three-year contractual period ends on November 30, 2001, and the State and Consultec must come to an agreement about whether to extend the contract. The Department reached a tentative agreement with Consultec on the financial terms for extending the contract in December 2000, contingent upon finalization of the State's budget for Fiscal Year 2002. Subsequently, the Department's request with regard to MMIS operational costs was incorporated into the finalized state budget, and HCPF anticipates that the contract will be extended for the full five "option" years. As a contingency, the Department requested and received a plan from Consultec for turning over operations to another vendor, should the contract negotiations ultimately fail.

# Audit Scope and Methodology

The purpose of the audit is to review the Department's controls over claims processing for health care services in the Medicaid program. We obtained and reviewed documentation and interviewed personnel at the Department and at Consultec, LLC, regarding the Department's oversight of claims processing and the performance of the MMIS. We analyzed information on claims processing, particularly with regard to accuracy and timeliness, as well as policies and procedures related to provider eligibility and enrollment in the Medicaid program.

As part of our audit, Buck Consultants was engaged to perform a technical review on specific aspects of MMIS operations, including system edits and the quality assurance function over claims processing. The results of the work performed by Buck Consultants have been incorporated into this report in the appropriate sections.

# Contract Oversight

## Chapter 1

## Introduction

The Department of Health Care Policy and Financing (HCPF) is responsible for overseeing the State's Medicaid program. One important aspect of this responsibility is ensuring that appropriate payments are made to the approximately 16,600 providers who furnish services to program recipients. If providers do not believe that payments are made promptly and accurately, this can affect their participation in the Medicaid program and ultimately, access to services for recipients. In Fiscal Year 2000 Medicaid had an average monthly enrollment of approximately 273,700 individuals and generated claims payments of about $148 million per month. Due to the large volume of expenditures, the Medicaid program has a significant impact on the State's budget and on the health care community in the State.

HCPF contracts with another entity to serve as the State's fiscal agent. The fiscal agent is responsible for ensuring that claims submitted by providers are processed through the Medicaid Management Information System (MMIS) in accordance with state Medicaid policy in a timely and accurate manner. In addition to overseeing the processing of claims, which average over one million per month, the fiscal agent is responsible for provider relations and enrollment into the Medicaid program. (Chapter 2 discusses providers and the Medicaid program.)

## Features of the New MMIS

In December 1998 the State implemented a new MMIS for the Medicaid program, and Consultec, LLC, assumed the responsibilities of being the State's fiscal agent. Consultec was also contracted to develop the new system.

The new MMIS represents an improvement in technology available to the Department for operating the Medicaid program. The system is a relational database operated on a mainframe, while the user interface operates on a local area network with the Windows operating system. Some of the enhanced programming features in the new MMIS are discussed later in this chapter.

One of the new MMIS's primary advantages is that it incorporates an executive information system and decision support system (EIS/DSS) accessible by HCPF staff. The EIS/DSS receives monthly uploads of MMIS claims data and stores fives years' worth of information. Staff are able to create their own reports and perform analysis on the data. If necessary, they can obtain the detailed individual claim data behind the summarized information in reports. This capability to access underlying data was not available on the previous system, or was only available with great effort and considerable time delays. Because of this expanded ability to analyze information at the most detailed level, HCPF staff have an increased ability to monitor trends in costs and utilization of services for the different populations in the Medicaid program. This analytical capacity can be used to assist with budgeting, rate setting for managed care contracts and, to some extent, identifying improper payments. These types of analyses are particularly important in the Medicaid program because of its large impact on the State's budget.

## Overview of Claims Processing

As mentioned, the fiscal agent currently oversees the processing of an average of over one million claims per month. This includes claims submitted by providers in paper and electronic format; approximately 5 percent of claims are submitted on paper. This does not include the monthly capitation payments to managed care organizations, including HMOs, that are also processed through MMIS. Capitation payments are based on enrollment rosters generated in MMIS from Medicaid eligibility information maintained in the State's eligibility system, the Client-Oriented Information Network (COIN). This eligibility information is uploaded routinely into MMIS.

Paper claims are imaged for archive purposes and then manually keyed into MMIS, at which point they are processed in the same manner as electronic claims. All claims are assigned a unique identification number. As claims are processed through MMIS, they are "reviewed" by a complex series of system edits. These edits represent logic programmed into MMIS that is designed to ensure each claim is processed appropriately based on the type of claim, the type of service, the eligibility category of the individual, and other factors. Edits are also intended to ensure that the claim contains all required information, meets basic criteria (e.g., the claim is not a duplicate; the claim has a prior authorization request associated with it, if required), and is internally consistent (e.g., the date of service is not after the date of claim submission).

MMIS contains approximately 700 edits for processing claims. As a claim is processed through MMIS, the edits are set to "flag" claims to be either paid, denied, or placed into suspense; an edit may also be set to "ignore" certain types of claims. These settings are referred to as "edit dispositions." When an edit causes a claim to be placed into suspense,

the claim must be manually reviewed by the fiscal agent's claim technicians. This review is referred to as the "edit resolution process." During this process the technicians resolve the edit or edits that caused the claim to suspend, using on-line text that specifically instructs the technician on the appropriate action to take, depending on the nature of the claim. The text is referred to as the "edit resolution text." After the resolution process is complete, the claim is placed back into the processing queue. System edits, and the related edit resolution process, are critical factors in ensuring that payments made under the State's Medicaid program are accurate and allowable.

Each Friday, all provider payment records, which are based on claims approved for payment during the previous week, are uploaded into COFRS, the State's financial system. On the basis of this information, payments are issued to providers by either warrants or electronic fund transfers. Remittance advice statements are furnished to all providers.

# Departmental Oversight of Claims Processing

For a program of the size and complexity of Medicaid, it is essential that performance measures are established and adequate controls are in place to assess whether or not requirements are met. This information becomes the basis for identifying problems and improving performance. In terms of claims processing, the key performance measures are those for timeliness and accuracy of claims payments. "Accuracy" in this context refers to whether or not claims are both accurately calculated and allowable under state Medicaid policy.

Our audit found that the Department has established performance expectations for claims processing in a number of areas, including timeliness of processing; however, it has not established measures for accuracy of payment. Further, although HCPF has numerous processes in place for overseeing the fiscal agent's activities and obtaining information about claims processing, the Department lacks adequate, systematic methods for monitoring the basic performance benchmarks of both accuracy and timeliness. Analysis performed during our audit indicates that accuracy rates for claims processing need to be improved and that certain timeliness requirements are not being met.

# Controls Over Claims Processing

The Department reports that although adequate testing of the new MMIS was performed to permit the conversion to take place in December 1998, there were some areas in which testing was not as thorough as the State had originally intended. In addition, staff point out that in the conversion of a system as massive and complex as MMIS, some unanticipated problems are likely to occur. Considerable effort has been expended over the first two years to correct various system problems. Overall, staff believe that system problems resulting from the conversion have been largely identified and addressed.

In terms of performance monitoring of operational requirements, the Department's primary concerns during the first two years have been with the fiscal agent's call center, which handles inquiries from providers; the number of claims held in suspense for more than 25 days; and processing requirements related to paper claims and prior authorization requests. The Department assessed liquid damages against the fiscal agent in the amount of almost $280,000 during the first year and a half of operations for problems in these areas, of which less than $40,000 was actually collected. During contract renegotiations, as part of a tentative agreement and upon consultation with the Governor's Office and the Joint Budget Committee, the Department agreed to drop outstanding damages except those related to the call center. It was agreed that these would be reassessed based on future performance in that area over a six-month period.

Currently the Department uses a variety of methods to oversee claims processing and to gain feedback about MMIS operations.

**Roles of HCPF personnel**. The Department's personnel have varying levels of involvement with the fiscal agent and different roles in the oversight process.

*Contract Administrator*. This individual has the primary responsibility for overseeing the fiscal agent's performance in terms of operations, or claims processing. Duties include:

- Monitor the fiscal agent's performance in relation to the contract requirements through reports and other means.
- Ensure necessary communications occur between the Department and the fiscal agent to appropriately implement new policy and program initiatives for the Medicaid program.
- Oversee provider relations with respect to claims processing and billing issues.
- Attend regular weekly and monthly meetings with the fiscal agent on various topics, including performance.

- Serve as the primary communication link between personnel at the Department and the fiscal agent to resolve questions about claims processing.
- Authorize formal transmittals, or change requests (such as requests for rate changes in MMIS), made to the fiscal agent, with the exception of requests for formal programming changes. Three other HCPF staff are able to authorize these transmittals.

*Information Systems (IS) Section*. The Manager of the IS Section serves as the technical liaison for HCPF with the fiscal agent and attends several key regular meetings with fiscal agent staff. As a whole, staff in the IS Section are responsible for oversight of the technical or "systems" aspects of MMIS and ensuring that policy decisions are appropriately operationalized. Duties include:

- Establish priorities for outstanding system change requests for MMIS.
- Direct the fiscal agent's systems staff on system changes to MMIS. Fiscal agent staff perform all programming; however, all changes must be reviewed and approved by HCPF staff prior to implementation.
- Serve as technical support on changes that do not require reprogramming but impact claims processing. For example, IS staff are routinely involved in decisions about edit dispositions in MMIS and changes to the dispositions.
- Perform periodic tests on samples of paid claims to assess the accuracy of the claims processing function at the fiscal agent.

*Other departmental staff*. The Department's program staff are responsible for setting policy for the Medicaid program. They interact with fiscal agent staff routinely on an "as needed" basis. A number of program staff have access to the MMIS decision support system software, and they are able to obtain and manipulate MMIS data and perform various analyses. Program personnel also interact with providers on a regular basis. While program staff do not have defined responsibilities to monitor specific aspects of MMIS claims processing—for example, through reviewing particular daily, weekly, or monthly reports—problems periodically come to their attention. In these cases they forward this information to the Contract Administrator or IS personnel for resolution with the fiscal agent. Both program and budget staff indicate that they generally review MMIS information from the viewpoint of identifying trends in caseloads, costs, and service utilization, rather than from a detailed level of assessing the accuracy of claims processing.

**Meetings between HCPF and the fiscal agent**. The Department and the fiscal agent have a number of regular meetings. There are two pivotal meetings that occur weekly:

- The status meeting, which reviews operational issues. This is routinely attended by the HCPF Contract Administrator and IS Manager and key operational and systems personnel from the fiscal agent. Directors of the Department's program

divisions (e.g., long-term care, managed care, health care programs, and health care systems) may attend periodically. At each meeting the fiscal agent presents reports on claims processing operations for the prior week.

- The system priority meeting, which reviews the status and priorities of outstanding system change requests. This is routinely attended by the IS Manager and key systems personnel from the fiscal agent.

Other regularly scheduled meetings include weekly meetings to review the edits and edit dispositions in MMIS and meetings on the operational "report card" issued by the fiscal agent to HCPF each month. Additionally, Department staff frequently meet with fiscal agent staff or otherwise interact with them outside of these regular meetings.

**Provider feedback**. There are numerous ways in which providers can give feedback about claims processing, policies, or other concerns about the Medicaid program.

- The Medical Services Board, which is the rule-making body appointed by the Governor for the Medicaid program, holds public meetings monthly. Providers often attend these meetings. The meetings are always attended by representatives from the Department, and upon occasion by the fiscal agent.
- There are two Medical Advisory Committees, one appointed by the Governor, that are composed of providers and health care trade associations. These Committees have monthly public meetings. The meetings are attended by representatives from the Department and the fiscal agent.
- The Department's program staff hold a variety of regular meetings for providers that furnish particular services (e.g., Home and Community Based Services) or serve a particular population.
- The fiscal agent maintains a provider call center that answers questions about claims and the Medicaid program. The fiscal agent also has a Provider Relations section that assists providers by holding trainings and issuing bulletins on the program.
- The Department has begun to conduct surveys to identify provider concerns with the Medicaid program and assess the fiscal agent's performance. The first one was conducted in the summer of 2000, and a second with Home and Community Based Services providers was completed in April 2001. The Department plans to continue these surveys, including using some to target different types of providers. As with the first survey, results will be communicated to the Medical Services Board and the fiscal agent. Feedback from the surveys will be used to improve performance.
- Providers contact the Department directly.

# Accuracy of Claims Processing

The Department has implemented various controls to ensure the accuracy of claims payments through MMIS. As mentioned earlier, in this context "accuracy" refers to whether or not claims are accurately calculated and allowable under state Medicaid policy. Although the Department reports that results of a recent claims audit performed on October 2000 claims were favorable, the audit identified areas in which improvements are needed to better ensure claims are processed and paid appropriately.

## Results of Tests on Suspended Claims

As part of our audit, Buck Consultants tested a random sample of 150 claims that had been suspended for manual review. The auditors found that 17.3 percent (26 claims) had some type of procedural error. A procedural error is defined as a claim containing one or more mistakes in the calculation of amounts payable for the claim, or in fields that potentially affect the calculation or management reporting of data (e.g., wrong "diagnosis code" on the claim). The procedural error *rate* is the number of claims identified with procedural errors divided by the total number of claims in the sample. While there is no industry standard for a tolerable error rate on suspended claims, there is general agreement that a procedural error rate of 17.3 percent is unacceptably high. Buck Consultants noted that suspended claims have already been subject to the fiscal agent's data entry quality assurance procedures, which should have identified and corrected the great majority of the errors identified. Instead, the data entry errors caused these claims to suspend, thus requiring manual intervention to correct these errors.

Although procedural errors may not have a financial impact in terms of incorrect payment of claims, the high incidence of procedural errors identified during the audit indicates a need to improve the overall accuracy and quality of claims processing. These factors ultimately can affect accuracy of payment. In its claims audits the Department only calculates the financial error rate. (A financial error rate was not calculated as part of Buck Consultants' audit because at the time of the audit these claims were not processed to the point of payment. Thus, the amount that was later paid on the claims approved for payment was not known.) The Department's claims audits are discussed below; the specific types of errors found by Buck Consultants are discussed later in this chapter.

Another reason for our concern about accuracy of payments is the problems with the edits and the edit resolution text identified by the Department and the fiscal agent's staff. As a result of these problems, the Department and the fiscal agent have begun a review of all edits, edit dispositions, and the edit resolution text to ensure that the edit dispositions reflect

state policy and that the related text is appropriate. By the end of our audit this review was less than one-third completed. Until this review is finished, the Department lacks assurance that all of these critical elements are correct. Problems in these areas can affect accuracy of claims processing. This review is discussed further later in this chapter.

# Mechanisms for Monitoring Accuracy: HCPF

Apart from quality assurance activities performed by the fiscal agent, which are discussed in the next section of this chapter, HCPF has three primary mechanisms it relies upon to ensure accuracy of payment: claims audits performed by Department IS staff on samples of paid claims, feedback from Department program personnel, and feedback from providers. These mechanisms and our assessment of them are described below.

***I. Claims audits performed by HCPF staff***. One of the Department's primary means of monitoring the accuracy of claims processing is the performance of claims audits by IS Section staff. This is the most direct method for the Department to assess payment accuracy. Until 1996 the federal Health Care Financing Administration (HCFA) mandated that claims audits be performed on a routine basis; states may now perform these reviews at their discretion. HCFA permits states to receive federal matching funds for the performance of the claims audits, and the Department has elected to continue performing the audits. We agree that continuing the audits is important because ultimately the federal government will hold the State responsible for amounts paid through the Medicaid program and require settlement for any improperly paid claims.

While the Department has taken a positive step by continuing the audits, it needs to use this tool in a more effective and systematic manner to ensure the audits detect and prevent errors in processing. We noted the following:

**Limited testing of paid claims by HCPF.** Although MMIS processes roughly one million claims per month, the Department has completed only three audits on samples of paid claims since the installation of the new MMIS on December 1, 1998. Audits were completed on January 2000 and March 2000 claims (about 200 nonpharmacy and 200 pharmacy claims each) in June of that year, and an audit of October 2000 claims (about 200 claims in total) was completed in March 2001. No claims audits were performed during the first year of operations; during this period over 12 million claims were processed. The Department reports that no IS staff were available to conduct reviews at that time because they were resolving various system issues that had arisen after implementation. The Department has stated that its intention is to conduct these claims audits in the future on a quarterly basis.

**Limited assessment of errors; lack of performance measures.** We found the Department does not fully utilize the data obtained from claims audits. First, the Department only calculates financial error rates. This rate is the absolute value of payment errors in the sample divided by the dollars paid for all claims in the sample. This is an important measure because it directly affects the dollars spent. However, HCPF should also calculate a procedural error rate in order to gain feedback on the overall quality of claims processing.

Second, in calculating the financial error rate the Department includes only those errors attributable to the fiscal agent. Errors that were identified but could not be attributed to the fiscal agent are not included. For example, in the January 2000 and March 2000 claims audits, the Department identified claims that were approved for payment without being matched with an approved prior authorization request, which was mandatory for these types of claims. Because this error was deemed not attributable to the fiscal agent, it was omitted from the final financial error rate. At the Department's request the fiscal agent reprocessed these claims, which resulted in a recovery to the State of about $1.1 million from 78 providers.

For the purpose of contractual oversight of the fiscal agent, it is appropriate to include only those errors attributable to the fiscal agent in the financial error rate. However, for the purpose of assessing whether payments are accurate and allowable under state Medicaid policy, all errors, regardless of source, should be reflected in an overall financial error rate calculation. This error rate should be a key performance measure for the Department that is reported to its upper management.

The table below summarizes the financial error rates from the three claims audits performed to date. For the January 2000 and March 2000 audits, we have calculated an overall Departmental error rate on the basis of the information in the reports. The narrative in the reports notes additional problems that likely should have been included in a procedural error rate, but we were unable to quantify these for the purposes of calculating this rate. The October 2000 report does not discuss any errors except those related to the fiscal agent, so no data were available to calculate an overall Departmental rate. With the exception of the October 2000 claims audit, all error rates are well above the 1 percent industry standard for financial error rates in an automated claims processing environment.

**Table 5: MMIS Financial Error Rates**
*Results of Claims Audits[1] Performed*
*by Department of Health Care Policy and Financing*
**Industry Standard for Financial Error Rate: #1%**

| Period Tested | Financial Error Rate[2] | |
|---|---|---|
| | **Fiscal Agent Error Rate** | **Overall Departmental Error Rate[3]** |
| ***January 2000*** | | |
| Nonpharmacy claims | 6.6% | 12.3% |
| Pharmacy claims | 27.0% | 27.0% |
| ***March 2000*** | | |
| Nonpharmacy claims | 4.0% | 10.4% |
| Pharmacy claims | 6.8% | 6.8% |
| ***October 2000*** | | |
| All claims | 0.002% | Unknown |

**Source:** Office of the State Auditor analysis of agency data.
[1]The Department performed separate claims audits on pharmacy claims, as opposed to all other claims, for the January 2000 and March 2000 audits. For October 2000, pharmacy claims were included in with other claims for the audit.
[2]The financial error rate is the absolute value of the dollars paid in error divided by the total dollars paid for the claims in the sample. Only paid claims are included in the sample.
[3]The "Overall Departmental Error Rate" includes the "Fiscal Agent Error Rate," plus those errors not attributable to the fiscal agent.

Our other concern in this area is that the Department has not established any specific measurable goals for accuracy of payment, either for the fiscal agent or for the Department itself. This means that in terms of the fiscal agent, the Department lacks contractual performance requirements for accuracy of payment. There are established measurements and benchmarks for accuracy of payment in automated claims processing environments that could serve as a model for the State in this respect.

**Lack of formal communication and adequate follow-through with the fiscal agent on results of claims audits.** For the January 2000 and March 2000 claims audits, the Department did not formally communicate results of the audits to the fiscal agent or ask for a corrective action plan to address the problems identified. Without corrective action, problems are likely to continue. Both reports noted that errors were primarily caused by failure of the fiscal agent's claim technicians to follow the claims resolution instructions that should be used to resolve suspended claims. No formal recommendation was made to the fiscal agent to address this deficiency. At a minimum the Department should have required that the fiscal agent conduct quality assurance tests of the claims resolution process, follow up with claim technician staff as appropriate, and report the results of quality assurance tests to HCPF on a routine basis.

The Department's October 2000 claims audit was completed during our audit in March 2001. The Department communicated the results to the fiscal agent and requested a response and a corrective action plan. Currently the Department is working with the fiscal agent on how deficiencies identified will be addressed.

**Lack of formal communication and adequate follow-through with Department staff on results of claims audits.** The January 2000 and March 2000 claims audits also contained recommendations to the Department on areas that needed to be addressed by its staff. The Department reports that steps have been taken to address a number of the issues raised in the reports, such as the comprehensive review of edits and edit resolution text referred to earlier. However, HCPF did not formally track how all problems identified were to be resolved, who was responsible, and time frames for completion. As a result, several problems were not addressed.

We found two issues identified in the claims audits that should have been referred to the Department's Program Integrity Unit, which is responsible for investigating instances of possible fraud and abuse in the Medicaid program. These problems were not referred to that Unit until after our inquiries during the audit. Thus, the referrals did not take place until over nine months after the issues were first identified.

Using the claims audits to identify not only fiscal agent errors but also areas in which the Department needs to make changes or perform research is a worthwhile use of the claims audits and the considerable resources required to complete them. We encourage the Department to continue using the claims audits in this manner. The audits are the only mechanism used by the Department to perform systematic and in-depth reviews of claims processing and payments, and this opportunity should be used to the fullest extent. HCPF should ensure corrective action plans and other appropriate follow-up are completed for all concerns found during the audits.

**No assessment of timeliness of payment.** Although the Department has information available on how long each claim took to pay when it performs the claims audits, it does not calculate timeliness of processing or payment as part of the claims audits. This is unfortunate because the information provided by the fiscal agent on timeliness is not adequate, as discussed later in this chapter. The Department should use these audits to assess timeliness of processing independently.

***II. Feedback from program personnel***. The Department's second mechanism for monitoring accuracy of claims processing through MMIS is feedback from the program personnel at HCPF. As mentioned earlier, these personnel provide important input on claims processing issues and concerns to the Contract Administrator and to IS Section staff. However, they do not have specific responsibilities assigned to them in terms of monitoring claims processing. Therefore, this mechanism cannot be relied upon to methodically and systematically assess accuracy of payments.

***III. Feedback from providers***. Finally, providers are a good mechanism for the Department to gain feedback regarding accuracy of claims processing. Providers have a vital role in the Medicaid program, and they rely on the Medicaid program to furnish appropriate reimbursement for services rendered. The Department reports that much of the information it receives about problems with claims processing comes from this source. HCPF's ongoing provider surveys should further enhance this important resource. The inherent limit to this mechanism is that providers will be more likely to report underpayments than overpayments.

For example, in the summer of 2000 Department program personnel investigated claims paid to nursing facilities. They identified instances in which some facilities had been overpaid because claims for nursing home residents with overlapping billing periods were not identified as duplicates. In other words, a nursing facility could submit a claim on behalf of a patient for care from April 1 through April 30 and then submit another claim for the same patient for April 13 through the 25, and both claims would be paid. The Department has determined that while this problem may have started prior to the implementation of the current MMIS, several factors have caused the problem to become worse over recent years. Specifically, nursing homes now submit claims almost exclusively using electronic, rather than paper, claims. This has resulted in the homes' routinely billing more than once each month; with paper claims, the homes practice was to bill only once a month. HCPF staff indicate that another contributing factor was a problem with the edit resolution text used by the fiscal agent's claim technicians.

The fiscal agent has determined that over 100 nursing homes, or just over half of the nursing homes receiving Medicaid payments, were overpaid a total of about $1 million

over a period of several years. One home received over $120,000 in overpayments. While these are relatively small amounts compared with the almost $358 million paid to the homes during Fiscal Year 2000 alone, it illustrates the inherent limitation in relying on providers to identify overpayment errors. This problem was not brought forward by the provider community.

### Increased Testing of Payment Accuracy and Allowability

As discussed earlier, the Medicaid program is the largest federal program administered by the State, with expenditures at approximately $2 billion annually. The Department should take stronger measures to ensure that payments for services under this program are accurate and allowable under the Colorado Medicaid program.

---

## Recommendation No. 1:

The Department of Health Care Policy and Financing should ensure claims processed through MMIS are accurate and allowable under the Medicaid program by:

a. Establishing performance measures for claims processing in terms of financial and procedural error rates.

b. Conducting regular claims audits on at least a quarterly basis. Timeliness of processing should be included in the testing procedures.

c. Reporting all errors and problems identified in the claims audit, regardless of source, and calculating procedural and financial error rates both for the fiscal agent and for claims processing overall.

d. Ensuring corrective action plans are developed and implemented in a timely manner by both fiscal agent and Department staff for all issues identified in the claims audits.

## Department of Health Care Policy and Financing Response:

Agree.

a. The Department will work on developing appropriate standards that include measures for procedural error rates. The Department will establish the

performance measures for the next scheduled Claims Processing Assessment System (CPAS) review for claims paid in June 2001.

b. Quarterly reviews are already being done. The timeliness calculation will begin with the next internal review process. To be completed by September 15, 2001.

c. The CPAS audit report will be enhanced to include newly defined procedural and financial error rates. To be completed by September 15, 2001.

d. The Department has already begun work in ensuring corrective action plans are developed and implemented. Issues from CPAS audit reports are being developed into recommendations for the fiscal agent when appropriate. Referrals to Department staff will now include more information to allow for adequate follow up. The Department will take corrective actions on the recommendation as quickly as resources allow.

## Mechanisms for Monitoring Accuracy: Fiscal Agent

The fiscal agent's Quality Assurance (QA) initiative has two components: internal programs run by several units in their own areas and the formal QA program run by the QA unit. Results of testing by internal programs are not reported to the Department, while results of testing performed by the QA unit are reported.

In terms of claims processing, procedures performed by the QA unit are limited and consist of tests over the processing of paper claims through the point at which the claims are manually keyed into MMIS. Paper claims represent only about 5 percent of all claims submitted. QA unit procedures include:

- **Document control and imaging**. QA staff perform a 100 percent review of all paper claims batched and scanned for archive purposes.

- **Data entry of paper claims**. QA staff perform audits on 10 percent of all paper claims manually keyed into MMIS by "exam entry" staff. Prior to the formal QA review, the exam entry unit itself reviews 50 percent of all data-entered claims. Thus, the data entry function on paper claims is reviewed twice.

The purpose of the QA procedures is to ensure paper claims are accurately entered into MMIS. Once paper claims are keyed into MMIS, they are processed identically to electronic claims.

The QA unit does not test a sample of paid claims to ensure payments are accurate and allowable under the Medicaid program. Instead, on a daily basis a list of the 10 highest-dollar claims paid in each category is produced. These lists are visually reviewed for "reasonableness," and if any claim appears questionable, fiscal agent staff will perform an audit of the actual claim file.

## Types of Errors Identified by Buck Consultants

As mentioned earlier, Buck Consultants tested a sample of 150 suspended claims during its audit at the fiscal agent and found a procedural error rate of 17.3 percent (26 claims). A procedural error is a claim containing one or more mistakes in the calculation of amounts payable on the claim, or in fields that potentially affect the calculation or management reporting of data, such as an error in a diagnostic code. Although procedural errors may not directly affect accuracy of payment, a high procedural error rate such as 17.3 percent indicates problems with the claims processing function. Buck Consultants found that the errors were attributable to two causes: (1) mistakes made in data entry of paper claims that were not corrected by the fiscal agent's quality assurance procedures and (2) problems with the edit resolution process.

**Data entry errors and QA procedures**. Buck Consultants found that 19 of the 26 errors identified in the sample of suspended claims were the result of data entry errors made by exam entry staff. However, claims processed to the point of suspense have already been subject to two levels of QA reviews: one performed by exam entry staff and a second performed by QA staff. The high incidence of these errors in the sample indicates that the fiscal agent's quality assurance procedures over data entry of paper claims are not effective. The weakness in QA procedures allowed these claims to continue processing until the point at which the errors caused the claims to suspend.
Additionally, the high incidence of these types of errors and lack of effectiveness of QA procedures presents the risk that other data entry errors may be occurring and are not being detected when the errors do not cause the claims to suspend. For example, system edits may not cause a claim with an incorrect "category of service" to suspend. In these cases, claims would be paid without the errors being detected and corrected unless the errors are identified by some type of postpayment review. However, as described previously, there are limited controls in place in terms of postpayment claims reviews.

Finally, undetected data entry errors increase the volume of suspended claims. This means claim technicians must spend more time resolving claims, thereby driving up administrative costs, processing times and, more importantly, delaying payments to providers.

**Edit resolution process**. Seven of the errors found were related to the edit resolution process. Some problems occurred because the technicians did not use the appropriate edit resolution text to resolve the claim. Other errors included a duplicate claim that was overlooked and approved for payment, and a claim approved for payment when there was a private insurance carrier listed as a third-party resource. Since Medicaid is the payer of last resort, the claim should have been returned to the provider for submission to the carrier. In two other instances there were no resolution instructions available on-line for the claim technician to use for resolving the edit.

**Factors affecting error rates**. Buck Consultants also identified several factors that can contribute to high error rates. First, the fiscal agent's claims processing staff had a high turnover rate (about 45 percent from July through December 2000). Second, the fiscal agent's training program is not as comprehensive as programs offered by other claims administrators. The fiscal agent provides three months of training, which is a combination of classroom and on-the-job training; other administrators provide two to three months of formal classroom training, and processors are in training status for six months. Third, the fiscal agent has set very high production requirements. Claims technicians are expected to resolve 500 claims per day after six months of experience; this calculates to less than a minute per claim based on an eight-hour day. This is not sufficient time to adequately review and process a payment and may explain why technicians do not always use the appropriate resolution text. Most administrators require claims processors to resolve 75 to 100 suspended claims daily.

## Improvements to QA Function

The results of the audit by Buck Consultants indicate the need for the fiscal agent to improve the QA function over both the exam entry and edit resolution processes. As part of this the fiscal agent should expand its QA function to include audits on a sample of paid claims. The type of review currently performed by the fiscal agent on paid claims does not substitute for a comprehensive internal quality assurance program that includes routine internal audits of paid claims. Buck Consultants reports that in a commercial automated claims processing environment, standards require that 3 percent of the volume of processed claims be audited. Overall, the Department needs to ensure that the QA process at the fiscal agent functions as an effective tool for maintaining accuracy of claims processing. Further, HCPF should work with the fiscal agent to ensure that production requirements for claims technicians do not have an unacceptably high impact on processing accuracy.

The Department did not include any specific requirements for the fiscal agent to perform audits of paid claims in the original contract, nor has it requested that the fiscal agent perform such audits. However, the contract clearly states the need for the fiscal agent to have a quality assurance plan that should be developed early in the implementation phase to "address the needs and specific opportunities for quality improvement *throughout the contract period*" (emphasis added).

As part of its effort to ensure Medicaid payments are accurate and allowable, the Department should work with the fiscal agent to implement adequate claims testing and improved quality assurance overall on an ongoing basis.

## Recommendation No. 2:

The Department of Health Care Policy and Financing should ensure claims processed through MMIS are accurate and allowable under the Medicaid program by requiring that the fiscal agent:

a. Expand quality assurance procedures for testing the accuracy of data entry on paper claims and report results to the Department. The Department should monitor results to ensure satisfactory data entry performance is achieved.

b. Conduct regular audits of paid claims on a defined percentage of processed claims and report the results to the State. The Department should monitor results against the performance measures established under Recommendation No. 1.

c. Increase oversight of edit resolution claim technicians and reassess production requirements to ensure suspended claims are appropriately resolved. In particular, the fiscal agent should ensure that all required resolution text is available and appropriately applied to claims and claims with third-party resources are returned to providers for submission to those parties.

### Department of Health Care Policy and Financing Response:

Agree.

a. The Department will begin work with the fiscal agent to expand quality assurance procedures for testing the accuracy of data entry of paper claims by September 1, 2001.

b. The Department will work with the fiscal agent to have it use the Claims Processing Assessment System (CPAS) for its own auditing purposes. Results will be measured against the standards established in Recommendation 1. The Department will work with the fiscal agent to begin the audits by September 2001.

c. Although the fiscal agent currently employs quality assurance activities over edit resolution technicians, the Department will work with the fiscal agent to establish a plan for achieving further oversight and increased accuracy by August 1, 2001.

## Review of Edits and Edit Resolution Text

As mentioned earlier, the Department and fiscal agent staff have initiated a review of all edits, edit dispositions, and the edit resolution text. The Department acknowledges that prior to implementation it was not able to adequately review the approximately 700 edits in the new MMIS. The purpose of the review would have been to ensure that the edit dispositions were correct and that the resolution text contained appropriate instructions for claim technicians to use during the edit resolution process of suspended claims.

The lack of an adequate initial review has been a concern because the edits in MMIS were brought in from another state's MMIS, while the edit resolution text was brought in from Colorado's previous MMIS. The Department and the fiscal agent report that a number of problems have resulted from the fact that the edit resolution text does not always appropriately match the edits in the new MMIS. Additionally, inappropriate edit dispositions themselves have in some instances contributed to inaccurate payment of claims and high volumes of suspended claims.

In July 2000 the Department and the fiscal agent embarked on a review of all edits, edit dispositions (e.g., pay, deny, suspend, ignore), and the associated edit resolution text. This review has not yet been completed. The Department reports that it plans to complete this task in May 2001; however, documentation provided to us indicates that fewer than 200 of the 700 edits in MMIS had been reviewed as of the end of our audit. It is critical that this task be completed as soon as possible. Until the review is finished and claim

technicians have been adequately instructed to use the revised text, there should be heightened attention to accuracy of payment.

### Recommendation No. 3:

The Department of Health Care Policy and Financing should establish the review of MMIS edits, edit dispositions, and edit resolution text as a high priority and work with the fiscal agent to complete this project as soon as possible. The Department should require that the fiscal agent conduct appropriate training and monitoring of claims processing staff to ensure changes are appropriately implemented.

### Department of Health Care Policy and Financing Response:

Agree. The Department has established the edit review process as a high priority by having regular, weekly meetings. The fiscal agent operations staff and the State's business analysts have been utilizing these weekly meetings to address edits in a critical priority order. A schedule has been developed with completion defined in July 2001. The Department will require the fiscal agent to provide enhanced training and monitor staff for appropriate implementation of the edits by August 2001.

## Timeliness of Claims Processing

In the area of timeliness of processing, the Department's contract with the fiscal agent includes specific performance expectations for processing claims through MMIS. While the contract requirements are clear, the Department has not obtained reports from the fiscal agent addressing the measures established in the contract. Instead, the fiscal agent's reports use different, less precise measures for timeliness. As a result, the Department is unable to determine if the contract requirements are being met.

Under the contract, the fiscal agent is required to meet the following standards for processing claims. A "processed claim" is one that has reached adjudication, or the point at which the claim has been either approved or denied for payment.

- **Paper claims** received in the fiscal agent's mail room:
  90 percent processed within 15 calendar days of receipt.
  95 percent processed within 30 calendar days of receipt.
  99 percent processed within 45 calendar days of receipt.
  100 percent processed within 90 calendar days of receipt.

- **Electronic claims**:
  100 percent processed in the next daily cycle after receipt.

- **Suspended claims** held for reasons other than medical review:
  100 percent processed within 25 calendar days of receipt.

Provider payment records based on claims adjudicated for payment are uploaded to the State's financial system each Friday and payments are issued the next week. This means that although a claim may have completed *processing* on a Saturday, it will not be part of the provider payment records uploaded for *payment* until almost a week later. The performance requirements in the contract are directed at holding the fiscal agent accountable for processing time, or the point at which the claim is approved or denied for payment.

# Timeliness Reports Available to the Department

The fiscal agent has made available to Department staff a variety of system-generated reports, and several of these reports address timeliness of processing. HCPF staff indicate that they most frequently rely on three system-generated reports: the Claims Processing Thruput Analysis, the Operations Performance Summary, and the Aged Detail Suspense Report. The first two present information on claims processed on a monthly basis. However, both present information in terms of "average" processing times for claims from entry to adjudication or to payment. Averages are not a satisfactory measure of claims processing because they can obscure "outliers," or instances in which some claims are taking an unacceptably long time to process. As shown above, averages are not the measurement required under the contract. The performance expectations in the contract are a more precise measurement of how long specific claims are taking to reach adjudication.

Further, we found that the meaning of some terms in the fiscal agent's reports was unclear, and Department staff were not always able to provide clarification. In particular, it was unclear whether the number of claims shown in suspense at the end of the month included (a) all claims in suspense, regardless of when they entered into MMIS, or (b) only claims in suspense from the population of claims that entered into MMIS in the current month.

Lack of clarity regarding the terms in the reports also contributes to questions about whether or not performance expectations are being met.

Another reporting tool used by the fiscal agent is the monthly report card on operations. While the report card furnishes some additional information on performance, this report does not furnish the State with information on whether claims are being processed within the time frames required by the contract. The report card is discussed later in this chapter.

## Claims Held in Suspense

Although the Department reviews reports with overall claims processing data, HCPF staff have been more concerned with obtaining information about the claims held in the suspense file awaiting manual resolution by claim technicians. These claims are most likely to experience delays in processing and create concern on the part of providers and the Department. The fiscal agent furnishes the Aged Detail Suspense Report, which contains good information on the amount of time claims are being held in suspense and whether or not the 25-day processing requirement in the contract is being met. However, this report is issued daily at a detailed level and is over 200 pages long. This makes it extremely cumbersome to review and track on a regular basis. Despite this, the Contract Administrator manually compiled a spreadsheet from the data in these reports from February through August of 1999 and again in October 2000 because of complaints from providers about late payments. The Department reports that problems with suspended claims have been reduced, and the Contract Administrator currently reviews these reports more informally.

In January 2001, over two years after implementation, at the Department's request the fiscal agent began to provide a report on the inventory of claims held in suspense at weekly status meetings with HCPF. While this is a good step, the report lacks information about the age of suspended claims. Therefore, it does not show how long the claims have been in the system or whether the fiscal agent is in compliance with the 25-day processing requirement.

Department staff have discussed with the fiscal agent the need to provide reports that delineate performance in terms of the requirements in the contract. However, because revising the reports will require time from the fiscal agent's programming staff, these requests have been placed on a lower priority than requests for programming changes that affect claims processing. Since the fiscal agent currently has a backlog of over 400 system change requests from HCPF, the Department is uncertain when appropriate reports will be available for monitoring contractual compliance. (This backlog of system change requests is discussed later in this chapter.)

In another effort to obtain some indication of performance in this area, HCPF staff recently requested that the fiscal agent's Quality Assurance staff develop a system for testing a

sample of claims for timeliness of processing requirements. Such a process has yet to be implemented.

## Delays in Processing Suspended Claims

During our audit, we obtained from the fiscal agent a download of information on all claims in suspense on February 28, 2001. Both HCPF and fiscal agent staff indicated that very few claims are held in suspense because of the need for medical review; therefore, almost all suspended claims are subject to the 25-day processing requirement.

Our analysis identified that the fiscal agent is not in compliance with the requirement that suspended claims must be processed to pay or deny status within 25 calendar days. As shown in Table 6 below, out of the nearly 25,400 claims in suspense on February 28, 2001, almost 23 percent (over 5,700 claims) had been in MMIS for over 25 calendar days. Over 900 claims had been in suspense for over six months.

**Table 6: MMIS Aging Summary of Claims in Suspense**

February 28, 2001

| Claim Type | Number of Calendar Days in MMIS From Date of Receipt | | | | | | Total Claims |
|---|---|---|---|---|---|---|---|
| | 1-25 | 26-60 | 61-90 | 91-180 | 181-360 | >360 | |
| Medicare Crossover | 5,556 | 873 | 260 | 699 | 16 | | 7,404 |
| Physician Services | 4,502 | 265 | 21 | 42 | 95 | | 4,925 |
| Nursing Facilities | 4,423 | 201 | 3 | 4 | 10 | | 4,641 |
| Medical Equipment | 1,828 | 246 | | 16 | 9 | | 2,099 |
| Capitation | 18 | 1,108 | 40 | 154 | 221 | 33 | 1,574 |
| Outpatient Hospital | 958 | 108 | 43 | 63 | 22 | | 1,194 |
| Transportation | 550 | 70 | 1 | 62 | 315 | | 998 |
| HCBS | 255 | 9 | 31 | 172 | 207 | | 674 |
| Home Health | 446 | 181 | 4 | 27 | 5 | | 663 |
| Dental | 394 | 21 | | | 5 | | 420 |
| Independent Lab | 325 | 7 | 9 | 3 | 3 | | 347 |
| Inpatient Hospital | 190 | 24 | 4 | 5 | 1 | | 224 |
| EPSDT | 211 | 7 | | 1 | | | 219 |
| **Total Claims** | **19,656** | **3,120** | **416** | **1,248** | **909** | **33** | **25,382** |
| ***% of all Claims*** | ***77.4%*** | ***22.6%*** | | | | | ***100.0%*** |
| **Total Value of Claims in Suspense** | | | | | | | **$17.9 million** |

**Source:** Office of the State Auditor analysis of agency data.

## Average vs. Actual Processing Times

In a separate analysis, we used information from work performed by Buck Consultants on suspended claims to illustrate how using averages to measure timeliness of claims processing can obscure performance problems. In Table 7 below, the calculation on the left side of the table shows an *average* processing time of 18.7 days for the sample of suspended claims tested by Buck Consultants from receipt to adjudication, or to "approved" or "denied" status. This appears to be well within the 25-day processing requirement for suspended claims.

However, the calculation on the right side of Table 7 shows that only 56.6 percent of the claims were in fact processed within the 25-day requirement. Here, processing time is tracked on the basis of the *actual* number of days each claim took to reach adjudication. The discrepancy between these results demonstrates that it is essential the Department require the fiscal agent to provide reports addressing the processing measures established in the contract. Otherwise, the State lacks assurance that requirements are being met, and timeliness of processing problems may go unidentified and unresolved.

**Table 7: Processing of Claims in MMIS Suspense File**
Comparison of *Average* Processing Time to *Actual* Processing Time

| No. of Days From Entry to Approve or Deny[1] | No. of Claims Processed | No. of Days Multiplied by No. of Claims | No. of Days From Entry to Approve or Deny[1] | Cumulative No. of Claims Processed | Cumulative % of Claims Processed |
|---|---|---|---|---|---|
| 2.5 days | 51 | 127.5 | 2.5 days | 51 | 35.7% |
| 7.5 days | 1 | 7.5 | 7.5 days | 52 | 36.4% |
| 12.5 days | 4 | 50.0 | 12.5 days | 56 | 39.2% |
| 17.5 days | 25 | 437.5 | 17.5 days | 81 | 56.6% |
| 22.5 days | 0 | 0.0 | 22.5 days | 81 | 56.6% |
| 27.5 days | 0 | 0.0 | 27.5 days | 81 | 56.6% |
| 32.5 days | 54 | 1,755.0 | 32.5 days | 135 | 94.4% |
| 37.5 days | 8 | 300.0 | 37.5 days | 143 | 100.0% |
| Totals | 143 | 2,677.5 | | | |
| ***Average* processing time for all 143 claims (2,677.5÷143)** | | **18.7 days** | **Claims processed within 25-day requirement** | | **56.6% (81 out of 143 claims)** |
| | | | **Claims not processed within 25-day requirement** | | **43.4% (62 out of 143 claims)** |

**Source:** Office of the State Auditor analysis of agency data and data provided by Buck Consultants.
[1]Buck Consultants grouped claims into 5-day intervals (1-5 days, 6-10 days, etc.) in its analysis. In this analysis, the mid-point of each interval was used in order to allow the calculation of average processing time.

## Provider Feedback

In the survey of about 280 providers conducted by the Department in the summer of 2000, the Department asked several questions related to the fiscal agent's performance in the area of timeliness of processing. On a scale from 1 to 10 (10 high), the fiscal agent rated a "7" on timeliness of claims payment, which is somewhat above average. In terms of timeliness of processing suspended claims, the fiscal agent was rated decidedly lower at "5.4." Further, the frequency distribution of providers' responses regarding timeliness of processing suspended claims indicates that providers' level of satisfaction in this area varied widely. Of the almost 100 negative comments the Department received back as part of the

survey, the greatest number of comments (35 percent) were in regard to the lack of timeliness of callbacks from the fiscal agent's provider call center. The second largest number of negative comments (23 percent) was complaints about some aspect of timeliness of processing claims. This is another indication that improvements need to be made in timeliness of processing, particularly with respect to suspended claims.

### Processing Requirements and Contract Renegotiations

The State's request for proposal, which was incorporated into the formal contract with the fiscal agent, states that the contractor has responsibility to:

> Develop, maintain, and provide access to those records required by the State to monitor all performance requirements and standards, including, but not limited to, reports necessary to show claims throughput activity, claims backlog, data entry backlogs, suspense files status, and other performance items. (Request for Proposal, Part III, Section 20.312)

Clearly, the Department must require that the fiscal agent furnish reports on a regular basis that reflect whether or not processing requirements are met. The new MMIS has now been operational for over two years. The Department reports that until recently the greatest concerns have been with resolving processing and system issues, rather than fixing operational reports. However, without the necessary reports, the Department lacks the tools to help identify processing problems. As part of the negotiations on the extension of the fiscal agent's contract, the Department must ensure that appropriate management reports on operations are provided.

---

## Recommendation No. 4:

The Department of Health Care Policy and Financing should ensure that timeliness of processing requirements are met for claims processed through MMIS by:

a. Requiring the fiscal agent to provide monthly management reports that measure claims processing in accordance with the performance expectations specified by the contract.

b. Requiring the fiscal agent to provide weekly inventory reports on claims held in suspense that include aging information on the claims.

c. Monitoring these reports on a routine basis and taking corrective action as appropriate.

### Department of Health Care Policy and Financing Response:

Agree.

a. The Department has been actively working with the fiscal agent to develop measures for reporting on timeliness of claims processing. Once these measures are completed, the results will be reported monthly. These efforts will be completed by September 1, 2001.

b. Although the Department currently uses the Aged Detail Suspense Report to monitor suspended claims, the Department will work with the fiscal agent to develop a more succinct and useful report. Work on this report will begin August 1, 2001.

c. The Department currently monitors suspended claims and will continue this on a routine basis. Over the last several months, there has been significant progress in reducing the number of suspended claims. The suspense file has been reduced by 67 percent since the February 2001 findings. As part of the Department's contract monitoring, this inventory will continue to decrease. The Department will apply corrective actions when necessary to eliminate claims outside contractual limits.

## Monthly Report Cards on Performance

The Department indicates that since the installation of the new MMIS over two years ago, it has worked to find an effective way to monitor operational performance requirements in the contract. In response, the fiscal agent began in February 2000 to issue a monthly "report card" on various performance areas. The areas in the report card were those of particular concern to the Department at the time. Currently the report card evaluates performance requirements in the fiscal agent's provider enrollment, claims control and data entry, prior authorization request processing, third-party liability, and call center units. The Department and the fiscal agent have expressed the intent that the report card, upon full development, should serve as the vehicle for reporting on all applicable performance requirements in the contract.

We noted the following problems with the report card:

- As stated earlier, the fiscal agent has not provided information allowing the Department to monitor timeliness of claims processing in accordance with

contractual performance requirements. This information is also lacking in the report card.

- Some operational areas are not included at all in the report card, even though there are specific, measurable performance requirements in the contract for these areas. The following are missing: electronic claims capture, claims pricing and adjudication, claims reporting and financial transactions, and reference file updates.

- Some of the measures provided are not meaningful or do not measure whether a requirement was met. For example, one of the areas of review in the third-party liability section is to receive and process updates to individual Medicaid recipients' files for third-party liability information from the State's eligibility system, COIN. The measure for this area is defined as the timely issuance of a report. Monitoring the production of reports does not constitute a quality review of whether MMIS is updated with COIN information accurately and regularly.

We recognize that the report card is not fully developed. In order for the report card to function as a useful monthly summary of overall performance requirements, the Department needs to ensure that the information reported is complete and meaningful. Additionally, upon implementation of more effective quality assurance procedures (Recommendation No. 2), the fiscal agent should include the results of these tests in the report card. Department staff should use information from the report card and HCPF claims audits as a basis for furnishing the Department's upper management with critical data on the claims processing function for the Medicaid program.

## Recommendation No. 5:

The Department of Health Care Policy and Financing should require that the fiscal agent furnish adequate monthly reports on contractual performance expectations. The Department should monitor compliance with requirements and take corrective action as appropriate.

### Department of Health Care Policy and Financing Response:

Agree. The Department has been working with the fiscal agent on revisions to the report card and other reporting mechanisms to include additional contractual standards. Areas of major importance have been reported, monitored, and corrective action taken when appropriate. Additional reporting of performance on

contractual requirements will be added to increase the overall analysis of contract performance. New measures will be added beginning September 1, 2001.

# System Change Requests

As mentioned earlier, the current MMIS represents a significant improvement in technology available to operate the State's Medicaid program. One area where this improvement has been evident is the relative ease with which changes can be made to the system. According to Department staff, some changes that required programming in the previous MMIS now can be made through changes to "reference tables." Reference tables are used in the present MMIS to store information needed to process claims appropriately, such as information on pricing, benefits, and edits (reference tables are discussed in the next section of this chapter). Further, the current MMIS can be programmed to make certain types of changes that would have been impossible to make in the previous MMIS.

For example, there has been a proposal to process managed care capitation payments under the Children's Basic Health Plan (CBHP) through MMIS. One advantage of this approach would be to help ensure that children are not simultaneously enrolled in both CBHP and Medicaid (the problem of simultaneous enrollment was described in the *Children's Basic Health Plan Performance Audit*, July 2000, conducted by the Office of the State Auditor). This type of expansion of MMIS to accommodate an entirely separate program would not have been possible under the previous MMIS.

## Backlog of Change Requests

Despite the flexibility of the current MMIS, there is a backlog of outstanding requests for system programming changes. As of the end of February 2001, there were 409 formal system change requests—referred to as Customer Service Requests, or CSRs—in various stages of development. Out of the total number of CSRs, 175 of them were a year and a half to two years old. According to the CSR tracking log, which tracks all outstanding CSRs, out of these 175 old requests there were nine system changes ranked "very high" in priority.

Table 8 below outlines the priority and age of outstanding CSRs as of February 28, 2001, according to the CSR tracking log.

**Table 8: Outstanding Customer Service Requests (CSRs) for MMIS**
February 28, 2001

| CSRs by Priority | Number of Months 0-6 | 6-12 | 12-18 | 18-24 | *Total* |
|---|---|---|---|---|---|
| **CSRs ranked "Very High"** | 19 | 12 | 11 | 9 | *51* |
| **CSRs ranked "High"** | 44 | 22 | 26 | 28 | *120* |
| **CSRs ranked "Medium"** | 21 | 23 | 28 | 80 | *152* |
| **CSRs ranked "Low"** | 6 | 13 | 9 | 58 | *86* |
| ***Total Outstanding CSRs*** | *90* | *70* | *74* | *175* | *409* |

**Source:** Office of the State Auditor analysis of agency data.

HCPF staff state that despite the age of some of the CSRs, critical requests have been and are being addressed. Each week, the Department discusses CSRs that are considered most critical with the fiscal agent at the regular system priority meetings. These CSRs are tracked on a "top priority" list, which normally has approximately 30 CSRs. For example, the list contains CSRs that address problems related to lawsuits that have been decided against the State. Input for determining these top priorities comes from the Department's upper management.

## Factors Contributing to the Backlog

Staff indicate that the existence of so many old CSRs has occurred for several reasons. First, as mentioned earlier, testing completed prior to implementation, although deemed adequate to proceed with the conversion, was not as extensive as the State had originally planned. As a result, the system has, in some instances, not functioned completely as intended. This has caused some claims processing problems. IS personnel believe that these problems have largely been addressed. Currently while there are still several outstanding CSRs that have potential financial impact for the State, most outstanding CSRs involve changes to reports or to the presentation of information on user screens. These CSRs were given lower priority than those created to correct processing problems. Our review of the CSR log and related documents confirms the Department's description of these outstanding requests.

The second reason for the backlog is that the Department has not been able to effectively use the 22,000 programming hours built into the contract with the fiscal agent for each contract year. These are hours that the fiscal agent is to provide for work on maintaining

the system, including making system changes that are not of sufficient magnitude to require a contract amendment and additional funding. At the end of each of the first two contract years there have been programming hours left unused; prior to contract renegotiations, there was a bank of approximately 12,000 unused programming hours that were "owed" to the State. As a result of the renegotiations, the Department was able to withdraw several budget change requests. The work required under these requests will be completed by the fiscal agent, using the bank of programming hours.

As part of the contract renegotiations with the fiscal agent, the Department requested and received a commitment from the fiscal agent to hire additional business analysts. The projects on which these staff will initially work were also defined. Additionally, the Department was appropriated another IS position for Fiscal Year 2002, which will give HCPF more staff to oversee the CSR process. Department staff believe that over the next year to two years substantial progress will be made in addressing the backlog of CSRs.

On a monthly basis the Department monitors programming hours expended by the fiscal agent. It should continue to use this tool, in addition to weekly meetings with the fiscal agent, to ensure that the State receives services for the full amount of programming hours provided in the contract and that the backlog of CSRs is addressed in a reasonable time frame.

## Recommendation No. 6:

The Department of Health Care Policy and Financing should continue to monitor programming hours performed by the fiscal agent. The Department should ensure that the State receives all programming hours stipulated in the contract and that system change requests for MMIS are addressed in a timely manner.

### Department of Health Care Policy and Financing Response:

Agree. The Department will continue to require the fiscal agent to provide all contracted programming hours as has been done through the monitoring process and the contract renegotiations process in the past. The Department will also focus the fiscal agent on the quality of programming time and appropriate staffing levels. This activity will be ongoing.

# Policy on Changes to the MMIS Reference Tables

MMIS contains a series of reference tables with a wide variety of data necessary for the various aspects of claims processing. For example, pricing and benefits data related to the array of services under Medicaid are maintained in these tables. Dispositions, or settings, for each of the approximately 700 edits in MMIS are also stored here.

Reference table data play a vital role in ensuring that claims are processed correctly and in accordance with state Medicaid policy. Because of this, the contract with the fiscal agent requires that changes to the reference tables must be approved by the Department prior to implementation by the fiscal agent. However, the Department has not established a formal and consistent policy regarding how these changes are to be authorized and communicated.

MMIS reference data changes occur through two different mechanisms:

- **Formal Transmittal**. The Department authorizes most changes to reference data, such as a pricing change or a change in benefits, through formal transmittals to the fiscal agent. Four individuals at the Department are designated to sign transmittals; however, most transmittals are signed by the Contract Administrator. Each transmittal includes a deadline for implementation by the fiscal agent.

  Once the fiscal agent receives a transmittal and implements it, the fiscal agent's quality assurance unit reviews the transmittal to ensure it was implemented accurately and within the specified time frame. The results of these quality assurance reviews are reported to the Department weekly.

- **Weekly Meetings With the Fiscal Agent**. As previously described, in July 2000 the Department and the fiscal agent began a series of weekly meetings to perform a systematic review of all edits, dispositions, and the related resolution text. Although changes to edit dispositions are changes to reference tables, the Department does not request changes approved at the meetings through a formal transmittal. Rather, an IS Section staff person authorizes the changes by signing a printout of the revised edit disposition. Fiscal agent staff implement the change and maintain a log that tracks all changes.

  Fiscal agent staff do not perform a quality assurance review on edit disposition changes authorized through these weekly meetings. Further, the fiscal agent's log of changes lacks critical information, such as the HCPF staff who approved the

change, the date on which the change was made, and the fiscal agent staff who implemented the change. Finally, although the Department personnel signing off on these edit disposition changes are authorized to do so, these individuals are not among the four authorized by the Department to sign formal transmittals for reference table changes.

The Department reports that it is aware of several instances in which the fiscal agent made unauthorized changes to edit dispositions in the reference table.

- In April 1999 the fiscal agent made an unauthorized change from "suspend" to "pay" on an edit related to practitioner claims. The result was an overpayment on approximately 7,400 claims to 346 providers in the amount of almost $938,000. The fiscal agent subsequently reprocessed these claims, thus recovering this amount for the State. The fiscal agent paid for the reprocessing of these claims.

- In January 2001 the fiscal agent made an unauthorized change from "suspend" to "ignore" for system-generated adjustment claims. The particular edit was originally set to flag claims to suspend if the last date of service is after the date the claim is received. Medicaid policy does not allow payment to be made in advance of the receipt of services. By setting the disposition to "ignore," the fiscal agent essentially disabled this policy. The fiscal agent explained that the change was necessary to implement a transmittal from the Department for another change. However, the fiscal agent did not request the Department's authorization for the initial change made to facilitate implementation of the transmittal; further, the fiscal agent did not reset the edit disposition appropriately once work on the transmittal had been completed. Fortunately, the Department caught this error quickly and there was minimal impact on processing.

We recognize that MMIS is a complex system involving many personnel and many decisions, and a high priority is set on keeping claims moving through the system. However, instances in which edit dispositions have, for whatever reason, been improperly set emphasize the need for the Department to have a very clear policy on reference table changes. The policy should be communicated internally to HCPF staff and to the fiscal agent in order to avoid possible misunderstandings over the appropriate manner for authorizing reference table changes. Further, the Department should ensure that all personnel signing authorizations for changes are appropriately designated, all reference table changes are included in the fiscal agent's quality assurance review, and all data related to the change are adequately tracked by the fiscal agent to minimize potential confusion about authorization and implementation.

## Recommendation No. 7:

The Department of Health Care Policy and Financing should establish a formal policy on requests to the fiscal agent for changes to the MMIS reference table data that:

a. Outlines the appropriate mechanisms by which changes to reference table data may be made, the individuals who may authorize these changes, and how an authorization is to be documented.

b. Requires that the implementation date on all changes is tracked.

c. Ensures that appropriate quality assurance procedures are performed on all changes by the fiscal agent.

This policy should be communicated to the fiscal agent and updated as necessary.

## Department of Health Care Policy and Financing Response:

Agree.

a. The Department has a formal procedure in place for all reference table changes. The transmittal process is used for rate changes, numerous provider changes, as well as other reference files changes. The Department's process for handling edit disposition changes was not as strong as necessary. A new process was created that included a clear and concise form that easily illustrates the desired changes as well as the State staff signoff. A policy will be written and in place by October 2001 that will authorize and clarify these formal procedures.

b. Although the Medicaid Management Information System does track changes that have been made to the reference table, reporting the information is time consuming due to a missing window in the MMIS. The Department, with the fiscal agent, has implemented a manual log that tracks the date of all changes to edit dispositions. Completed May 2001.

c. Many types of transmittals require 100 percent quality assurance by the fiscal agent. The Department will work with the fiscal agent to expand quality assurance measures to cover all communications related to this policy by October 1, 2001.

# Medicaid Providers

## Chapter 2

## Introduction

The Department of Health Care Policy and Financing (HCPF) is responsible for reimbursing the providers in the State's Medicaid program for health care services furnished to program recipients. As of April 2001 almost 16,600 providers had submitted claims to the Medicaid program during the current fiscal year. Altogether, reimbursements to providers average about $148 million each month. In order to receive reimbursement, providers file claims with the State's fiscal agent for Medicaid, which is currently Consultec, LLC. The fiscal agent is responsible for overseeing Medicaid claims processing through the Medicaid Management Information System (MMIS). This is the State's automated claims processing system.

Medicaid providers include a broad range of professions and facilities. The following is a list of some of the different types of providers that furnish services to the Medicaid program:

- Physicians
- Hospitals
- Pharmacies
- Nursing facilities
- Dentists
- Laboratories
- Optometrists
- Clinics
- Registered nurses
- Nurse practitioners
- Physical therapists
- Audiologists
- Chiropractors
- Dialysis centers
- Federally qualified health centers
- Hospice providers
- Mental health practitioners
- Ambulances
- Rural health centers
- Occupational therapists
- Speech therapists
- School-based clinics

When a claim is submitted for processing through MMIS, the system checks the provider database to ensure the provider is enrolled in the Medicaid program. Providers submit claims in both electronic and paper format, and payments are issued to providers either by state warrant or by electronic fund transfers. Reimbursements for health care services are paid either to the providers who themselves render the services or to billing providers who bill Medicaid and then reimburse the rendering providers. For example, a hospital may bill for services on behalf of a physician.

# Fiscal Agent Responsibilities and Providers

The fiscal agent, in addition to being responsible for processing claims for the Medicaid program, has a number of responsibilities related to the provider community. These include:

- Processing provider applications and enrolling new providers accepted into the Medicaid program by entering them onto the MMIS provider database.
- Maintaining a call center that responds to provider questions and billing inquiries.
- Maintaining an automated recipient eligibility verification system to verify recipient eligibility through direct electronic inquiry.
- Giving training sessions for providers on billing procedures, both in the metro area and statewide.
- Publishing provider manuals and mailing news bulletins to providers on changes in requirements and other necessary information.

The fiscal agent's provider relations personnel attend several monthly meetings with providers to obtain feedback, answer questions, and furnish information.

## Enrollment Process for Providers

Upon request, the fiscal agent mails enrollment materials to any provider that expresses interest in furnishing services in the Medicaid program. These materials include guidelines for Medicaid providers, a Medicaid provider agreement, and an application. Providers submit the completed agreement and application to the fiscal agent, along with other required materials such as a copy of the relevant license or certification.

The fiscal agent reviews the provider materials and verifies that the tax identification number agrees to the same information on the State's financial system. Upon acceptance of the application and agreement, the fiscal agent enrolls the provider into the Medicaid program by entering the provider's information into MMIS. During this process, the provider is assigned a unique provider billing identification number. As noted earlier, MMIS automatically verifies whether a provider is enrolled prior to processing a claim.

# License and Certification Requirements

Under state and federal requirements, a provider receiving reimbursement under the Medicaid program must have a valid license or certificate, as applicable, to furnish the goods or services charged to the program. The Department of Health Care Policy and

Financing is responsible for ensuring this requirement is met. Additionally, the Department handles complaints that arise about Medicaid providers.

Other state agencies are responsible for issuing licenses and certifications and otherwise regulating the various types of providers that practice in the State, regardless of their participation in the Medicaid program. The Department of Regulatory Agencies oversees many professional licenses and certifications, including those for physicians, dentists, pharmacies and pharmacists, optometrists, podiatrists, and nurses. The Department of Public Health and Environment oversees licenses and certifications for nursing facilities, laboratories, home health agencies, home and community based services agencies, and others. These two Departments are responsible for handling complaints brought against providers and administering disciplinary actions as appropriate. These Departments also oversee the renewal process for the licenses and certifications under their jurisdiction.

# Maintenance of the Provider Database

Since all Medicaid payments are made to providers, ensuring that only legitimate providers receive these payments is essential. Over the past several years, the federal government has targeted states' practices for maintaining provider information under the Medicaid program as a way to prevent and detect erroneous and fraudulent payments. Attention has been focused on states' practices in enrolling providers and maintaining current information on providers after they are enrolled in the Medicaid program.

In Colorado the Office of the State Auditor has issued several reports with recommendations to the Department of Health Care Policy and Financing directed at ensuring the integrity of information in the MMIS provider database (*Medicaid Fraud and Abuse Programs Performance Audit* (July 1999), *Statewide Single Audit Report*, Fiscal Year 1999 and Fiscal Year 2000). Among other things, these reports contained recommendations directed at the need to:

- Verify licensing and other credentials for providers.
- Perform periodic reenrollments of providers.

The Department is in the process of attempting to address concerns raised in the earlier audits. Because of the importance of provider information, this audit reviewed the progress made by the Department in improving provider data.

# Maintaining Current Information on Enrolled Providers

As described above, the process for obtaining license and certification information during the initial enrollment period is fairly straightforward. The more difficult and problematic issue is that of maintaining current information on providers once they are enrolled in the Medicaid program. A provider's license or certification status may change for a variety of reasons. Many professional licenses must be renewed every two years, and a provider may choose to be placed on inactive status or may allow the license to lapse altogether. In some cases a provider may be subject to disciplinary actions, such as probation, suspension, or revocation, that restrict or eliminate the provider's ability to legally perform services in the State. If adequate controls are not in place to ensure providers' credential information is routinely updated, the Department risks making payments to providers that do not have valid licenses or similar credentials. The fact that a provider is submitting claims for payment does not necessarily mean that the provider is appropriately licensed or otherwise certified.

## Results of the Audit Sample

For the purposes of identifying unlicensed providers in the Medicaid program, as part of our audit we obtained a download of the MMIS provider database for three of the major professions (physicians, pharmacists, and dentists) and downloads of licensed individuals for these professions from the Department of Regulatory Agencies (DORA). We identified 1,308 providers from the MMIS database that did not appear to match with the DORA files, on the basis of a preliminary review. Since a number of factors could account for the MMIS and DORA information not matching (e.g., data entry errors), we selected a sample of 131 providers from this pool to be tested for whether or not they had valid licenses to practice in the State of Colorado.

Out of the sample of 131 providers, we found that only 65, or just under half, currently have valid licenses; the remaining 66 do not. Because of the manner in which we chose our sample, these results are not indicative that a similar percentage of all MMIS providers lack licenses. However, these results do confirm that there are unlicensed providers in the MMIS database with active billing identification numbers.

Further, out of the 66 unlicensed providers identified, we found 7 that had received payments from the Medicaid program. Altogether these providers received almost 580 payments totaling about $2540. All of these payments were made during the past two and a half years, and all were for services provided after the providers' respective licenses had

become inactive or were allowed to lapse. Individual providers received payments for periods ranging from 4 months to 22 months. Almost all of the payments were monthly capitation payments intended to be made to a Medicaid recipient's primary care physician under the Medicaid managed care program.

We recognize that these are small amounts compared with total monthly program volumes of over a million claims and average monthly payments of around $148 million. Nonetheless, the identification of unlicensed providers in the provider database—along with the fact that, in some cases, payments were made to these providers—demonstrates that there are problems with provider data in MMIS. These problems can allow erroneous or fraudulent payments to be made in the Colorado Medicaid program.

# Department Efforts to Improve Provider Data

Department staff report that it has been about ten years since it has required Medicaid providers to reenroll in the program and resubmit materials, including credential information. During the last ten years, Colorado has allowed providers to bill the Medicaid program indefinitely once they were enrolled. This is a concern because the Department has not fully developed and implemented controls to ensure that all enrolled providers are appropriately licensed. The Department's current procedures for verifying licenses of enrolled providers, including recent initiatives to improve the integrity of provider data, are summarized below.

**Health Maintenance Organizations (HMOs)**. The Department's Quality Assurance staff report that they perform comprehensive site visits every five years to each HMO enrolled as a Medicaid provider. Currently there are five HMOs in the Medicaid program. As part of their review HCPF staff ensure that licensing and other credentials are verified with the issuing authority for all providers that render services under the HMO. In periods between site visits, HCPF may perform additional testing related to provider credentials or other matters on the basis of deficits identified during the visits, or significant changes made by the HMO.

**Reenrollment of providers**. In response to an earlier audit comment, the Department committed to reenrolling all providers in the Medicaid program over a five-year period ending on July 1, 2005. As part of this the Department has created an enrollment committee. The first stage of the overall reenrollment has been a three-year project to reenroll all Primary Care Physicians (PCP) participating in the Medicaid program. These physicians act as "gatekeepers" to health care services for Medicaid recipients. Currently there are about 1,700 PCPs in Medicaid, and each year about a third of these will be

required to reenroll. The Department is in the process of reenrolling the first group of PCPs effective as of July 1, 2001.

Under the reenrollment, PCPs are asked to complete and sign a new provider agreement, which, among other things, requires that the PCP submit relevant licenses and other credentials. Unlike the prior PCP agreement, which had no end-date, the new agreement expires after three years and will require renewal. As part of this reenrollment, the Department is in the process of contracting with an outside entity; one of the contractor's duties will be to verify the credentials of the PCPs submitting reenrollment materials. The verification process will include checking credentials with the issuing authority. Thus, credentials of PCPs will be verified every three years.

In terms of Medicaid providers that are not PCPs, the Department has not yet fully developed a plan for reenrolling these providers, or a policy on how often reenrollment would be required. Staff report that the enrollment committee plans to develop a strategic plan that would address all providers.

**Deactivation of nonparticipating providers.** Another project undertaken by the enrollment committee has been the deactivation project, which focused on enrolled providers who were not participating in (i.e., billing) the Medicaid program. Over the past several months, the Department has worked with the fiscal agent to identify all enrolled providers that have not submitted claims to the Medicaid program in three years. This resulted in over 6,000 providers being placed on "inactive" status in MMIS. In order to submit claims, these providers will be required to reapply to the Medicaid program, which includes resubmitting licenses and other credentials. The deactivation decreased the number of enrolled providers from over 28,000 to the current 22,200. Although the Department indicates it will likely perform deactivations in the future, it has not established a policy formalizing how often deactivations will be performed or whether the three-year benchmark would continue to be used.

The deactivation of the 6,000 providers will result in some savings to the State. Since many of the deactivated providers were receiving mailings, the postage costs associated with these providers will be eliminated. Postage costs are passed directly through to the State under the contract with the fiscal agent. The fiscal agent estimates that roughly $1,300 per month will be saved in postage costs from the deactivation. Future deactivations would presumably also help keep postage costs to a necessary minimum. In Fiscal Year 2000, postage costs averaged about $27,700 each month for the Medicaid program.

Deactivation of nonparticipating providers, although an important tool in helping to maintain the provider database, is not a sufficient control to ensure the integrity of that information. The unlicensed providers we identified during the audit that were receiving payments would

not have met the Department's criteria for deactivation, since claims were processed on their behalf during the last three years. Thus, additional controls need to be in place.

**Data match project with Department of Regulatory Agencies**. A third aspect of the enrollment committee's efforts has been the data match project. The Department has several staff working on matching licensing information from DORA with providers on the MMIS database. The process involves considerable manual work because of design differences between the two databases. At the time of our audit this data match project had been in process for about six months and was not yet completed. The Department plans to enable MMIS to electronically perform this match with data from DORA, but no time frame has been established for implementation.

Data matches should be performed with DORA at a minimum on intervals that correspond to the renewal period for the specific license. For example, physician licenses must be renewed on May 31 in every odd-numbered year. A data match performed on physicians several months after the renewal date would identify those providers that have chosen to register as inactive or have allowed their license to lapse altogether.

**Program Integrity Unit**. This Unit, which is under the Quality Assurance Section at the Department, has the ongoing responsibility of obtaining information from several sources on providers that have been sanctioned as a result of disciplinary actions. These providers no longer have valid licenses and thus are ineligible to participate in the Medicaid program. The Program Integrity Unit receives and reviews information from several sources at the federal level and from the State Board of Medical Examiners. The Unit relays information about providers that can no longer participate to the Department's Contract Administrator, who furnishes it to the fiscal agent. The fiscal agent removes the provider from active status in MMIS.

While the information forwarded by the Unit serves an important role in maintaining the integrity of provider information, the Unit has not established routine communication procedures with other state regulatory boards at DORA in addition to the Board of Medical Examiners. For example, the Department does not receive regular updates on disciplinary actions from the Board of Dental Examiners, the Board of Pharmacy, the Board of Nursing, or the Board of Optometric Examiners; there are additional boards as well whose regulatory authority affects providers in the Medicaid program. While the Unit reports that it receives information from the federal level on providers other than physicians, the information would be more complete and timely if the Unit established routine communication with these other state boards.

It should be noted that the information received by the Program Integrity Unit does not include providers that have changed their status to inactive or have allowed their license to lapse. Therefore, this communication does not fulfill the same function as performing a data match with DORA boards.

## Formalization of Policies and Procedures Affecting Provider Data

Overall, the Department has undertaken several important initiatives to improve the quality of provider data. These should assist with detecting and preventing improper Medicaid payments. The Department should ensure these efforts are fully implemented and utilized by formalizing policies and procedures, establishing time frames, and monitoring completion of these tasks.

---

## Recommendation No. 8:

The Department of Health Care Policy and Financing should develop and implement adequate controls over the provider database in MMIS by establishing formal policies, procedures, and time frames for the following:

a. Routine reenrollment of Medicaid providers.

b. Deactivation of providers who have not submitted claims to the Medicaid program for specified lengths of time.

c. Periodic data matches on provider credential information with other state agencies that regulate Medicaid providers.

The Department should monitor all of these projects to ensure completion.

### Department of Health Care Policy and Financing Response:

Agree.

a. As mentioned in prior audit responses, the Department is working on a five-year plan for reenrollment. The five-year plan is scheduled to be completed by July 1, 2005. A reenrollment committee has been established and reenrollment activities have already begun. This committee will be addressing the issue of policy, procedure, and time frames for provider reenrollment. A strategic plan will be developed by August 1, 2001.

b. The Department conducted deactivation activities this year and will continue such activities on a yearly basis. Again, the committee will address the ongoing policy and procedures of this activity.

c. Periodic data matches, while technically possible, are extremely complex and manually time consuming. Based on the current experience of matching data with the Department of Regulatory Agencies for eight types of practitioners, this has required a tremendous amount of manual verification. During Fiscal Year 2001-2002, the Department will be investigating with DORA to determine how to resolve the differences in required unique key information to allow a possible electronic interface. This will allow the Department to update licensure information for prescribing physicians. Until there is an electronic solution, the manual process will be used as appropriate.

### Recommendation No. 9:

The Department of Health Care Policy and Financing should establish routine communication on disciplinary actions taken by other state agencies that regulate Medicaid providers and ensure the provider database in MMIS is updated as appropriate.

### Department of Health Care Policy and Financing Response:

Agree. By August 31, 2001, the Department will develop routine communication mechanisms with other state agencies to identify providers who should be terminated from the Medicaid program. The Department will terminate those providers from active status in the MMIS.

# Certifications for Laboratory Providers

Medicaid regulations require that providers furnishing laboratory services must have a certification under the federal Clinical Laboratory Improvement Amendment (CLIA) program. The certification is intended to establish quality standards for all laboratory testing to ensure accurate, reliable, and timely patient test results across all facilities. The federal Health Care Financing Administration (HCFA) oversees the CLIA program; however, HCFA contracts with entities at the state level to administer the program. In Colorado the Department of Public Health and Environment (DPHE) conducts the CLIA certification process for laboratories on behalf of HCFA. Each certified provider is issued a CLIA number. Certifications also indicate the level of laboratory services the provider is permitted to perform. All providers of laboratory services, including physicians' offices that perform less complex laboratory work, are required to have some type of CLIA certification.

DPHE reports that there are about 2,500 CLIA-certified sites in the State. In Fiscal Year 2000 the State paid almost $8 million to providers for laboratory services under the Medicaid program.

During the audit the Department reported that CLIA certification numbers are routinely collected from appropriate providers and entered into MMIS. The MMIS system was developed with edits that were designed to ensure that claims for laboratory services are not paid unless the provider has the appropriate level of CLIA certification. However, the Department reports that these edits have not worked properly since the implementation of the new MMIS, and therefore, the CLIA requirements are not being enforced. In other words, laboratory claims may be paid regardless of whether the provider has the necessary CLIA certification. The Department reports that the delay in correcting this problem is due to turnover in program staff with knowledge about CLIA requirements.

Although our audit did not identify instances in which laboratory claims were paid without evidence of required CLIA certification, the Department should ensure that this safeguard is operating appropriately in MMIS in order to prevent improper payments.

## Recommendation No. 10:

The Department of Health Care Policy and Financing should implement edits in MMIS to review laboratory claims for compliance with CLIA requirements in accordance with state Medicaid policy.

### Department of Health Care Policy and Financing Response:

Agree. The Department has recently hired a new policy person, who will review and address the Clinical Laboratory Improvement Amendment (CLIA) issues. This activity has started this month including review of policy, edit dispositions, and systems issues. A plan to address these issues will be completed by June 2001.

# Electronic Claims Filing and Provider Payments

As mentioned earlier, providers may submit claims either on paper or electronically. Similarly, providers may receive Medicaid reimbursements either by payment through state warrants, which are similar to checks, or by electronic fund transfers. The audit identified opportunities to increase efficiencies in both areas.

## Paper and Electronic Claims

The fiscal agent processes roughly one million claims each month through MMIS. While the great majority of the claims are filed electronically, the fiscal agent reports that it processes over 600,000 paper claims annually for the Medicaid program. Paper claims must be used in certain types of instances, such as when attachments are required with the claim. However, the Department reports that in some cases providers file paper claims even though there is no applicable requirement dictating the use of paper.

Processing time and costs are significantly greater for paper than for electronic claims. In terms of processing time, our review of claims data for February 2001 shows that paper claims took on average from 40 percent to 400 percent longer than electronic claims for the same category of service (inpatient, outpatient, physician, etc.). In terms of days this means that paper claims, on average, were taking from roughly two days to up to three weeks longer, depending on the category of service. As noted above, in some cases the providers may be required to use paper filing, and these claims may require more time to process due to their complexity. However, there are inherent aspects of paper claims processing, such as the need to manually open, sort, image, and data enter the claims, that add processing time to even the simplest claims.

Looking at costs, the fiscal agent estimates that it costs about four times as much to process a paper claim as an electronic claim; however, specific costs related to processing are not separately tracked. Therefore, we were unable to calculate the cost savings related to increased utilization of electronic claims. Further, under the State's contract with the fiscal agent, the amount of the State's payment is based on claim volume rather than type of claim (paper or electronic). Therefore, processing savings would accrue to the fiscal agent and not directly to the State under the present contract terms. However, it is in the State's long-term interest to keep processing costs as low as possible, regardless of the reimbursement basis of the contract.

### State Policy on Paper Claims

State Medicaid regulations require providers to transmit claims to the fiscal agent in an approved electronic format unless the Department specifically authorizes submission of paper claims. In practice, this has meant that the Department allows providers to use paper if they submit on average fewer than 10 claims per month. However, this limit is not always enforced. The Department reports that in a recent four-month period, there were 47 providers submitting paper claims that averaged from 10 to as many as almost 140 claims per month.

HCPF staff indicate that providers do not incur significant start-up costs for filing electronic claims. Providers only need to have a computer with Windows software in order to use the fiscal agent's electronic claims software. The Department plans to encourage providers exceeding the 10 claims per month average to change to electronic filing. We recommend the Department implement the electronic claim filing requirement to enhance processing times and decrease administrative costs.

## Recommendation No. 11:

The Department of Health Care Policy and Financing should work with Medicaid providers and implement electronic claims filing for the Medicaid program as required under state regulations.

### Department of Health Care Policy and Financing Response:

Agree. Currently in a four-month period only 47 providers submitted paper claims exceeding more than ten per month. This number is out of approximately 16,660 participating providers who submit claims in a fiscal year. The Department will work with the fiscal agent to identify current providers who are filing more paper claims than policy allows. The Department will work with these providers to assist them in implementing electronic filing. To allow time for providers to become electronically capable, the work will be completed by April 2002.

# Payments by State Warrants and by Electronic Fund Transfers

The Department of Health Care Policy and Financing issues payments for Medicaid through the Colorado Financial Reporting System (COFRS), the state financial system. Each Friday financial information is uploaded from MMIS into COFRS, and payments are issued the following week.

The Medicaid program has no regulations that require provider payments be made using electronic fund transfers (EFTs). In fact, currently most payments are made by warrants. In 2000 about 121,200 payments were made by warrants and 107,700 were made by EFTs. In terms of dollars, however, warrants accounted for payments totaling about $323 million, while EFTs accounted for payments of over $1.5 billion. In contrast, the Department of Human Services (DHS) has in recent years started to require payments to providers be made by EFT unless there are extenuating circumstances. As a result, DHS issues the vast majority of provider payments for several of its large programs by EFT. The table below compares monthly payment information for the two Departments.

**Table 9: Comparison of Monthly Payments by Warrant and by EFT[1]**

| Type of Payment | Department of Health Care Policy and Financing[2] | | Department of Human Services[3] | |
|---|---|---|---|---|
| **Payments by warrant** | 10,098 | **53.0%** | 702 | **6.0%** |
| **Payments by EFT** | 8,972 | **47.0%** | 11,086 | **94.0%** |
| **Total** | 19,070 | **100.0%** | 11,788 | **100.0%** |

**Source:** Office of the State Auditor analysis of agency data.
[1]Electronic Fund Transfer.
[2]Based on payments to Medicaid providers from January through December 2000.
[3]Based on payments to providers in the Child Care, Child Welfare, and Low Income Energy Assistance Programs for February 2001.

There are some savings to the State if payments are issued to providers by EFTs rather than warrants. However, these savings would likely be minimal in the Medicaid program because the fiscal agent mails remittance statements to all providers, including those paid by EFT. If HCPF were to furnish remittance statements electronically and eliminate hard copy mailings, this would increase the opportunity for savings.

In any case the use of EFTs for payment has advantages over issuance of warrants. EFT payments cannot become lost in the mail or misplaced. Additionally, the State Treasurer's Office reports that the use of EFTs by agencies increases the predictability of the State's cash flow, thus enhancing investment activities. In the case of EFTs, the Treasurer's Office is informed of EFT clearance dates several days ahead of time; in the case of warrants, the clearance time is less certain.

The Department reports that it last approached the Medical Services Board (Board) about passing a rule requiring EFT payments under the Medicaid program in 1994, at which time the Board rejected the Department's proposal. In the last seven years, electronic commerce has become much more widely used. The Department should pursue EFT payments with the Board.

## Recommendation No. 12:

The Department of Health Care Policy and Financing should propose rules to the Medical Services Board to require electronic payments to providers under the Medicaid program.

### Department of Health Care Policy and Financing Response:

Agree. The Department will evaluate the possibility of requiring electronic funds transfers (EFT) for all providers by December 2001. Though there are many advantages to EFT, there are many providers who prefer warrants and forcing them otherwise may discourage providers from participating in Medicaid and limit services to our clients. In addition, the Department's experience with the State's Colorado Financial Reporting System (COFRS) indicates that a significant amount of manual investment to handle the volume of providers associated with a "pre-note" process (initial establishment of the transfer) or EFT rejection (changes in the financial institution) would be required.

# Provider Relations

As part of our audit, Buck Consultants performed audit work at the fiscal agent to review claims processing for the Medicaid program. This work identified several areas affecting provider relations. The summary below, prepared by Buck Consultants, describes the findings in this area.

## Buck Consultants: Summary of Findings

The audit found that the program parameters established by the State and used by the fiscal agent place all the responsibility for complete, thorough, and accurate claim submission on the providers in the Medicaid program. The slightest deviation from these requirements causes a claim to be denied. In addition, the State has required that the fiscal agent place the burden on the provider to determine the reason for the denial, make the necessary adjustments, and resubmit the claim. Although the instances described below were not counted as errors in our testing (described in Chapter 1), these matters are reported because of their potential impact on providers. Requiring providers to resubmit claims that are essentially complete and would be acceptable to any other payer could contribute to provider dissatisfaction and reluctance to participate in the Medicaid program.

- Several claims submitted with another carrier's "explanation of benefits" statement, which indicated other coverage, were returned to the provider because the provider did not check the appropriate box on the Medicaid claim indicating that there was other coverage. Clearly, these claims could have been paid.

- Certain types of claim forms must be filled out by the Medicaid recipient, who must write in the name of the provider despite the fact that the provider also furnishes this information on the form. However, if the Medicaid recipient neglects to enter the provider's name on the form, the fiscal agent denies the claim. The claim must be resubmitted with the provider's name written on the appropriate line in the appropriate column before the charges will be reimbursed.

- The program has a timely filing requirement. The audit identified a claim submitted with a letter from the provider stating he did not know the patient had Medicaid at the time services were rendered. After the provider was notified that the patient had Medicaid coverage, a claim was filed within acceptable filing requirements. The claim technician acknowledged that the patient was eligible for Medicaid and that the claim was submitted within the appropriate time frame. Despite this, the technician denied the claim for failure to file on a timely basis because the provider did not check the appropriate box on the claim form.

The fiscal agent's goal is to limit the number of manual interventions required to process a claim, resulting in a greater percentage of claims processing automatically. Limiting intervention in these types of instances is an attempt to reduce administrative costs. However, unnecessarily denying claims that have adequate information for processing results in avoidable claims resubmission and reprocessing, which increases administrative costs. It should be noted that the Department is billed on the basis of the volume of claims processed, which includes resubmitted claims.

Conversely, we identified another instance in which an error in submitting claims did require that the claims be returned to the provider. However, the fiscal agent has no defined procedures for notifying a provider relations representative if an issue is identified that is related to a specific provider. In this case more than 10 claims submitted by one provider used the incorrect format for reporting the number of units provided to the patient. The claims were denied, and the issue was not forwarded to provider relations to discuss with the provider or his staff. Clearly, contact with the provider was indicated and could facilitate future claim submissions.

## Recommendation No. 13:

The Department of Health Care Policy and Financing should work with the fiscal agent to minimize the cost of processing resubmitted claims by establishing and implementing guidelines for denying claims due to incomplete information and form submission.

### Department of Health Care Policy and Financing Response:

Agree. The Department does have guidelines and supports revising guidelines for denying claims due to incomplete information and form submission. The Department would not support the fiscal agent making decisions on attachments that may not have clear and consistent information. The Department must comply with federal and state requirements in this area. Review and possible revision of the guidelines will be complete by April 2002.

## Recommendation No. 14:

The Department of Health Care Policy and Financing should work with the fiscal agent to establish specific criteria for claims processing staff to use in identifying claims that should be referred to provider relations for follow-up with specific providers.

## Department of Health Care Policy and Financing Response:

Agree. The Department has already begun working with the fiscal agent on revising operating procedure in the claims processing unit. One of the primary goals has been to enhance communication between the various units (claims processing unit, provider relations unit, etc.) at the fiscal agent. The Department will continue this effort until guidelines and procedures are completed by December 2001.

# Distribution

**Copies of this report have been distributed to:**

Legislative Audit Committee (12)

Department of Health Care Policy and Financing (8)

Joint Budget Committee (2)

Department of Personnel
d.b.a. General Support Services
Executive Director (2)
State Controller (2)

---

Honorable Bill Owens, Governor

Office of State Planning and Budgeting (2)

Depository Center, Colorado State Library (4)

Joint Legislative Library (6)

State Archivist (permanent copy)

National Conference of State Legislatures

House Health, Environment, Welfare and Institutions Committee (11)

Senate Health, Environment, Children and Families Committee (7)

Legislative Legal Services

Auraria Library

Colorado State University Library

**Copies of the report summary have been distributed to:**

Members of the National Legislative Program Evaluation Society

Members of the Colorado General Assembly

National Association of State Auditors, Comptrollers, and Treasurers

**Report Control Number 1334**